To: NHS London

North West London
Shaping a Healthier Future

Visit 1: Emergency and Urgent Care
Date of visit: 18 April 2012

NCAT Visitors
Dr David Colin –Thome
Dr Tajek B. Hassan
Mrs Catherine McLaughlin

Introduction
The National Clinical Advisory Team (NCAT) was invited by the Shaping a healthier future Programme Board for the Joint Committees of Primary Care Trust (JCPCT) of North West London, to assess the proposals for reconfiguration of health services, in advance of public consultation. It was decided to first look at the plans for emergency and urgent care and the bigger picture re-organisation of the hospital services which concern this visit; and secondly to look separately at maternity and paediatric services, that visit to take place on 25 April with maternity and paediatric experts.

The NCAT team, Dr D Colin-Thome, Dr Tajek Hassan, Mrs C McLaughlin participated in a one-day review of the work done to date on the proposed changes to services. The scale and complexity of the reconfiguration is challenging and this report attempts to summarise our findings as well as draw attention to areas that require further work in advance of public consultation.

Meeting Schedule with NCAT
Attached at Appendix 1 is the meeting schedule, detailing whom NCAT met with on Wednesday 18th April 2012.

Evidence and supporting documentation
NCAT were furnished with details of the work done to date, minutes of meetings, terms of reference, project initiation documents, risk register, a series of slides detailing the thinking and analysis undertaken on bed configuration, capital spend, workforce implications and engagement with stakeholders. (Appendix 2)

Background and Context
The NHS in North West London serves a population of 1.85m and has 9 acute hospitals and a further 5 specialist hospital sites.
In its 2010 strategy NHS North West London set out its overall vision – to localise care close to patients’ homes, to centralise specialist care and to integrate care for people with long term conditions and the elderly. This set out how the activity flows between providers would change to reflect this shift from acute to out-of-hospital settings. It did not explicitly say what the service configuration would look like for each provider but instead asked providers to begin this thinking, based upon likely changes in activity flows.

The Case for Service Change

Both commissioners and providers in NWL believe that services in NWL will need to change to deliver better care more effectively. There are four major reasons underpinning the need to change services;

- **The need to ensure care is delivered in the most appropriate setting** – a high volume of patients use acute services who could be treated closer to home by primary care or community care.

- **The need to make better use of the clinical workforce** - a key element of the quality standards is better workforce provision. Research demonstrates that consultant-delivered services achieve better clinical outcomes. Consolidating some services onto fewer sites would enable the consolidation of the associated workforce; improving the service available to patients and, in particular, supporting a move towards 24/7 consultant presence in key specialties of the emergency care system (e.g. in the Emergency Departments of major centres and at least 16 hours of cover / day for others.)

- **The need to centralise some services** – there is increasing evidence that units with larger volumes of activity achieve better clinical outcomes as long as they are appropriately resourced to meet the needs of the increased workload and its complexity.

- **Need to make effective use of resources and achieve financial sustainability for commissioners and providers in NWL** - budget forecasts suggest that the current
configuration of services is unsustainable. Services are fragmented across community and acute sectors and need to be better integrated. Consolidation of some acute services onto fewer sites would enable more efficient use of resources. In the present climate this is a vital area for consideration.

The health needs of the people of North West London are changing; demands on health services are increasing; the way care is organised requires some change.

Providing suitable care, to support prevention, to improve access to high quality GP services and particularly to support the elderly and those with long term conditions, will mean providing more proactive services in the community and spending proportionately more on those services in local communities, and less on hospitals. Doing so could result in 20-30% of patients who are currently admitted to hospitals in NW London as emergencies being more effectively cared for in their community. Progress has been made through initiatives such as STARRS and the ICP, demonstrating that better care for patients is delivered and resources are utilised more effectively and efficiently.

Alongside this, people needing hospital care must be sure of receiving the best possible services, which is not happening consistently across NW London. There are big differences in the quality of care patients receive depending on which hospital they visit and when they visit. Recent analysis across London has shown that those people attending and admitted to hospital during evenings, nights or at the weekend are more likely to die that people admitted at times when more senior staff are available.

North West London has more hospital space per resident than in other parts of the country and uses a greater proportion of the NHS budget on hospital care than average. In addition, the majority of NHS buildings in NW London are in a poor state of repair and three-quarters of hospitals require significant work to meet modern standards, at an estimated cost of £150m.

Financial analysis based on a scenario where ‘no change’ was made to services shows that hospitals in North West London will have significant financial challenges even if they become as efficient as they can be. The acute sector in NWL faces a very challenging period in terms of financial pressures due to a combination of the current starting position, planned activity and tariff reductions, and the requirement to meet new standards. These pressures will result in a financial gap by 2014/15 that, in the current site configuration, would require unprecedented levels of savings to achieve financial viability; in some cases the gap is larger than the productivity opportunity that either the Trust or peer benchmarks suggest can be delivered without service reconfiguration.

The pressures facing Trusts over the coming three years to 2014/15 result in a £332m gap to achieve 1% surplus (taken as the minimum requirement for viability although Foundation Trusts would be aiming for higher surpluses for reinvestment).

Vision
Clinicians have set out three overarching principles that underpin the care that they want to deliver; localising routine medical care, centralising specialist services and integrating primary and secondary care with involvement from social care to give patients seamless care.

Out of Hospital (OOH) visions.
The key component of the vision for community services is around localising routine medical care. Each CCG has developed a vision for OOH care. These visions quantify what
care will be delivered, who does it and where it takes place in order to deliver a clinically and financially viable health economy in 2014/15. Whilst the visions will vary according to local borough needs, there are five core themes on how to transform OOH care.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Easy access to high quality, responsive care to make out of hospital care first point of call for people</td>
</tr>
<tr>
<td>2</td>
<td>Clearly understood planned care pathways that ensure out of hospital care is not delivered in a hospital setting</td>
</tr>
<tr>
<td>3</td>
<td>Rapid response to urgent needs so that fewer people need to access hospital emergency care</td>
</tr>
<tr>
<td>4</td>
<td>Providers (social and health) working together, with the patient at the centre to proactively manage LTCs, the elderly and end of lifecare out-of-hospital</td>
</tr>
<tr>
<td>5</td>
<td>Appropriate time in hospital when admitted, with early supported discharge into well organised community care</td>
</tr>
</tbody>
</table>

Providing suitable care, to support prevention, to improve access to high quality GP services and particularly to support the elderly and those with long term conditions, will mean providing more proactive services in the community and spending proportionately more on those services in local communities, and less on hospitals.

For the acute sector, clinicians have also defined clinical standards, which have supported the development of clinical service models, which will drive the development of reconfiguration options.

The key component of the vision that impacts on acute services is centralising specialist services. Clinicians have used the latest evidence and research and have identified that there are significantly improved outcomes for patient and improved patient experiences when certain specialist services are centralised.

Clinicians have developed a set of clinical standards, based on latest evidence from Royal Colleges, reviews by the NHS in London, NICE guidelines Emergency Surgery and Emergency Medicine (A&E), Maternity and Paediatrics) following the visions that have been developed for these three areas. The clinical standards are summarised as follows;

- Access to senior and specialist skills 24/7
- Access to diagnostics 24/7
- Access to multi professional teams

Underpinned by a rigorous and consistent process.
**Acute clinical service models.**

Clinicians have developed the main acute service clinical interdependencies to determine possible individual hospital configurations.

This has enabled clinicians to develop the Service Delivery Models (SDMs), which have formed the basis of possible service configuration options for hospitals across the Cluster.

The recommended SDMs are shown in the diagram below:
The Proposed Service Model

The following is an overview of the service model being considered by NWL for consultation;

- Out of hospital services will be expanded and improved in all areas
- The 9 current acute sites will retain SDM1 services as a minimum, providing c.75% of all current activity (including specialist activity)
- All Specialist Hospitals (SDM5s) will remain
- The care provided at Elective Hospitals (SDM4s) will continue on the Central Middlesex site
- The remaining decisions are about the location of Major Hospital services (SDM3)

Clinicians have followed a process, supported by activity flow analysis, bed capacity analysis, travel analysis and capital investment projections, to develop the medium list. Clinicians recommend that:

1. SDM3 is the service delivery model that is required to ensure high quality care based on the acute clinical standards
2. Only the 9 existing acute sites should be considered
3. North West London needs 5 SDM3’s. Reducing to 3 or 4 SDM3’s would be a significant scale of change and attempting to implement that change could negatively impact quality of care as well as being lengthy and expensive.
4. Based on available evidence (to support achievement of clinical standards), patient volumes, implications for the clinical workforce and the interdependencies between different acute services and their required clinical support, having more than 5 SDM3s would result in unsustainable clinical rotas. Due to the close geographical locations of the existing acute sites, low blue-light travel times for emergency care mitigate the need to have an alternative to a 24/7 acute take model.
5. Northwick Park and Hillingdon hospitals are proposed as SDM3’s in all options to minimise the impact on access. In addition both hospitals are two of the three hospitals with the largest current bed capacity and will therefore need minimal additional investment.
6. Central Middlesex hospital is proposed to not become an SDM3. Central Middlesex has seen a number of services removed from the site (which it would then need to see relocated back onto the site) and it would require the largest expansion of any site, as it is the smallest of the 9 acute sites in North West London. In addition, it doesn’t have sufficient population to support the location of an SDM3 on the site.

7. An even geographic distribution is proposed to apply to the remaining sites to minimise impact of changes on local residents, leading to the choice of:
   a. Either Hammersmith or St Mary’s
   b. Either Ealing or West Middlesex
   c. Either Charing Cross or Chelsea and Westminster

Views Expressed to the NCAT Team

During the whole of the day, the views of all we met with are captured in the one statement, "do nothing is not an option".

The leaders of the program are obviously keen to move to consultation in June 2012, especially as there is another major organisational change happening in the NHS. The abolition of NHS London and the PCTs is driving the pace for the consultation. However, there are areas within the plan that are sketchy and require some further detailed work before consultation is embarked upon.

Out of Hospital Care - We heard about integrated care pilots and STARRS and were given cogent arguments by those we interviewed as to the value these services are adding for patients. We were given the out of hospital quality standards, which are linked to the vision for care outside of hospital. However, we did not meet any of the operational clinicians, or have an impact assessment of these services on admissions or length of stay.

There is some scepticism about these types of services particularly amongst Emergency Medicine clinicians and acute medical teams as the impact of these services is not clearly quantified and indeed not experienced by acute hospitals who regularly deal with high volumes of patients seeking urgent care. The patient representatives as well as the local authority representatives expressed their concerns about the impact these services are having and are likely to have now and in the future. There was little evidence provided about the services, the scope of the services, the geographical cover, the criteria for taking patients on to the case load how many patients per day are managed by these services, how many admissions are avoided etc. In addition, a lot of emphasis is being placed on acute care, ensuring rotas are robust etc., but the same descriptions, level of detail is not available about community services. If community services are not robust, championed by strong leaders, then this reconfiguration may fall at the first hurdle!

Recommendation

1. The overarching vision for out of hospital care is well articulated but there is insufficient operational detail in particular for the public. Is it enshrined in the model of service delivery for community nursing and therapy services?

2. Ensure capacity and capability exists within the services to operate 24/7

3. The OOH quality standards are not outcome focused and these need to be developed. A clear set of metrics needs to be described that are embedded within existing or future informatics systems that will give confidence to all stakeholders that steady progress will be made in OOH services to support the scale of reconfiguration
proposed. Failure of the metrics to show success will provide warnings on a the areas of the system that need a cost effective focus.

4. The likely impact of out of hospital care on admissions, length of stay needs to be modelled and articulated, so there is system wide confidence in the out of hospital strategy

5. There is a lack of confidence in the capacity and capability of current provision of primary and community services-strategies for addressing this are required in advance of consultation.

Urgent Care Centres
In the proposals all hospitals will have an Urgent Care Centre, each with a common specification and operational framework. This is an excellent proposal and ensures consistency for patients and staff. We did not receive the specifications in the information pack prior to the desktop review. Urgent Care Centres are blighted with the same constraints as emergency departments in terms of staffing, clinical leadership and delivering quality outcomes consistently.

There is a good understanding of what needs to happen in the emergency departments, how many staff are required and the standards of care expected across all departments. There is a lack of description and detail around how these will operate, the interfaces with the existing EDs, the corporate governance structures, lines of responsibility and most importantly the economic models on which they will be run. Critics will argue that this is all part of the implementation phase, however gaining support for the model especially in those hospitals that have a Type 1 emergency department currently, will stand or fall on the description of the UCC model

Recommendation

1. What is the case mix going to be for each of the UCCs and what is it for the EDs?
2. What is the economic model for running each of the UCCs (payment per patient by a private AQP model or as part of an EM commissioned integrated service)?
3. How will patients who are seen by a private AQP in an UCC who are then transferred to an ED be costed and what is the scale of this work (this model has recently started in the West Middlesex Hospital and there may be valuable data to apply in any modelling).? What cost efficiencies will be realised in this type of model versus an integrated EM service?
4. What is the staffing model for each of the UCCs and EDs based upon the above. It is not enough to say “we want ED Cons on 24/7 basis in the big centres”. Indeed it is unlikely that ED Cons on a 24/7 basis will be achievable at any of the centres in the foreseeable future.
5. What is the depth of the senior decision makers (ie number of senior decision makers on at any one time during peak periods) in the EDs to cater for the high intensity workload and how will they ensure it is a sustainable multidisciplinary workforce that they have created within a wider EM system in the NWL health economy?
6. What is the likely cost model of expanding the EM senior workforce to provide that level of cover and what are the likely timescales to coincide with the proposed reconfiguration?
7. What is the detail around an integrated training strategy for EM doctors, nurses, ENPs, ANPs, PAs etc. Linking all major EDs and UCCs together with a
consistent clear governance system will be vital to selling it to the staff – the most valuable commodity!

8. How exactly will the Out Of Hours GP service work and where will they be based? What is the predicted workload that it will off load from the UCC and EDs based upon the success of the last 3 years?

Emergency Departments
The case for changing the current configuration of emergency departments was made very succinctly.

That said, there is still a lot of work to be done to win over the clinical teams in the existing emergency departments, along with patient representatives and local authority representatives.

The clinical teams are concerned that the out of hospital strategy will not deliver, the movement of staff across department will not happen and the aspirations of reconfiguration will not deliver. The patient groups do not understand how things will work if this reconfiguration happens and are finding it difficult to describe what services at any one of the nine hospitals will look like.

During the course of our discussions especially with the emergency care clinical teams, an emerging dichotomy began to surface, bigger departments requiring consultant delivered services versus smaller departments with consultant led services. Added into that mix, the decreasing number of middle grade trainees coupled with a lack of strategy around training an alternative workforce to support the hands on delivery of clinical care, could result in difficulties during the course of consultation.

In addition, an important issue will be the movement of primary ambulance borne patients in the reconfigured system and the impact these will have where the bed base proves inadequate to meet demand.

Evidence of the impact on secondary transfer of patients within the region and the economic impact that may occur (eg on London Ambulance Service) is also advisable to develop within the business model.

A recurrent theme of large scale reconfiguration is that ‘exit block’ from the main ED is the major factor in compromising patients safety and system performance. A dedicated workstream to have a strategic focus to address this issue is vital.

Recommendation
1. The NCAT team supports moving from 8 emergency departments to 5.
2. Better modelling data is recommended in order to understand the scale of higher dependency (ambulance borne) patients that will be redistributed around NWL after reconfiguration and ways in which ‘exit block’ from the ED into the hospital bed base can be minimised?.
3. The clinical teams within existing emergency departments do not feel they are involved enough in the process and developing the “story” of the emerging models being proposed for unscheduled care.
4. Nurses are key to this reconfiguration, and they need to be more involved. All the key leadership positions within the clinical redesign program are held by doctors!
5. NCAT recommends some more modelling work around the likely admission rates
and length of stay at each of the proposed EDs, this is to give the clinical teams
certainty in the proposals.

6. The story of what services will be available at each of the sites is something that
needs to be developed. The public are not interested in the number of doctors and
the quality of doctors, they want to know what can be treated in each of the sites and
what cannot be treated.

7. Some detail around the development of the workforce to support the middle tier of
clinical decision-making would be helpful.

Conclusions
NCAT support in principle the proposals outlined in the *Shaping a healthier future*. Due to
the scale of the reconfiguration, we would recommend a repeat visit at some point to assess
the preparedness of the clinical models, the clinical support for the reconfiguration and the
plans for addressing the workforce issues.

Dr David Colin –Thome
Dr Tajek B. Hassan
Mrs Catherine McLaughlin

National Clinical Advisory Team
### Appendix 1: Meeting Schedule

<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Attendees</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NCAT arrive</td>
<td>NCAT team, KD will be available</td>
<td>9.00-10.00</td>
</tr>
</tbody>
</table>
| 2. | Programme Executive       | Anne Rainsberry, CEO & SRO (11.30-12.00)  
Daniel Elkeles, Director of Strategy (11.30-12.00)  
Luke Blair, Engagement & Communications Workstream Lead  
Dr Mark Spencer, Medical Director  
Simon Marshall, Finance & Business Planning Workstream Lead  
Dr Susan La Brooy, Medical Director  
Kevin Atkin, Deputy for Director of Delivery Support Unit  
Dr Mike Anderson, Medical Director, Chelsea & Westminster  
Dr Tim Spicer, CCG Chair Hammersmith & Fulham & Programme Medical Director  
Kate Woolland, Programme Manager | 10.00-12.00 |
| 3. | Lunch                     | NCAT                                                                                                                | 12.00-12.30|
| 4. | OSC representatives       | Cllr Charles Williams, Deputy for Chair of OSC, Kensington & Chelsea  
Cllr Anita Kapoor, Chair, OSC, Ealing Council  
Cllr Sheila D’Souza, Westminster City Council  
Cllr Barrie Taylor, Westminster City Council | 12.30-13.30|
| 5. | PPAG representatives      | Julian Maw, Harrow LINk  
Trevor Begg, Hillingdon LINk | 13.30-14.30|
| 6. | CCG Chairs                | Dr Paul Shenton, Deputy for Chair of Great West Consortium at NHS Hounslow  
Dr Mohini Parmar, Chair, Ealing CCG  
Dr Tim Spicer, Chair, Hammersmith & Fulham CCG | 14.30-15.30|
| 7. | A&E clinicians            | Dr Jas Johal, Assoc. Clinical Director, A&E, Hillingdon  
Wendy Stevens, Matron, Hillingdon  
Dr Sean Williams, North West London Hospitals  
Julie O'Donoghue, Senior Nurse, A&E, North West London Hospitals  
Catherine Sellu, Lead Nurse, A&E, Ealing Hospital  
Dr Caroline Smith, Consultant, Emergency Medicine, WMUH  
Dr Elinor Beattie, Consultant, Emergency Medicine, Ealing Hospital  
Dr William Oldfield, Consultant in Respiratory Medicine, Chief of Service for Emergency Medicine, Imperial  
Dr Alex Lewis, Medical Director & mental health rep, CNWL  
Dr Claire Emerson, Consultant, Emergency Medicine, | 15.30-16.30|
<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Attendees</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Chelsea &amp; Westminster Andrea Travers, Matron, Chelsea &amp; Westminster Rick Strang, Emergency Department Interim Manager, WMUH Hugh Rogers, Consultant Surgeon, WMUH Prof Rory Shaw, Medical Director, NWL Hospitals Jeremy Thompson, Divisional Medical Director for Medicine and Surgery, Chelsea &amp; Westminster Nebil Behar, Consultant Emergency Surgeon, Chelsea &amp; Westminster Janindra Warusavitarne, Consultant Emergency Surgeon, NWL Hospitals Patrick Roberts, Lead Clinician, Emergency Dept, Chelsea &amp; Westminster Wendy Matthews, Consultant Emergency Medicine, St Mary's</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Feedback to NHS NWL team</td>
<td>Daniel Elkeles, Director of Strategy Dr Mark Spencer, Medical Director</td>
<td>16.30-17.30</td>
</tr>
</tbody>
</table>
## Appendix 2 – Documentation received

<table>
<thead>
<tr>
<th>Item</th>
<th>Document</th>
</tr>
</thead>
</table>
| **Stakeholder event 15 Feb** | 1.6.1.a) 150212 Morning - FINAL agenda  
1.6.1.c) 15Feb.EventReport.final.12.04.03 FINAL  
1.6.3.a) Stakeholder engagement events - attendance lists 050412 |
| **Stakeholder event 23 Mar** | 1.6.2.a) 23 March.SHFMorningSessionAgenda FINAL  
1.6.2.c) Feedback from 23rd Mar event FINAL  
1.6.3.a) Stakeholder engagement events - attendance lists 050412 |
| **Programme Board** | 13.1) 2011-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0  
4.1) 2011.11.24 Reconfiguration Programme Board Agenda V1.0  
4.1.a) 2011.11.24 Reconfiguration Programme Board minutes V1.0  
4.2) 2011.12.15 Reconfiguration Programme Board Agenda v1.0  
4.2.a) 2011.12.15 Reconfiguration Programme Board minutes V1.0  
4.3) 2012.01.16 Reconfiguration Programme Board Agenda v1.0  
4.3.a) 2012.01.16 Reconfiguration Programme Board minutes V1.0  
4.4.a) 2012.02.16 Reconfiguration Programme Board Agenda V1.0  
4.4) 2012.02.16 Reconfiguration Programme Board minutes V1.0  
4.5) 2012.03.15 Reconfiguration Programme Board Agenda V1.0 |
| **Clinical Board** | 13.1) 2011-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0 |
| **Stakeholder engagement - OSC** | 1.4.1a) 2011.12.06 CllrAbdullahGulaid, ealing.11.12.06  
1.4.1.b) 2011.12.06 CllrAnnGate, harrow .11.12.06  
1.4.1.c) 2011.12.06 CllrJudithCooper, hillingdon .11.12.06  
1.4.1.c) 2011.12.06 CllrJudithCooper, hillingdon .11.12.06  
1.4.1.e) 2011.12.06 CllrMaryWeale, kensington & chelsea.11.12.06m  
1.4.1.f) 2011.12.06 CllrPoonamDhillon, hounslow.11.12.06m  
1.4.1.g) 2011.12.06 CllrSandraKabir, brent.11.12.06  
1.4.1.h) 2011.12.06 CllrSarahRichardson, westminster.11.12.06m  
1.4.1.j) CllrAlisonCornelius, barnet.11.12.08  
1.4.1.k) CllrCarolineUsher.11.12.08  
1.4.1.l) CllrEdwardDavie.11.12.08  
1.4.1.m) CllrJohnBryant.11.12.08 |
<table>
<thead>
<tr>
<th>Stakeholder engagement – GPs &amp; CCGs</th>
<th>Item</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Board</td>
<td>13.1) 2011-12-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0</td>
<td></td>
</tr>
<tr>
<td>Clinical Board</td>
<td>13.1) 2011-12-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0</td>
<td></td>
</tr>
<tr>
<td>Out-of-Hospital Care Working Group</td>
<td>13.1) 2011-12-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0</td>
<td></td>
</tr>
<tr>
<td>Programme Executive</td>
<td>13.1) 2011-12-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0</td>
<td></td>
</tr>
<tr>
<td>24 November 2011, item 5, Programme Board</td>
<td>4.1.a) 2011.11.24 Reconfiguration Programme Board minutes V1.0</td>
<td></td>
</tr>
<tr>
<td>CEC briefings</td>
<td>1.2.1) 2012.01.26 Draft CEC minutes V1 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2.2) 2012.02.16 CEC_FINAL AGENDA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2.3) 2012.03.01 CEC_draft agenda_FINAL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2.3.a) 2012.03.01 CEC minutes V0 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2.4) 2012.03.15 CEC_FINAL agenda</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2.4.a) 2012.03.15 CEC minutes _FINAL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2.5) 2012.03.29 CEC final agenda_FINAL</td>
<td></td>
</tr>
<tr>
<td>Stakeholder engagement - clinical</td>
<td>Item</td>
<td>Document</td>
</tr>
<tr>
<td>Stakeholder event 15 February 2012</td>
<td>1.6.1.b) 150212 Afternoon - FINAL agenda</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.6.1.c) 15Feb.EventReport.final.12.04.03 FINAL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.6.3.a) Stakeholder engagement events - attendance lists 050412</td>
<td></td>
</tr>
<tr>
<td>Stakeholder event 23 March 2012</td>
<td>1.6.2.b) 23March.SHFAfternoonSessionAgenda FINAL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.6.2.c) Feedback from 23rd Mar event FINAL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.6.3.a) Stakeholder engagement events - attendance lists 050412</td>
<td></td>
</tr>
<tr>
<td>Clinical Board</td>
<td>13.1) 2011-12-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0</td>
<td></td>
</tr>
</tbody>
</table>
### Stakeholder engagement - providers

<table>
<thead>
<tr>
<th>Programme Board</th>
<th>13.1) 2011-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Board</td>
<td>13.1) 2011-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0</td>
</tr>
<tr>
<td>Out-of-Hospital Care Working Group</td>
<td>13.1) 2011-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0</td>
</tr>
<tr>
<td>Finance and Business Planning</td>
<td>13.1) 2011-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0</td>
</tr>
<tr>
<td>Communications &amp; Engagement</td>
<td>13.1) 2011-12-04 NWL Reconfiguration Programme Working Groups ToR v1.0</td>
</tr>
<tr>
<td>24 November 2011, item 5, Programme Board</td>
<td>4.1.a) 2011.11.24 Reconfiguration Programme Board minutes V1.0</td>
</tr>
</tbody>
</table>

### Other documentation

<table>
<thead>
<tr>
<th>Item</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>7.1) 26_03_27 Programme Risk Management Approach v1.0</td>
</tr>
<tr>
<td>Project Initiation document</td>
<td>8.1) 20120403 Project Initiation Document_Reconfiguration v1.0</td>
</tr>
<tr>
<td>Options appraisal</td>
<td>10.2) 120315 Reconfiguration Programme Board Agenda v1.0</td>
</tr>
<tr>
<td></td>
<td>10.2.a) PAPER 5.0 - 20120315_programme board v12</td>
</tr>
<tr>
<td></td>
<td>10.3) 120412 Reconfiguration Programme Board Agenda v1.0</td>
</tr>
<tr>
<td></td>
<td>10.3.a) PAPER 3_0 UPDATE 20120412_Medium List Option Evaluation_pre_read_updated</td>
</tr>
<tr>
<td></td>
<td>10.3.b) PAPER 3_0 20120405_Medium List Option Evaluation v1.0</td>
</tr>
<tr>
<td>Financial baseline</td>
<td>6.1) 120307 PAPER 3 2 - FBP Trust 'base case' forecasts_v1 12</td>
</tr>
<tr>
<td>Pre-consultation business case</td>
<td>9.1.a) ShAHF PCBC skeleton summary v0 12 (for NCAT)</td>
</tr>
</tbody>
</table>