Development of Long List and Evaluation Criteria

Report to:	**Programme Board**
Subject:	**Development of Long List and Evaluation Criteria**
Report by:	**Mike Sharon, Programme Director**
Date:	**17th September 2014**

1 Executive Summary

The Evaluation Panel appointed by the Board has held a number of meetings since June, and a report of these follows. At the conclusion of its last meeting the Panel agreed the following recommendations to the Board. The Board has now considered these recommendations and agreed both a Long List of Options and a set of Evaluation Criteria to be used in determining a Short List.

1.1 Long List

The Panel agreed to recommend a long list of eight options (see over) comprising:

i) A 'do minimum' option (as required by the Treasury);

ii) Seven options for the location of the Emergency Centre and the Diagnostic & Treatment Centre (all of which deliver the approved clinical model); and

iii) A range of between four and seven Urgent Care Centres which should ideally be co-located with Local Planned Care facilities and Community Units, and should be scaled to serve local need.

The Panel noted the potential for further UCCs to be developed in Powys but felt it was beyond its remit to include a formal recommendation on the location of facilities in Powys.

The Panel also suggested that, whilst recognising the clinical and logistical rationale of co-locating UCCs with existing acute and community facilities, travel analysis should be undertaken to determine whether there are alternative and/or additional locations in Shrewsbury and Telford which could provide significantly better UCC access for the respective urban populations than existing acute hospital sites.

Programme Board accepted the proposed Long List and the Panel's other recommendations.

Recognising the recent development of a Women and Children's Centre at Princess Royal Hospital, Telford (PRH), the Board also agreed that the potential to locate consultant-led obstetrics either at the Emergency Centre (EC) or at PRH should be considered as a variant to options which do not locate EC at PRH.

1	**Do Minimum** - Provider & Commissioner efficiency strategies implemented but no major service change. **Existing dual site acute services (including A&E).**		**Four community hospitals and MIUs** providing services as currently.
2	**EC with UCC & LPC at RSH; ***	**DTC with UCC & LPC at PRH;**	**Two to five further UCCs ideally co-located with LPCs & CUs**
3	**EC with UCC & LPC at PRH;**	**DTC with UCC & LPC at RSH;**	
4	**EC with UCC at new site; ***	**DTC with UCC & LPC at PRH; UCC & LPC at RSH;**	
5	**EC with UCC at new site; ***	**DTC with UCC & LPC at RSH; UCC & LPC at PRH;**	
6	**EC & DTC with UCC & LPC at RSH; ***	**UCC & LPC at PRH;**	
7	**EC & DTC with UCC & LPC at PRH;**	**UCC & LPC at RSH;**	
8	**EC & UCC with DTC at new site; ***	**UCC & LPC at PRH & RSH;**	
** the potential to locate consultant-led obstetrics either at the Emergency Centre or at PRH should be considered as a variant to these options.*			

1.2 Evaluation Criteria

The Panel agreed a set of four criteria appropriate for shortlisting purposes only, and agreed to meet again at the end of September to review the criteria as confirmed by Board and to develop them in further detail.

The Panel noted that these four criteria (and their associated measures) are a subset of the overall benefits sought by the Programme and which a preferred option will need to demonstrate that it can deliver. The rationale for this subset is that it is intended to be amenable to objective differentiation between options.

The proposed criteria are:

ACCESSIBILITY FOR PATIENTS

- **a)** Total miles travelled
- **b)** Total time travelled
- **c)** Net gain (loss) by area (overlaid with Index of Multiple Deprivation)
- **d)** Comparison against average national travel times to A&E
- **e)** Impact on ambulance services

QUALITY OF CARE

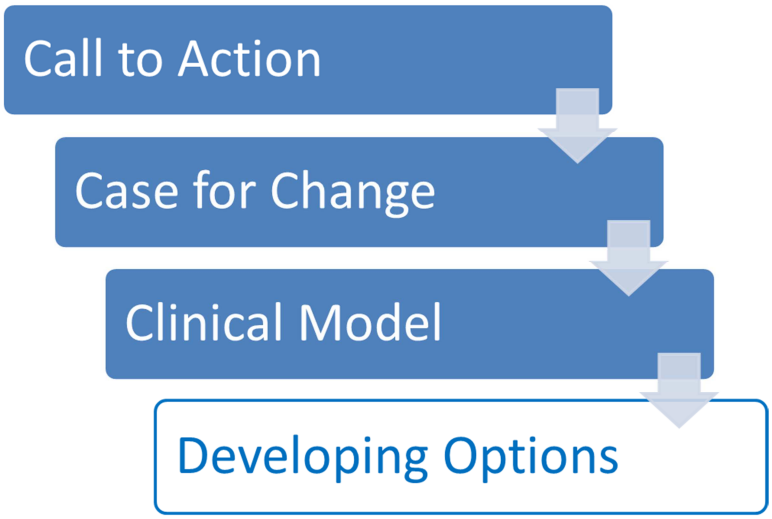
- **a)** Change in number of people who are more than 45 minutes from an Emergency Centre (potential to allow for differential Ambulance access should be explored)
- **b)** Ability to recruit & retain key clinical staff
- **c)** Extent of consultant delivered high acuity services
- **d)** Potential for better enabling partnership working

DELIVERABILITY	AFFORDABILITY
a) Timescale for delivery (the shorter, the better) allowing for phasing of benefits **b)** The amount of disruption for existing services (the less, the better) **c)** Ability to flex in response to future service needs beyond Future Fit (the greater, the better) against 3 scenarios **d)** Extent of remaining backlog maintenance	**a)** Can be accommodated within projected future resources **b)** Net revenue cost impact

The Board approved the criteria and confirmed the need for further work to be undertaken on the detail of how the criteria should be measured.

2 Introduction

The work of the Clinical Design workstream to define the future model of care was completed in May and was subsequently approved by Programme Board. The focus of the Programme then turned to the identification of options for how the clinical model of care might be delivered. The process for undertaking this work, in line with national guidance, was approved by the Board in May. This included the appointment of an Evaluation Panel (Appendix A) to prepare recommendations for the Board.



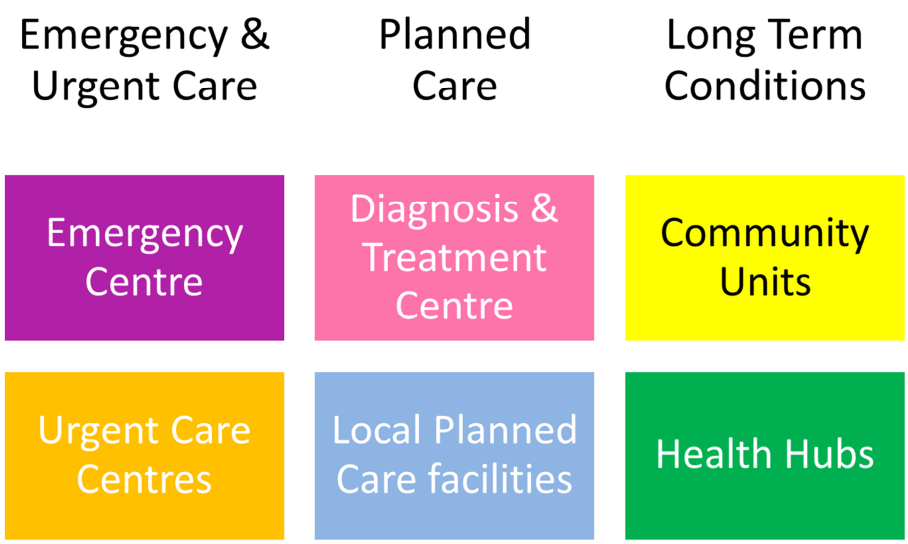
The purpose of this report is to present to the Board the Evaluation Panel's recommendations on a Long List of options and on the Evaluation Criteria to be applied in reducing that Long List to a Short List. The report also described the process the Panel went through to reach those recommendations.

3 Long List of Options

The development of the Long List comprised three key tasks:

- Generating ideas;
- Engaging the Community and Clinicians, and;
- Describing the Long List.

At the outset of its first meeting, the Panel was presented with background demographic and geographic information to inform the generation of ideas, and the nature of the various physical components of the model were described.



3.1 Generating Ideas

The Panel was presented with an overview of the options development process (see over), and an option was defined as 'a unique combination of the number, location and co-location of the model's components'.

It was pointed out by panel members that the model was open to interpretation. It was also pointed out that the clinical model highlighted the need for, for example, integration between social care and health, integrated health records, a more empowered community and that these were not guaranteed to happen. This was recognised and panel members were asked to state their assumptions in developing the options.

The Panel was then asked to work individually, in groups and then in plenary on developing a range of possible options. At this stage the panel was asked not to constrain their thinking and was asked to think innovatively about possible solutions.

Individuals were asked to set out location of model components on maps. Groups were asked to record their discussion and the rationale for proposing or discarding options.

In total, some 41 ideas were generated, all of which contained one Emergency Care centre and varying combinations of numbers, locations and co-locations of the other components of the model.

The location of components generally assumed that they would be located in the larger population centres both in Shropshire and, less frequently, in Wales. In some cases, however, other locations were proposed - most frequently for Local Planned Care services and Health Hubs. In one case, other locations for Urgent Care Centres were suggested.

The Emergency Centre (EC)

The emergency Care centre location was proposed in one of three locations, PRH site, RSH site or new build on another site. The new site was always placed on the A5, either on the Shrewsbury ring road or on a site between Shrewsbury and Telford.

In some cases the Emergency Centre was co-located with the Diagnostic and Treatment Centre and, in others, they were on separate sites.

The Urgent Care Centres (UCC)

The number of UCCs proposed ranged between one and eight with an average of six locations proposed. Most but not all ideas assumed a co-location of the EC with a UCC. Once idea proposed only a single UCC co-located with EC.

The geographical spread of UCCs was wide including proposed new locations in the north and south of the county, in Powys, and in the centre of Telford. Most ideas, however, had UCCs in one of the existing hospital sites and/or in some or all of the existing Community Hospital/MIU locations. Again, most ideas proposed the co-location of UCCs with other services such as Local Planned Care, Community Units and Health Hubs.

Diagnostic and Treatment Centres (DTC)

Nearly all ideas proposed a single DTC. However, one proposed five DTCs as well as five Local Planned Care Centres (LPCs), and another proposed three DTCs. Half of the ideas proposed a new build EC also proposed a co-located new build DTC.

Across all ideas, excluding that with five DTCs, a total of four sites were proposed for the DTC. These were:

- New site EC
- PRH
- RSH
- Oswestry

In cases with a DTC on an existing hospital site most ideas did not co-locate the DTC with the EC. This occurred more frequently as an option for the PRH site than for the RSH site.

1. Drivers
2. Ideas
3. Long List
4. Short List
5. Preferred Option
Parameters
Key Benefits
Clinical Model
Demography
Parameters
• Workshop 1
Generating Ideas
• Workshop 2
Proposing Criteria
• Public Engagement
• Workshop 3
Weighting Criteria
• Workshop 4
Evaluating Options
• Public Engagement
• Appraisal
Financial
Non-financial
• Public Consultation
• Decision
• Outline Business Case(s)
An infinite range of ways to implement the model needs to be reduced to a provisional long list of around 12.
Criteria for evaluating the long list also need to be drafted.
Following extensive engagement the long list & evaluation criteria are confirmed by Board, and descriptions of the options developed.
Agreed criteria are then weighted and the options scored against the criteria.
A recommended short list is proposed to Board.
Following confirmation of the short list, options are further developed alongside more engagement on the model and the agreed list.
The detail of this stage is yet to be agreed by Board.
A preferred option emerges from the appraisal process – and subject to various approvals – that option will be subject to Public Consultation and fully developed within one or more Outline Business Cases.

Community Units (CU)

The number of CUs proposed ranged from 0 to 11 with most ideas proposing five, six or seven. CU locations were widespread, most often in exiting Community Hospital locations but also including existing hospital sites (although not on a new site EC). In some cases CUs were located in Wales. CUs were nearly always co-located with other services.

Health Hubs (HH)

Health Hubs did not feature in some ideas. The maximum number proposed was fourteen.

HHs represent probably the widest geographical spread of all of the components of the model, with HHs proposed in some areas without any other components of the model. Although some HHs were proposed as standalone, the majority of HHs were co-located with other facilities such as community units. A minority of ideas showed HHs co-located with the EC, together with other services.

Local Planned Care (LPC)

Local Planned Care facilities did not feature in all ideas. The maximum number proposed was ten with most options proposing six or seven

LPCs showed a broad geographical spread and were usually co-located with UCCs and CUs. A small number had LPCs as standalone units

The key issues discussed in plenary session were:

Access

This was believed to be one of the most important factors to be taken into account when developing options. Some argued that ease of access was more important for planned care than for the Emergency Centre to which travel was more likely to be by ambulance.

There was also a debate on whether services should be made more accessible even if that meant that they were adequate rather than excellent. This was not generally supported.

Access for the population living in Wales was felt to be a particular concern which is why some contributors had placed some facilities in Wales.

The ability of populations to access peripheral providers would need to be taken into account in any travel time modelling.

There was also a discussion about the variability of public transport. It was accepted that public transport was largely absent form many parts of the County and that even where it did exist in more urban areas it could not necessarily be relied upon for travel to healthcare facilities when this was needed because it was too infrequent or had stopped too early.

Achieving a natural clustering of services

Most members of the Panel had taken a view that it would be preferable to achieve a clustering of services in population centres to make services as accessible as possible and to achieve a critical mass of services in a single location.

Making best use of existing facilities

Groups reported that making effective use of existing facilities was an assumption underpinning most of the options. However, it was pointed out that making the best use of existing facilities did not necessarily mean that they should be used for the same purpose or that they could not be sold to provide funding for facilities in another location.

In this context the use of Robert Jones and Agnes Hunt was raised as an issue. It was suggested that either its work could be moved to the DTC or that its existing capacity could be used to provide all elective orthopaedic provision in the County.

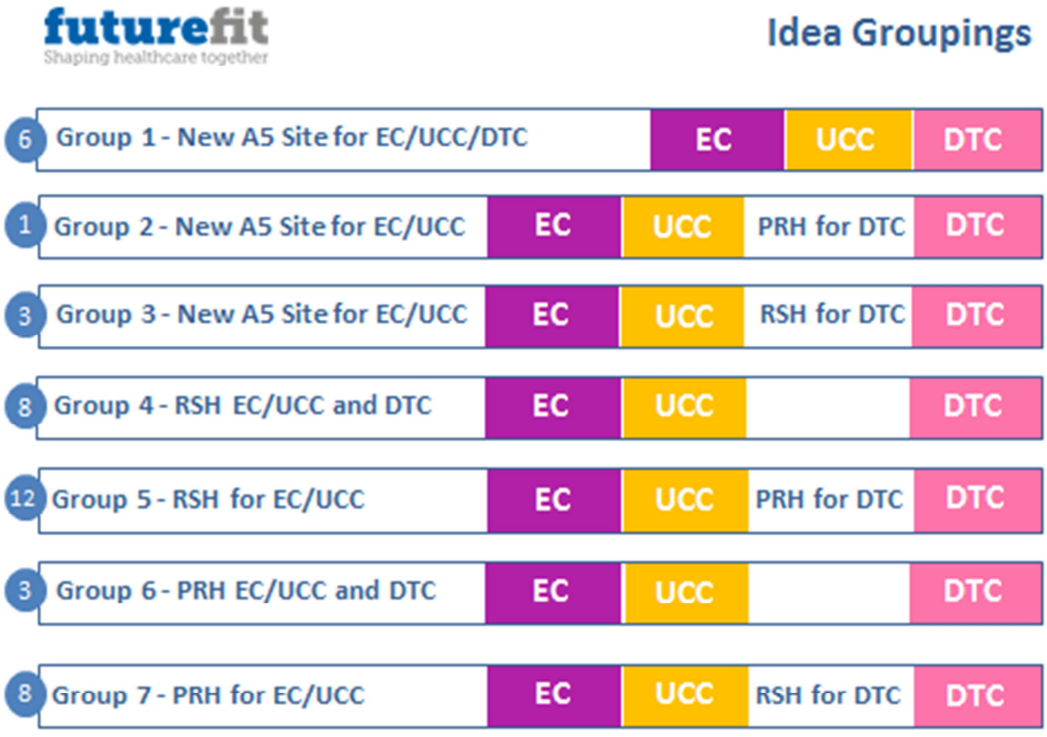
Finance

It was recognised by panel members that the affordability of options would become an issue. However, in general this had not been used as an overriding consideration when options were being developed.

Politics

It was also recognised by some panel members that political considerations could play a part in determining future consideration of options. There was a desire that politics should not be a determining factor in options development or evaluation and generally this had not been a factor taken into account in the development of options.

Following this first Panel workshop, the Programme Office was asked to synthesise the ideas generated. Whilst there was a great deal of diversity in proposals for the more local components of model, there was a clearly discernible set of idea groupings in relation to EC and DTC. These are summarised in the table below (the number on the left indicates the frequency with which that grouping was proposed).



3.2 Engaging the Community and Clinicians

Following this initial generation of ideas by the Panel, a series of further clinical design discussions were initiated. Key conclusions from these discussions were:

i) Co-location of DTC with EC is not essential although it may be desirable from the perspective of workforce efficiency;

ii) Acute patients admitted to the Emergency Centre could be transferred to a sub-acute/community facility when clinically appropriate (this can often benefit patients and relatives if the right rehabilitation and re-ablement culture is in place more locally) but transfers during an acute stay should not be factored into service planning;

iii) Should there be a failure to find a deliverable local option this needn't deny all aspects of the model. A theoretical (but not desirable) alternative would be use of out of County ECs which also supported enhanced UCCs in County;

iv) DTC should operate for 3 sessions (morning, afternoon, evening) and for 7 days a week supported by a large specialist staff – overnight it would be covered by a small generalist staff;

v) UCCs should be open 16 hours/day co-located with OOH GP services;

vi) Staffing would comprise Nurses, Enhanced Nurse Practitioners and GPs plus prompt remote support from Acute specialists;

vii) Co-location of UCCs with LPCs is desirable and with CUs, too, in rural areas;

viii) There are advantages in using existing community facilities;

ix) For a rural population of c.50k it would be possible to extend the range of services currently provided in MIUs so long as there are adequate diagnostics (X-ray and ultrasound), near-patient testing and IT (including telemetry);

x) Shrewsbury and Telford should each have a UCC/LPC given their populations;

xi) Further UCC/LPCs (along with CUs) should be based around some or all of the existing MIUs (minimum 2) to take advantage of existing facilities and build on current services.

In addition to these clinical discussions, public engagement activities in August included four deliberative events and a stratified telephone survey of 1000 people. These activities are the subject of a separate report but their key outputs were presented to the Panel to inform its identification of a long list of options.

3.3 Describing the Long List

At two further workshops in September, the Evaluation Panel reviewed its initial ideas and received further information in relation to:

i) Summary of Clinical Discussions

ii) Public Engagement feedback

iii) Access Analysis

iv) Emergency Centre Feasibility Study key findings

v) Activity Modelling.

At the second workshop the Panel was invited to consider an emerging long list which reflected its initial ideas and subsequent clinical discussions. This was offered as a starting point but not as a constraint, and the Panel (working in groups) was asked to identify their own lists and to specify their rationale for these. The key points then discussed in plenary session were as follows:

i) It was agreed by all groups that options with out-of-county Emergency Centres should be excluded due to excessive access times for patients and the referral complexity for GPs (creating a further risk for patients);

ii) After extensive discussion it was concluded that rather than specify a fixed number of UCCs (with CUs/LPCs), each option (other than the required 'Do Minimum') should have a range of four to seven UCCs. It was noted that, in the original panel ideas, the average number of UCCs proposed was six, and that this was echoed in subsequent clinical discussions (which also suggested a minimum of four);

iii) Although each UCC would be scaled to reflect its local catchment (whilst maintaining a common service offer), there was some feeling that Shrewsbury and/or Telford populations warrant more than one UCC each. The modelling of alternative and/or additional locations in Shrewsbury and Telford was agreed (within the overall range of four to seven);

iv) There was some feeling that the exact location of UCCs might vary in each option, depending on the location of the EC in that option; and.

v) Whilst the Panel recognised the potential for UCCs to be developed in Powys, it felt that it was beyond its remit to propose locations in Powys.

As a result of these discussions, the Panel agreed to recommend a long list of eight options (see over) comprising:

iv) A 'do minimum' option (as required by the Treasury);

v) Seven options for the location of the Emergency Centre and the Diagnostic & Treatment Centre (all of which deliver the approved clinical model); and

vi) A range of between four and seven Urgent Care Centres which should ideally be co-located with Local Planned Care facilities and Community Units, and should be scaled to serve local need.

The Panel noted the potential for further UCCs to be developed in Powys but felt it was beyond its remit to include a formal recommendation on the location of facilities in Powys.

The Panel also suggested that, whilst recognising the clinical and logistical rationale of co-locating UCCs with existing acute and community facilities, travel analysis should be undertaken to determine whether there are alternative and/or additional locations in Shrewsbury and Telford which could provide significantly better UCC access for the respective urban populations than existing acute hospital sites.

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** the potential to locate consultant-led obstetrics either at the Emergency Centre or at PRH should be considered as a variant to these options.*			

Once the Board has determined a final Long List, it will then be necessary to prepare a brief description of each option to inform the subsequent short-listing process. These descriptions will directly address each of the evaluation criteria.

Whilst this work is being undertaken, there will also be a further series of public engagement activities to gather public feedback on the long list. A report on these activities will be provided to the Evaluation Panel before it evaluates the long list.

4 EVALUATION CRITERIA

In parallel with the development of a long list of options, the Panel was also charged with proposing a set of Evaluation Criteria for use in differentiating between options. It was highlighted to the Panel that these criteria need to be:

- Grounded in what has been agreed to date as part of the Programme (the Clinical Model; the Case for Change; the Programme Objectives)
- 'Co-produced' with patients, public and clinicians
- Agreed by constituent boards to help bind collective decision making
- Capable of balancing financial considerations with a thorough assessment of how to best meet the needs of all the people served by the Future Fit economy , urban and rural.

For the criteria to do what is required of them, they also need to be:

- Clearly defined
- Measurable or at least capable of being informed by 'marker measures' that are measurable.

At the outset of its initial deliberations, the Panel discussed and agreed two important matters:

- The difference between a criterion that has value in discriminating between options (evaluation criteria) and one which has value in determining later on whether what was done worked in delivering, for example, better health (benefits realisation criteria). This is particularly relevant in the case of Future Fit as the options are all, in principle, capable of delivering the Clinical Model (except the 'do minimum' option). This means that it would not be possible to differentiate between them in relation to some of the quality improvements that the model is intended to deliver…..whereas it is vital that having chosen one and implemented it we seek to measure whether it is actually delivering that quality improvement.
- The advantages of carefully specified criteria in ensuring that comparative assessment is well grounded and well informed by relevant evidence (measurable) and that the decision-making process is less open to capture by the 'politics, history and habit' that the public response to Call to Action specifically asked Future Fit to avoid .

The Panel began its deliberations about criteria with three core inputs:

- The objectives of the FutureFit Programme as defined in the Programme Execution Plan and agreed by the Programme Board as well as each of the constituent boards and the Joint HOSC;
- The headings for option evaluation criteria that are suggested in guidance by the Department of Health; and
- A set of 21 statements /principles that had been drawn by the Clinical Design Group from the Clinical Model which was agreed at the Programme Board in June 2014.

Members of the Panel were then asked individually and then in small groups to undertake the following considerations:

- Which of the list of 21 derived from the Clinical Model could be developed as a criterion, and if so would it be an option evaluation criterion or a benefits realisation criterion (or both)?
- Given the objectives for Future Fit, were there any important option evaluation criteria that were needed but which didn't arise from the list of 21?
- Which of the criteria were most important in differentiating between options intended to deliver the Clinical Model? (their 'top 5')

- How might the criteria be measured?

The conclusions of each group were shared with the whole Panel and debated. Members were encouraged throughout to voice any questions or observations about the exercise. They were asked to approach the task mindful of the fact that they were the people who ultimately would be asked by the Programme Board to score options against these criteria.

The Panel reached some initial agreement on potential high–level criteria that were most important and relevant. They were able to make some specific recommendations on some of the sub-headings or 'markers' that might be amenable to measurement for the top three criteria though they asked for further work to be done on these by the Programme Office prior to further consideration in September.

The subsequent development of the criteria by both the Panel and the Programme Office was informed by:

- Public engagement activities;
- Discussion in the Assurance and Impact Assessment workstreams; and
- Review against standard DH benefit criteria and recommended areas for impact assessment.

As a result, a comprehensive list of criteria and supporting measures was provided to the Panel. This was subsequently reduced by the Panel to a list of four criteria appropriate for shortlisting purposes only, and it was agreed to meet again at the end of September to review the criteria as confirmed by Board and to develop them in further detail.

The Panel noted that these four criteria (and their associated measures) are a subset of the overall benefits sought by the Programme and which a preferred option will need to demonstrate that it can deliver. The rationale for this subset is that it is intended to be amenable to objective differentiation between options.

The panel also noted that the proposed criteria should be presented in a way which demonstrates a clear focus on the perspective of patients.

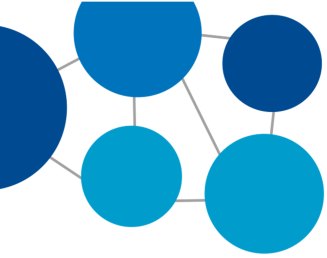
No measures are proposed which directly address the quality of planned care (as opposed to urgent and emergency care) because it is assumed that accessibility is an appropriate proxy for this given the evidenced impact of distance on patient utilisation of planned care services (e.g. radiotherapy).

The proposed criteria are:

ACCESSIBILITY FOR PATIENTS **f)** Total miles travelled **g)** Total time travelled **h)** Net gain (loss) by area (overlaid with Index of Multiple Deprivation) **i)** Comparison against average national travel times to A&E **j)** Impact on ambulance services	**QUALITY OF CARE** **e)** Change in number of people who are more than 45 minutes from an Emergency Centre (potential to allow for differential Ambulance access should be explored) **f)** Ability to recruit & retain key clinical staff **g)** Extent of consultant delivered high acuity services **h)** Potential for better enabling partnership working
DELIVERABILITY **e)** Timescale for delivery (the shorter, the better) allowing for phasing of benefits **f)** The amount of disruption for existing services (the less, the better) **g)** Ability to flex in response to future service needs beyond Future Fit (the greater, the better) against 3 scenarios **h)** Extent of remaining backlog maintenance	**AFFORDABILITY** **c)** Can be accommodated within projected future resources **d)** Net revenue cost impact

Mike Sharon

Programme Director



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Shaping healthcare together

APPENDIX A

EVALAUTION PANEL ATTENDEES

17 JUNE 2014

ORGANISATION	Invited	Attended
Shropshire Clinical Commissioning Group	**Dr Julian Povey, Clinical Director of Performance and Contracting**	**Dr Julian Povey, Clinical Director of Performance and Contracting**
Telford & Wrekin Clinical Commissioning Group	**Chris Morris, Exec Lead for Nursing and Quality**	**Chris Morris, Exec Lead for Nursing and Quality**
Powys Local Health Board	**Victoria Deakins, Lead Therapist for North Powys**	**Victoria Deakins, Lead Therapist for North Powys**
Shrewsbury and Telford Hospital NHS Trust	**Mr Mark Cheetham, Scheduled Care Group Medical Director**	**Debbie Vogler, Director of Strategy – AM** **Mr Mark Cheetham, Scheduled Care Group Medical Director - PM**
Shropshire Community Health NHS Trust	**Dr Emily Peer, Assistant Medical Director & GPSI**	**Dr Emily Peer, Assistant Medical Director & GPSI**
Shropshire Patient Group	**Pete Gillard**	**Pete Gillard**
Telford & Wrekin Health Round Table	**Christine Choudhary**	
Healthwatch Shropshire	**Vanessa Barrett**	**Vanessa Barrett**
Healthwatch Telford & Wrekin	**Martyn Withnall**	**Kate Ballinger**
Shropshire Council	**Kerrie Allward**	**Andy Begley**
Telford and Wrekin Council	**Liz Noakes, Assistant Director and Director of Public Health**	**Liz Noakes, Assistant Director and Director of Public Health**
West Midlands Ambulance Service NHS FT	**Sue Green, Director of Nursing & Quality**	**Sue Green, Director of Nursing & Quality**
Welsh Ambulance Services NHS Trust	**Heather Ransom, Head of Service & Resourcing**	
Robert Jones & Agnes Hunt Hospital NHS FT	**John Grinnell, Director of Finance**	**John Grinnell, Director of Finance**
South Staffs & Shropshire Healthcare NHS FT	**Lesley Crawford, Director of Mental Health**	**Lesley Crawford, Director of Mental Health**
LMC/GP Federation	**No nominee**	
Shropshire Doctors' Cooperative Ltd	**Ian Winstanley**	
NHS England Shropshire & Staffordshire Area Team	**Liz McCourt, Head of Assurance**	

2 SEPTEMBER 2014

ORGANISATION	Invited	Attended
Shropshire Clinical Commissioning Group	**Dr Julian Povey, Clinical Director of Performance and Contracting**	**Dr Julian Povey, Clinical Director of Performance and Contracting**
Telford & Wrekin Clinical Commissioning Group	**Chris Morris, Exec Lead for Nursing and Quality**	**Chris Morris, Exec Lead for Nursing and Quality**
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Telford & Wrekin Health Round Table	**Christine Choudhary**	**Christine Choudhary**
Healthwatch Shropshire	**Vanessa Barrett**	**Carole Hall**
Healthwatch Telford & Wrekin	**Martyn Withnall**	**Jane Chaplin**
Shropshire Council	**Kerrie Allward**	**Kerrie Allward**
Telford and Wrekin Council	**Liz Noakes, Assistant Director and Director of Public Health**	**Liz Noakes, Assistant Director and Director of Public Health**
West Midlands Ambulance Service NHS FT	**Sue Green, Director of Nursing & Quality**	**Sue Green, Director of Nursing & Quality**
Welsh Ambulance Services NHS Trust	**David Watkins, Locality Manager**	**David Watkins, Locality Manager**
Robert Jones & Agnes Hunt Hospital NHS FT	**John Grinnell, Director of Finance**	
South Staffs & Shropshire Healthcare NHS FT	**Lesley Crawford, Director of Mental Health**	**K Mansell**
LMC/GP Federation	**Jessica Sokolov**	
Shropshire Doctors' Cooperative Ltd	**Ian Winstanley**	
NHS England Shropshire & Staffordshire Area Team	**Liz McCourt, Head of Assurance**	
Montgomery Community Health Council	**Observer status only**	
Shropshire HOSC	**Observer status only**	**Gerald Dakin**
Telford & Wrekin HOSC	**Observer status only**	

9 SEPTEMBER 2014

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Shropshire Clinical Commissioning Group	**Dr Julian Povey, Clinical Director of Performance and Contracting**	**Dr Julian Povey, Clinical Director of Performance and Contracting**
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Shrewsbury and Telford Hospital NHS Trust	**Mr Mark Cheetham, Scheduled Care Group Medical Director**	**Mr Mark Cheetham, Scheduled Care Group Medical Director**
Shropshire Community Health NHS Trust	**Dr Emily Peer, Assistant Medical Director & GPSI**	**Dr Emily Peer, Assistant Medical Director & GPSI**
Shropshire Patient Group	**Pete Gillard**	**Pete Gillard**
Telford & Wrekin Health Round Table	**Christine Choudhary**	
Healthwatch Shropshire	**Vanessa Barrett**	**Vanessa Barrett**
Healthwatch Telford & Wrekin	**Martyn Withnall**	**Kate Ballinger**
Shropshire Council	**Kerrie Allward**	**Andy Begley**
Telford and Wrekin Council	**Liz Noakes, Assistant Director and Director of Public Health**	
West Midlands Ambulance Service NHS FT	**Sue Green, Director of Nursing & Quality**	
Welsh Ambulance Services NHS Trust	**David Watkins, Locality Manager**	**David Watkins, Locality Manager**
Robert Jones & Agnes Hunt Hospital NHS FT	**John Grinnell, Director of Finance**	**John Grinnell, Director of Finance**
South Staffs & Shropshire Healthcare NHS FT	**Lesley Crawford, Director of Mental Health**	
LMC/GP Federation	**Jessica Sokolov**	**Jessica Sokolov**
Shropshire Doctors' Cooperative Ltd	**Ian Winstanley**	
NHS England Shropshire & Staffordshire Area Team	**Liz McCourt, Head of Assurance**	
Montgomery Community Health Council	**Observer status only**	
Shropshire HOSC	**Observer status only**	**Gerald Dakin**
Telford & Wrekin HOSC	**Observer status only**	**Derek White**