Questions for NHS Organisation in Shropshire and Telford and Wrekin May 2016 from Shropshire and Telford & Wrekin Joint Health Overview and Scrutiny Committee

1)	Risks	Response	
a)	What are the risks of not progressing to consultation on the Future Fit proposals within the planned timescales?	Urgent written response	If Public Consultation cannot be initiated at the beginning of December 2016 it is likely to have to be deferred until May 2017 due to the time needed for consultation (especially over a holiday period) and to the pre-election period for local elections in 2017.
b)	What are the views of the clinicians in the most vulnerable acute services (Emergency Medicine, Acute Medicine and Critical Care) if Future Fit is delayed?	Urgent written response	The consultants are working with the Medical Director on a 'Plan B' if there were any delay as services would have to move and some stop to allow safe levels of staffing to be introduced and prevent existing staff from leaving.
c)	Can the acute trust provide assurance that the services	Urgent written response	The services provided at present are assured as safe by CCG, CQC, Healthwatch, NHSI, NHSE, SATH governance committees, External reviews from ECIP, Royal Colleges etc

currently provided are safe?		
Clarification: Analysis of research on the centralisation of emergency services (If this is not available before the meeting this issue will be discussed at the Committee meeting and Members will request a report to follow) A balanced analysis of the research on the impact of closing a smaller A&E department and centralising emergency services in a single department. This should include details of the risk of increase travel time for patients balanced against the benefits of a specialist service with greater consultant cover?		At the outset of the clinical design process, local clinicians were provided with an analysis of the evidence relating to acute and episodic care, including references to the underlying research papers. This evidence review will be refreshed as part of the senate review and non-financial appraisal processes. The evidence review summary is attached.
2) Activity and Capacity		
a) How has the information from the Activity and Capacity workstream informed the	Written response to Joint HOSC meeting	The assumptions around activity and capacity modelling are set out in the SOC. The Phase 2 modelling estimate the consequences of more radical redesign and built on the Phase 1 modelling that estimated the levels of activity that the Trust and Shropshire Community Trust might be expected to manage in 2018/19. It took into account demographic change, a range of commissioner activity avoidance schemes and provider efficiency schemes. Aspects of demographic change were also considered and modelled. The headline outputs in terms of potential activity shifts are:

<table>
<tr>
<td>clinical model and Strategic Outline Case? In particular:
• What assumptions does the activity and capacity modelling make?
• How many beds are planned in the SOC for the emergency department? How does this compare to the number of beds at both current A&E sites?
• Under the SOC and clinical model what activity will be transferred to community and primary care settings?</td>
<td>in July (date TBC)</td>
<td>

69% of front door urgent care activity incorporating activity currently in a number of different services could be managed at an Urgent Care Centre, with the remaining 31% (circa 68,000 attendances) requiring care in the Emergency Department (ED)
75% of the activity being managed by the Urgent Care Centres will take the form of minor injuries or ailments, 12% as Ambulatory Emergency Care, 8% as frailty management and 5% as others
Approximately 35,000 follow-up outpatient attendances managed by the local planned care centres could take place virtually
Of the 10,000 emergency admissions associated with either frailty or long term conditions in 2012/13, the phase 1 models suggested these admissions could fall by 8% by 2018/19 (largely as a consequence of improvements in primary care management and through better use of community hospitals)
The Phase 2 models suggests that a further 24% could be avoided by reducing the prevalence of the key risk factors that give rise to Long Term Conditions (e.g. smoking, high cholesterol, high blood pressure) and through greater integration of community and primary care.

<table>
<tr><th></th><th>2014/15 Outturn</th><th>Projected 2019/20</th></tr>
<tr><td>Elective Daycase</td><td rowspan="2">47,431</td><td>42,775</td></tr>
<tr><td>Elective Inpatient</td><td>6,806</td></tr>
<tr><td>Non Elective</td><td>47,151</td><td>42,902</td></tr>
<tr><td>Non Elective Other</td><td>8,137</td><td>8,647</td></tr>
<tr><td>First Attendance</td><td rowspan="3">401,806</td><td>91,927</td></tr>
<tr><td>Follow Up Attendance</td><td>166,862</td></tr>
<tr><td>Outpatient Procedure</td><td>109,656</td></tr>
<tr><td>A&E</td><td>109,360</td><td>112,836</td></tr>
</table>
To support this activity, the SOC assumes that the total numbers of beds required are 781.
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<tr>
<td>b) Which organisations</td>
<td>Written response</td>
<td>The organisation who were involved in the Activity & Capacity work are:
• Telford & Wrekin CCG
• Shropshire Community Health NHS Trust</td>
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have been involved in the work to model the activity and capacity?	to Joint HOSC meeting in July (date TBC)	• Shropshire CCG • Shrewsbury & Telford Hospital NHS Trust • Midlands and Lancashire CSU • Shropshire Patient Group • Healthwatch Shropshire
c) What proportion of urgent care and trauma patients currently go out of county to Wolverhampton and Stoke? Can you break this down to show the medical conditions or reason for specialist services e.g. heart attack or injury due to road traffic accident?	Written response to Joint HOSC meeting in July (date TBC)	This analysis could be made available but will require a report to follow. An update can be provided at the meeting.
Clarification Details of work undertaken by the Future Fit Activity and Capacity and Workforces Workstreams: Figures on the number of patients		Nationally, there is evidence that supports the local view that large numbers of patients attending A&E do not require emergency or life-saving care. The original Future Fit algorithm has been applied to the Trust's activity data for 2015/16 to determine the future baseline activity numbers with regards to ED and UCC. This simply reviews previous attendances and what happened to each patient during their admission. It then determines whether

<table>
<tr><td>who are currently treated at either A&E department who would be treated at the Emergency Department in the Future Fit Clinical model?</td><td>they need emergency or urgent care services. For example, was the patient admitted to hospital after their A&E attendance; did the patient need a CT scan; did they get discharged from A&E without treatment. The outcome of this analysis has determined the suggested numbers of patients needing care in the Emergency Centre or Urgent Care services.
Complaints/conditions to be treated at the Emergency Department include: anaphylaxis; stroke; severe chest pain; multiple trauma; compound fractures; moderate burns; poisoning. Complaints/conditions to be treated within Urgent Care services are: sprains and simple fractures; cuts and scrapes; asthma; ENT conditions; scalds; bites and stings.</td></tr>
<tr><td>Under the Future Fit Clinical Model – how many of the patients who are currently treated at A&E would be diverted from both the Urgent Care Centres and the Emergency Department and would be treated by primary or community care?</td><td>Our latest estimates on the numbers of additional1 patients who could shift from the urban UCC to a rural urgent care services based on the opening hours of 8am to 8pm with availability of plain film x ray and near patients testing between the hours of 9am-5pm are detailed in the table below. These estimates need to be further tested through the prototype process.
<table>
<tr><th>Locality</th><th>Total A&E activity</th><th>UCC appropriate pts</th><th>UCC as a % of total A&E activity</th><th>RUCC activity based on latest model of care</th><th>RUCC as a % of total potential UCC activity</th></tr>
<tr><td>Bishops Castle</td><td>3,385</td><td>1,546</td><td>46%</td><td>735</td><td>48%</td></tr>
<tr><td>Bridgnorth</td><td>2,956</td><td>1,401</td><td>47%</td><td>580</td><td>41%</td></tr>
<tr><td>Ludlow</td><td>2,772</td><td>1,366</td><td>49%</td><td>723</td><td>53%</td></tr>
<tr><td>Oswestry</td><td>6,656</td><td>2,929</td><td>44%</td><td>1383</td><td>47%</td></tr>
<tr><td>Whitchurch</td><td>2,492</td><td>1,301</td><td>52%</td><td>651</td><td>50%</td></tr>
<tr><td>Grand total</td><td>18,260</td><td>8,543</td><td>47%</td><td>4072</td><td>48%</td></tr>
</table></td></tr>
<tr><td>Can you provide a one page summary setting out what funding</td><td>The STP finance plan assumes that £6m will be invested in new primary/community and social care capacity. The expectation is that the benefit from improved integration will fund the £6m development.</td></tr>
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[1]does not list numbers of patients who currently attend the Minor Injuries Units in these localities

will be available to resource the transferred care from the hospital to primary, community and social care i.e. the Community Fit Programme? What are the anticipated net savings from the transfer of this care which will contribute to the delivery of the health economy deficit reduction plan?	The hospital business case becomes possible through reduced hospital activity which is dependent upon the community and primary care model. This is said to be circa £16m.
Can you please send details of the modelling used to plan patient flow to the Urgent Care Centres and Primary Care, including the anticipated number of patients accessing these services in the Future Fit Clinical model? What criteria does the modelling for patient flow use to distinguish between patients who should access primary care and those who should access an Urgent Care Centre? If a patient who should be seen in primary care goes to a UCC – would he / she be seen and treated or referred to their GP?	The numbers of patients that would access UCC services in the future is based on current patients who currently accesses services at A&E with an urgent care illness or injury. Should a patient presenting at the UCC be better treated within Primary Care, then patients will be advised of this, however, should they perceive that they need urgent care services they will be accommodated within the UCC.
What training / recruitment will be required to ensure that staff at the UCC have all the relevant skills?	A programme of training is currently underway to develop experienced heath care professionals such as Nurses, Physiotherapies, Paramedics to become Advance Clinical Practitioners (ACPs). This training is fulltime over 3 years and follows the regional ACP framework. The clinical skills within the emergency medicine training documentation follow the same clinical criteria as the medics and are approved by

		the royal college of emergency medicine. All health professionals undergo an annual training programme to ensure that they have the relevant skills and competencies to deliver safe and effective care to patients. The UCC will be delivered along-side the ED departments with on-going mentorship, training and appraisals by the Consultant teams. The UCCs will be fully integrated within the ED Governance Structure.
3) Clinical Model		
a) What is the view of the West Midlands Clinical Senate on the clinical model?	To include response in report to July HOSC Urgent written response	A full external clinical assurance of the acute proposals is being planned for Autumn 2016. An initial review of the whole-system clinical model was undertaken in 2014. The Senate concluded as follows: The Clinical Senate Review panel has concluded that there is an unsustainable health model across the Shropshire, Telford and Wrekin's health and social care economy which warrants a need for fundamental change and improvement. Future Fit therefore, provides the opportunity to improve the quality of care provided to the Shropshire, Telford and Wrekin's changing population. The panel agree that the remodelling and redesign of the whole health and social care economy should be commended and the approach taken reflects the scale of changes proposed and the challenges faced. However, the Clinical Senate Review Panel also recognises clinical and financial risks which will require further exploration and clarification before the NHS England stage 2 review. There are also some risks from interdependencies outside of the terms of reference of the review, and therefore beyond the remit of the Senate review panel. These risks are all clearly defined within the report, alongside some key recommendations for consideration by the Future Fit Programme.
b) What other clinical organisations have a role in approving the clinical model? What views have these organisations give so far?	to include response in report to July HOSC Urgent written response	Formal approval is via the two Clinical Commissioning Groups. The West Midlands Senate provides clinical assurance as part of wider NHS England pre-consultation assurance processes but they are not asked to approve the model. As part of CCG approval and wider assurance processes, obtaining support from GP practices will also be required.
c) What		The Clinical Design Group which includes GP representatives have been tasked to set out the case for

discussions are taking place with GPs and the Local Medical committee to address the concerns regarding primary care?	Urgent written response	change for community provision and the detailed work streams necessary to support the redesign. Engagement at locality level is planned for June and July. A further CRG is planned for 22nd June primarily for GPs. The AO, CCG Clinical Chairs and SATH CEO have met with the LMC to discuss their concerns.
Clarification Will there be a definitive clinical view on the need to co-locate the Emergency Department and Women's and Children's Services or will the clinical senate / advice from Royal Colleges assess the benefits and risk of options C1 and C2 and the CCG board will consider this when deciding on the preferred location of these services in the preferred option?		The description of the options to be used in the appraisal process will set out what would need to be put in place to deliver each option, including their impact on access, quality, workforce, deliverability and cost. A wide range of expert clinical views will inform that process in relation to option C2: • Relevant SaTH specialists are considering what would be the consequences of separating women's and children's services from an Emergency Centre, and their conclusions will inform the appraisal document, following review by the Programme's Clinical design workstream; • These local views will be independently reviewed by a group of clinicians for another health economy, covering the range of specialties affected by the variant. A report of this independent external review will be provide to the non-financial appraisal panel; • The options under consideration will then be submitted for formal clinical assurance by the West Midlands Clinical Senate before Public Consultation can be authorised by NHS England. The identification of any preferred option by the CCG Boards will be informed by these various expert sources as well as by the findings of the Integrated Impact Assessment which may include potential mitigations. The final decision by CCG Boards on the location of services will also be taken in the light of the outcomes of Public Consultation, including any recommendations from the Joint HOSC.
4) Urban Urgent Care Centres		
a) What evidence can be provided about the percentage of		In other rural systems like Scotland where such models are in use up to 70% of the traditional AED workload is managed in a new UCC.

cases that can be dealt with at an Urgent Care Centre that currently go to A&E?		
b) What evidence is there from other areas about the need to transfer patients from Urgent Care Centres to an Emergency Department? Has this been included in the clinical model?		Examples like Blackburn, Halton provide the transfer data on this but the occasions are very low less than 1 a week.
c) When will information about the services that will be provided at Urban Urgent Care Centres be available? How will this be communicated to the public?		The spec is being drawn together and a group of clinicians is looking at this to support the briefing paper which will then compare existing AED to UCC and provide a clear detailed assessment for the public to see. This work will be complete before the end of Sept.

5) Rural Urgent Care Centres		
a) What are the key stages and time line to implement the prototype for the rural urgent care centres and then for implementation ? In particular: • What criteria will be used to determine the services provided at each Rural Urgent Care Centre? How many Rural Urgent Care Centres there will be • How the Rural Urgent Care Centres will be staffed? • What hours the rural urgent care centres will		The exact number of rural urgent care centres has not yet been decided; we are focusing as much on the services available as the centre they operate from. We are scoping the potential to implement a full prototype in Bridgnorth. We are also examining opportunities to put in place point of care testing in other sites. In parallel we are holding discussions with all Shropshire CCG localities to discuss what other improvements may be feasible to implement rapidly, working with other providers. As we test and refine the prototype, we will learn which elements of the service are proving most effective and consider wider roll-out. We are planning to staff the rural urgent care service with existing staff working differently e.g. GPs, and other practice staff, staff working in minor injuries units, community hospitals, Shropdoc and other voluntary, social care and mental health service staff as appropriate to the locality. Opening hours will be determined through the prototype process.

be open		
6) Community Fit and Primary Care		
a) What are the key stages and time line to implement the prototype for Community Fit and primary care to ensure that appropriate service are in place to respond to the activity that will be transferred to the community?		As yet there is no planned prototype for Community Fit. We are currently working through a process as part of the STP to scope phase two of Community Fit which will seek to: (ii) clearly articulate the case for change for the way in which services are provided in the community. (ii) share the insights from phase one of Community Fit to ensure that future plans are credible and respond to our insights into the way our populations currently access health and care services. (iii) building on existing work, develop specific detailed care pathways applicable across Telford & Wrekin and Shropshire for key long term conditions. (iv) Learn from national developments such as the Vanguard and New Model of Care programmes to develop a credible locality based delivery model for community services (v) learn from the urgent care prototype and plan for further roll-out
b) What funding will be made available to enable primary and community care services to manage this additional demand? How has this been		As the CCG's AO clearly articulated at the last Future Fit board meeting, the programme has always worked to the established principle that the funding will follow the patient / service user. Our current plans are not yet sufficiently developed to enable a detailed assessment of the funding requirements to be made, but the whole system financial plan does take account of the need for funding to support the shift in activity.

costed and will the funding available be recurring?		
c) Why has the impact of the Future Fit Programme on Primary Care, Community Care and the Community and Voluntary Sector not been included in the Impact Assessment recently produced?		The Integrated Impact Assessment report which went to the Future Fit programme board at the end of last year, set out the requirements and parameters for assessing the impact of Future Fit. The full impact assessment is now underway and will report on the health socio-economic and environmental impacts of the proposed changes, as well as including an equality impact assessment. Examples of areas that are being considered for inclusion in the impact assessment are, under the health section, immunity services and under the socio-economic section impact on local community cohesion. The options appraisal will also consider some elements of community impact.

Clarification Please provide details of the timescale for the development of Community Fit, Primary Care services When will prototype rural urgent care centre for Bridgnorth be operational? How long will the prototype be run before it is rolled out into other areas?		The Community Fit and primary care resilience work isin the process of being subsumed within the Neighbourhoods work for the STP. We anticipate that firm plans will be developed on a locality basis and implementation will be underway by September 2016. We are currently working with the locality to firm up the proposed rural urgent care prototype. Decisions regarding further roll-out will be made by the CCG, depending on a range of success criteria, which will include the effectiveness of the prototype and the views of the local population.
7) Integration		
a) How will the clinical model for acute services (Future Fit) and the clinical model for Primary and Community Services (Community Fit) be integrated so that there are clear patient pathways between different services and organisations?	Written response to Joint HOSC meeting in July (date TBC)	As articulated in 5(a) above, the pathway work is underway.

b) How is the Better Care Fund being incorporated into the clinical and financial modelling for Future Fit and Community Fit?	Written response to Joint HOSC meeting in July (date TBC)	We have been conscious from the outset to build on existing work and both the BCF initiatives and Community Fit will form an integral part of the STP system architecture references in (8) below. This will provide a positive partnership working environment to build on the strong foundations of these existing workstreams and ensure a consistent approach which makes sense to service users and the public.
8) Deficit Reduction / Sustainable Transformation Plan (STP)		
a) How are the cost implications of the different programmes (Future Fit, Community Fit and Primary Care and Rural Urgent Care Centres) being taking into account in the STP which has to be signed off by the end of June?		The Future Fit Community Fit etc are all being subsumed into the STP board and will see a new system architecture emerge with both LA and Health and Wellbeing boards to provide oversight on the implementation of the system plan which will reflect on the existing work already undertaken and merge this with care and wellbeing programmes .
b) Where is the		The STP will transfer funding from Future fit and community fit across plus each organisation will need

money for the STP coming from? How much money does Shropshire and Telford and Wrekin anticipate on getting and when will this funding be available?		to provide a supporting sum to establish the team to drive the changes and co-ordinate the work across our system. Transformation funding will be bid for alongside IM&T bids so where ever funds occur the STP will bid to secure this support
c) How does Shropshire CCG plan to overcome the deficit and how does this affect the Future Fit Programme and the STP?		Shropshire CCG is in the process of developing a medium term financial plan which will eliminate its deficit. This will feed into the Deficit Reduction Plan and STP.
d) Does the STP provide a clear definition of prevention? Is this preventing people getting ill or preventing ill people going unnecessarily to		It is both but does include addressing social issues as well such as isolation

hospital or both?		
e) What funding across the health and social care system is currently used for preventative services? What funding will be available for preventative services under the STP?		This is difficult to quantify as preventative services take place as part of many routine consultations. The focus of the STP is a much greater emphasis on wellbeing and self-management which will include prevention.
Clarification When will Shropshire CCG publicly report its deficit reduction strategy?		A report is expected at July Board.
When will the health economy deficit reduction strategy be publicly available? How does this take into account the continued cuts to local government which affect Adult Services and the increasing difficulty in hospital discharge?		The STP Board has acknowledged the on-going difficulties being experienced in local government and intends to incorporate this difficulty within the finalised STP, likely to be in September 2016.
How will the debt incurred for the Women's and Children's unit be take into account in the financial appraisal, including the cost of relocation under C1		The financial consequences arising from the establishment of the women and children's facility are already provided for within the Trust's existing financial resources, and so are not affected.

9) Governance and Timescales		
a) Are all key stakeholders represented and active members of the relevant work streams and the Programme Board? E.g. How are the views of welsh patients and organisations being represented in the decision making process? How have care providers been engaged in the decision making process?		Yes. The Programme Board comprises sponsor and stakeholder members from all local health and care organisations, including from Powys. All of these organisations also participate in the non-financial appraisal panel. The final decision lies with the two CCGs following consultation and post-consultation engagement with the Joint HOSC. [can list orgs if helpful]
b) What is the role of NHS England in the Future Fit Programme and the STP?		NHS England is the system regulator for commissioners and provides assurance around their functions. This includes Stage 2 pre-consultation assurance of proposals for major service change and the assurance of Sustainability and Transformation Plans (on which future transformation funding allocations depend). It also has a role as the direct commissioner of specialised acute services. NHSE is represented on the Programme Board and non-financial appraisal panel.
c) How has the representation		The Programme Board determined a membership based on representation from all sponsor and stakeholder members of the programme with Joint HOSC Chairs having observer status. It is for each

on the Appraisal Panel been determined? Is this proportionate to the location and size of the populations affected and the cost of the services provided in the respective areas? E.g. are patient from East Shropshire and Powys appropriately represented?		organisation, including patient groups, to determine who represents them and it would be inappropriate for the Board to seek to influence those decisions. However, the access data which forms a key part of the appraisal does set out the impact of proposals on each of 9 geographical areas (as advised by Local Authority colleagues) and on groups with Protected Characteristics.
d) When will it be determined if the Future Fit Programme will be delayed? If it is not delayed, when will the preferred option for the Emergency Centre be		It is not expected that the Programme will be delayed. Since October 2015, the Board has been clear on three high level milestones: 1) Identification of preferred option in Summer 2016; 2) Consultation from December 2016; and 3) Final Commissioner decision in June 2017. Whilst the timing if tasks supporting those milestones will flex from time to time, the Programme does not expect to depart from those key milestones, subject to securing the necessary external assurance and approvals Including HM Treasury) which are beyond its control.

<table>
<tr><td>published? How will this be communicated to the public?</td><td></td><td></td></tr>
<tr><td colspan="2">Clarification
What information on the relative geographical need for women's and children's services will inform the decisions made by the non-financial option appraisal panel?
What is the composition of the non-financial option appraisal panel, numbers voting from each organisation, areas served by the organisation, current office bases of the NHS staff concerned?</td><td>This will be built into the non-financial appraisal as it has been previously. The access modelling is founded on actual activity in 2015-16 and consequently directly reflects local demand. The current composition of the non-financial appraisal panel is below:
<table>
<tr><th>ORGANISATION</th><th></th></tr>
<tr><td rowspan="2">Shropshire Clinical Commissioning Group</td><td>2 Clinicians</td></tr>
<tr><td>1 Manager</td></tr>
<tr><td rowspan="2">Telford & Wrekin Clinical Commissioning Group</td><td>2 Clinicians</td></tr>
<tr><td>1 Manager</td></tr>
<tr><td rowspan="2">Powys Teaching Health Board</td><td>2 Clinicians</td></tr>
<tr><td>1 Manager</td></tr>
<tr><td rowspan="2">Shrewsbury and Telford Hospital NHS Trust</td><td>8 Clinicians</td></tr>
<tr><td>4 Managers</td></tr>
<tr><td rowspan="2">Shropshire Community Health NHS Trust</td><td>2 Clinicians</td></tr>
<tr><td>1 Manager</td></tr>
<tr><td>Shropshire Patient Group</td><td>3 Patient Representatives</td></tr>
<tr><td>Telford & Wrekin Health Round Table</td><td>3 Patient Representatives</td></tr>
<tr><td>Healthwatch Shropshire</td><td>3 Patient Representatives</td></tr>
<tr><td>Healthwatch Telford & Wrekin</td><td>3 Patient Representatives</td></tr>
<tr><td>Powys Patients (via PTHB)</td><td>3 Patient Representatives</td></tr>
<tr><td>Shropshire Council</td><td>2 Clinicians/Managers</td></tr>
<tr><td>Telford and Wrekin Council</td><td>2 Clinicians/Managers</td></tr>
<tr><td>Powys County Council</td><td>1 Clinician/Manager</td></tr>
<tr><td>West Midlands Ambulance Service NHS FT</td><td>1 Clinician/Manager</td></tr>
<tr><td>Welsh Ambulance Services NHS Trust</td><td>1 Clinician/Manager</td></tr>
<tr><td>Robert Jones & Agnes Hunt Hospital NHS FT</td><td>1 Clinician/Manager</td></tr>
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<tr><td>South Staffs & Shropshire Healthcare NHS FT</td><td>1 Clinician/Manager</td></tr>
<tr><td>LMC/GP Federation</td><td>1 Manager</td></tr>
<tr><td>Shropshire Doctors' Cooperative Ltd</td><td>1 Clinician/Manager</td></tr>
<tr><td>NHS England</td><td>1 Manager</td></tr>
</table>
Each panel member independently scores each option against each criterion. Sensitivity analysis of panel scores is able to test the robustness of appraisal results against a number of variant factors, including organisational location.
</td></tr>
<tr><td>Under the current timetable for the Future Fit Programme when would the new Emergency Department be open to patients?</td><td>The phasing of the construction (and therefore opening) of the new facilities is being reviewed as part of the development of the Outline Business Case for all options. As this information becomes available it will be shared.</td></tr>
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