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Independent Review: Future Fit Programme Options Appraisal Process

NHS Shropshire CCG / NHS Telford & Wrekin CCG

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24th July 2017

Glossary

A&E	Accident and Emergency
ACP	Advanced Clinical Practitioner
AHP	Allied Health Professionals
ANP	Advanced Nurse Practitioners
ARP	Ambulance Response Programme
BCBV	Better Care Better Value
CC Unit	Coronary Care Unit
CCG	Clinical Commissioning Group
CHC	Community Health Council
CSU	Commissioning Support Unit
DGH	District General Hospital
DH	Department of Health
DMBC	Decision Making Business Case
DTC	Diagnostic Treatment Centre
DToC	Delayed Transfer of Care
EC	Emergency Centre
FF	Future fit
FTEs	Full Time Equivalents
GP	General Practitioner
HEEWM	Health Education England West Midlands
HWB	Health & Wellbeing Board
IIA	Integrated Impact Assessment
IM&T	Information Management & Technology
IT	Information Technology
JSNA	Joint Strategic Needs Assessment
(J)HOSC	(Joint) Health Overview & Scrutiny Committee
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NOC	Net Present Cost
OBC	Outline Business Case
PCBC	Pre-Consultation Business Case
PDC	Public Dividend Capital
PEP	Programme Execution Plan
PHB	Powys Health Board
PRH	Princess Royal Hospital

Glossary

QIPP	Quality, Innovation, Productivity & Prevention
RSH	Royal Shrewsbury Hospital
SaTH	Shropshire and Telford Hospitals NHS Trust
SOC	Strategic Outline Case
SRO	Senior Responsible Officer
SSP	Sustainable Services Plan
STP	Sustainability Transformation Plan
TDA	Trust Development Authority
ToR	Terms of Reference
T&W	Telford & Wrekin
UCC	Urgent Care Centre
WAS	Welsh Ambulance Service
WMAS	West Midlands Ambulance Service

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Private and confidential
Simon Freeman and David Evans, Joint SROs for Future Fit Programme
NHS Shropshire CCG and NHS Telford & Wrekin CCG

24th July 2017

Dear Simon and David

Independent Review of Future Fit Options Appraisal Process

This report contains the findings of our independent review of the Future Fit options appraisal process, as described in our engagement letter dated 16th June 2017.

The scope of the procedures we have performed is set out within the report, as is the information on which we relied in performing our review. The purpose of the review was to provide information to the Future Fit programme board to assist with its decision making.

The agreed procedures do not amount to an audit performed in accordance with any standards applicable to auditing, a review performed in accordance with any standards applicable to reviews or assurance performed in accordance with any standards issued by the IAASB. This is in line with our engagement letter. Had we performed additional procedures beyond those described within this report, other matters may have come to light that would have been reported.

This report is restricted to those parties that have agreed to the procedures to be performed, namely NHS Shropshire CCG and NHS Telford & Wrekin CCG. It is addressed to the accountable officers for these CCGs, in their capacity as joint senior responsible officers for the Future Fit reconfiguration programme. To the fullest extent permitted by law, we will accept no responsibility or liability in respect of our report to any party other than you and your CCGs.

We understand that you wish a copy of our report to be made available to the sponsor and stakeholder members of the Future Fit programme board. Exceptionally on this occasion we are willing to agree to this, subject to the condition and on the basis set out in our engagement letter.

We would like to thank you and your programme team for your assistance during our fieldwork. We hope you find our report useful in informing your work in the future.

Yours sincerely

Rob Jones

Director

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Executive summary

Headline findings, areas for attention & methodology

Headline Findings

This review was commissioned by the Joint Senior Responsible Officers (SROs) for the Future Fit reconfiguration programme. Our brief was to provide an independent view on the options appraisal process culminating in late 2016 which was designed to select a preferred option on which to conduct formal public consultation.

In undertaking this review we have sought to compare written evidence to best practice guidance produced by both NHS England and NHS Wales. Our methodology is set out in detail on page 11.

Following our fieldwork, we have arrived at **headline findings** against each of the objectives set out in the scope of this engagement – these are set out below and overleaf. Detailed findings against each objective are set out in **Section One.**

Our findings have been informed by evidence of alignment to best practice guidance from the NHS in England and Wales. This is set out in detail in **Section Two**.

Commentary within **Sections One** and **Two** identifies various points where the programme could be more aligned with best practice. The majority of these are captured by three overarching **areas for attention,** set out on page 10. We recommend these are addressed by the programme before moving to public consultation.

Objective One: Shortlisting Methodology

— Strategic objectives for the programme were established by the Future Fit Programme Board prior to constructing a longlist of options. These were refined as the longlist was developed. Critical success factors were defined, linked to the strategic objectives and required benefits of the programme. These factors were developed into four suitable non-financial criteria which were used for subsequent assessment and scoring purposes.

— Shortlisting took place in several stages, moving from an initial list of 40 down to an eventual pre-options appraisal shortlist of four, including the 'do nothing' case, as per Treasury guidance. Public engagement continued throughout the process to raise visibility of the programme and provide views to inform stakeholders.

— Shortlisting was undertaken by a panel, drawn from stakeholder organisations, which was provided with detailed information, including clinical reference reports, on which to make a decision. The shortlist arrived at was confirmed by the Programme Board and carried forward to be prepared for an options appraisal exercise.

— The programme reconsidered this shortlist after conducting this initial options appraisal in 2015 and requested further revision and development of the options to satisfy concerns around a variety of issues, most notably cost and balance.

— We have identified some areas where the shortlisting process could have been improved, including a clearer definition of how deliverability and affordability would be measured, and governance arrangements that were more capable of dealing with predictable disagreements between stakeholders over the location of services.

continued overleaf

Headline Findings

Objective Two: Design of Options Appraisal Process

— The options appraisal process was designed to test options against the four non-financial criteria established at the outset of the programme, in addition to financial evaluation of the affordability of each option. The structure and sequencing of the process was in line with wider NHS practice, as were the financial comparators;

— Due to the services under consideration all being delivered by SaTH, extensive reliance was placed on iterations of the trust's business case for the programme. The work undertaken to produce this case was designed to inform both the non-financial and financial appraisals. We have reviewed the business case in detail within this report and identified various areas for improvement, acknowledging that such business cases are routinely iterated during the course of reconfiguration processes;

— Specific pieces of analysis and assurance work were commissioned to inform the appraisals, with additional exercises and reports commissioned to supplement the results of the scoring exercise and provide the Programme Board with additional material on which to select a preferred option;

— The design of the process was articulated to and approved by the Programme Board in advance of both appraisal events in 2015 and 2016. Composition of the panel was also approved by the Programme Board, drawing on all main stakeholders with a particular emphasis on clinicians and patient representatives, in line with good practice.

— Telford and Wrekin Council have raised concerns around some of the details of this process, arguing that the composition of the panel should have been approved by both CCG Boards in addition to the Programme Board, and that the financial evaluation process was not clearly articulated and used flawed measures. Governance documents are unclear around the need for two-stage approvals and while the financial evaluation could have been more clearly illustrated, no concerns were raised when it was proposed. Neither aspect is out of line with wider NHS practice for such reconfigurations.

Objective Three: Enactment of Options Appraisal Process

— Two options appraisal exercises were conducted, in September 2015 and September 2016. Our work has focused on the 2016 exercise as this has directly informed the subsequent progression of the programme. We did not focus our work on comparing the two events, although we did review material relating to both.

— We found that the September 2016 non-financial appraisal panel had been conducted as designed, including: panel composition, material made available, weightings of criteria and scoring approach. The overall options appraisal process was set out at a joint CCG board development session in early September ahead of the panel day.

— The results of the 2016 panel were captured in a report to the Programme Board in November 2016. This was produced by the CSU and set alongside the financial evaluation, and various additional pieces of information including an impact analysis and various independent clinical perspectives. This collation of evidence to inform the selection of a preferred option was as designed, although assurances around the viability of associated community services and the availability of capital funding were both lacking in detail. Sensitivity analysis was provided to contextualise both the panel scoring and financial information.

— Further sensitivities were explored at a joint CCG committee in December 2016 using analysis produced by both Telford and Wrekin Council and (in response) the CSU. These focused on exploring different methods for weighting the financial and non-financial scoring. Neither meeting was able to reach complete consensus.

— Various concerns have been raised with the options appraisal process by stakeholders from Telford and Wrekin. Evidence suggests that although the panel day was the trigger for the majority of these concerns, the substantive issues raised relate predominantly to the design of the process. Providing further detail to stakeholders around the approach to be taken may have avoided some of these challenges being raised following the completion of the appraisal.

NHS England Key Tests: alignment to best practice

In order to satisfy the requirements of NHS England guidance on service change, reconfiguration proposals must meet four 'key tests', as set out in guidance most recently updated in 2015. Proposals must also demonstrate affordability. During 2017 the NHS announced an additional test, relating to 'alternative provision' within service changes that involve bed reductions (https://www.england.nhs.uk/2017/03/new-patient-care-test/). No formal guidance has get been released around this new, 'fifth' test and it did not apply during the period of the programme under review. Our work on this test is therefore additional to the agreed scope and does not draw on formal guidance.

All of these tests must be met over the entire span on the programme, with assurances built up over time. For example, public engagement is presumed to be required throughout, but with particularly specific guidance in place for the formal consultation period. For the purposes of this review we have conducted procedures to link evidence to the key tests in proportion to what regulators may expect at this stage in the programme, i.e. pre-consultation. Detailed mapping can be found at Section Two.

Strong public & patient engagement	A clear clinical evidence base	Consistency with current & prospective need for patient choice	Support for proposals from clinical commissioners	Proof of sufficient hospital beds and alternative provision
Various public engagement events have been held throughout the process to date, including around both the longlisting and shortlisting stages. Patient representatives were involved in the appraisal panel and views have been sought from hard to reach groups. In addition, stratified telephone surveys were undertaken to inform the two options appraisal exercises in September 2015 and September 2016. The Gateway review in December 2016 acknowledged the engagement to date but queried its impact. It should be noted that the reconfiguration process is not yet at the formal public consultation stage. Any engagement undertaken to date has been to inform pre-consultation option selection and development.	Significant effort has been put into developing a clear clinical evidence base for the proposed reconfiguration. Two clinical senate reports have been received, plus two detailed reports around the option of separating critical care from obstetrics (C2), one from SaTH and one from the NHS Transformation Team. All of these reports were used to further inform the options appraisal. The SaTH business case also includes extensive clinical discussion of the arguments for co-location of obstetrics and critical care. Provision of rural urgent care centres has also been articulated, although it is noted that some concerns have been expressed as to the maturity of the community services offer that will complement the reconfigured acute services covered by Future Fit.	As the primary impetus for reconfiguration has been workforce issues, there is an acknowledged trade-off within the documentation between choice by site and deliverability. Within the constraints imposed by workforce, documents refer to offering a range of forms of access to urgent care, and to women's and children's services. Demographic projections are built into plans. Further work is required to provide assurance that a complementary community/neighbourhood model is aligned to the Future Fit programme, to help enable achievement of its objectives. This is an identified risk for the programme and work has been commissioned by both CCGs to address this risk. Further detail around maternity services is expected following parallel reviews by both CCGs to respond to the national Better Births strategy.	Future Fit is a reconfiguration programme that has been led by the two local CCGs throughout. The Programme Board is constituted from members of each CCG, plus the Powys Health Board (acting as commissioner for the majority of Welsh patients). The programme has proceeded with the support of both CCGs for the majority of its term. However, in October 2016 various concerns were expressed by the Clinical Chair for Telford & Wrekin CCG on behalf of attendees at the 2016 options appraisal exercise. Since receipt of that letter, the Programme Board has paused progression of a preferred option. However, it has continued to meet and to commission additional work to provide assurance over the integrity of the process and further inform stakeholders around the impact of the proposed options.	The business cases considered as part of the Options Appraisal process articulate changes in hospital bed bases for different patient cohorts. Various assumptions underpin the figures within these documents, which we have discussed within the relevant 'best practice' areas in the Evidence section of this report. Alternative provision, particularly reconfigured community care, is acknowledged to be required to deliver some of the projected bed capacity and throughput figures included in the proposed model. The business plans include content on work underway as part of the local STP to deliver on this key dependency. Further work is currently underway to develop the detail behind these plans.

Affordability
In addition to satisfying the tests above, service changes are also required by regulators and the Treasury to demonstrate the affordability of the proposed changes to the public purse. We have conducted procedures to identify evidence of this with reference to the Finance and QIPP section of the best practice checklist within the NHS England guidance (pages 22-29).

Areas for Attention

Based on our review, we have identified the following issues where increased assurance will be critical to the success of the wider Future Fit Programme. Each of these can be related to findings from the Independent Reconfiguration Panel, an advisory non-departmental public body sponsored by the Department of Health*. It is essential that progress is made against each of these issues before the programme moves forward to public consultation and a decision-making business case.

Clarity around funding availability and affordability

Insufficient parameters for affordability were set at the inception of the programme. We would have expected to see a projected financial envelope for the options and an assessment of the level of capital development that the local health economy could both fund and resource in recurrent terms. While it is clear that options were excluded at the shortlisting stage on grounds of general affordability, no firm parameters were set on which to base this decision. Nor, despite making reference to capital funding, was availability of funding explicitly addressed within the Deliverability criteria during options appraisal.

It is currently not clear whether the health economy is in a position to source the required capital funding for any of the shortlisted options. While it is unusual for the Department of Health to provide firm commitments to such substantial funding at this stage in a business case, we would expect some form of initial assurance to have been provided. We were also told by multiple stakeholders that the local Trust was actively exploring alternative funding routes on the assumption that the total cost may not be covered by public dividend capital (PDC) funding. Such strategies are also referred to in the business case. However no shortfall has yet been quantified within documents considered by Programme Board.

We recommend the programme seeks the rapid provision of assurances around the proposed funding solution for the programme, including the mix of sources if PDC is considered unlikely to be sufficient. We would also suggest sensitivity analysis is conducted to demonstrate what level of capital development and reconfiguration could be achieved with lower levels of funding, should the current total costs prove unaffordable.

Clarity around community models to address urgent and planned care needs

Since inception Future Fit has been described as an acute and specialist services reconfiguration programme, reflecting the fact that the stated primary driver for change was recruitment of acute staff, particularly in emergency care, and the impact that was having on maintaining safety. However, early in the programme significant consideration was also given to models of community care that would complement the services being reconfigured in acute settings. Reports on the shortlisting process identified the substantial co-dependency between acute and community reconfiguration, to influence volumes and flows to improve sustainability.

An additional analytical exercise, Community Fit, was commissioned to understand the current position around community care, focusing on demand, volumes and flows across the local health economy. Work around a 'neighbourhoods' offer has since been subsumed within the local STP which contained specific content on this area of care.

However, it is currently not yet clear how the local health economy will execute its community reconfiguration, nor how this will be funded, particularly in the context of uncertain funding for Future Fit itself and an overall substantial deficit for the health economy. Failure to deliver an effective and sustainable community service for both urgent and non-urgent care will impact on the viability of the acute reconfiguration covered by Future Fit. The programme may also fail to meet the 'fifth test' introduced by NHSE in 2017.

We recommend that proposals for reconfiguration of community care, and specifically those elements directly impacting on local acute care flows, be rapidly described and costed.

Clarity around governance and conflict resolution

In reviewing the options appraisal process and how the outcomes of that exercise were dealt with by the Programme Board and CCG boards, we have compared the situation with learnings from similar exercises around the country which have run into difficulties. It is clear that a barrier to further progress is a fundamental disagreement between stakeholders within the two main localities, and an inability for the local governance mechanisms to deliver a shared preferred option.

We understand the local CCGs have been asked by NHSE to re-establish their joint committee with three independent voting members, including an independent chair. This joint committee, working closely with Programme Board, will be tasked with identifying a process for reaching resolution on a preferred option to allow reconfiguration to progress.

* https://www.gov.uk/government/publications/learning-from-reviews-third-edition

Review Methodology

The diagram below explains how we conducted our review, mapping evidence to best practice guidance and reconciling our findings to the objectives of the review

Gather Evidence

The Future Fit Programme Team provided our review team with documents related to the programme, including all documents presented as part of the shortlisting and options appraisal meetings, minutes of meetings and copies of both the SOC and OBC produced by SaTH.

Correspondence between the Programme Team and stakeholders, including local authorities, was also reviewed.

For clarity, our assessment of the Options Appraisal process focused on the exercise conducted in September 2016, as this is the latest such exercise for the Programme.

A timeline for the Future Fit Programme is set out at Appendix One.

Interview Stakeholders

Interviews were undertaken with the Programme Team plus representatives from the CCGs, local authorities, Powys Health Board and staff from the Midlands & Lancashire CSU Strategy Unit.

The primary purpose of the interviews was to identify if any further written evidence existed that needed to be reviewed to inform our findings.

A full list of interviewees is provided at Appendix Two.

Assess against Guidance

In order to assess the design and enactment of the shortlisting and options appraisal process against good practice, the review team compared the evidence to guidance prepared by NHS England, plus various other regulatory and advisory bodies.

The primary source of guidance used is entitled Planning, Assuring and Delivering Service Change for Patients (NHSE, 2015)

Detailed findings against this guidance plus relevant NHS Wales guidance are set out from page 22 onwards.

A full list of guidance documents referred to is provided at Appendix Three.

Reconcile to Key Tests

Central to the conduct of a robust options appraisal process is satisfaction of NHS England's four Key Tests:

a) Strong public and patient engagement;

b) A clear clinical evidence base;

c) Consistency with current and prospective need for patient choice; and

d) Support from clinical commissioners

By conducting procedures to identify evidence to match best practice guidance, our review team assessed how the programme could demonstrate progress against these four tests as part of the review.

We also sought evidence to compare the programme against the additional 'key test' announced by NHSE in March 2017, concerning alternative provision and bed reductions.

The additional requirement to demonstrate Affordability, was assessed under our review of evidence in relation to NHS England best practice guidance around 'Finance/QIPP'.

Reconcile to Brief

To fulfil the brief provided by the SROs, the review team reconciled its findings back to the three objectives required by the scope:

1) Shortlisting process methodology;

2) Design of evaluation for shortlisted options;

3) Enactment of the evaluation for shortlisted options.

A detailed assessment against each of these phases is provided in the following section, linking the evidence for each phase back to best practice guidance and the 'Key Tests'.

In agreement with the Joint SROs for Future Fit, we have agreed the following alterations to our initial scope:

a) We have not considered the Gunning Principles, as initially scoped, on the grounds that these principles apply predominantly to the formal public consultation phase of reconfiguration programmes, and this phase has not yet been reached.

b) We have agreed to additionally compare evidence from the programme to the additional 'fifth test' set out by the Chief Executive of NHS England in March 2017, although this is set to be formalised in guidance and did not form part of NHS guidelines at the time of the options appraisal exercise.

Section One

Commentary on review objectives

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Shortlisting Process Methodology

Objective One

Review of Shortlisting Process Methodology

The shortlisting process was designed and agreed by the Future Fit Programme Board aligned with standard NHS practice and the strategic objectives of the programme.

Shortlisting was conducted in phases by a balanced group of stakeholders, eventually arriving at a shortlist of four options.

These options were subsequently exposed to further analysis and scrutiny to address concerns around affordability.

The shortlisting process incorporated assurances around NHSE's four key tests by drawing on a clinical evidence base, considering patient choice, incorporating various forms of public engagement and demonstrating support from clinical commissioners.

High level affordability was addressed through financial analysis, although the parameters of this were not always clear.

The shortlisting process undertaken incorporated all four key tests, as per NHS England guidance: commissioner support, clinical evidence, public engagement and patient choice. Issues of affordability and alternative provision were also addressed, although only at a high level at this stage. Plans to address these issues, in addition to implementation of a governance model capable of delivering reconfiguration while incorporating divergent views, should have been articulated more clearly at this stage.

Overview of Process

The Future Fit Programme was established in 2013 under the joint leadership of the two CCGs covering Telford and Wrekin and the county of Shropshire. The process of arriving at a shortlist of options was conducted primarily in 2014 and early 2015 with the support of the local CSU. An initial longlist of 40 options was grouped into 13 'scenarios' before being reduced to eight options, four of which involved the construction of a new site and the rest involving reconfiguration of existing estate at the two current SaTH sites.

The new site options were subsequently excluded from consideration in mid-2015, principally on the grounds of cost, and an initial shortlisting exercise was conducted on the remaining four options (including 'do nothing') in September 2015. Following a decision to postpone selection of a preferred option, further work was undertaken to develop the options, before a second panel in September 2016.

Critical Success Factors and Selection Criteria

The impetus behind the reconfiguration was discussed in detail in long-form as part of early documents, identifying workforce pressures (including recruitment difficulties, high vacancy rates, adverse training and career development environments and safety concerns) as the primary motivating factor with an emphasis on a sustainable clinical care model. However, critical success factors (CSFs), capturing the primary aims of the reconfiguration could have been made more explicit and SMART*.

Selection criteria were agreed and applied to drive the grouping and shortlisting process undertaken subsequently. The criteria applied were in line with practice elsewhere in the NHS for similar reconfigurations and appear to have been applied consistently to reduce the size of the longlist. Finally, the exclusion of the 'new site' options on the grounds of affordability was decided following receipt of a detailed feasibility study and discussion at Programme Board. While these options were clearly excluded on grounds of cost, no overall affordability envelope was set more generally for the programme at this time, which may have helped with subsequent financial analysis.

Subsequent Refinement of Shortlisted Options

It is noted that the shortlist of four options was in existence from summer 2015 onwards and that the three reconfiguration options (excluding the 'do nothing' base case) were subject to refinement from this point through to the most recent options appraisal exercise in September 2016. Responding to views from some stakeholders and sections of the public, the Programme Board made a decision to retain one option that did not co-locate emergency care and obstetrics, to allow further detailed clinician testing of the viability of this option.

Composition of Evaluation Panel

A group of 17 representatives from sponsor and stakeholder organisations conducted the final shortlisting evaluation, comprising all principal commissioners and providers impacted by the reconfiguration, plus representatives from local authorities, patient groups and Healthwatch organisations. The process was facilitated by the CSU and programme staff and informed by early public engagement, a Clinical Design Report on 'networks of care', feasibility studies and accessibility data. A baseline impact assessment was also received.

* SMART = specific, measurable, achievable, realistic and time-bound

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Design of Evaluation for Shortlisted Options

Objective Two

Review of Design of Evaluation for Shortlisted Options

The design of the evaluation of shortlisted options was agreed by the Programme Board in advance and reflected both the evaluation criteria used for shortlisting and NHSE guidance around producing a balanced assessment.

The scoring approach was in line with standard practice and weightings were informed by a variety of sources, including public engagement.

Financial comparator measures were agreed and reflected those recommended by guidance and used elsewhere for NHS business case appraisal.

The same applied to measures to bring together the financial and non-financial scores.

The design of the process for evaluating the shortlisted options incorporated all four key tests set by NHS England. The design was approved unanimously by clinical commissioners, emphasised the need for clinical evidence to support proposals and incorporated patient engagement into weightings and option design. A second options appraisal process was run in 2016 specifically to ensure that patient choice (reflected in public feedback) and affordability had been more thoroughly considered.

Approach to Design

The design for the options appraisal process was presented and unanimously endorsed at the Programme Board in April 2015, ahead of the first exercise in September of that year. A supplementary paper on design was presented in May 2016 ahead of the September 2016 exercise. A joint CCG board development session in early September 2016 also set out how the outputs of the options appraisal exercise were to be combined with other sources of information (impact analysis, clinical senate report, etc) prior to selection of a preferred option.

Panel Composition

The panel for the September 2016 scoring exercise was comprised of stakeholders from all the principal providers and commissioners in the immediate health economy. A decision was made to increase the size of the panel from that used for shortlisting and specifically to increase the number of patients and SaTH clinicians involved. This decision was based on a desire to ensure the viability of the clinician case and to hear the views of patients and users of services. Composition was approved at Programme Board in 2015 and again in 2016.

Non-Financial Criteria

Four criteria were selected for assessment: quality, accessibility, workforce and deliverability. Such criteria are in line with those used in similar assessments elsewhere in the NHS, and reflect the priorities of the programme and its stakeholders. Definitions were provided for each criteria. Weightings for the scores for each criteria were agreed in advance, informed by a variety of sources, including a phone survey. Greater clarity could have been provided around the specifics of the 'deliverability' criteria, particularly with regard to funding.

Scoring Approach

Each criteria was designed to be scored against an eight point (0-7) scale. Panel participants were to be given an opportunity to revisit their initial scoring, prior to collation. Use of such scales is in line with similar exercises, although we note that limited definition for the points on the scale was provided ahead of voting. We would usually expect to see a more detailed rubric provided.

Financial Evaluation

The Programme Board agreed its approach to financial options appraisal in 2015, with the design of the assessment reiterated in 2016. The approach included use of net present cost (NPC) and equivalent annual cost (EAC) as comparative measures, in addition to the basic revenue and capital costs of each option. Use of such comparators is in line with Treasury guidance. Reliance was placed on SaTH to produce the business case for the options. This was reasonable given SaTH provides all the acute services under review. However, the decision created a risk that the case would fail to provide clarity on the impact the proposals would have on wider health economy finances, and to fully articulate the model and costs of provision required in the community on which assumptions in the Trust business case relied.

Merging of Scores

Programme Board agreed an approach for bringing together the scoring / ranking of the financial and non-financial elements of appraisal. This included a proposal to use cost per benefit point (an approach used widely in NHS business cases) and a commitment to test the relative strength of proposals through sensitivity analysis. Subsequent challenge of this approach by Telford and Wrekin Council suggests that the approach to weighting and calculating merged scores may have benefitted from more explicit articulation prior to agreement.

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Enactment of Evaluation for Shortlisted Options

Objective Three

Review of Enactment of Evaluation for Shortlisted Options

We found the evaluation of shortlisted options to have been enacted as designed and approved by the Programme Board.

Information was distributed as planned and the appraisal panel met in line with planned composition.

The appraisal event was opened with a briefing to members and structured as designed and in line with guidance, with the opportunity for panel members to sift documentation, hear presentations and vote.

Financial evaluation was provided to the Programme Board in parallel to a report on the non-financial options appraisal event.

Sensitivity analysis was conducted and, following challenge, subsequently augmented for presentation to a Joint CCG Board in December 2016

The conduct of the non-financial appraisal panel was largely in line with the process designed and agreed by Programme Board. The same applies to the financial analysis, which was presented to Programme Board in parallel to the panel evaluation report.

Content & Distribution of Datapacks

Datapacks were distributed electronically to the panel eight days ahead of the event in September 2016 and we understand hard copies were posted the same day. The proposed content had been discussed at a joint CCG board development event two weeks ahead of the panel. Pertinent material was provided around all four of the non-financial criteria, although there appears to have been some lack of clarity around the evidence required for the 'deliverability' criteria beyond estates plans.

Stakeholders from both the council and CCG in Telford and Wrekin have complained about perceived bias in the packs, however any differences in the written presentation of options appears minor.

Training & Briefing for Panel Members

A briefing session had been provided for panel members ahead of the September 2015 event, in May of that year. No such event was repeated in 2016, despite almost 50% churn in participants. We would normally expect this to occur. We understand some stakeholders held briefing sessions with their attendees ahead of the panel, to explain the materials and approach for the day.

A briefing was provided by the Programme Director at the start of the 2016 Options Appraisal day, accompanied by slides. This covered the purpose and structure of the day, an explanation of the scoring scale and process, and the establishment of various ground-rules in terms of the responsibilities of panel members to remain impartial and focused on the programme's objectives. We understand the size of panel and room layout may have made acoustics difficult.

Structure & Conduct of Panel Event

Attendees were arranged in tables which mixed stakeholder groupings. This is a reasonable approach given the common goal. While some discussion time was allocated, voting was carried out on an individual basis.

Prior to initial vote casting, the panel received a series of presentations expanding on the data provided to support the various criteria. These presentations were led by a mixture of programme staff and SaTH clinicians. This was suitable given the nature of the subject matter and the significant involvement of SaTH in both developing proposals and delivering the services under consideration. We are unable to comment on any verbal bias that may or may not have been apparent in these presentations.

Initial voting was then conducted using the agreed scale and the panel paused for a lunchbreak. In the afternoon sessions panellists were given the opportunity to hear responses to clarification questions from subject matter experts at the event. This exercise was time limited, which is reasonable. It is not clear from documentation how questions were selected. We are unable to comment on the manner in which questions were selected, although subsequent correspondence suggests some attendees remained unclear around some areas.

Finally the panel were asked to revisit their scores where considered necessary. Once this exercise was concluded, the panel session concluded and scores were collected and collated by CSU staff to allow the production of a summary report to Programme Board.

Objective Three

Review of Enactment of Evaluation for Shortlisted Options, continued

We found the evaluation of shortlisted options to have been enacted as designed and approved by the Programme Board.

Information was distributed as planned and the appraisal panel met in line with planned composition.

The appraisal event was opened with a briefing to members and structured as designed and in line with guidance, with the opportunity for panel members to sift documentation, hear presentations and vote.

Financial evaluation was provided to the Programme Board in parallel to a report on the non-financial options appraisal event.

Sensitivity analysis was conducted and, following challenge, subsequently augmented for presentation to a Joint CCG Board in December 2016

Financial Evaluation

As agreed, no financial evaluation was presented to the non-financial options appraisal panel. Instead information and analysis based on the SaTH OBC was provided at the subsequent Programme Board session. Analysis was in line with the approach previously unanimously agreed by the Programme Board (see Objective Two commentary plus evidence around Finance in Section Two). The evaluation compared NPC and EAC figures for each option and ranked the options on this basis. The figures were derived from the SaTH SSP outline business case as it stood at the time of finalising the report in November 2016.

No assurance was provided that funding for the proposals was probable, either under the financial evaluation or the 'deliverability' criteria of the non-financial evaluation. A description of the deliverability criteria presented to Programme Board in 2015 suggested that such assurances would be considered as part of the appraisal.

Subsequent Reporting

A comprehensive report on the panel day was produced by the CSU in October/November 2016, including the outcome of the scoring exercise. This was combined into a pack for the November 2016 Programme Board alongside the panel pack, financial evaluation, IIA and various clinical perspectives. The aim was to inform decision-making around a preferred option. The information provided was in line with the sources outlined at the joint CCG board development day in September 2016.

Combination of Scores

Content provided articulating how the financial and non-financial scoring could be combined. In addition to presenting the scores and rankings for comparative purposes, the report also provided detailed analysis of how the two elements could be combined. An initial 50:50 weighting was applied to produce a combined ranking.

This merging of the scores also included a calculation of cost per benefit point which is in line with similar practice elsewhere in the NHS. We have analysed eight different outline business cases for significant service change which utilise the same approach. A variety of methods for combining and comparing the scores was presented transparently for the panel, each yielding a different relative position for the four options. Different weightings were also applied to sensitise the relative impact of financial and non-financial scores.

Further Sensitivity Analysis

Alongside detailed raw scores and rankings for each criteria, sensitivity analysis was conducted to illustrate how scoring compared across various stakeholder groups within the panel, e.g. clinicians, patients and representatives from specific localities. This analysis provided assurance that the overall ranking of options was largely mirrored within specific interest groups.

Additional sensitivity analysis from Telford and Wrekin Council was presented to the joint CCG committee in December 2017 as part of a summary of challenges to the process. This analysis was reviewed and responded to by the CSU in a paper provided to the programme team. These documents set out a variety of alternative approaches to interpreting the 50:50 weighting between financial and non-financial scores. From comparison of the papers presented and approved by the Programme Board, it is clear that the method of calculation was not precisely defined enough to avoid misinterpretation. However, the original calculation uses a valid method and the sensitised approaches put forward by the CSU provide additional assurance and consistently yield the same result: a preferred option of C1.

KPMG

Section Two

Evidence of best practice

KPMG

Evidence: assessment against NHSE Key Tests

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
QIPP / Finance		Financial appraisal, including assessment of affordability, did not form part of the options appraisal panel held in September 2016. However, the subsequent Programme Board received financial analysis based on figures contained within the SaTH outline business case (OBC) covering Future Fit. The director of finance at SaTH is the finance lead for the programme. Our review of the evidence concerning finance and affordability against best practice guidance in this section has focused on the financial analysis presented to the Programme Board by the CSU and the SaTH SOC and OBC documents which underpinned this.
	How does the proposal support commissioner financial sustainability and what is the impact on providers?	All three potential options developed in the outline business case (OBC) demonstrate that the Trust will achieve a recurrent revenue surplus by 2020/21. This is based on a series of assumptions around workforce savings, activity shifts (including shifts to the community, between sites and from repatriation), capacity requirements (primarily the inpatient bed base) and required financing that were developed by the Trust in consultation with stakeholders. Financing assumptions include the full receipt of capital funding through public dividend capital (PDC). No sensitivities were applied to model the impact of a reduced amount of PDC funding. All assumptions were considered relevant at the time the OBC was developed. Commissioner financial sustainability and the impact of the SSP on the wider health economy (via the STP) were more explicitly addressed at the SOC than the OBC stage. Delivery of the Sustainable Services Programme (SSP) is paramount to achieving a financially sustainable solution for the local health economy (LHE) given the Trust is the main provider of acute hospital services. It is not possible to fully reconcile between the LHE positions reported in the SOC and OBC due to differences in presentation. The reported savings initiatives in the OBC do not result in the disclosed £8.7m surplus position for the LHE. The analysis should be reviewed for accuracy and to ensure there is a clear link to the original LHE financial position reported in the SOC. The interdependency between the SSP and community-based provision and the recurrent financial impact on the main community provider is unclear. Within the SOC a £6m Community Fit fund was referenced, although the rationale for this figure is unclear and content around community provision in the OBC is less clear, partly as the STP had subsequently taken on work around this area of care, which SaTH does not provide. The OBC presents a sustainable financial position for the Trust, which in turn supports a sustainable position for the health economy. The two are interlinked and cannot be considered in isolation. The reported recurrent financial impact on the Trust as per the OBC is reported below as a recurrent annual outturn position. Options A (do nothing), B (Telford as emergency site) and C1 (Shrewsbury as emergency site) are presented for analysis while Option C2 is not presented since it was deemed to be clinically unsustainable and not deliverable:

	Option A £000s	Option B £000s	Option C1 £000s
Recurrent 2016/17 Baseline Position	-16,553	-16,553	-16,553
Recurrent 2020/21 Position	-10,114	6,231	2,594
Recurrent	6,439	22,784	19,147
Recurrent saving relative to option A		**16,345**	**12,708**

NHS England Best Practice Checks

<table>
<tr><th>Criteria</th><th>Guidance Prompts</th><th>Evidence</th></tr>
<tr><td></td><td></td><td>The recurrent saving of option B relative to A (the “do nothing” option) is £16.3m and for option C1 £12.7m. The £3.6m difference between the two options can be accounted for as follows based on variable projected workforce savings and financing costs:
<table>
<tr><th></th><th>Option B
£000s</th><th>Option C1
£000s</th><th>Difference
£000s</th></tr>
<tr><td>Workforce savings</td><td>14,589</td><td>14,203</td><td>386</td></tr>
<tr><td>Finance costs</td><td>-5,433</td><td>-8,684</td><td>3,251</td></tr>
<tr><td>Total</td><td>9,156</td><td>5,519</td><td>3,637</td></tr>
</table></td></tr>
<tr><td>QIPP / Finance</td><td>Does the proposed change improve quality and reduce cost?

How (e.g. reduced duplication, increased efficiency)?</td><td>The proposed change is aimed at driving quality improvements and reducing cost. The new clinical model is described as delivering a “balanced-site” approach with one emergency site and one planned care site, albeit with both sites retaining some aspects of urgent care. Activity is designed to be “clinically optimised” across the two. This is supported by recent service reconfiguration examples within the Trust, which have led to improved clinical outcomes.

The proposed change addresses the Trust’s service and workforce challenges by delivering better clinical outcomes, as well as improved recruitment and retention of specialist clinicians. The reduction in staff costs is driven by reductions of between 225 – 371 WTE (options A to C1). In addition there is a plan to achieve a reduction in pay costs of £4.1m through role re-design, which applies to all options. The key drivers for the reduction in pay costs can be linked to the components of value for money as follows:
• Economy: Reduction in the cost per WTE of the future establishment e.g. ensuring that staff spend a greater proportion of their time conducting tasks appropriate to their grade through role re-design and the introduction of more junior roles.
• Efficiency: Productivity driven reductions in workforce, leading to fewer WTE to deliver a given quantity of activity e.g. use of technology and improved processes
• Effectiveness: Activity and pathway driven changes in workforce e.g. acute intake on one site, strengthened elective provision, improved rota management and removal of duplication, reducing reliance on high cost temporary staffing

Improved efficiency is also represented through activity assumptions that have been applied in calculating the bed base of the new model. These have been subject to sensitivity analysis on the “shift left” assumptions at the request of commissioners including:
• Significant developments in integrated primary and community care services;
• The estimated impact of 7-day working; and
• A 50% reduction in delayed transfers of care (DTOCs).

The above equates to a reduction in bed capacity of 97 beds, the largest contributory factor to which is the reduction in DTOC. The role of local authority partners in agreeing the DTOC assumptions should be made more explicit, while the capacity and financial impact on community services should be quantified so that the financial impact is considered from a LHE perspective. This is currently only considered at a very high level within the published STP.</td></tr>
</table>

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
QIPP / Finance	What are the savings in financial terms?	The key differences between options B and C1 relative to the 'do nothing' option A are as per the below table, which sets out additional income, savings and costs at 2020/21, and reconciles to the summary positions on page 22-23 (circled in red):

	Option A £000s	Option B £000s	Option C1 £000s
Recurrent 2016/17 Baseline Position	-16,553	-16,553	-16,553
Less SSP Incremental Finance Costs		2,000	2,000
Recurrent 2016/17 Baseline Position	-16,553	-14,553	-14,553
Revenue Impact			
Demographic Growth	28,584	28,584	28,584
Increased Cost of Demography	-28,584	-11,501	-11,501
QIPP		-17,295	-17,295
QIPP Savings		6,800	6,800
Inflation	-38,790	-38,790	-38,790
Tariff Uplift	8,221	8,221	8,221
CIP	30,978	30,978	30,978
Repatriation Income Gain	10,000	10,000	10,000
Repatriation Increased Cost	-4,000	-4,000	-4,000
Other Recurring	4,630	4,630	4,630
SSP Workforce	-4,600	14,589	14,203
SSP Additional Non Pay		0	0
SSP Incremental Finance Costs		-6,000	-6,000
SSP Finance Costs		-5,433	-8,684
Recurrent 2020/21 Position	**-10,114**	**6,231**	**2,594**
Itemised by:			
Demographic Growth		17,083	17,083
QIPP impact		-10,495	-10,495
Finance costs		-9,433	-12,684
Workforce savings		19,189	18,803
Recurrent saving relative to option A		**16,344**	**12,707**

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
QIPP / Finance	What are the savings in financial terms? (continued)	The OBC highlights four principal areas where options B and C1 differ from the "do nothing" option: 1. Through management of the effects of demographic change, driven by the new model of care: £17.1m benefit. 2. QIPP initiatives and savings: (£11.3m) cost. 3. Additional finance costs (£9.4m) and (£12.7m) respectively. 4. Workforce savings: £19.2m and £18.8m respectively. Area (2) assumes opportunities are presented that enable the Trust to remove costs in line with the planning assumptions developed as part of the OBC. All options (A, B and C1) assume the same benefit in respect of the following by 2020/21: a) Cost Improvement Plan (CIP) on a recurrent basis: £31.0m. b) Net repatriation gain: £6.0m. c) Other recurring (development) income and cost savings: £4.6m. The only variables between options B and C1 are staff costs and finance costs and with the latter relating to the difference in capital expenditure. C1 has a higher workforce requirement of 11 FTE (comprising 8 FTE clinical and midwifery and 3 WTE clinical support staff). The rationale for this difference should be made more explicit. The financial impact of this difference is £0.4 million, which is reasonable based on 11 FTE i.e. £36k per WTE. A reduction in the average cost per WTE is also assumed. This links in with a wider point around restructuring and could assume, for example, that certain job roles are downgraded. This could incur non-recurrent transitional costs relating to pay protection and training. The difference in finance costs is encapsulated under the capital expenditure section.
	What changes to capacity are proposed?	The main change to capacity is a reduction in the inpatient bed base. This is based on a series of activity-related efficiencies, including "shift left" assumptions, optimal occupancy and reduced length of stay. Although all capacity modelling has been carried out in consultation with clinical teams it would be benefit from additional benchmarking against national standards, where practicable. One positive exception is that the inpatient bed base reduction has been compared with Better Care Better Value indicators. A total reduction of 31,187 bed days is assumed, which constitutes a 6% reduction (Women & Children's specialties, clinical haematology and oncology are excluded from the above as separate assumptions have been made about these specialties). These capacity calculations have identified the need to provide 765 adult general beds and compared to a 2015/16 baseline of 808 beds: a 5% reduction. It has been calculated by applying the existing number of adult patients within the general bed base (excluding Adult Critical Care) at the future planned occupancy of 89%. A total of 97 beds would be required to accommodate the additional community activity (via the shift left assumptions). This equates to an additional three acute wards at a projected cost of £25.5m. This includes both recurrent and non-recurrent capital and revenue expenditure. Additional detail is required to assess the adequacy of this figure and to facilitate comparison with the cost to the LHE of providing alternative provision in a community setting. Such assurance will be important in satisfying NHSE's fifth test.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
QIPP / Finance	How, when and where is a saving made? Is it a cash releasing saving?	Appendix 14b highlights a phased reduction in revenue costs for both options B and C1 from years 0 (2016/17) to 4 (2020/21), after which point revenue costs become uniform with no changes assumed. Revenue savings are realised from year 1 (2017/18) onwards. All revenue savings would be cash releasing. Finance costs have been removed from the net present cost calculation, reflecting Treasury guidance on options appraisal.
	Are the transitional costs (including non-recurrent revenue and capital) identified and properly accounted for? How will they be funded?	The OBC would benefit from more explicit reference regarding the treatment of non-recurrent revenue costs, as well as a supporting rationale for their inclusion or exclusion. At present, it is unclear as the extent to which non-recurrent transitional revenue costs have been included in the financial modelling assumptions. For example, in table 39 the row headed "SSP additional non-pay" is nil for all options. The focus in the OBC is on differences in the "recurrent" financial position which gives no indication of any investment required to achieve the highlighted "recurrent" financial savings. For example: ▪ Restructuring costs associated with the smaller workforce are not included. From subsequent discussions this is due to current high vacancy rates, which is assumed to make transition possible without extensive spend. ▪ Staff training and "dual running" costs. ▪ Specialist consultancy / professional fees outside of capex. Reference is made to a "suitable contingency" within capital and revenue costs to cover the risks identified although this requires quantification for revenue costs, as above. 10% has been allowed for capital. This is assumed to cover estates-related transitional costs that are not directly included in the fee estimates but can be capitalised, including: 1) Hire of temporary buildings, works associated with temporary accommodation, or temporary diagnostics. 2) Costs for decanting, moves, moving equipment, and items moved off site (eg medical records). 3) Legal fees. Non-recurrent capital costs relating to investment for the two principal options (B and C1) are identified. It is assumed that capital will be funded through the receipt of PDC although this is unconfirmed and has not been subject to sensitivity analysis. Reference is made to the Trust considering a number of commercial opportunities to reduce the overall capital cost of the project, including revenue-led solutions for new multi-storey car parks, energy supply contracts to fund new energy plant; and increased revenue opportunities through cafes and retail. No financial assumptions have been applied in respect of these opportunities although we understand that discussions have been held with potential strategic estates partners.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
QIPP / Finance	Capital investment implications have been considered in terms of the viability, deliverability and sustainability of the proposal and the economic (value for money) impact	The capital outlay for options B and C1 is £249m and £311m respectively. Costs were identified by Rider Hunt and have been assessed as reasonable in an independent review commissioned in 2016, relative to recent NHS capital construction projects. Lifecycle costs for building and engineering elements are based on standard NHS asset lives and replacement cycles, and lifecycle of equipment, with replacement occurring between 5-15 years depending upon the classification of the asset have also been assumed. A “lifecycle new works” capital receipt is assumed in year 6 (option B) and year 7 (option C1) and for £40m and £53m respectively. Residual values are also included at £177m (B) and £167m (C1) respectively. Although the financial impact between the two options is immaterial once discounting is applied, the source of such figures should be verified. Both options have been assessed using net present cost (NPC), equivalent annual cost (EAC) and whole lifecycle cost criteria and over 60-year and 30-year timeframes. There is a transposition error in Table 35. Option B delivers the lowest cost option under all three criteria, although its “winning margin” differs under each criterion. Value for money has been assessed through an economic appraisal that combined financial-non-financial scoring approach expressed through ranking comparisons, weighted scoring and a cost per benefit calcuation. Its findings, as presented to the November 2016 Programme Board, have resulted in a difference of opinion between programme stakeholders, with particular concern expressed by Telford and Wrekin Council. While valid criticisms of the limitations of some of the evaluation approaches used have been made, we note that such approaches are widely used in NHS business cases, and that the Future Fit evaluation was comprehensive in employing a number of methods, transparently laid out for wider consideration and discussion. Treasury guidance recommends informed discussion of the value provided by different options, taking into consideration contextual information around non-financial criteria. The combination of financial and non-financial scores via a calculation (however expressed) is only one piece of evidence in a wider decision-making process. It is not incumbent on the programme to select the lowest cost option as its preferred option. However, given that the option that scored highest in the non-financial appraisal (C1) was not the lowest cost, the programme may wish to explore the underlying causes of the additional costs, and compare the value of the additional investment to parallel investments in other services, e.g. neighbourhood care. Such analysis could be tied into STP discussions around the comparative funding of different elements of the local health system. continued overleaf

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
QIPP / Finance	Capital investment implications have been considered in terms of the viability, deliverability and sustainability of the proposal and the economic (value for money) impact (continued)	Viability has not been formally assessed in terms of the likelihood of the Trust receiving the full amount of capital funding, although the design has been developed in a "modular" way which maximises the Trust's options should a reduced amount of capital funding be received. Clarity around the viability of alternative sources of funding is also lacking. Related to the issue of funding, any capital costs in respect of the re-location of Women's & Children' (W&C) services to Shrewsbury under option C1 are assumed funded from PDC under the legacy of a previous scheme (that transferred W&C services to Telford in 2014). Development costs for services at Shrewsbury would be higher. The assumption of PDC availability requires validation, given known capital constraints. There could be a value-for-money question from the regulator given that W&C services were only transferred, at considerable capital cost, in 2014. The case may benefit from greater clarity as to the use to which the W&C development at Telford will be put, should services move to Shrewsbury. General IT equipment is included under all options and is encapsulated within the figures of £13m (option B) and £15m (option C1). These figures will require validation to ensure they are reasonable based on the percentage assumptions applied. Specialist ICT equipment (that may be needed to support delivery of the Trust's ICT strategy) is excluded. It is unclear as to whether or not incremental ICT costs that would support implementation of the Channel 3 Consulting report are fully included. Programme Board minutes reference ongoing concern that the programme has a dependency on IM&T investment (including in the community setting) that may not be fully funded or on schedule to deliver.

NHS England Best Practice Checks

<table>
<tr><th>Criteria</th><th>Guidance Prompts</th><th>Evidence</th></tr>
<tr><td>QIPP / Finance</td><td>Finance links consistently to workforce and activity models</td><td>
The reductions in pay costs can be linked to the assumed reduction in workforce numbers, itemised as follows:
<table>
<tr><th>Staff group</th><th>Est 31/03/16</th><th>Demand B</th><th>Demand C1</th></tr>
<tr><td>Non-Medical</td><td>WTE</td><td>WTE</td><td>WTE</td></tr>
<tr><td>Registered nursing and midwifery</td><td>1415.62</td><td>1299.86</td><td>1307.86</td></tr>
<tr><td>Qualified ST and T</td><td>262.97</td><td>208.9</td><td>208.9</td></tr>
<tr><td>Other ST and T</td><td>345.81</td><td>326.75</td><td>326.75</td></tr>
<tr><td>Support to clinical</td><td>1396.02</td><td>1311.39</td><td>1314.39</td></tr>
<tr><td>Non clinical</td><td>964.48</td><td>874.48</td><td>874.48</td></tr>
<tr><td>Medical</td><td></td><td></td><td></td></tr>
<tr><td>Consultant</td><td>282</td><td>290.5</td><td>290.5</td></tr>
<tr><td>Career/Training grades</td><td>366</td><td>350</td><td>350</td></tr>
<tr><td>Total</td><td>5032.9</td><td>4661.88</td><td>4672.88</td></tr>
<tr><td>Total reduction</td><td></td><td>371.02</td><td>360.02</td></tr>
<tr><td>Average salary per WTE lost</td><td></td><td>£39,321</td><td>£39,451</td></tr>
</table>
Specifically the reductions under options B and C1 both assume an average salary per “lost” WTE of £39,000. The recurrent reduction of £4.1m in pay costs owing to role-re-design will need to be developed and allocated to divisions and job roles, although it is acknowledged this information is sensitive.

The financial impact of activity assumptions for the Trust has been considered in determining the bed base of the new balanced site care model, as well as the activity shifts across care settings and their contribution to QIPP/CIP initiatives: £31m and £10.5 on a recurrent basis by 2020/21.Specifically, the Midlands and Lancashire Commissioning Support Unit (CSU) supported the system to develop a range of models to estimate future activity levels.

Many of the acute sector changes are heavily dependent on initiatives and changes to models of care in primary and community services and social care – a key dependency. Notably the proposed activity shift will require significant recruitment at the community level as the acute provider reduces its workforce establishment.

Commissioners and HOSCs have focused on the robustness and financial impact of the “shift left” activity assumptions, while the activity associated with repatriation, and its related financial benefit of £6m, requires review. We understand the local community health provider has been involved through attendance at Programme Board and at options appraisal, but there is little evidence of this within detailed plans. An integrated, LHE approach approach to revenue sensitivity modelling is likely to be of benefit going forward.
</td></tr>
</table>

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Clinical quality and strategic fit	Clear articulation of patient, quality and financial benefits	The non-financial panel met in September 2016 and were asked to consider how the options would promote quality of services. During this, the panellists were presented with the clinical model for the OBC. The slides presented set out a clear case of how this will improve the service for patients through improving patient experience and flow. The slides include detail about why one of the options (C2) is not feasible from a clinical perspective. The slides set out how each individual option will impact on quality. No specific metrics were provided in order to measure progress against patient and quality benefits. Workforce savings and costs associated with each of the options formed part of the financial appraisal and are set out in the OBC. The financial appraisal considers the financial consequences (including benefits) of all options (including option A which is to do nothing). The Future Fit Programme Board also commissioned a Clinical Senate review in 2016. While the review outlined that 'a clear and compelling case for change was made', the review also highlighted that the Programme would benefit from a more structured approach to patient outcomes and appropriate metrics to track progress.
	Clinical case fits with national best practice	The clinical model has been developed using clinical best practice, benchmarking and a review of national guidelines. The strategic case for change is well documented and it is clear that the 'do nothing' option is not feasible from a clinical perspective. Following the shortlisting of the four options, clinicians within SaTH raised concerns over the safety and deliverability of Option C2. Manchester CSU Clinical Review Group were commissioned to perform a review of the feasibility of Option C2 with clinical input from SaTH. This review identified that the option C2 would not meet the necessary standards of the Royal Colleges and CQC issues would be raised. The West Midlands Clinical Senate produced a review in January 2015 and one in November 2016. The OBC incorporates the feedback from both reviews and details the recommendations raised. The Health Gateway review completed in December 2016 comments that 'the written evidence to support the case for change is copious and the clinical narrative is strong'. The Gateway review does criticise the uncertainty of the impact on the Women and Children's service. A separate IIA has been commissioned to address this concern. The local model of care for maternity services will need to be aligned to the national Better Births strategy, which was released during 2016, with further guidance for local maternity systems in March 2017. This does not preclude advancing with a preferred option to public consultation.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Clinical quality and strategic fit	Fit with local H&WB strategy and aligned with the objectives and commissioning intentions contained in local commissioners' strategic plans	As a core element of the local acute Trust's strategic plan, Future Fit is necessarily closely aligned with local health strategy, including the strategies of its three core commissioners: the two local CCGs and Powys Health Board. We note that the local STP is currently led by the Chief Executive at SaTH. The OBC describes how the changes propose align with the objectives and intentions of the local Sustainability and Transformation Plan (STP) including detail on the 'neighbourhoods' model within Shropshire and Telford and Wrekin and more specifically the Urgent Care Centre (UCC) model. The OBC also outlines the health and wellbeing strategy that the Neighbourhood workstream is following. This has clear links with local authority place-based strategies, although the level of engagement and alignment with the local councils is not made clear. It is also noted that each of the three local authority areas concerned have differences in their approach to delivering place-based services. However, as mitigation all three local authorities covered by Future Fit are stakeholders of the programme board, and we saw evidence of briefings and correspondence with both Health and Wellbeing boards and HOSCs. Both local Directors of Public Health sit on the respective CCG Boards. The acute sector changes described under Future Fit are heavily reliant on changes to models of care in primary and community health. An additional analytical exercise, Community Fit, was commissioned in 2014 to understand the current position around community care, focusing on demand, volumes and flows across the local health economy. Since the creation of STPs and the increasing ownership of the Future Fit business plan by SaTH, the community and acute care models have been dealt with separately, with meeting minutes suggesting delays in the development of plans. Several programme stakeholders have also expressed ongoing issues with the lack of clarity around UCCs, particularly from the public, despite repeated attempts to clarify and add detail to the model and potential distribution. A pilot scheme is currently underway in one locality to further prove the concept. It is not yet clear how the local health economy will execute its community reconfiguration, nor how this will be funded, particularly in the context of uncertain capital funding for Future Fit and an overall substantial deficit for the health economy. These concerns have been raised at Programme Board meetings and by HOSCs. This is a major dependency for the project going forward. The 2016 Clinical Senate report raised this as a concern with a recommendation that the required commitments from other stakeholders need to be clarified and developed. Given the financial challenges of both CCGs, but particularly Shropshire, it is not clear from documents how the community services developments on which some of the assumptions within Future Fit rest will be funded. Not withstanding that the programme is explicitly concerned with acute and specialist services, we would expect greater evidence of alignment with other commissioning strategies.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Clinical quality and strategic fit	Options appraisal (inc. consideration of a network approach, cooperation and collaboration with other sites and/or organisations)	The Future Fit programme considers acute care across Shropshire and Telford & Wrekin. Future Fit forms part of the delivery of the Shropshire and Telford & Wrekin Sustainability and Transformation Plan (STP). The reconfiguration of Shrewsbury and Telford hospitals is one of the priority actions of the STP and feeds into the wider system change. There is an assumption that by moving the services within SaTH's Trust there will be minimal impact on patient flows. There has been little analysis of the potential increased patient flows to Wolverhampton and Wales. The 2016 Clinical Senate report recommends that the Future Fit Programme Board needs to further analyse the proposed changes within a broader health economy context.
	Macro-impact is properly considered	
	Alignment with QIPP workstreams	The 2016 Clinical Senate report recommends that community service alignment across the system should be revisited as the community transformation has not yet been developed in detail and it remains unclear what the commitments from other stakeholders will be and how these will be delivered. QIPP workstreams are discussed within the Finance section of the OBC. However, as this is a SaTH document, it should be noted that it does not present the QIPP content from a commissioner perspective, or articulate wider saving or investment opportunities that will support and complement Future Fit, for example within the community setting. The STP describes savings from a LHE perspective at a high level.
	Full impact analysis across CCG / NHS England commissioned services and shared sign up of all parties to analysis	An integrated impact analysis (IIA) was carried out in November 2016 and received by the Programme Board. This analysis focused on acute services and it has been noted that before deciding on a preferred option the implications of other types of care must be assessed. An additional analysis of changes to Women and Children services has been commissioned but not published at the time of writing. This has been commissioned following the Gateway Review in December 2016. The Review highlighted the lack of clarity on the impact on Women and Children's services. The new IIA will consider the potential impacts and equality effects under each option. The preferred options would have a significant impact on the provision of trauma care. RSH is already a designated trauma unit at RSH. Prior to the September 2016 options appraisal, the regional lead for major trauma and the provider of adult major trauma services in Stoke indicated a preference for option C1. This information was provided verbally to the panel session and a letter subsequently circulated to Programme Board. The 2016 Clinical Senate report also states that evidence has been received from the trauma network that trauma unit status could be obtained at the Telford site. However, it acknowledges that this option would disadvantage the population of Powys. All parties are not signed up to the over impact analysis on services as concerns have been raised by various stakeholders following the options appraisal, specifically from Telford and Wrekin, where both the CCG Clinical Chair (on behalf of some panel attendees) and the local authority have written with concerns. While a preferred option was adopted by Programme Board in November 2016 (without unamimous support), the process has since stalled due to ongoing disagreements and challenges.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Clinical quality and strategic fit	Does the proposal align to the new models of care in the Five Year Forward View?	Future Fit forms part of the delivery of the STP. The STP's purpose is to determine how local services in Shropshire, Telford and Wrekin will evolve and become sustainable over the next five years as part of delivering the NHS Five Year Forward View. The 2016 Clinical Senate review identifies that the Future Fit programme aligns with the Five Year Forward View through its promotion of delivering as much care as possible in people's homes, local surgeries and communities. There is clearly therefore a dependency on the community services to complement the acute proposals within Future Fit. These services are linked via the 'activity shift' away from hospitals and into neighbourhoods, as described by the STP. The Five Year Forward View identifies five vanguard types. Although the OBC and programme documents do not make specific reference to these vanguard types (which have been promoted by the NHS later in the programme's development) the Future Fit programme as part of the wider STP focuses primarily on two of these; urgent and emergency care and integrated primary and acute care systems. Further assurance would be provided if the programme articulated how it was using Vanguard best practice to shape the detail of the clinical models being proposed. From 1st April 2017, NHS organisations have to show that significant hospital bed closures subject to the current formal public consultation tests can also meet one or more of three conditions before NHS England will approve them to go ahead. The programme will need to demonstrate that sufficient alternative provision is being put in place or that it has a plan to use beds more efficiently where it has been underperforming in the past without affecting patient care. The Future Fit programme will therefore need to clearly articulate how its community care reconfiguration will be executed as it moves towards public consultation. The OBC presented to Programme Board as part of its option appraisal deliberations in November 2016 references the STP and assumptions around activity shifts, but the flows of patients and assumptions underpinning them would benefit from fuller exposition in future iterations of the business case. As noted earlier in this report, the local health economy should also prepare to articulate how the Future Fit programme will align to plans to develop local maternity services in line with the national Better Births guidance, which relate directly to the women's and children's services which may move under the proposals. We understand that the two CCGs are due to submit maternity plans to NHSE by October 2017.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Activity	All relevant patient flows and capacity are properly modelled, assumptions are clear and reasonable	The NHS Midlands and Lancashire Commissioning Support Unit (CSU) was commissioned as part of the Future Fit programme to develop a range of models to estimate future activity levels. Activity projections are based 2015/16 baseline activity and flexed to take into account demographic growth, model of care changes, 7 day working and reductions in delayed transfers of care. Capacity modelling and capacity requirements are set out by SaTH in the SOC and the OBC. The assumptions are outlined and the SOC makes it clear that these assumptions apply to all potential solutions. The data used to drive the assumptions is historic with the 2015-16 out-turn figures used as a baseline. The OBC also considers the impact on capacity if the assumption that patients will in the future receive care within the community setting does not materialise. Mitigating actions are documented if this was to happen. Assumptions have also been considered within the QIPP/Finance section of our report, above, including commentary around the clarity of some of the assumptions used.
	What are the changes in bed numbers?	Projected inpatient bed requirements for 2018/19 based on throughput and utilisation assumptions are set out in the SOC. An assessment has been made to quantify and plan for inpatients that do not require acute hospital care. A projection of total inpatient bed days saved has been calculated. Note this calculation does not include women and children's specialities, clinical haematology and oncology. The explanations of the movements in bed days projections are clear. The OBC compares this calculation with the Better Care Better Value Indicators. The projected net outcome of the SSP programme in terms of reduced bed days more than realises the total saving opportunity identified by current performance indicators. This content aligns with the patient care test for hospital bed closures effective from the 1st April 2017 which states major service reconfigurations will only be supported if sufficient alternative provision will be put in place or if specific new treatments/therapies will reduce specific admissions or where hospitals can demonstrate that they have developed a credible plan to use beds more effectively. The modelling in the SOC assumes that sufficient alternative provision will be provided within community settings and that Trust wide service efficiencies and improvements will lead to a more effective use of beds. This case will need to be demonstrated in greater detail prior to public consultation commencing.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Activity	Activity and capacity modelling clearly linked to service change objectives	Activity and capacity modelling is linked to the Future Fit principles as detailed in the SOC and the OBC. The SOC outlines how the SSP options align to the service principles within Future Fit. The SOC details that 65% of the patients that currently attend A&E could potentially be seen in an Urgent Care Centre (UCC) and the remaining 35% could be treated in the single proposed Emergency Centre (EC). Urgent Care Centres will be located in more local facilities than Shrewsbury or Telford. Acutely ill patients would then be taken to the EC. Locations have been proposed and discussed by Programme Board, although noting that the volume of urgent case delivered outside these two main locations will be low. The EC will also serve as a Trauma Unit and will be co-located with a single Critical Care Unit. Both sites will host outpatients and planned procedures. Capacity modelling has been linked to comparisons between current and anticipated staffing models, with assumptions made around improvements in vacancy rates and coverage. Activity modelling has incorporated assumptions around repatriation and demographic change.
	Activity links consistently to workforce and finance models	Workforce plans and assumptions link back to the activity plans and assumptions as documented in the workforce change programme in the OBC. The financial model incorporates the same activity assumptions. The business case acknowledges that further updates to the activity data that feeds the workforce and finance models will be required in the pre-consultation business case, partly due to delays in decision-making that have reduced the relevance of the original data used.
	Modelling of significant activity, workforce and finance impacts on other locations / organisations	The modelling covers both of the SaTH sites; Shrewsbury and Telford. Patient choice will impact on the surrounding health economy however it remains unclear what the impact on other providers will be. The 2016 Clinical Senate report advises further work should be done to analyse this. Some repatriation has been assumed in the models for activity currently being performed for local residents in organisations outside the local health economy. As discussed above in the QIPP/Finance section, this assumption requires review.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Workforce	Do you have a workforce plan integrated with finance and activity plans?	Workforce challenges are one of the drivers for clinical change. Challenges include recruitment difficulties in both medical and non-medical services, duplicate services on two sites requiring double the workforce, inadequate staffing levels to provide 7-day working and to meet safe staffing levels. During the longlisting process workforce implications were considered as part of the quality of care criteria. In the shortlisting process workforce was separated from quality so it could be considered one of the high level criteria within the options appraisal process. A workforce plan is outlined in the OBC. Workforce demand and workforce savings/costs are detailed for each option alongside the workforce change programme. Workforce plans and assumptions link back to the activity plans and assumptions as documented in the workforce change programme in the OBC. The financial model incorporates the same activity assumptions. Workforce shortages in A&E are noted as one of the key risks in the Programme Risk Register at November 2016. A number of other workforce risks are noted alongside mitigating actions and further actions, including the feasibility of the deployment of increased numbers of clinical staff in community settings.
	Are you making most effective use of your workforce for service delivery and is it compliant with all appropriate guidance?	There are statements of assurances in the OBC that the workforce plan incorporates the guidance from the National Quality Board so that all opportunities to maximise the contribution of multi-disciplinary teams and the number of care hours per patient per day have been considered.
	Consider the implications for future workforce	The OBC outlines total workforce numbers across the three options in comparison with the workforce at the financial year end 2016. The document also comments on the workforce changes across the different service models. Reductions in excess of 300 WTEs are seen in both options B and C1. The non financial appraisal panel was required to consider workforce as a separate criteria and was asked to consider to what extent each option could improve the recruitment and retention of staff in critical shortage areas. Information was provided by SaTH management and clinicians to inform this.
	Have staff been properly engaged in developing the proposed change?	Workforce has been considered throughout the process. The OBC states 55% of the consultant workforce has been engaged in discussions. Other areas of staff engagement include Task and Finish Groups with clinicians, staff and operational teams, weekly road shows, Clinical Working Groups and Critical Friends Groups. We understand unions have been consulted around the proposed options.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Travel	Has the travel impact of proposed change been modelled for all key populations including analysis of available transport options, public transport schedules and availability / affordability of car parking?	Average journey times were assessed for each Lower Super Output Area. This has been done to show different modes of transport and different types of care. The impact on access to urgent and emergency care and to non-complex planned care is analysed within the IIA which was received by the Programme Board in November 2016. The impact on non-complex planned care was presented as part of the non-financial appraisal panel data in September 2016. The slides presented considered journey times for urgent and non-complex planned care for patients travelling to their current 'chosen' sites and then an analysis in both graph and map format to show the relative impact of each option. This analysis also considers the impact on displaced patients across protected groups across each option. It is acknowledged that public transport is limited as much of the population live outside of urban centres. The IIA received in November 2016 outlines how journeys by public transport to access non-complex planned care could become less convenient under each of the preferred options. The additional IIA will cover implications for womens and children's services. The provision of adequate car parking is currently reported as an issue at the current sites in the SaTH Framework Travel Plan. Car parking and alternative pricing structures are both outlined as a potential commercial opportunities within the OBC. There is a risk that the funding solution for the programme could contradict its accessibility aims. The Trust's Travel and Transport aspirations are to be developed further during the Full Business Case (FBC).
Ambulance services	Have the implications for ambulance services (emergency and Patient Transport Services) been identified and impact assessed and appropriate discussions been held with ambulance service providers?	Representatives from the Welsh Ambulance Services NHS Trust (WAS) and the West Midlands Ambulance Service NHS Trust (WMAS) were part of the panel reviewing the non-financial appraisal. Both ambulance services also sat on the longlisting panel that met in 2014-2015 to identify a shortlist. The November 2016 Clinical Senate report identified areas for action with regards to ambulance services. This includes the requirement for further modelling to be undertaken around transfers in conjunction with the Air Ambulance Service. The report also recommends that should be collaboration between the programme and the ambulance services to better understand patient pathways and travel and clinical activity modelling, including women's and children's services. Partly in response to this, correspondence was exchanged between September 2016 - May 2017 around internal transfers. Meetings have taken place with WMAS and an engagement plan has been agreed to understand the implications for this service. Quarterly meetings have been established between SaTH's SSP team and WMAS, WAS and Air Ambulance from January 2017. Attendance by the Air Ambulance is particularly relevant given the rurality of some of the affected population and the helipad at RSH. A commissioner-led Task and Finish Group has been agreed to coordinate activity and contract elements of the change. Activity and contracting conversations are led by the CCGs.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Resilience	How will the proposed change impact on the ability of the local health economy to plan for, and respond to, a major incident?	The impact on the ability of the local health economy to plan for, and respond to, a major incident has not been documented. However, SaTH already has a major incident plan and this has been considered when developing the plans for a single EC site with the architects.
	Has a business impact analysis been conducted for all impacted organisations and appropriate changes made to Business Continuity Plans?	Business impact analysis has been progressing with other organisations primarily around emergency care, for example with Wolverhampton Trust and the ambulance services discussions have been held around potential activity flows. In terms of planned care however these discussions are yet to take place.
	Local Health Resilience Partnership impact assessment on resilience?	A Local Health Resilience Partnership impact assessment has not yet been completed. This will form part of the next steps at the FBC stage.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Communication & Engagement	Are there plans to appropriately and effectively engage and involve all stakeholders, to include: • staff, • patients, • carers, • the public, • Healthwatch, • GPs, • media, • local authority overview and scrutiny functions, • Health and Wellbeing Boards, • local authorities, • MPs, • other partners and organizations; and • fulfil commitments under s.14Z2 and s.13Q of the Health and Social Care Act?	**Staff:** Clinical staff have been involved throughout. The SSP is described has having been clinically-led. Key clinical leaders have been involved in all aspects from planning to delivery of the programme. Various groups for staff have been established including weekly road shows, clinical working groups and critical friend groups. SaTH clinicians and GP leads were part of the acute activity and capacity sub groups. Clinical staff at SaTH collaborated to produce a multi-service, detailed paper on the C2 option. Finally 15 clinicians from SaTH, the community provider, ambulance services and out of hours GP services sat on the Options Appraisal panel and clinicians were also heavily involved in the longlisting process. **Patients, the public and media:** Public engagement events have continued throughout the programme, from 2014 onwards. Two sets of stratified telephone surveys have been carried out by the Midlands and Lancashire Commission Support Unit which have informed weighting of scores ahead of both options appraisals. Other communications are listed in the OBC, including the NHS Future Fit website and live radio interviews including phone ins with lead clinicians. Social media has also been used to issue updates to the public. Nine patient group representatives were on the non-financial appraisal panel in September 2016. The Health Gateway review completed in December 2016 acknowledged that there has been considerable communication with stakeholders however it criticised the content and messages of the communications. The review described the language used as clumsy and often using NHS jargon and criticised the programme's perceived failure to reach all key stakeholders. Health scrutiny and patient representative bodies were highlighted as stakeholders that the programme must engage with further. **Healthwatch:** Three representatives each from Healthwatch Shropshire and Healthwatch Telford & Wrekin were on the September 2016 appraisal panel. The OBC states updates were regularly provided to both groups. **GPs:** A newsletter is sent to all local stakeholders including GP practices. An engagement programme was undertaken with GP practices over the course of the development of the SOC and the OBC. Clinicians representing the CCGs, LMC and local out of hours service sat on the options appraisal panel, and the longlisting panel.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Communication & Engagement (continued)	Are there plans to appropriately and effectively engage and involve all stakeholders, to include: • staff, • patients, • carers, • the public, • Healthwatch, • GPs, • media, • local authority overview and scrutiny functions, • Health and Wellbeing Boards, • local authorities, • MPs, • other partners and organizations; and • fulfil commitments under s.14Z2 and s.13Q of the Health and Social Care Act?	**Overview and scrutiny functions:** There is a joint Health Overview Scrutiny Committee (HOSC) for Shropshire and Telford & Wrekin. The Programme has been in dialogue with the Committee and details of the questions posed by the HOSC members are included in the OBC. Joint HOSC members were observer members of the September 2016 non-financial appraisal. There is also engagement with the two individual HOSCs. **Local authorities:** Two members of Telford & Wrekin Council, two members of Shropshire Council and one member of Powys Council were on the non-financial appraisal panel. The Directors of Public Health from the two English local authorities sit on the Boards of the respective CCGs in their area. Telford & Wrekin Council has subsequently raised objections to the process, some of which concern the design and preparation and some the execution of the options appraisal process, including both the non-financial appraisal panel and the financial analysis. Correspondence has been exchanged between the council, CCGs and Programme Team. Formal responses to the council's objections were made at the December 2016 Joint CCG Committee meeting. No objections have been received from either Powys or Shropshire local authorities. **MPs:** Chief Executive briefings have been held with MPs and Assembly members and correspondence exchanged. **S.14Z2 and S13Q :** The CCGs and NHS England as part of the Programme Board have made arrangements to ensure that individuals in receipt of the services being provided are involved in planning, developing and considering and deciding on the changes to commissioning arrangements as documented above. There is a formal communication and engagement plan and workstream in place. Engagement and communications updates are provided to the Programme Board on a regular basis. The 2016 Health Gateway review report noted that, despite significant communication activities, the programme has not always successfully conveyed its vision.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
Equality Impact	There has been an appropriate assessment of the impact of the proposed service change on relevant diverse groups?	The Integrated Impact Assessment (IIA) carried out in November 2016 by an independent consultancy working with the CSU's Strategy Unit. The document covers the impact of the changes on diverse groups across the different options and followed an approach and format used widely in relation to NHS reconfigurations. The IIA scope was restricted to the assessing the impacts of the changes to acute hospital care. An additional analysis of changes to Women and Children services has been commissioned but not published at the time of writing. The decision to expand the scope of the IIA followed discussion at Programme Board around the need to understand the impact of potential site changes on specific risk cohorts utilising women's and children's services. The non financial appraisal panel in September 2016 were asked to consider equity of access and were provided with information on displaced patients in protected groups as part of the accessibility analysis. The IIA was not made available for this panel (it was completed in November 2016) but was made available for the November 2016 Programme Board which considered both the outcomes of the non-financial appraisal panel, and the financial analysis. This was in line with the approach laid out at the joint board development session conducted earlier in September 2016, which itself repeated the approach agreed in 2015. The decision not to provide the appraisal panel with the IIA has subsequently been challenged by some stakeholders. However, it is not clear which of the four non-financial criteria it would have provided evidence against (given that the accessibility evidence addressed risk groups and potential inequalities) and we note that its inclusion was not agreed in advance by the Programme Board.
	Has engagement taken place with any groups that may be affected?	As part of the IIA interviews were conducted with local organisations that represent different population groups. Data analysis was also conducted around patient flows and demographics. Further work was carried out by a separate consultancy to gain the views of particularly hard to reach groups across both Shrewsbury and Telford. This work was reported in June 2016. A schedule of all engagement work to date was provided as an appendix to the OBC detailing all internal and external engagement activity. Once the additional impact assessment has been completed, we understand the programme team plans to engage with specific groups affected, in parallel with more general formal public consultation.
	What action will be taken to mitigate any adverse impacts identified?	Actions to mitigate any adverse impacts identified will need to be considered and acted upon once the next IIA is received and suitable engagement has taken place.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
IT	Does proposal make best use of technology?	As per the SOC, the potential solution requires investment in current systems to ensure they meet the 'minimum standard' required. An outline approach for use of Health Informatics to support proposed reconfigured services is provided in report format as an appendix to the OBC. This sets out the vision for Health Informatics in the future trust, the technology requirements in the future Trust and example clinical scenarios. The document sets out how each element of Health Informatics (eg. holistic patient records) will benefit the Trust. There is a Digital Strategy Group who are tasked with a number of objectives that will support Future Fit and the wider STP, including being paper free at the point of care by 2020. An IT workstream has been developed as part of the SSP team. Concerns have been expressed at Programme Board that the IT enabling work to support Future Fit is currently underdeveloped and lacks a clear funding plan.
	Assessment of the impact on local informatics strategy & IT deployments	There is recognition that the IM&T procurement for the Trust will be wider than the SSP however it is recognised that IT development is a key enabler to the programme. The main aims of the ICT strategy are outlined in the OBC with details of how each element will benefit the Trust and its patients.
	Are there likely to be any data migration costs?	There is no mention of data migration costs within any of the documents reviewed however it is expected these would be minimal given the reconfiguration focuses on a single, current provider.
	Are there any implications for specialist or network technology/equipment contracts associated with the service?	There is no mention of this in the documents reviewed. The dependencies on Community Fit mean there could be a requirement to invest in new systems, devices and other equipment. Concerns were expressed at the Programme Board meeting in May 2016 around different NHS groups working independently and not co-operating.

NHS England Best Practice Checks

Criteria	Guidance Prompts	Evidence
TDA/Monitor	Is proposal aligned with the Trust Development Authority's (TDA) / Monitor's approach (now NHSI)	Given that the local acute provider is an NHS Trust, and regulated by the TDA (now under the auspices of NHS Improvement) the OBC has been developed following NHSI guidance. Given the level of capital investment required, the business case can also be expected to go through standard regulatory assessment. No transaction is proposed so there is no requirement to satisfy that aspect of NHSI guidance.
Others	Consistent with rules for cooperation and competition (Monitor/OFT/CC)	There is no merger or acquisition, nor is there a significant change in market share anticipated so this part of the guidance is not considered to be applicable. However, the programme should satisfy itself that the NHSI concurs.
	Consideration given to the most effective use of estates	SaTH currently faces a high level of backlog maintenance and poor quality existing facilities and therefore in addition to delivering a safe and sustainable clinical model there is a need to address these issues with the existing estate. Following the options appraisal in 2015 a decision for a preferred option was deferred until it could be assured that there was an approvable case for investment. A major source of concern was the level of estates investment proposed in the original shortlist. As a result, SaTH was asked to develop solutions within the resource available locally. Estates is discussed in detail in the OBC which brings together a Technical Team review, Six Facet Estates survey and a Clinical review. This includes an estates impact review. Estates was also discussed at the Options Appraisal panel in 2016, with presentations on the proposed site reconfigurations linked to the Deliverability criteria.
	Robust programme and risk management arrangements	A programme team has been in place since the inception of the programme. The programme director has changed in that time but consistent project management documentation has been used. Support has been provided consistently by the CSU and additional expertise has been bought in as required. Assurance over the progress of the programme has been tested at key points by the Cabinet Office via two 'gateway' reviews, with recommendations made around next steps. An NHSE assurance gateway is also mandated prior to formal public consultation, and is currently scheduled for August 2017. Risk management has been provided in the form of a programme risk register which has been presented routinely at Programme Board meetings.
	Identify and reduce the privacy risks	There is no mention of this in the documents reviewed. It is not anticipated that data transfers will be part of the reconfiguration. The pre-consultation business case (PCBC) should summarise information governance issues identified by the privacy impact assessment as per NHS England's best practice checks.

NHS Wales Guidance

NHS Wales 'Guidance on engagement and consultation on changes to health services' is presented in a different format to NHS England guidance. We have sought to draw out the four key elements of the guidance and apply them to the Future Fit programme. As with the NHS England guidance, we note that it covers the entirely of change programmes, including the formal public consultation phase, which has not yet been reached by Future Fit.

Requirement	Guidance	Evidence
Continuous Engagement	The Welsh Assembly Government "*now expects organisations to pay considerably more attention to continuous engagement to ensure that all organisations are responsive to the needs and views of their citizens*." In addition "*the NHs should use a two-stage process where extensive discussion with citizens, staff, staff representative and professional bodies, stakeholders, third sector and partner organisations is followed by a focused formal consultation*"	Welsh commissioners have been involved throughout via membership of the Programme Board. Welsh providers were also involved in the longlisting process. Engagement events have also been held with the public within Powys, organised directly by the Programme team and augmented by events run by PHB and the local CHC. The Welsh Ambulance Service have also been involved in generating travel time and accessibility datasets to inform each phase of the options appraisal, including longlisting. PHB have gained assurances from the Programme team that any subsequent formal consultation shall meet the standards set by NHS Wales, which in some cases exceed those required by the NHS in England.
Substantial Change	"*There may be some cases where, exceptionally, the view is that a more formal consultation is required. A key issue to be determined as to whether formal consultation is required is whether the change is substantial or not*."	Given the scale of the reconfiguration proposed, Future Fit can be regarded as "substantial change" and engagement has been proportionate to this per the guidance. Formal consultation has been planned into the programme, although this stage has not yet been reached.
Urgent Change	"*Special arrangements apply where an NHS body believes that a decision has to be taken on an issue immediately in the interests of the health service or because of a risk to the safety or welfare of patients or staff*"	Urgent change has not formed a part of Future Fit, as the programme concerns complex, substantial change which cannot be enacted urgent. However, there have been requests from commissioners, including PHB for SaTH to develop urgent options to stabilise fragile services as an interim measure before Future Fit concludes and becomes operationalised.
CHC Input	CHCs "*represent the interests of the public in the health service in Wales*" and have a role comprising involvement in planning and service change and should be given the opportunity to comment and engage with proposals. Where dissatisfied they have recourse to the Welsh Ministers.	The Powys Community Health Council (CHC) have been involved in observing various events as part of Future Fit, including the options appraisal panel in September 2016. CHC representatives have also routinely attended Programme Board meetings as observers. No formal concerns have been expressed with the design or conduct of the process. However dissatisfaction has been noted with the length of time the programme has taken to date.

KPMG

Appendices

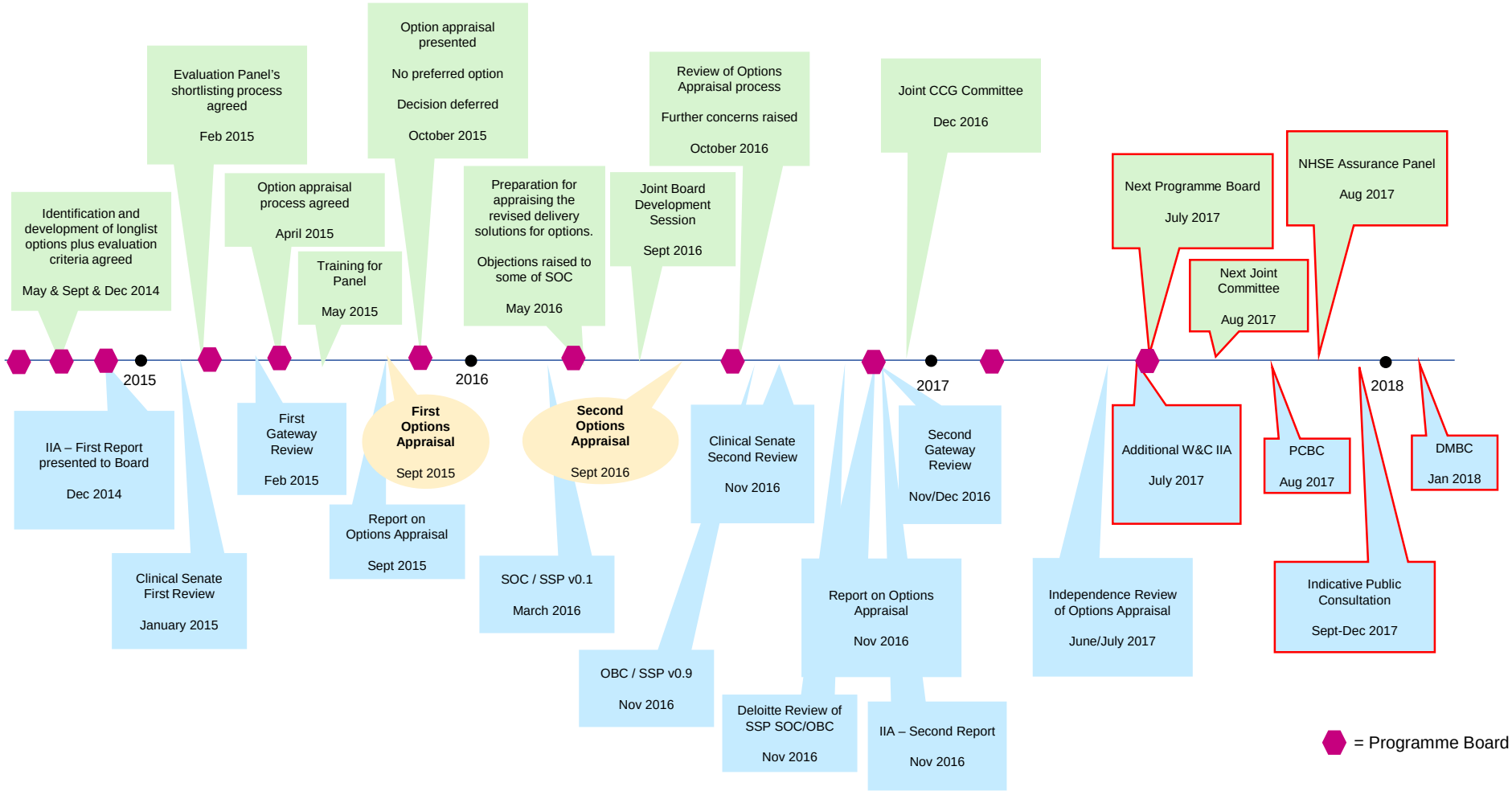
1: Programme Timeline

2: Interviewees

3: Guidance

Appendix One

Future Fit: Programme Timeline



Appendix Two

List of Interviewees

Debbie Vogler, Programme Director, Future Fit

Emma Pyrah, Programme Manager, Future Fit

Dave Evans*, Accountable Officer, NHS Telford & Wrekin CCG

Simon Freeman*, Accountable Officer, NHS Shropshire CCG

Dr Jo Leahy, Clinical Chair, NHS Telford & Wrekin CCG

Dr Julian Povey, Clinical Chair, NHS Shropshire CCG

Liz Noakes, Deputy Chief Executive and Director of Public Health, Telford Council

Clive Jones, Director of Social Care, Telford & Wrekin Council

Paul Thomas, Senior Research & Intelligence Officer, Telford & Wrekin Council

Paul Martin, Senior Lawyer, Telford & Wrekin Council

*** Note:** Dave Evans and Simon Freeman, as Accountable Officers for the two CCGs leading the Programme, are Joint Senior Responsible Officers (SROs) for Future Fit.

Rod Thomson, Director of Public Health, Shropshire County Council

Hayley Thomas, Director of Planning & Performance, Powys Teaching Health Board

Carol Shillabeer, Chief Executive, Powys Teaching Health Board and Interim Director of People Services at Powys County Council

Mike Sharon, formally Programme Director, Future Fit (until January 2016), currently Director of Strategy & Planning, Royal Wolverhampton Hospitals NHS Trust

David Frith & Peter Spilsbury, Midlands and North Commissioning Support Unit (CSU)

Neil Nisbet, Director of Finance, Shrewsbury & Telford Hospital NHS Trust

Appendix Three

Guidance

Planning, Assuring and Delivering Service Change for Patients, NHS England (v2015)

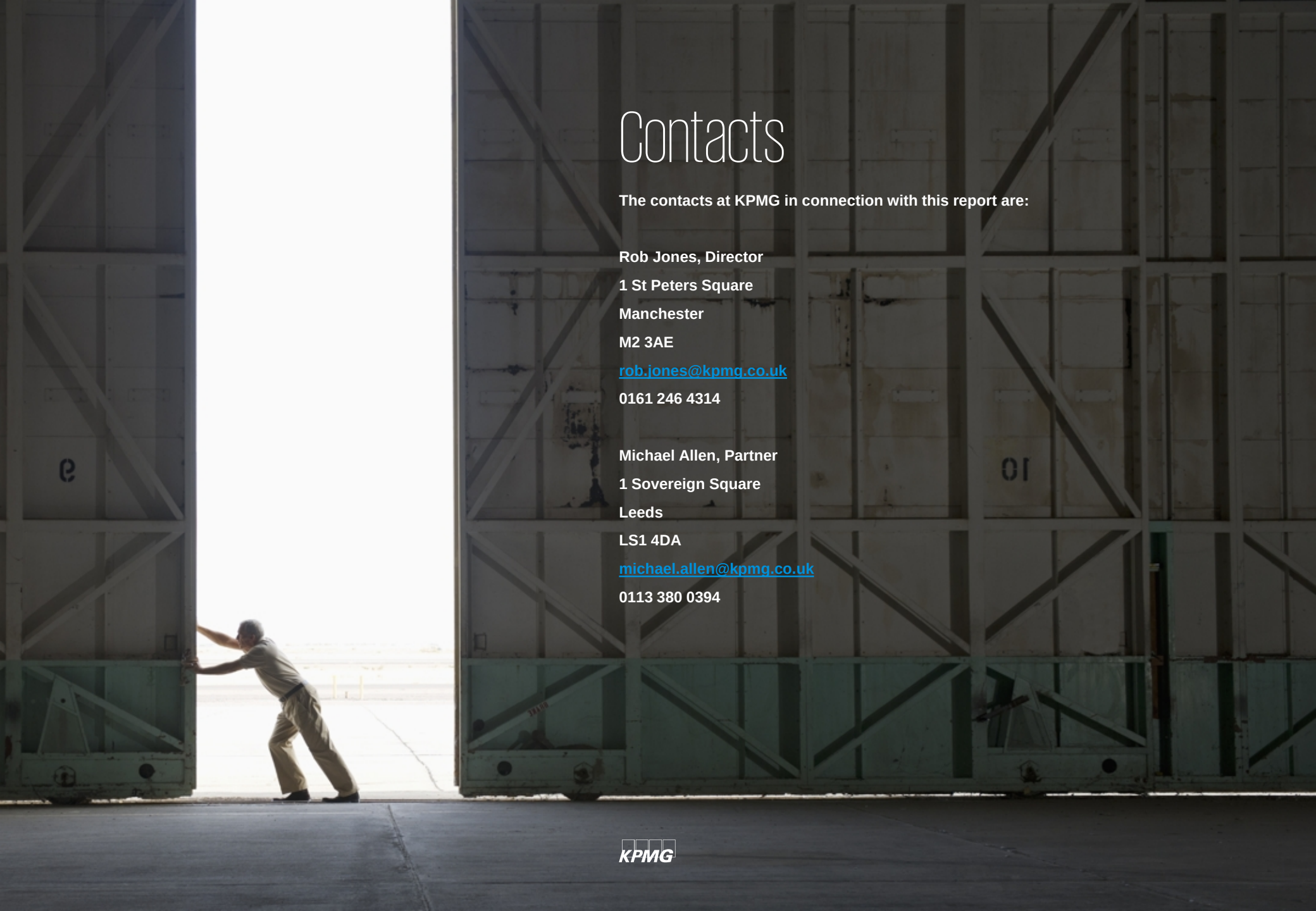
Supplementary Green Book Guidance: Public Sector Business Cases, HM Treasury (v2013)

Substantive guidance on the Procurement, Patient Choice and Competition Regulations, Monitor (v2013)

Guidance on Engagement & Consultation on Changes to Health Services, NHS Wales (v2011)

Appraisal & Evaluation: The Green Book, HM Treasury (v2011)

Learning from Reviews, Independent Review Panel (v2010)



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