NHS Shropshire, Telford & Wrekin Clinical Commissioning Groups Future Fit Joint Committee Meeting

6.00pm Thursday 10th August 2017
Clayton Hall,
Shrewsbury College SY2 6PR

NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

A G E N D A

The meeting is to be held in public to enable the public to observe the decision making process. Members of the public will be able to ask questions at the discretion of the Chair

1.	***Welcome & Apologies***	**Simon Brake Independent Chair**	**6.00**	*Verbal*
2.	***Members' Declaration of Interests*** 2.1 Declarations of Interests	**Simon Brake Independent Chair**	**6.05**	*Verbal*
3.	***Introductory Comments from the Chair including Code of Conduct*** ***Principles for joint working and member code of conduct***	**Simon Brake Independent Chair**	**6.10**	*Enclosure 1*
4	***Terms of Reference for the Joint Committee*** ***For information***	**Simon Brake Independent Chair**	**6.15**	*Enclosure 2*
5.	***Items for Discussion/Approval***			
	5.1 Report from the Future Fit Programme Board Meeting on 31st July 2017 **Annex 1**: Future Fit Integrated Impact assessment November 2016. **Annex 2**: KPMG Independent Review of the Option Appraisal Process Report July 2017 **Annex 3**: Future Fit Integrated Impact Assessment: Additional Analysis of Potential Changes to Women's and Children's Services July 2017	**David Evans & Simon Freeman Future Fit Joint SROs** **Debbie Vogler Programme Director**	**6.20**	*Enclosure3*
	5.2 Board discussion		**6.30**	
	5.3 Questions from members of the public. At the discretion of the Chair questions from members of the public will be invited.		**7.15**	
	5.4 Board discussion and decision		**7.45**	
5.	**Closing Remarks including Next Steps**	**Simon Brake Independent Chair**	**8.00**	*Verbal*

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Shaping healthcare together

Enclosure 1

NHS Shropshire, and Telford and Wrekin CCG Future Fit Joint Committee

Principles for Joint Working

Given the transformation task necessary over the coming years, it is recognised by all parties that complex and difficult decisions lie ahead if the Future Fit Programme is to succeed in delivering the improvements to care and to health that we seek for the populations we serve. There are several potential trade-offs which cannot be avoided. In every one of these there will be a balance to be found, but one which can never satisfy every individual interest:

The 'common good' (for all who look to services in this geography for their care) versus the individual or locally specific good (the preferences of sub groups);

The present versus the future;

Organisational interest versus public interest;

One priority versus another when resources are limited.

It is the role of members of the Future Fit Joint Committee (FFJC) to reach decisions on these, and to do so transparently and objectively.

The Future Fit Programme is a collective endeavour. Working collectively, whilst still acting as separate statutory organisations, requires agreement on ways of working designed to help navigate through issues when it gets difficult and when the 'trade-offs' have to be decided jointly.

We have as a system as part of the STP Programme already agreed the following principle - we are therefore proposing the Future Fit Joint Committee will also hold themselves to account against this, and would ask others to do the same:

"We are concerned with the interests of all of the populations in England and Wales who use health and care services provided within the territories of Shropshire and Telford and Wrekin, whilst acknowledging the specific planning footprint for the STP in Shropshire, Telford and Wrekin. We desire to maximise benefit for that whole population. Whilst our decisions seek to deliver the greatest benefit to the whole population we serve, we will always consider the consequences of any options for either specific local populations or for the needs of minority and deprived groups and will be explicit about how we weight these and our rationale for so doing."

Member Code of Conduct

The public has a right to expect appropriate standards of behaviour of those who serve on the Joint Committee. Members of the Joint Committee have a responsibility to make sure that they are familiar with, and that their actions comply with, the provisions of this Code of Conduct.

GENERAL PRINCIPLES

The general principles upon which this Code is based should be used for guidance and interpretation only. These general principles are:

- Duty - You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. If you are a member of a public body, you have a duty to act in the interests of the public body of which you are a member and in accordance with the core functions and duties of that body.

- Selflessness - You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

- Integrity - You must not place yourself under any financial, or other, obligation to any individual or organisation

that might reasonably be thought to influence you in the performance of your duties.

- Accountability and Stewardship - You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others.

- Openness - You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.

- Honesty - You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

- Respect - You must respect fellow members of your working group, treating them with courtesy at all times.

CONFIDENTIALITY REQUIREMENTS

There may be times when members will be required to treat discussions, documents or other information relating to the work of the body in a confidential manner. Members may receive information of a private nature which is not yet public. They must always respect the confidential nature of such information and comply with the requirement to keep such information private.

All Programme information will be made public (except where it would be in breach of patient or staff confidentiality or of commercial interests). The timing of publication, however, is a matter for the CCG Boards to determine. Members of the Joint Committee are not at liberty to publish information provided to them by the Programme until such time as that information is formally published.

The limited sharing of Programme information by members of Joint Committee within their nominating sponsor/stakeholder organisation is permitted, however, and does not constitute publication under this code. In such circumstances, members must ensure that those receiving the information understand and accept the responsibility not to make that information more widely known.

All Joint Committee members will be required to sign a confidentiality agreement before gaining access to such information.

Enclosure 2

NHS Shropshire, Telford & Wrekin CCG
Future Fit Joint Committee
Terms of Reference

1. Introduction

These Terms of Reference set out the revised process by which Shropshire and Telford & Wrekin CCGs will make joint decisions regarding the Future Fit Programme.

At their respective meetings in March 2017, the Governance Board of Telford & Wrekin CCG and the Governing Body of Shropshire CCG ("Governing Bodies") agreed to a revision of the Future Fit Joint Committee Constitution set out in September 2016, to include 3 independent members, one of whom will be the managerial independent Chair, two of whom will be clinicians, and all of whom will be voting.

The reconstituted Joint Committee will have the single responsibility of determining agreement or otherwise to the recommendations of the Future Fit Programme Board. The CCGs "joint committee" shall be called the Future Fit Joint Committee (FFJC)

2. Establishment

These Terms of Reference are drawn up in line with:
NHS Shropshire CCG Constitution: Section 6
NHS Telford & Wrekin CCG Constitution: Section 6

In the event of contradiction or dispute, this document should be seen as the authoritative document in respect of the NHS Future Fit Joint Committee functions

The CCGs have agreed to establish and constitute a Joint Committee with these terms of reference to be known as the FFJC.

3. Functions of the Committee

Following the Future Fit Programme Board receiving the outcome of the independent review of the option appraisal process and the supplementary IIA report on Women and Children's services, the FFJC will be convened and on behalf of the two CCGs act as the decision-making body:

(a) To receive the recommendation from the Future Fit Programme Board on the outcome of the option appraisal process for the reconfiguration of Acute Hospital Services.
(b) To confirm which options the CCGs believe at this stage remain deliverable and will therefore form part of the NHSE Stage 2 Assurance Process and the CCGs' public engagement.
(c) To confirm or otherwise the Future Fit Programme Boards recommendation of a preferred option that will be presented to: i) the NHSE Stage 2 Assurance Process and ii) to the public in the CCGs' decision making, including formal consultation where appropriate.

4. Membership

The Joint Committee will be constituted solely of voting members.
The Joint Committee will be chaired by a voting Independent Chair. It is expected that this will be an officer from another CCG outside of area.

In addition to the voting independent Chair, the voting members of the Joint Committee shall comprise:

- 3 Clinicians from each CCG (who would be members of the Governing Body)
- 2 Lay Members from each CCG
- 1 Executive from each CCG Governing Body (this will specifically exclude the Joint SROs)
- 2 Clinicians from outside of area

The Voting Independent Chair and the Voting Independent Clinicians will be appointed by NHSE and approved by both the two CCG Governing Bodies.

Powys Health Board will be invited to the FFJC but will be non-voting. This reflects the Powys health Board's position regarding voting.

Observers at the FFJC will include:

- Telford and Wrekin Healthwatch one representative
- Shropshire Healthwatch one representative,
- Shropshire Patient Group one representative,
- Telford Patient First Group one representative,
- Powys Community Health Council one representative,
- Telford and Wrekin Council one representative
- Shropshire Council one representative

All members are required to comply with the NHS Shropshire, Telford and Wrekin CCG Future Fit Joint Committee Principles for Joint Working and Member Code of Conduct.

5. Voting

The voting members (which, for the avoidance of doubt, include any deputies attending a meeting on behalf of the Joint Committee Members) shall each have one vote.
The decision of the Joint Committee would be by majority vote and be binding on both CCGs.

6. Deputies

Any other individual (subject to compliance with the constitution) may deputise for any Joint Committee Member provided that the relevant CCG has made a request in advance of the meeting to the Chair of the Joint Committee to arrive no later than the day before the relevant meeting (or within such shorter period before the meeting as the Chair may in his or her sole discretion decide).

7. Meetings

The Joint Committee shall meet at such times and places as the Chair may direct on giving reasonable written notice to the members of the Joint Committee. Meetings of the Joint Committee shall be open to the public unless the Joint Committee considers that it would not be in the public interest to permit members of the public to attend.

8. Quorum

The quorum for a meeting of the Joint Committee shall be that all of the voting members or their nominated deputy of the Joint Committee must be in attendance.

9. Attendees

The Chair of the Joint Committee may at his or her discretion permit other persons to attend its meetings but, for the avoidance of doubt, any persons in attendance at any meeting of the Joint Committee shall not count towards the quorum or have the right to vote at such meetings.

10. Administrative Support

Support for the Joint Committee will be provided by the Future Fit Programme Team. Papers for each meeting will normally be sent to Joint Committee members no later than one week prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to members earlier if possible.

11. Notice

Either CCG may withdraw from these arrangements and revoke its delegation to the Joint Committee at any time by notice given by its Governing Body to the members of the Joint Committee. Neither CCG can retrospectively revoke the constituted JC or its decisions.

NHS
Telford and Wrekin
Clinical Commissioning Group

NHS
Shropshire
Clinical Commissioning Group

Agenda item:5
Future Fit Joint Committee: 10th August 2017

Title of the report:	Report from the Future Fit Programme Board Meeting on 31st July 2017
Responsible Director:	David Evans and Dr Simon Freeman Joint SROs Future Fit
Author of the report:	Debbie Vogler Programme Director
Presenter:	David Evans Joint SRO

Purpose of the report:

The purpose of this report is to set out the recommendations made by the Future Fit Programme Board on the 31st July 2017 to the Joint Committee of the two CCG.

It also references and summarizes the relevant documents that were received by the Programme Board in concluding its recommendations:

- Annex 1: Future Fit Integrated Impact assessment November 2016.
- Annex 2: KPMG Independent Review of the Option Appraisal Process Report July 2017
- Annex 3: Future Fit Integrated Impact Assessment: Additional Analysis of Potential Changes to Women's and Children's Services July 2017

The aim of the report is:

- To restate a summary of the evidence that was considered by the Programme Board in concluding its decision and recommendations it made to the Future Fit Joint Committee (FFJC) that met on 12th December 2016.
- To present to members of the FFJC the summary findings of the Independent Review of the Programme and the Integrated Impact Assessment for Women and Children that have both been commissioned, reported and considered by the Programme Board since that meeting.
- To present to members of the FFJC the conclusions the Programme Board reached on 31st July 2017 having considered these additional reports and whether it should reaffirm its original recommendations made in December 2016.

Recommendations:

The Joint Committee is asked to:

1. SUPPORT the recommendation from the Future Fit Programme Board that there has been no material evidence presented in the Independent Review of the Option Appraisal or in the W&C IIA Reports that should change the original four recommendations to the Joint Committee as set out in December 2016 and therefore that they should be reaffirmed. Therefore,

2. APPROVE the 4 original recommendations from the Programme Board:

2.1 Whilst 'do nothing' is not seen as a deliverable option, it needs to remain in business cases as the baseline. The narrative during consultation will explain why it has been discounted.

2.2 Option C2 is not clinically deliverable and is therefore is not taken forward into formal public consultation as a deliverable option.

2.3 Both Options B and C1 are deemed financially and clinically deliverable and will therefore form part of the public consultation process.

2.4 Option C1 is taken into the consultation process as the preferred Option

In doing so the Joint Committee CONFIRM:

The options the CCGs believe at this stage remain deliverable and will therefore form part of the NHSE Stage 2 Assurance Process and the CCGs' public engagement.

A preferred option that will be presented to: i) the NHSE Stage 2 Assurance Process and ii) to the public in the CCGs' decision making, including formal consultation.

Enclosure 3

REPORT FROM THE FUTURE FIT PROGRAMME BOARD
TO THE JOINT DECISION MAKING COMMITTEE OF THE CCG BOARDS

10TH AUGUST 2017

Summary and Introduction

1 The purpose of this report is to set out the recommendations made by the Future Fit Programme Board on the 31st July 2017 to the Joint Committee of the two CCG. It references and summarises the relevant documents that were received by the Programme Board in concluding its recommendation and other information that was considered in the discussions.

2 The aim of the document therefore is:

- To restate a summary of the evidence that was considered by the Programme Board in concluding its decision and recommendations it made to the Future Fit Joint Committee (FFJC) that met on 12th December 2016.
- To present to members of the FFJC the summary findings of the Independent Review of the Programme and the Integrated Impact Assessment for Women and Children that have both been commissioned, reported and considered by the Programme Board since that meeting.
- To present to members of the FFJC the conclusions the Programme Board reached on 31st July 2017 having considered these additional reports and whether it should reaffirm its original recommendations made in December 2016.

The Current Position (December 2016 -July 2017)

3 On 12th December 2016 the Joint Committee of the two CCGs met and was asked to receive and approve 4 recommendations from the Programme Board on the outcome of the option appraisal process for the reconfiguration of Acute Hospital Services:

- Whilst 'do nothing' is not seen as a deliverable option, it needs to remain in business cases as the baseline. The narrative during consultation will explain why it has been discounted.
- Option C2 is not clinically deliverable and is therefore is not taken forward into formal public consultation as a deliverable option.
- Both Options B and C1 are deemed financially and clinically deliverable and will therefore form part of the public consultation process.
- Option C1 is taken into the consultation process as the preferred Option

And in doing so,

- To confirm which options the CCGs believe at that stage remain deliverable and would therefore form part of the NHSE Stage 2 Assurance Process and the CCGs' public engagement including formal public consultation.

- To identify a preferred option or options and to present options to i) the NHSE Stage 2 Assurance Process and ii) to engage with the public and involve the public in the CCGs' decision making, including formal consultation where appropriate.

4 As a result of queries raised by the Gateway Process in November 2016 and by Telford & Wrekin CCG and Telford & Wrekin Council since the option appraisal process concluded in September 2016, the Joint Committee of the two CCGs was not able to reach a majority view on these recommendations including the preferred option. The matter was therefore referred back to the Programme Board.

5 In response to these concerns an independent review of the process, scoring and methodology was commissioned and conducted by KPMG. An Integrated Impact Assessment on the move of some of

Women's & Children's Services under C1 to the RSH site was also conducted by Midlands & Lancs CSU Strategy Unit in partnership with ICF.

Reconstituted Joint Committee

6. In parallel with the commissioning of the independent review, the Govern9ng Board of Telford & Wrekin CCG and the Governing Body of Shropshire CCG's respective meetings in March 2017, agreed to a revision of the Future Fit Joint Committee Constitution originally set out in September 2016, to include 3 independent members, one of whom will be the managerial independent Chair, two of whom will be clinicians, and all of whom will be voting.

The reconstituted Joint Committee would have the single responsibility of determining agreement or otherwise to the recommendations of the Future Fit Programme Board.

6 This report therefore has four key elements:

- It provides a summary position of where the Programme got to in its processes and decision making by December 2016, and in doing so references and summarises the relevant key documents that have support these processes and decisions.
- It highlights the key messages from the KPMG Independent Review of the Option Appraisal Process Report
- It highlights the key messages from the additional Impact Assessment Analysis of Potential Changes to Women's and Children's Services and in doing so refers to the original Future Fit Integrated Impact assessment from November 2016.
- It provides a recommendation to the FFJC having received the outcome of this additional evidence on whether the original recommendations made by the Programme board in December 2016 should be reaffirmed.

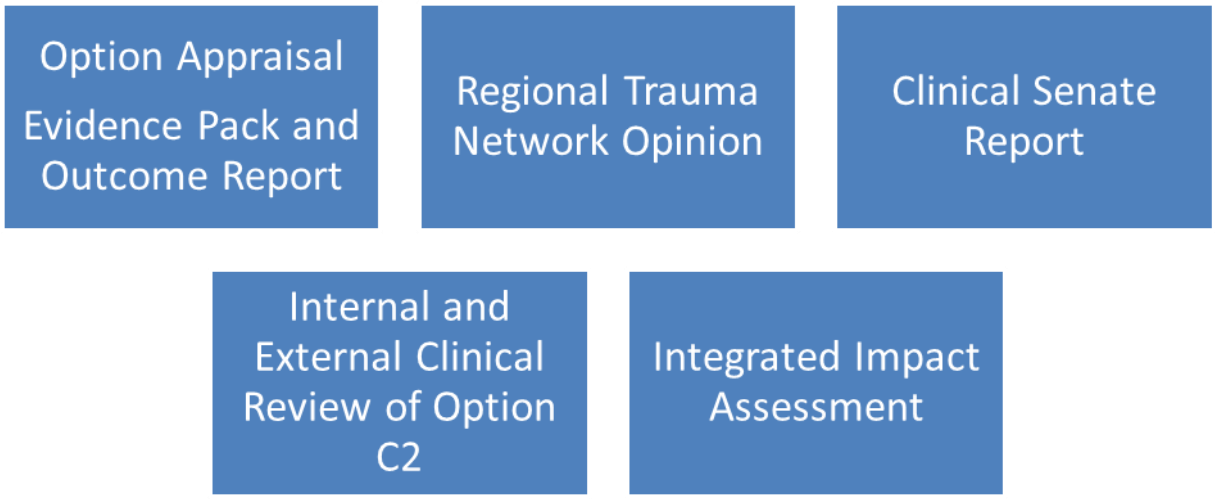
7 The following documents are provided as key Annexes and must be read in conjunction with this summary report in considering this question:

- **Annex 1**: Future Fit Integrated Impact assessment November 2016.
- **Annex 2**: KPMG Independent Review of the Option Appraisal Process Report July 2017
- **Annex 3**: Future Fit Integrated Impact Assessment: Additional Analysis of Potential Changes to Women's and Children's Services July 2017

The Joint Committee Considerations 2016

8 The Future Fit Programme Board met on 30th November 2016 and considered the evidence available to it in order to reach a decision and recommendation to the Joint Committee of the CCGs about which options should be taken to public consultation and which option was the 'preferred option'. There were a number of elements to this evidence that were presented to the Programme Board and to the Joint Committee, shown below:

Figure 1: Key evidence considered by Programme Board and Joint Committee 2016



The Evidence Considered in 2016

9 The **Option Appraisal Process** in 2016 determined:

- In the non-financial analysis, Option C1 ranked 1st over Option B by a margin of 21.1%. The analysis demonstrates that, although various changes to the weighting and/or scoring of options could reduce that margin, no single analysis undertaken prompts a switch in ranking;
- In the financial analysis conversely, Option B ranked 1st over Option C1 by a margin of 0.8%;
- In the overall economic analysis which combines the result of the financial and non- financial analysis, it was found that Options B and C1 score significantly higher than Options A and C2.
- Depending on the methodology used, Option C1 out-performs Option B by a margin of either 10.2% (50:50 weighting of combined scores) or 25.7% (cost per benefit point).

On the basis of these analyses, therefore, Option C1 was the option that offered the best value for money, including in respect of the 'no change' option (Option A) and therefore was preferred.

10 **The WM regional Senate Review** took place in October 2016. It made a series of 18 recommendations relevant to all options and supported the case for change and the clinical model:

"The Panel was of the view that a clear and compelling case for change was made, based on sound evidence presented to it on current performance, improvements seen in other regions by reconfiguration of services with multi-site Trusts, the potential long-term benefits, and alignment with national NHS strategy"

11 They acknowledged that the decisions the health economy are trying to make are difficult:

"We were made aware of the differing current and future demographics pulling maternity and paediatrics toward PRH where it is has recently been built but more elderly around Shrewsbury pulls in the opposite direction. Moving the Trauma unit and therefore other acute and time-dependent services from Shrewsbury might disadvantage residents of Powys but advantage residents of Telford.

Decisions are difficult and trade-offs inevitable but the time has come to make them. After all, both sites will get considerable and needed capital investment."

12 The Clinical Senate also supported the colocation of Obstetrics and Paediatrics with the Emergency Centre and that therefore C2 would not be clinically sustainable or deliverable. Option C2 is a variant option of C1 with the Emergency Centre at Royal Shrewsbury Hospital but with Women and Children's remaining sited on the Planned Care site at Princess Royal Hospital.

13 In light of the internal and external review reports on C2 and the Senate Report concluding the same, the Programme Board unanimously agreed that C2 is not clinically deliverable and is therefore should not be taken forward into formal public consultation as a deliverable option**.**

14 Future Fit was discussed at the request of the programme at the **North West Midlands and North Wales Trauma Network's Governance Meeting** In November 2016. The view of the Network was that the preferred site for the Trauma Unit should be Shrewsbury. This reflected its geographical location and an increased risk for the group of patients from Powys if it was sited at Telford. Wherever the Unit is sited the Network emphasised that it would need to comply with the National Standards for Trauma Units. Shrewsbury is already accredited. Telford would have to undergo a formal accreditation process to become a Trauma Unit.

Integrated Impact assessment 2016

15 In support of the decision making process, the Programme Board and FFJC also received the Integrated Impact assessment report (IIA) on acute services*: Future Fit Integrated Impact assessment November 2016.* The scope of the report and summary of the key findings are detailed below and the full report can be seen in Annex 1.

16 The Integrated Impact Assessment (IIA) report completed in November 2016 was produced jointly by ICF and the Strategy Unit, Midlands and Lancashire Commissioning Support Unit. The aim of this IIA was to conduct a robust, independent assessment of the potential impacts and equality effects of the options. An IIA includes economic, environmental, health and equalities impact assessments. A three stage process was undertaken to: scope potential impacts; assess key impacts; and, assess equality effects including those identified as having protected characteristics under The Equality Act (2010).

17 The IIA assessed potential impacts for different localities in addition to for the area as a whole and for specific equality groups. The scope was restricted to assessing the impacts of the changes to acute hospital care. The IIA adopted a 25 year forward view, assessing the impact of the changes over a 25 year timescale.

18 The IIA also provides recommendations for how any negative impacts and effects could be mitigated and positive impacts and effects maximised.

19 The purpose of any impacts assessment is not to determine the decision about which option would be selected; rather they act to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve.

20 The IIA is a live resource that is intended to provide the basis for further assessment as the programme progresses through different stages. This includes the mitigation strategies which will continue to be refined during subsequent consultation.

21 Subsequent phases of the IIA process will refine the Mitigation Action Plan to be developed during the consultation phase. During the consultation phase, experts and local people will also be offered the opportunity to provide any further information that can inform the action plan.

The Population

22 Over the next 25 years the population across the catchment is projected to grow and become increasingly weighted towards older age groups. In 2036 23.5% of the combined catchment will be age 70 and over; 18% in T&W, 25.4% in Shropshire and almost 29% in the affected parts of Powys.

Three age groups are potentiality more sensitive to changes in local acute hospital services than others: pre-school age children; young adults; and older people. Children 0-4 have amongst the highest rates of

A&E attendance of any age group (2014/15 in Shropshire 310 per 1000 population and 354 per 1000 population in Telford).

Young adults 20-29 represent 14.6% of all A&E attendances at RSH and PRH combined. The geographical distribution of young adults is similar to that of young children with the highest concentrations in Telford & Wrekin. There are also relatively high concentrations in parts of Shrewsbury & Atcham and Oswestry.

People aged 60 and over account for over 27% of all A&E attendance and those over 75 are the most likely of any adult age group to attend. The geographical distribution of older people is largely the inverse of that of young people with the highest proportion in the most rural catchment parts namely Powys, South Shropshire and Bridgnorth.

Despite the overall low levels of deprivation in the catchment area, there are a number of wards within and immediately around Telford and two wards within Shrewsbury that are amongst the 20% most deprived in England. This equates to 14,093 people in Shrewsbury and 45,326 in Telford. There are also areas that are amongst the 40% most deprived nationally in other parts of Telford, The Wrekin, Shrewsbury and Atcham, South Shropshire, Oswestry and North Shropshire. The affected parts of Powys contain two areas that are amongst the 20% most deprived with a combined population of 3,448.

Key Findings and Impacts

The report concluded that in terms of overall health impacts, in either option, (B or C1) the main changes are expected to sustainably improve the effectiveness, safety and patients' experience of clinical care provided to the affected populations.

The projected positive overall health impacts achievable under both Options B and C1 are the most significant of all the impacts assessed. However these are partly offset under option B by projected negative impacts on **access** to urgent and emergency care of a similar scale.

It could be said that the greatest benefits will accrue to those types of patients who are the higher users of hospital servcies than the general population;including young children, young adults, older people, people with disability, BAME groups and people living in deprivation.

23 For travel times to access urgent and emergency care, the majority of urgent and emergency care patients (76% - 108,133) would be unaffected. Option B generally has an adverse impact on patients from South Shropshire, Shrewsbury and Atcham, Powys and Oswestry. Option C1 generally has an adverse impact on North Shropshire, Bridgnorth, Lakeside South, The Wrekin and Hadley Chase.

24 For travel times to access non-complex planned care, some patients would face longer travel times by car or by public transport to the planned care site. Option B generally has an adverse impact on patients from North Shropshire, Bridgnorth, Lakeside South, The Wrekin and Hadley Castle. Option C1 generally has an adverse impact on South Shropshire, Shrewsbury and Atcham, Powys, Oswestry and (for patients travelling by public transport) north Shropshire.

25 In Option B (where the trauma unit would be located in Telford and therefore the majority of planned care in Shrewsbury), it would no longer be possible to access non-complex planned care provision directly by public transport from any area in Telford and Wrekin, and multiple changes would be required from over half of Telford and Wrekin to access planned care at RSH. Shropshire and Powys would be largely unaffected. In Option C1, the impacts are largely reversed.

26 The potential equality effects arising out of each impact have been assessed for all the protected characteristic groups defined under the 2010 Equality Act and for deprived groups in the catchment area. In practice there was little variation in the projected equality effects between the options. The projected positive health impacts would have a positive equality effect on several groups. Equally, these groups would potentially experience a negative equality effect arising out of the projected impact on access to urgent and emergency care.

27 Data is not routinely reported on the proportion of A&E attendances that are made by people with a disability. However the wider evidence- base strongly suggests that disability is associated with higher levels of need for emergency services – particularly mental health and learning disabilities.

28 No evidence was identified to indicate that pregnant women and mothers of newborn children have disproportionate or differential needs in relation to acute hospital services. However, under one of the options (C1) other women and children's services would be relocated. This was not in the scope of the report.

29 However it was noted that one key point of difference between the options concerns young children, women, and the pregnancy/maternity group, who may experience a negative equality effect under Option C1 arising from the relocation of Women & Children care from PRH to RSH.

30 There are far fewer equality effects across the projected economic, social and environmental impacts. No single group emerges from the assessment as being significantly more disadvantaged than another.

31 Section 7.3 of the full IIA Report in Annex 1 describes strategies for mitigation and priorities for further investigation. Subsequent phases of the IIA process will refine the Mitigation Action Plan to be developed during the consultation phase. During this consultation phase, experts and local people will be offered the opportunity to provide any further information that can inform the action plan

The Programme Board and Joint Committee Conclusions 2016

32 Four recommendations were made to the Joint Committee based on analysis of all the evidence received by the Programme Board as detailed in paragraph 3 of this report.

33 In addition it was acknowledged that the impact assessment focused primarily on only the impacts of acute service change and that there are elements of the Future Fit programme that have implications beyond acute services for other types of care such as women and children's. A number of stakeholders felt that the potential impacts of these also needed to be assessed.

This was acknowledged by the Programme but not felt sufficient to stop a recommendation on a preferred option and that the further work could be done in parallel alongside wider consultation with the public and other stakeholders.

34 The Joint Committee met on 12th December and received a summary of the evidence described in this report together with the full Option Appraisal Report and Evidence Pack and the IIA Report in full.

35 The recommendations did not achieve a majority vote with a split vote reflective of the differing position of the two CCGs.

36 As a result of this position, together with the recommendations from the Gateway Review agreement was reached to carry out the two additional pieces of work prior to proceeding further: an independent review of the process, scoring and methodology of the option appraisal and an Integrated Impact Assessment on the potential move of some of Women's & Children's Services under C1 to the RSH.

Independent Review of the Option Appraisal Process

37 KPMG were selected to provide an independent view on the options appraisal process which culminated in late 2016 which was designed to select the preferred option on which to conduct formal public consultation. In undertaking this review they compared written evidence to best practice guidance produced by both NHS England and NHS Wales.

38 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: strong public & patient engagement; a clear clinical evidence base; consistency with current & prospective need for patient choice; support for proposals from clinical commissioners. Proposals must also demonstrate affordability. These tests formed the basis of this review.

39 KPMG was provided with three objectives centred on objections to the recommendation made by the Programme Board to the Joint Committee:

- Review of Shortlisting Process Methodology
- Review of the Design of the Evaluation for Shortlisted Options
- Review Enactment of the Evaluation for Shortlisted Options

40 The full KPMG report *Independent Review: Future Fit Programme Options Appraisal process July 2017* can be found as Annex 2
Some minor points were noted under each objective where improvement could have been made in retrospect; these are fully noted in the detailed sections of the report. Headline findings against each of the objectives and associated comments are summarised below.

41 *Shortlisting process methodology*

- The shortlisting process undertaken incorporated and met all four key tests, as per NHS England guidance: commissioner support, clinical evidence, public engagement and patient choice. The process was therefore deemed robust.
- Issues of affordability and alternative community 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.

42 *Design of the Evaluation of 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 nonfinancial scores.
- The design of the process for evaluating the shortlisted options was found to incorporate all four key tests set by NHS England. The design was therefore deemed robust.
- 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.
- 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.

43 *Review of Enactment of the 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

44 *Other Areas for Attention*

Various points were highlighted in the reports where the Programme could be more aligned with best practice. The majority of these have been captured by three overarching areas for `attention, set out on page 8 of the Report:

- Clarity around funding availability and affordability and assurances around the proposed funding solution for the programme, including the mix of sources if PDC is considered unlikely to be sufficient and an analysis of what 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 with reconfiguration of community care, and specifically those elements directly impacting on local acute care flows, needing to be rapidly described and costed
- Clarity around governance and conflict resolution. This was primarily around reconstitution of the joint committee with three independent voting members, including an independent chair.

45 In the case of 'affordability'/capital availability and fully developed community models, these are currently being reviewed by the CCGs and will be considered by each CCG Board as part of the pre-consultation Business Case approval process. Assurance of whether these areas have been sufficiently addressed at this stage in the process will be tested though the NHSE Stage 2 Assurance Process. This fits well with the KPMG recommendation that these issues are addressed by the Programme before moving to public consultation.

Impact Assessment Analysis of Potential Changes to Women's and Children's Services (W&C IIA)

46 The full report: *Future Fit Integrated Impact Assessment: Additional analysis of potential changes to Women's and Children's services 11 July 2017* can be found in full as Annex 3. This complements the IIA on acute services conducted in 2016 and both should be read in conjunction when concluding on any relative impacts analysis on our populations.

In reviewing this report, it should be noted that the impacts for women and children represent a sub-group of the impacts for the population as a whole. The impacts across the population were fully stated in the 2016 IIA and the scale of impacts for women and children should be reviewed in this context.

47 The aim of this additional analysis was to conduct a robust assessment of the potential health, access, economic, social and environmental impacts and equality effects of the proposed changes to Women's and Children's services.

W&C IIA Scope

48 It was agreed by the Programme Board that the proposed specification for the work should be developed and agreed by the IIA steering group in detail to ensure it is fit for purpose. The legacy IIA Steering Group was therefore reinstated for the work and the membership supplemented with the necessary expertise. The Steering Group had GP representation from the CCGs, Powys THB, public health experts from both Shropshire and T&W Council. doctors, nurses and midwives from SaTH Women & Children's Centre together with Healthwatch and other patient representative Groups from the two CCGs and Powys.

49 It was also agreed that the steering group should commence the formulation of a mitigation action plan for women's and children's services, in anticipation of the final report, which would be further developed throughout the consultation process.

50 Under Future Fit Option B the current configuration of services for women and children would largely be retained, although the majority of gynaecology day case services would also be delivered at RSH rather than at both sites.

51 Under Option C1 in-patient services for women and children would be relocated from PRH to RSH. Most out-patient services would continue to be delivered at both sites. The majority of gynaecology day case services would be delivered at PRH.

52 The assessment of **health impacts** in the report was informed by a clinical workshop with a wide range of expert stakeholders from across the local health and care economy. A large number of data sources were reviewed as part of this work attempting to examine relative need, access and outcomes for our different populations. Findings from a public survey and equalities activities undertaken by Shropshire CCG, Telford and Wrekin CCG, and Powys Teaching Health Board have also been drawn upon within this report.

53 In order to gauge current levels of accessibility and measure the impact of any service relocation, a quantitative survey was developed and distributed through a variety of channels across the region.

54 The objectives of the survey were to provide qualitative data and to gauge current levels of accessibility and to measure how this would be impacted by any movement in services. It was also to understand key influencers and motivations behind choosing where individuals seek treatment. The survey was for anyone who has used the services for women and children at the Princess Royal Hospital in Telford in the last two years as a patient, relative, friend or carer. Overall 863 responses were received. The analysis can be found in Annex 3 of the Report.

55 The assessment of **access impacts** was based on statistical analysis of journey times and distances. To aid comparison both car and public transport journey times have been calculated for daytime off-peak travel (between 10am and 4pm). Maps are used to provide a visual representation of journey times. The executive summary of the report describes the net effect on median journey times (so a small number of very long or very short journeys are not skewing the figures) across the whole population whilst the detailed narrative provides additional information on average (mean) journey times, the distribution of all journey times as well as present the impact on journey times and distances for patients within each of the 9 localities.

56 The assessment of **equality effects** explores the potential disproportionate and differential equality effects of the proposed changes on different groups in the local population, including those groups protected under the 2010 Equality Act. Women and Children are of course are a category within these groups.

57 It is impossible to summarise and make conclusions from all the analysis of data that has formed part of this work in this report and the full report must be read for individuals from their different perspectives to draw fully on their own conclusions.

Key Findings and Impacts

The Affected Population

58 The affected population for women and children is described within the report. It is useful to understand the scale of services that formed part of this supplementary IIA relative to the whole in interpreting the findings of the report.

- The total combined catchment population served by the Trust is 542,222.
- There are 223,303 adult women living in this catchment area: 127,807 in Shropshire, 66,836 in Telford and Wrekin, and 28,660 in the affected parts of Powys.
- There are 104,588 children living in the catchment area: 55,462 in Shropshire, 36,945 in Telford and Wrekin, and 12,181 in the affected parts of Powys
- In 2015/16 there were over 640,000 patient contacts within SaTH (Ref SSP Draft OBC 2016)

59 Within the scope of the activity and services included in the supplementary IIA there were:

48,455 users of Women's and Children's Centre Services in 2015/16

7, 621 used in-patient Women's services (9,647 spells of care)

4,633 used in-patient Children's services (5,840 spells of care).

60 It is primarily these inpatient services that would potentially move from the W&C Centre at Telford onto the Emergency centre site under the option C1.The report begins by describing the demographic differences between the different populations:

- Telford and Wrekin has a higher proportion of women aged 18-44, BAME women and women living in deprivation than the other two areas. However, in absolute terms Shropshire is home to the largest number of women aged 18-44 (43,670 compared to 29,206 in Telford and Wrekin and 9,163 in the affected parts of Powys).
- Telford and Wrekin has the largest number of BAME women (4,879 compared to 2,556 in Shropshire and 311 in the affected parts of Powys) and women living in deprivation (17,185 compared to 5,408 in Shropshire and 1,354 in the affected parts of Powys).
- In absolute terms, Shropshire is home the largest number of women living in a rural area (73,119 compared to 23,720 in the affected parts of Powys and 4,143 in Telford and Wrekin
- The characteristics of the child population in the catchment area follow a similar pattern to the adult female population, with more children living in rural areas in Shropshire and Powys, and higher proportions and numbers of BAME and deprived children in Telford and Wrekin
- Infant mortality rates in Shropshire (3.1 per 1,000 live births) and Powys (3.8 per 1,000 live births) are slightly below the national average (3.9 per 1,000 live births), while they are higher in Telford and Wrekin (6.5 per 1,000 live births)

Key Findings on Impacts

61 Both the Executive Summary and Section 8 of the full report provide a summary the conclusions and recommendations of the work within this supplementary IIA report and are represented here.

- It should be noted that the impacts for women and children represent a sub-group of the impacts for the population as a whole. The impacts across the population were fully stated in the 2016 IIA and the scale of impacts for women and children should be reviewed in this context.
- Option B and Option C1 would both have positive health impacts for all users of Women's and Children's services across the catchment area.
- Most **access** impacts are neutral under Option B and negative under Option C1 at the scale of the catchment area as whole, due to higher overall average journey times. However this varies widely for different localities within the catchment area, with some projected to experience shorter journey times, including some who currently have the longest journeys, and others longer.
- Under Option C1 the most positive impacts on **access** would be experienced in Shrewsbury & Atcham, Oswestry and Powys. The most negative impacts would be experienced in Bridgnorth and the three Telford and Wrekin localities: Hadley castle, Lakeside South and the Wrekin. The average journey times though do conceal variations in the projected journey times for women and children who live in different localities.
- The projected economic, social and environmental impacts are all either of a minimal scale, neutral or uncertain at the time of writing.

62 Detailed evidence on the health characteristics and locality profiles of different groups of women and children are included in the report and are provided in Annex 3 of the IIA report. It includes detailed locality profiles of population characteristics, a description of utilisation rates of services within the scope of this IIA and average travel times in car and on public transport. The reader is commended to read the whole report.

63 Activity at any of the SATH sites during 2015/16 are used as *proxy measures of need* by lower super output area and are included as maps. However people across the footprint may use other providers which will not be included. Relative rankings of utilisation using crude population rates together with actual numbers in 2015/16 are then provided by locality.

For paediatric admissions, The Wrekin is the locality with highest population ranking and for actual activity it is Hadley Castle.

For birth inpatient spells, Lakeside South has the highest population ranking with the highest actual number of births from Shrewsbury & Atcham

For neonatal admissions, Powys has the highest population ranking with the highest actual number of admissions for neonates from Shrewsbury & Atcham

For gynaecology day rates, the Wrekin has the highest population ranking with the highest actual number of Gynaecology day cases from Shrewsbury & Atcham.

Key Findings on Equality Effects

64 Several groups of women and children would experience a combination of positive and negative equality effects arising from the projected impacts. They may be disproportionately most likely to use the affected services, and therefore benefit the most from the project positive health impacts. Equally some may be disproportionately affected by the longer projected journey times from certain localities.

65 There are some potential cross cutting impacts and equality effects. Women and children in different protected characteristic groups (as defined by the 2010 Equality Act) may have differing health and healthcare experiences, which could mediate how they would be affected by the proposed changes.

These groups include:

- Pregnant and maternal women: key user group of the affected services; main determinants of healthcare experiences are safety, choice and continuity of care.

- New-born and neonate children: the most likely of any age group to require specialist medical care due to premature birth and/or a medical condition that requires monitoring or specialised treatment.

- BAME women: higher than average rates of maternal mortality and stillbirths (particularly for mothers born outside the UK).

66 Awareness and understanding of the detail of the proposed changes to Women's and Children's services is currently low amongst the affected population, which is likely to be mediating the concerns and views they currently have.

67 Perceptions of the existing Women's and Children's services at PRH are very positive, which prompted questions about value for money of the proposed changes and a need for reassurance that any relocated services would meet the same standards.

68 Journey times to access the affected services are shared concern for women and children amongst all protect characteristic equality groups. Equally, specific combinations of characteristics and circumstances may lead to particular differential effects.

Mitigation and enhancement

69 Key recommendations for mitigation and enhancement include: reducing unnecessary journeys and transfers; safer care pathway agreements for children; and reducing risk factors before, during and after pregnancy.

70 The following priorities for further investigation were also identified:

- Work to enhance the availability of urgent services in remote locations;
- Additional data and information requirements to better understand patient experience;
- A strong public awareness campaign surrounding the correct service to access in the case of a medical emergency potentially targeting the population as a whole, with emphasis on current and future services across the sites.
- Build on existing and planned public health interventions and consider a more proactive/aggressive system-wide approach to prevention, bridging deprivation and other equalities gaps which would more effectively and appropriately support the reconfiguration and improve outcomes for women and children.
- Continued Engagement with West Midlands Ambulance Service and Welsh on the proposed model and on Ambulance response times across Shropshire, Telford & Wrekin and Powys.
- Consideration as to whether a review of the location of Breast Services provided by Shrewsbury & Telford NHS Trust is required.

71 Finally in line with an assessment against NHS best practice guidance, it is the view of the programme at this stage that there has been an appropriate assessment of the impact of the proposed service change on relevant diverse groups; that appropriate engagement has taken place with any groups that may be affected and that possible action and next steps to be taken to mitigate any adverse impacts have been identified.

72 It must be restated however that the IIA is seen as a live resource that is intended to provide the basis for further assessment as the programme progresses through different stages. This includes the mitigation strategies which will continue to be refined during subsequent consultation.

73 Subsequent phases of the IIA process will refine the Mitigation Action Plan to be developed during the consultation phase. During the consultation phase, experts and local people will also be offered the opportunity to provide any further information that can inform the draft action plan.

Reflections on the two Impact Assessments

At the Programme Board on 31st July there was considerable debate on what conclusions can be drawn from impact assessment reports. It is important that both IIA's are considered alongside each other and also that there are aspects not covered by the two IIA's.
This section draws on that discussion.

74 The IIA in 2016 identified that for the majority of people they will continue to go to the hospital they go to now for urgent and emergency care. For travel times to access urgent and emergency care, the majority of urgent and emergency care patients (76% - 108,133) would be unaffected. Option B generally had an adverse impact on patients from South Shropshire, Shrewsbury and Atcham, Powys and Oswestry. Option C1 generally has an adverse impact on North Shropshire, Bridgnorth, Lakeside South, The Wrekin and Hadley Chase.

75 Much has been made of the potential move of the Women and Children's Centre under Option C1 and any potential impact it might have on disadvantaged groups within our catchment population. The W+C IIA report itself concludes through the engagement work that the public awareness and understanding of the detail of the proposed changes to Women and Children's services is currently low amongst the affected population. Offering assurances to the population is key on what services will be available locally under each option.

76 The majority of services would remain in the existing Women and Children's Centre in Telford under Option C1 including the majority of Gynaecology day cases. It is only the Inpatient Obstetric and Paediatric services that would need to be colocated with the Emergency Centre (EC).

77 Most Women and Children will receive the majority of their care and treatment in the same place as they do now in either option:

- Midwife-led unit, including low-risk births and postnatal care
- Maternity outpatients including antenatal appointments and scanning
- Gynaecology outpatient appointments
- Early Pregnancy Assessment Service (EPAS)
- Antenatal Day Assessment
- Children's outpatient appointments
- Neonatal outpatient appointments.

The majority of Children who currently access urgent and emergency care can also continue to come to their local hospital in the proposed configuration of services under either option.

78 High risk women and children's services need to be based on the emergency site. This is the clear view of the experts both locally and nationally.

79 When considering both IIA's the question is what impacts should take precedent and be the primary driver in considering the options; Emergency care to the wider population or the location of the Obstetric and inpatient paediatric services, or the location of planned care services

80 Strong link between access and travel time and outcomes are not always evident. There is clear evidence however received by the programme that the increase travel time of option B for trauma patients would adversely impact on health outcomes for some patients. Expert clinical advice states categorically that there will be worse outcomes for the people of Powys under option B should the trauma unit move to Telford.

81 Influencing health outcomes is difficult, and what is not always evidenced is that adjacency is necessarily equivalent to better care. For example, in the case of stroke care or in the increased travel time to access primary PCI, the time from onset of symptoms to accessing the most appropriate diagnostics and professional opinion and therefore the most optimal treatment, is more relevant and can result in better outcomes.

82 It must be remembered in the proposed models that those most at risk will be taken directly by ambulance to the EC or be directed there by their GP for assessment. The W+C IIA sets out the small number of children who need to be admitted and will need to be safely transferred potentially from the UCC at the planned care site to the emergency site. It is worth noting that the average length of stay for children is a little over 1 day.

83 Both IIA reports concluded that in terms of overall health impacts, in either option, (B or C1) the main changes are expected to sustainably improve the effectiveness, safety and patients' experience of clinical care provided to the whole population. .

84 The 2016 IIA describes the disproportionate use of A&E services for some including the very young, the older population, BAME, those with disabilities and those from the most deprived localities. It is worth restating that the majority of these people will continue to use the A&E they do now through the 24/7 urgent care centres. The greatest benefits will accrue to those types of patients who are the higher users of hospital services than the general population. In the case of A&E attendances and urgent care, it must be said that utilisation rates are not necessarily a good proxy for need for acute services, but rather a need for some form of urgent care.

85 In the W&C IIA Annexes locality profiles, activity and relative admission rates by locality for obstetrics, neonates, paediatrics and gynaecology procedures, are set out and in these cases are perhaps a reasonable proxy for need. The information is comprehensive and shows differences in relative rates across the 9 localities but also actual numbers of patients from localities need to be given due consideration. It is supported by other annexes that include some outcome date for example relative differences in planned and emergency caesarean section rates and in neonatal length of stay that we see in the different localities across the catchment. The dilemma is should these differential impacts influence the location of acute services?

86 Where there is a difference in access or need suggested by demography, is this a difference to the extent that outcomes will be different and we need to change the plan, or to the extent that further information will be needed and robust mitigations in place and evidenced before implementation?

87 Other Issues clearly affecting outcomes are Public Health issues – smoking, obesity, accessing community services early in pregnancy and these are unrelated to hospital services. They do need addressing, and should have additional focus, but they are not primarily addressed by inpatient care, but by wider community based Public Health work.

88 Within the IIA, including the Women and Children's impacts as described and other evidence presented, the link between differences in outcomes and access and deprivation may not be clear.

89 As the WM senate concluded in their review, dilemmas and trade- offs emerge from studying the two IIA reports and which the decision making bodies need to consider. They identify clearly, for instance, that some people will travel further under option B than options C1, for some services, and vice versa. However what it doesn't show is the resultant health outcome from these different travel times.

90 All members of the decision making bodies will read the IIA in their own way, and likely focus on a different section of the population they are tasked with looking after. What the Joint Committee need to be absolutely sure of though, is that any plans made on acute provision, and any changes to plans made, are made on the basis of clear evidence that outcomes are affected by those decisions.

91 It is worth restating that the purpose of any impacts assessment is not to determine the decision about which option would be selected; rather they act to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve. The IIA is a live resource that is intended to provide the basis for further assessment as the programme progresses through different stages. This includes the mitigation strategies which will continue to be refined during subsequent consultation.

92 Subsequent phases of the IIA process will refine the Mitigation Action Plan to be developed during the consultation phase. During the consultation phase, experts and local people will also be offered the opportunity to provide any further information that can inform the action plan.

Conclusions

93 In reviewing all the additional evidence presented as part of the two reports:

- Independent review : Future Fit programme Options Appraisal Process report July 2017;
- Future Fit Integrated Impact assessment: Additional Analysis of Potential Changes to Women and Children's Services

94 The Programme Board therefore have concluded that:

- The Independent Review of the Option Appraisal Process has not identified any issues to the process that would have materially changed the outcome of the preferred option; and that

- The Option Appraisal Process for determining a preferred option was robust in its design and enacted in line with what was agreed by the Programme and its sponsors.

- There are a number of *Areas for Attention* identified in the report that the CCGs are aware of and will be addressed within the Pre consultation Business Case (PCBC) which will be received by the CCG Boards in August

- The Supplementary Integrated Impact Assessment on Women and Children's Services has been completed in line with NHS best practice guidance including:

    - An appropriate assessment of the impact of the proposed service change on relevant diverse groups;

    - Appropriate engagement taken place with any groups that may be affected.

    - Possible action and next steps to be taken to mitigate any adverse impacts have been identified.

- The IIA has identified that both options have positive health impacts for all users of Women's and Children's services across the catchment area.

- The IIA has identified several groups of women and children who would experience a combination of positive and negative equality effects arising from the projected impacts. They may be disproportionately most likely to use the affected services, and therefore benefit the most from the project positive health impacts.

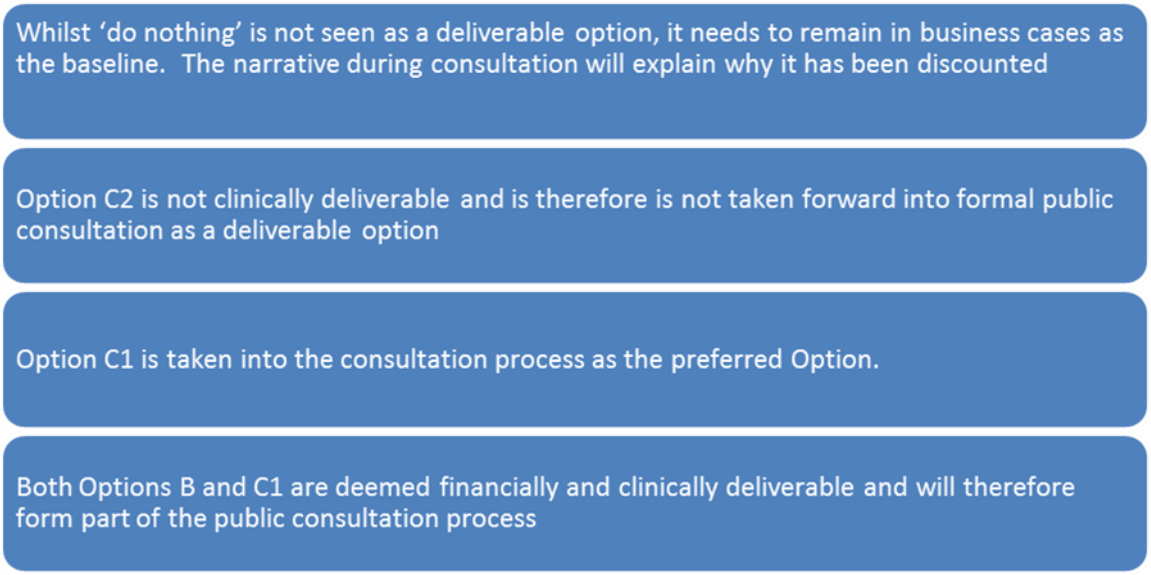
- There are however, some groups that may be disproportionately affected by the longer projected journey times from certain localities.

- A number of areas for mitigation have been identified and include build on existing and planned public health interventions and considering a more proactive/aggressive system-wide approach to prevention, bridging deprivation and other equalities gaps which would more effectively and appropriately support the reconfiguration and improve outcomes for women and children.

- A draft mitigation plan will require further development and further impacts and mitigation strategies will continue to be refined during subsequent consultation.

Recommendation

95 The Joint Committee is therefore asked to consider the evidence in front of them and support the recommendation from the Programme Board that there has been no material evidence presented in the Independent review of the Option Appraisal or in the W&C IIA Reports that should change the original four recommendations to the Joint Committee as set out in December 2016 and therefore they should be reaffirmed:



In doing so,

The Joint Committee will:

- Confirm which options the CCGs believe at this stage remain deliverable and will therefore form part of the NHSE Stage 2 Assurance Process and the CCGs' public engagement.
- Confirm a preferred option that will be presented to: i) the NHSE Stage 2 Assurance Process and ii) to the public in the CCGs' decision making, including formal consultation.