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NHS South Tyneside CCG
By email

David Gallagher,
Chief Officer
NHS Sunderland CCG
By email

Ken Bremner,
Chief Executive,
City Hospitals Sunderland NHS Foundation Trust,
and Chief Executive,
South Tyneside and Sunderland
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By email

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Dear David, David and Ken

Re: Joint NHSE/NHSI Stage 2 assurance of Path to Excellence Phase 1a proposals

I am pleased to share the final NHS England assurance position on the Path to Excellence Phase 1a service proposals following the culmination of a stage 2 assurance review at the North Regional Management Team this week and subsequent approval from the Regional Director. As you are aware, this process is intended to assess the readiness of proposals to progress to consultation and, in this case, has been undertaken jointly with NHS Improvement colleagues and has been informed by input from Health Education North East.

This feedback builds on previous correspondence from Tim Rideout, supporting the broader Path to Excellence change programme and specific support for the temporary stroke inpatient pathway relocation, subject to further, future public consolidation.

Firstly I would like to commend you and your teams on the tremendous progress made in recent months. NHS England colleagues do not underestimate the significant amount of work that has been undertaken to move the change programme forward, particularly over a challenging winter period. The Path to Excellence programme remains a cornerstone of local transformation planning in the South Tyneside and Sunderland area to ensure hospital services are as safe, clinically sustainable and affordable as possible to ensure they are retained for our local communities. The formation of the Healthcare Group is acknowledged as an essential part in ensuring pace and cross-site commitment to change.

NHS England fully appreciates the current workforce pressures driving the Phase 1a proposed changes and, as such, accepts the importance of seeking to deliver local solutions to such challenges out with the wider change programme. The programme has clearly placed the medical workforce challenges at the heart of the clinical design process and the attempts to 'future proof' services, through the proposed amalgamation of rotas and a move away from reliance on medical roles, is welcomed in light of known future recruitment and medical workforce availability challenges

The proposals represent the local delivery of the hospital-based elements of many strands of national strategy and policy which NHS England is pleased to see being taken forward and we recommend the careful positioning of the proposals as part of this wider strategic changes in order to build local confidence that the acute change proposals are part of broader suite of pathway improvement plans.

Bringing the proposed permanency to the temporary stroke inpatient pathway supports NHS England's advocated move towards specialist stroke service provision for populations, as is set out in the recent NHS Five Year Forward View Delivery Plan. NHS England is pleased to note the positive clinical developments reported from the temporary stroke service change. Similarly, the proposals represent a desire to improve maternity outcomes and deliver maternity services across larger populations, as expected in the Maternity Services five year forward view, Better Births, while the proposals to re-balance emergency specialist paediatric care with more locally accessible urgent paediatric care, contributes to the implementation of the Urgent and Emergency Care Review.

The clinical origins of the scenarios is acknowledged with a robust clinical design structure, CCG GP and acute clinician leadership and credible attempts to source appropriate clinical assurance to strengthen the efficacy of proposals. Such planning has also evidently been as outwardly transparent and inclusive as possible as has been evidenced through ongoing dialogue with your local Joint Health Overview and Scrutiny committee, the role of the patient reference group and patient and public engagement work and both GP and acute clinical leadership throughout. The programme has made clear efforts to retain local scenario options and preserve as much patient choice where it is clinically safe to do so.

Due regard has been paid to statutory responsibilities with high quality, externally-commissioned pieces of work to understand the impact of the proposed changes on equality, health and health inequalities. This, combined with the travel and transport impact assessment review, clearly provides valuable insight into the potential benefits and drawbacks of the proposals and NHS England looks forward to further understanding how any risks will be proportionately addressed.

Demand and capacity modelling across the sites and related services has been undertaken at both a service-specific and aggregated level. However, further work is advised to validate some aspects of this to ensure sufficient system flexibility in the case of best and worst case scenarios, particularly where patient choice plays a key part and where other potential

proposed service changes may impact on future capacity. While block contracting arrangements and relatively limited potential deviation in projected activity, mitigates any current commissioner financial risk around the proposals, any further activity modelling needs to be reflected in a full financial risk assessment across both commissioners and providers. The programme is also encouraged to ensure future phases have sufficient financial headroom to further offset the residual net losses across the services, together with ensuring appropriate alignment of the phase 1a efficiencies with STP financial planning.

While the activity numbers do not suggest significant additional ambulance activity, further NEAS data is required to provide capacity, cost and performance assurance, as the programme has acknowledged. This is particularly important ahead of any public consultation commencing to ensure maximum preparedness for what is likely to be a source of public and political challenge. I personally have noted the request to consider how NHS England and the broader healthcare system can best support NEAS in fulfilling such analytical requests for future phases of the programme and/or wider STP slivery, and I will confirm any potential options open to us in due course.

Equally, I am sure that the importance of continuing stakeholder engagement to build local understanding of the drivers for change is not underestimated. It is clear that robust communications and consultation planning is in place and the DCO team encourages regular briefings, particular with MPs, to continue. The recently announced general election brings with it the usual purdah period and consequently you are actively encouraged to consider your consultation and decision-making timeline in light of this to ensure that you are able to deliver a balanced consultation process which enables meaningful local contributions.

The interdependency of the Phase 1a proposals with peripheral change programmes to the North (as part of the STP optimising acute sector workstream) and South (as part of Better Health Programme) is well-recognised by the programme and NHS England advises that close working across the programmes continues to ensure strategic alignment of the final scenarios and appropriate system capacity as a result of any shifts in patient flows.

NHS England has reviewed the service change plans against the four reconfiguration tests, together with the recently announced ‘fifth test’ to be applied to be any change proposals that involve potential bed closures. Evidence reviewed so far suggests a proportionate satisfaction of these tests at this point in the change process. Further work to fully validate maternity service activity projections, develop organisational development plans to mitigate against potential staff losses, and the continuation of GP engagement as part of the consultation process, will bring further rigour to the tests’ application prior to any final decision being made. A breakdown of NHSE/NHSI analysis against all assurance criteria, including the reconfiguration test compliance is in the enclosed feedback grid.

Overall the joint organisational assessment has culminated in NHS England agreeing a **partially assured** position for the Phase 1a proposals. This means that NHS England is happy to support the planned move to enter into public consultation with a number of caveats (listed overleaf), some to be satisfied prior to consultation and others to be satisfied post-consultation and prior to any final decision being made. The partially assured position is by no means a reflection on the quality and amount of work undertaken or indeed a reflection on the safety of the scenarios themselves; it is merely indicative of where the proposals are in a fast-developing process.

The programme is encouraged to fully review and address the caveats and build sufficient time into the decision-making planning process to enable NHS England to have meaningful discussion around these issues and for the North Regional Management Team to review any further evidence well in advance of your decision-making Governing Body meeting. The format of any further pre-decision assurance will be determined in due course.

Should you require any clarification on any elements of the assurance feedback, leads within our various teams and directorates would be more than happy to help. Please contact Jill Simpson via jill.simpson2@nhs.net who will be happy to co-ordinate the appropriate input.

Finally, I would like to thank your teams for their personal contribution in bringing the first phase of the programme to this point. I wish you well as you take the proposals to public consultation and look forward to hearing the programme's plans for further Path to Excellence phases in the near future.

Yours sincerely,

Alison Slater
Deputy Director of Commissioning Operations
NHS England North: Cumbria and the North East

CC:
NHS England:
- Tim Rideout, Director of Commissioning Operations, Cumbria and the North East
- Ben Clark, Assistant Director of Clinical Strategy, Cumbria and the North East

NHS Improvement:
- Tim Rideout, Director of Delivery, North East & Cumbria
- Edmund King, Senior Delivery and Improvement Lead

Clinical Commissioning Groups:
- Christine Briggs, Chief Operating Officer, South Tyneside CCG
- Scott Watson, Director of Contracting & Informatics, Sunderland CCG

NHS Foundation Trusts:

- Dr Shaz Wahid, Medical Director, South Tyneside NHS Foundation Trust
- Peter Sutton, Director of Strategy and Business Development, City Hospitals Sunderland NHS Foundation Trust
- Patrick Garner, Programme Manager, South Tyneside and Sunderland Healthcare Group
- Patrick Pearce, Project Accountant, South Tyneside NHS Foundation Trust

Enclosed: Caveats of NHS England's Partially Assured Position for Phase 1a of the Path to Excellence programme:

Prior to the start of formal public consultation:

- Further consideration be given to the consultation and decision-making timeline, in light of the impending general election purdah period

- Obtaining aggregated capacity and performance impact assessment for NEAS

- Ensuring planned actions are fully completed, including ensuring neonatal network support for SCBU proposals, agreeing future SCBU numbers and modelling accessibility implications for South Tyneside residents who are likely to travel north for required treatment

- Explicitly communicating capital-dependency of scenarios in consultation materials to ensure realistic expectations and informed feedback

- Ensuring known and advised amends to PCBC and consultation documentation are made

Prior to final decision being made:

- Ensuring alignment with any evolving plans emerging from both the STP optimising acute sector workstream and/or the LMS, as well as ensuring alignment with final Better Health Programme scenarios to demonstrate system capacity

- Validating maternity activity modelling to ensure as robust system capacity planning as possible, ensuring a full consideration of patient choice, best and worst case scenarios and provider resilience to flex service capacity accordingly (across both CHS and Newcastle & Gateshead sites)

- Use of further scenario modelling to provide capacity assurances around medical boarders

- Financial modelling aligned to best/worst case scenario modelling with financial risks around any potential contracting implications fully reflected and mitigated

- Re-assessing NEAS impact arising from the combined impact of multiple acute change programmes, once scenarios for BHP etc. working with the lead NEAS CCG commissioner to obtain necessary assurances around capacity, performance and any cost implications

- Robust plans to mitigate A&E four-hour delivery risk

- Neonatal transport implications to be fully assessed

- Demonstrating robust staff engagement and clear organisational development plans to build the necessary cross-site culture to support effective workforce transfer

- Carefully considering nomenclature for any future minor ailment/injury paediatric service to ensure both local and national alignment with Urgent & Emergency Care Vanguard conventions and/or NHS England guidance

- Further exploration the potential benefits of Early Supported Discharge and modelling of what the highest-quality ESD could have on the quality of rehabilitation, length of stay and bed model

NHS England Cumbria and North East Director of Commissioning Operations service change assurance grid: Path to Excellence Phase 1a service proposals, South Tyneside and Sunderland Clinical Commissioning Groups, April, 2017

Assurance domain(s)	Assurance required	Fully/partially /not assured	Assurance obtained	Further assurance required
Safety & quality	• Clear and convincing case for change including external clinical drivers and risk analysis of status quo • Proposals in line with most up to date evidence base and clinical best practice nationally, regionally and/or locally • Projected and quantifiable clinical quality outcomes clearly articulated • Consideration of impact on reducing inequalities of outcomes and access • Improvements to patient experience clearly articulated • Impact on patient safety clearly considered and actions in place to ensure safety • Impact on safeguarding clearly considered	Fully	Drivers for change clearly articulated across all specialities with workforce pressures a primary driver, particularly the limited availability of middle grades, high locum use and reliance on non-training medical grades at South Tyneside, with evident quality and sustainability challenges in current service models. Proposals consistent with national strategy including Five Year Forward View (and subsequent Delivery Plan), Better Births and Urgent & Emergency Care Review. Work ongoing to ensure consistency with draft current regional STP, together with peripheral transformation programmes such as the Better Health Programme. Options assessed against relevant Royal College clinical standards, local, clinically-agreed standards and key elements of national strategy delivery. Research evidence base considered and evidence of analysis of other similar service configurations.	Agreement of future SCBU cot numbers in collaboration with NHS England specialised commissioners and neonatal network. Assessment of impact on neonatal transport network. Development of reliable handover pathways and protocols for escalations, inter-site transfers, self-presenting patients, early discharge etc. at implementation stage, once a final service model is known. Appropriate IT enabling work to support effective electronic record access across sites. Further NEAS data and senior assurances. Further analysis of the highest-performing early supported discharge service model on the proposed bed model.

			Internal clinical assurance processes in place through clinical design teams, senior medical, nursing and CCG GP challenge through Clinical Services Review Group. External clinical advice on O&G proposals received from North of England Clinical Maternity Network clinical leads. Clear plans to secure equivalent clinical advice from nominated representatives from informal local Child Health Network, Neonatal Networks, national Stroke Clinical Director and clinical senate if required.. Estimated NEAS data to suggest minimal capacity and performance challenges, however, further detail required at aggregated level and modelling to build local confidence in proposed changes. Quantifiable clinical quality improvements clearly articulated in terms of increased senior medical cover, improved SSNAP data and clinical service sustainability. Improvements in thrombolysis performance for South Tyneside patients as a result of the temporary stroke inpatient pathway move are acknowledged. Patient experience considered at a high level with further insight gathered as part of pre-engagement activities across all	Proportionate and appropriate mitigating actions to address risks highlighted through integrated equality, health and health inequalities and travel and transport impact assessments.

			relevant services. Evidence of insight impact on scenario-development process and plans in place to incorporate patient experience into future monitoring and evaluation metrics. Patient safety risks considered, particularly in relation to self-presenting patients, inter-site transfers and pathway handovers. Accessibility risks also comprehensively assessed with clinical outcomes outweighing the travel impact for what is expected to be discreet acute episodes of care. Safeguarding implications fully considered with O&G and Paediatric proposals particularly mindful for South Tyneside NHS FT's recent CQC report and Joint Targeted Strategic Assessment Review and proposals intended to create dedicated safeguarding capacity. Service interdependencies fully considered across specialities. SCBU dependency on maternity model acknowledged and NHS England Specialised Commissioners supportive of the proposals, subject to further work to agree future cot numbers aligned to activity and understanding of any neonatal transport service implications.	

			Impact on health inequalities assessed to a high-level as part of Integrated Assessment Impact for each set of service proposals. Early Supported Discharge Model considered to reasonable extent with some improvements in supported discharge already achieved through the amalgamation of community stroke teams.	
Clinical support	• Clear sources of appropriate clinical advice and rigorous internal clinical assurance processes • Support from GP commissioners and wider GP community (or medical directors if NHS England commissioned service) • Wide-ranging clinical sign-up to proposed service model(s), across patient pathway • Sufficient staff engagement at all stages of reconfiguration proposal across all relevant professions likely to be affected by change	Partially	Clinically-led process through Clinical Design Teams and Clinical Services Review Group. Senior clinical leadership evident from commissioners and providers. Clinical support obtained from North of England Maternity Clinical Network Clinical Leads and equivalent support being sought from nominated, non-conflicted representatives of informal Child Health and Neonatal Networks. GP commissioning support secured to proportionate extent at this point in process and in line with CCGs' constitution through CCG Executives and Governing Bodies, with updates to broader practice membership at Time in/Time Out and Council of Practices session and extensive GP engagement	Wider GP and staff engagement as part of planned consultation. Child Health Network and Neonatal Network support for proposals.

			planned as part of consultation process. Neighbouring CCG and NHS England Specialised Commissioning support for proposals being sought. Service-specific and general staff engagement undertaken to date with further planned engagement as part of consultation process.	
Workforce	• A clear understanding of workforce capacity and competency requirements underpinned by clearly costed plans in place to safely and appropriately staff the proposed new model to deliver anticipated outcomes • Workforce plan aligned with finance, activity and implementation plans • Safe staffing levels embedded in proposed service models • Workforce impact and risks fully assessed and mitigated, including TUPE, training, recruitment, redundancies etc.	Partially	Comprehensive analysis of workforce pressures and benefits of service change undertaken across specialities. Benefits anticipated in consolidation of consultant and middle-grade rotas in terms of increased senior medical presence, improved quality through consistent staff, rota sustainability and enhanced future recruitment. Any reduction in PAs is intended to level workload with non-clinical PA activities also retained i.e. governance, education etc. Joint working with Health Education North East ongoing and mechanisms in place to enable this to continue. A full assessment of operational impact on the 7 affected trainee doctor placements is planned. HENE support for proposals to move to consultation phase has been	Clear organisational development and staff engagement plans to address any cultural barriers and ensure maximum workforce availability to staff final service delivery model. Continued working with HENE to assess impact on trainee doctor posts and ensure competency and capacity requirements can continue to be met.

			obtained. Nursing and midwifery establishments sufficient to support delivery of proposed service models, including paediatric nurse practitioners, should the option of a residual paediatric minor injury/ailments service be pursued. Director of Nursing sign-off of scenarios obtained throughout and monitoring processes for midwifery staffing levels in place Staffing ratios fully considered throughout with anticipated improvement in SCBU staff-to-cot ratios. Workforce impacts fully considered in terms of competencies and capacity with plans in place to support skill retention and development i.e. in terms of cross-site midwifery rotation to ensure competencies of staff within the proposed FMLU.	
Strategic fit	• Clear understanding of co-dependent services and full impact analysis on CCG / NHS England/ LA commissioned services and shared sign up of all parties to analysis • Clinical case fits with national best	Partially	Proposals consistent with national NHS England strategy (as detailed above), cognisant of Royal College guidance and best practice and aligned to the regional emerging STP. Proposals in line with JSNAs and local	Confirmed, written commissioner and provider support for proposals, including high-level scenario planning to ensure future capacity requirements.

	practice • Alignment to JSNA and fit with local health and wellbeing strategies and commissioning plans • Assessment of impact on the quality and delivery of all commissioned services across the local health economy with risks recorded and mitigated • Alignment with Arms Lengths Bodies views i.e. CQC, NHS Improvement		health and wellbeing priorities. High-level assessments have been undertaken on the impact and delivery of all commissioned services, with ongoing discussions with neighbouring acute providers, CCGs, NEAS, NHS England's North Specialised Commissioning Team and Better Health Programme with support for proposals secured as is appropriate at this stage. Programme cognisant of embryonic Local Maternity System, links established with LMS clinical leads and both provider and commissioner input into LMS. Alignment with NHSI expectations in terms of both clinical and cost improvement programme delivery. HENE support for proposals to move to nest phase, subject to further operational discussions around trainee doctor roles. Proposals intended to contribute to addressing staffing and safeguarding issues raised in South Tyneside NHS FT CQC report and Joint Targeted Strategic Assessment Review.	

Implementation and monitoring	• Appropriate safety, quality and clinical outcomes identified with metrics embedded in outline monitoring and evaluation framework	Partially	Outcomes and metrics implicit in scenario development and impact analysis against clinical standards. High-level implementation considerations to assess deliverability undertaken. Plans in place to develop full suite of KPIs once final service models are known. Stroke services post-implementation due to temporary change so outcome measures already in place.	Outline implementation and monitoring plan (O&G, paeds & SCBU) with delivery timescales, underpinned by system metrics aligned to both intended outcomes and risks.
Equality	• Equality analysis completed for proposed option(s) and appropriate action identified to address any potential negative impact on population sectors, particularly on those groups with protected characteristics	Fully	Comprehensive integrated equality, health and health inequalities impact assessment (IIA) externally commissioned and complete for each service and common themes identified at aggregated level with a full review and risk mitigation process underway.	Evidence of risk mitigations in light of risks raised through IIA.
Accessibility	• Comprehensive assessment of travel/transport implications including public transport, travel times, community transport, PTS provision and availability and affordability of car parking • Clear impact assessment on relevant	Fully	Comprehensive accessibility impact assessment externally commissioned spanning emergency, routine and patient transport service travel. Assessment complete with work underway to ensure due rigour and to extend scope to staff and patient flows outside of South	Neonatal transport service implications to be understood. NEAS capacity, performance and cost implications to be fully understood. Completion of further, planned

	affected populations, analysis of clinical outcomes versus any adverse travel impact and proportionate actions to address issues • Full assessment of impact of proposed service models on patient choice and attempts through reconfiguration proposal(s) to develop and support patient choice		Tyneside and Sunderland footprint. Travel impact considered in terms of distance, volume of patients and nature of acute episode in relation to positive health outcomes highlighted in IIA. High-level NEAS ambulance service impact obtained with activity numbers suggesting limit impact, however further detail being sought. Review of national evidence base for intrapartum transfer times from freestanding MLUs complete, with further consideration of perceived risks through North of England Clinical Maternity Network Clinical Leads. Choice fully considered as part of scenario development and evaluation process with a clear consideration of choice implications, particularly in relation to maternity service change proposals.	accessibility impact work.
Service change process	• Development of proposals are consistent with rules for cooperation and competition • Robust and fully resourced programme management	Fully	Consistent and transparent scenario development process in place, informed by best practice. Plans in place to test decision-making	Outline implementation and monitoring plan (O&G, paeds & SCBU) with delivery timescales, underpinned by system metrics aligned to both intended outcomes

	arrangements • Proposals and consultation plan fully risk assessed with actions identified and undertaken to mitigate clinical, financial, legal and reputational risk • Rigorous, inclusive and transparent scenario development process and options appraisal with a fair options appraisal based on relevant and agreed criteria • Strong corporate governance to manage conflicts of interest • Outline, deliverable implementation plan, aligned to workforce and finance plans and including transitional arrangements and evaluation framework to measure impact of change		criteria as part of consultation process. Proposals within existing providers and therefore are consistent with rules for cooperation and competition. Risks fully assessed, understood and mitigated. Conflicts of interest risks mitigated through multi-site and multi-CCG representation at all levels of programme governance. External assurance and/or sense-checking also sought/obtained. High-level implementation considerations to assess deliverability undertaken. Stroke service post-implementation, as per above. Plans in place to develop full suite of KPIs once final service models are known.	and risks.
Capacity and delivery	• Fully modelled patient flows, activity and bed numbers with clear and reasonable assumptions and sensitivity analysis • Full impact analysis on quality and delivery of other sites, services and organisations, including ambulance	Partially	Patient flows, activity and bed numbers clearly modelled with best and likely case scenarios available and consideration of out of area flows. Capacity for likely case scenarios demonstrated to be sufficient with slight additional capacity increases required to accommodate obstetrics activity at SRH, with further additional	Further sensitivity analysis to ensure implications of choice (for maternity scenarios) is fully considered with assurances that worst case scenario activity flows can be absorbed within current capacity and alignment to financial

	services • Alignment of activity and capacity modelling with workforce and financial analysis and plans • Impact on EPRR fully modelled and risks identified and mitigated • Clearly articulated interventions to support any activity reduction or redirection • Appropriate use of technology and assessment of data sharing/IT infrastructure implications and costs, including a privacy impact assessment to identify requirements for lawful information sharing		capacity required for SCBU cots, subject to agreement around future SCBU capacity requirements. Case mix change factored into modelling. Positive impact on LOS of temporary stroke inpatient pathway transfer acknowledged with flex for medical boarders incorporated into financial envelope. Work ongoing to address DTOCs and as part of broader out of hospital work to stem acute flow and speed up discharge across medical pathways. High-level impact analysis on neighbouring sites and ambulance services undertaken, as per above, with further NEAS detail awaited. Capacity impact for interdependent and/or enabling services assessed, including diagnostics, theatres and clinical support services. Potential performance impact of scenarios on contractual and constitutional delivery standards considered. RTT/cancelled operations risks are greater under current service models due to medical workforce	modelling. Further work to validate medical boarding capacity implications. Assurances that growth capacity has been factored into modelling. Robust plans to mitigate 4-hour A&E delivery risk, ahead of service implementation. Assessment of both out of hospital stroke prevention services and potential value of Early Supported Discharge to ensure optimal bed model through and equal interventions to minimise admissions and LOS from stroke. Final future SCBU capacity to be agreed across commissioners and in partnership with Neonatal Network. Physical capacity for SCBU shift to be fully assessed and any premises and capital impact to be assessed. Review and revision of business continuity and major incident plans, once final service models are known.

			challenges. Potential shortfall against 4-hour A&E delivery of <1% with mitigating actions around DTOCs/MCP and Urgent Care Vanguard work. Programme cognisant of EPRR risks and requirements with work planned for implementation stage, once final service models are known.	
Financial viability, sustainability and risk	• Demonstrable affordable, quantifiable improvements in quality and/or efficiencies in relation to the 'do nothing' scenario • Comprehensive financial plan underpinning service change proposal(s) with costs, including set-up and transitional costs, funding sources, savings, cash-release mechanisms and/or re-investments clearly articulated • Financial plan aligned with workforce and activity plans/models • Capital investment implications considered • Analysis of premises implications and costs, including rent, void costs,	Partially	Clear financial case for service change to reduce locum expenditure, release reinvestment funds for therapy and reduce provider deficit across NHS FTs. No commissioner financial impact within current activity modelling. Contract renegotiation in 18/19 will take account of dispersed activity and mitigate any activity fluctuation to some extent. Potential capital investment requirement of some but not all options of between £250,000-£628,628. Potential reduction to £250,000 (with only one O&G scenario) if SCBU cot numbers reduce and remove the need for SCBU capacity-creation. National STP capital funding requested with local capital funding sources also being fully explored. Capital funding sources not deemed to be a risk.	Further validation of modelling, as per above, including financial planning aligned to worst case scenario modelling and reviewing both provider and commissioner contractual, cost and service delivery impacts. Final capital investment level and funding source to be established, working with NHS England Specialised Commissioners and Neonatal Network to optimal SCBU cot numbers. Any further cost implications through travel, NEAS, patient education to be fully considered as part of final decision-making process. Links to be established with wider

	capital receipts etc.		Contribution to business as usual efficiencies within STP financial plan, although less than initially projected. Financial plans will contribute to expected NHSI efficiencies through service reconfiguration, however potentially at a lower rate than anticipated. Financial risks reflected in risk log and appropriate risk mitigations in place.	STP financial planning to ensure accurate modelling and monitoring.
Communication engagement and consultation plans	• Proposals underpinned by rigorous stakeholder engagement at all relevant stages with statutory involvement requirements for patients and the public, overview and scrutiny committees and protected characteristic groups fully met • Comprehensive, deliverable and resourced communications and consultation plans in place. • Consultation plan fully risk assessed with actions identified and undertaken to mitigate clinical,	Fully	Communications, engagement and consultation resources in place with external assurance arrangements in place through Consultation Institute. Thorough patient and public insight programme complete across all specialities with evident impact on scenario development process. Robust communications strategy and consultation plan in place and consultation planning underway. Patient reference group established and providing clear critical friend role throughout.	Final consultation document. Mitigating actions for risks identified within IIA. Continued stakeholder engagement, particularly with MPs.

	financial, legal and reputational risk • Sound understanding of stakeholders and likely impact and interest, including corporate, patient and public and providers • Draft consultation documentation in place • Equality analysis completed for both pre-engagement and planned communications and consultation activity with action identified to address any potential negative impact on population sectors, particularly on those groups with protected characteristics		Programme well-informed of local reputational and political risks with targeted, ongoing engagement with key stakeholders, including MPs, and regular attendance at the joint health OSC. Elected member involvement in travel impact assessment procurement and survey development process. Integrated Equality, Health and Health Inequalities Impact Assessment complete as per above. Results of integrated equality, health and health inequalities impact assessment informed pre-engagement and consultation planning processes.	