KENT HEALTH
OVERVIEW AND SCRUTINY COMMITTEE
5 MARCH 2020

A SUMMARY OF EVALUATION PROGRESS FOR OPTIONS FOR THE CONFIGURATION OF HOSPITAL SERVICES IN EAST KENT:

Report from:	**East Kent Transformation Programme**
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Introduction

This is a summary of a paper presented to the Kent and Medway Joint HOSC on 6 February and is for information to the Kent HOSC. The document provides an overview to the Committee on progress with the East Kent Transformation Programme.

Background

The pre-consultation business case (PCBC) sets out proposals for the reconfiguration of acute hospital services in east Kent, underpinned by changes that are already underway to strengthen and expand the delivery of local care and improve prevention of ill-health, to enable people to stay well and live independently. It is based on work undertaken by NHS organisations and partners in east Kent since 2015 to develop proposals for meeting the changing health and care needs of local people in a sustainable way.

Progress to Date

This document details key activities undertaken over the last year.

Evaluation Summary

Two options for the configuration of hospital services in east Kent were selected for evaluation against five criteria as set out below:

1. Clinical Sustainability
2. Accessibility
3. Implementable
4. Strategic Fit
5. Financial Sustainability

Each option was assessed independently of the other, against a "Do Minimum" control option. The evaluation process focussed on the options appraisal of acute hospital reconfigurations.

An evaluation panel consisting of The Sustainable Healthcare in East Kent Joint Committee voting members was called upon to review each of the five criterion and to award scores based on each option's outcomes, compared to the Do Minimum. As the Do Minimum is the key comparator, it was agreed that it would score zero across all five criteria.

In January 2020 the east Kent clinical commissioning groups confirmed that both options were shortlisted for inclusion in the pre-consultation business case to be reviewed by NHS England and NHS Improvement.

1. Pre Panel and Programme Assessment

1.1 Development and assessment of the standardised templates

Analysis was undertaken by the Trust, STP workforce and estates leads and independent experts, to respond to each of the evaluation questions in the form of a standardised template.

These templates were designed to ensure consistency in the evaluation response approach and were populated with support from the CCG leads.
These templates were reviewed through and signed off by the East Kent Transformation Programme to ensure robust scrutiny, impartiality and transparency of the analysis undertaken.
Once the templates were signed off and endorsed by the East Kent Transformation Programme, the content of the templates became the basis of the evaluation reports, developed by the CCG.

1.2 Development of the evaluation reports

The endorsed contents of the templates were systematically summarised into a series of evaluation reports to enable the Evaluation Panel to review outcomes against the ‘‘Do Minimum’’ and score accordingly.

To aid the Evaluation Panel in its systematic review of each option, separate reports were prepared comparing each option against the ‘‘Do Minimum’’.

The five reports were reviewed and endorsed through the East Kent Transformation Programme governance structure, before being distributed to the Evaluation Panel in advance of the Panel sessions.

The corresponding templates were also included within the appendices section of the reports to ensure that the panel members had all evidence available to them to support their scoring.

2. The evaluation panel and report

The Panel comprised of an independent chair, as well as scoring members. The role of the independent chair was to mediate discussions during the panel sessions and to facilitate consensus on scores awarded. The scoring members were voting members of The Sustainable Healthcare in East Kent Joint Committee

Three separate panel sessions were held in September, the:

- first session took place on 4th September to evaluate accessibility and strategic fit;
- second session took place on 11th September to evaluate financial sustainability and whether proposals were implementable; and
- final session took place on 18th September to evaluate clinical sustainability.

Subject Matter Experts (SME) were available before each scoring session of the panel, to provide expert knowledge and additional guidance to the scoring members. However, the scoring members deliberated scores in isolation with the independent chair to ensure and maintain impartiality. Members of the East Kent Transformation Programme were also present to provide support to scoring members.

3. Draft Pre Consultation Business Case, Clinical Senate Review & NHSE/I assurance

3.1 Draft pre-consultation business case

A mature draft of the PCBC was finalised and endorsed through our programme governance during October as detailed below:

- Transformation Delivery Board: 21st October 2019
- System Board: 29th October 2019
- The Informal seminar of Sustainable Healthcare in East Kent Joint Committee: 30th October 2019
- Mature draft of the PCBC shared with NHSE/I and the Clinical Senate for review: 11th November 2019

3.2 Clinical Senate review

The Clinical Senate has reviewed the draft PCBC in advance of final submission to NHSE and NHSI in accordance with the major service change assurance processes. Inclusive of all clinically related elements, the review included, but is not limited to, the case for change. The Senate also reviewed shortlisted service configuration options, including the proposed clinical models and standards for ED; Urgent and Acute Care (inclusive of critical care); Planned Care; Cancer sub-specialties; and Paediatrics.

The recommendations from the Senate will be incorporated into the final report that will be submitted to NHSE/I.

4. Finalising the PCBC

4.1 Internal Governance

The steps that will be completed to finalise the PCBC are detailed as follows:

- Completion of additional work identified as required for the final draft of the PCBC including incorporating the recommendations from Clinical Senate and initial review by NHSE/I/E.

- Final draft to be reviewed through internal governance process by end of February 2020.

- Final draft PCBC, endorsed by Provider Boards and Joint Committee, by end of March 2020.

4.2 Key Planning Assumptions/ NHSE/I Assurance Process

NHSE/I will receive a final draft PCBC in April 2020 and consultation will follow conclusion of assurance process

5. Next Steps

The timescale for delivery of the revised PCBC means that a final draft, that addresses actions identified by the Senate, will be completed by 12th February. This will allow for the PCBC to be reviewed and agreed in accordance with CCG and provider governance processes.

The evaluation panel will meet again in February to review:

- the information requested for assurance at the panel meetings in September;

- issues that have been considered through the change control process and may present a material change to the outcomes from evaluation; and

- information that may present a material impact to the PCBC and evaluation of options, this includes responses to Clinical Senate recommendations.

6. Appendix

1. The Evaluation Process
2. Options Summary (including do minimum)
3. Evaluation Criteria

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Appendix 1 The Evaluation Process

The end to end evaluation process involves three key stages:

Objectives

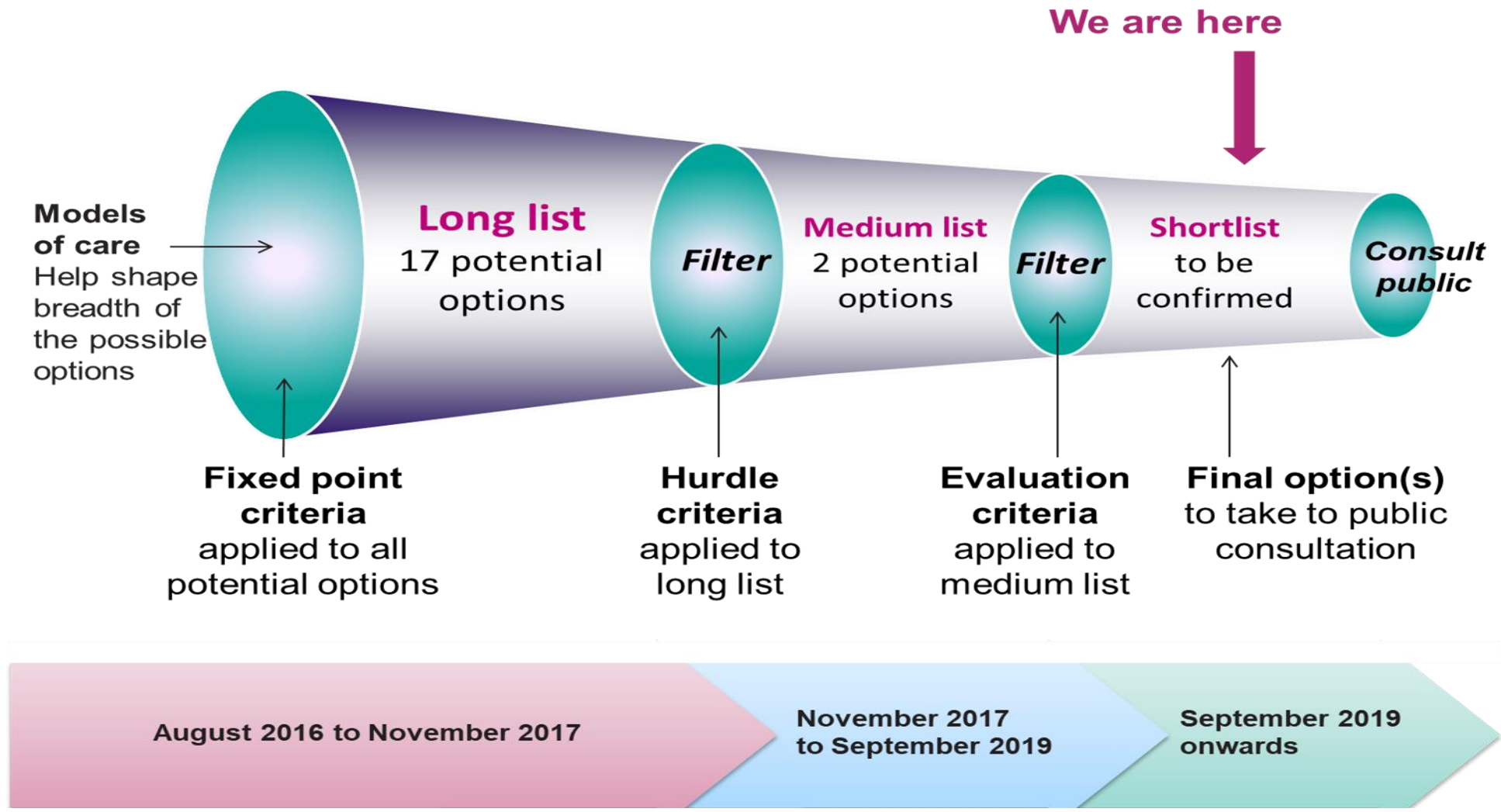
Key objectives of the evaluation process include:

- Provide an objective and transparent framework for the assessment of all possible UEC reconfiguration options
- Derive a manageable shortlist of options from the longlist of options
- Ensure that shortlisted options would enable East Kent local health economy's objectives to be met

The three key stages of the evaluation process

- **Stage 1: Hurdle Criteria (completed):** Application of agreed hurdle criteria with a clear threshold which the options either pass or fail
- **Stage 2: Ranking Criteria (completed):** Where multiple permutations of the same reconfiguration model (e.g. "one UEC site" or "two UEC site") are qualified, the options are ranked to select the best option of that type
- **Stage 3: Full Evaluation (current) :** This will form the final detailed evaluation stage

Options development and assessment



Application of hurdle criteria

- Following the completion of the previous first stage of evaluation, a proposal from Quinn Estates (land developer) to provide a “hospital shell” on/adjacent to the Kent and Canterbury Hospital site for a single Major Emergency Centre was received

- This inferred a substantial and material capital benefit to the East Kent health economy. This option was agreed to be included in the original medium list, announced in November 2017

- Following an assessment from EY, a decision was taken to rerun the first stage evaluation in order to put the newly emerged option through the same degree of scrutiny and rigour as other options to clarify whether this option passed the hurdle stage

- Reapplying the hurdle criteria to the long list of options, included revising the hurdle criteria

The Hurdle Criteria

The table below summarises the hurdle criteria that was applied. Please note, that strategic fit is greyed out to highlight that it was not used as a hurdle criteria, but was taken forward as a criterion in the full evaluation.

#	Criteria	Criteria Description
1	**Is the potential configuration option clinically sustainable?**	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver this and will it assist in addressing the workforce sustainability issues? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effective?
2	**Is the potential configuration option accessible?**	• **Urgent Care:** East Kent patients can access a UEC site within 60 minutes • **Trauma:** Trauma Units are on route to the major trauma centre (MTC); i.e. going to the trauma unit for stabilisation does not take the patient away from the MTC) • **Trauma:** the proportion of patients with **45min** access to a trauma unit is maintained or improved relative to the previous site designation (i.e. trauma Unit at WHH) • **Cardiac:** all Kent and Medway patients can reach pPCI centre within 90 minutes • **Stroke:** 95% of the East Kent population can access a stroke unit within 60 minutes (to enable call to needle time within 120 minutes) • **Vascular:** 95% of the East Kent population can access vascular services within 60 minutes
3	**Is the potential configuration option financially sustainable?**	• Will the option generate a cost of capital for the acute provider that is no more than £25m per annum?
4	**Is the potential configuration option implementable?**	• Will the option be implemented within a reasonable timescale i.e. no more than 12 years from completion of the public consultation?
5	**Is the potential configuration option a strategic fit?**	

Medium list of options

- Stage 1 (hurdle criteria) and stage 2 (ranking criteria) took the long list of seventeen options down to two options

- It should also be noted in July 2018 - there was a proposal of an independent review of the capital costs of Option 9 (a single emergency model at William Harvey Hospital). This review was taken forward and confirmed that capital costs did not meet the hurdle criteria for financial viability

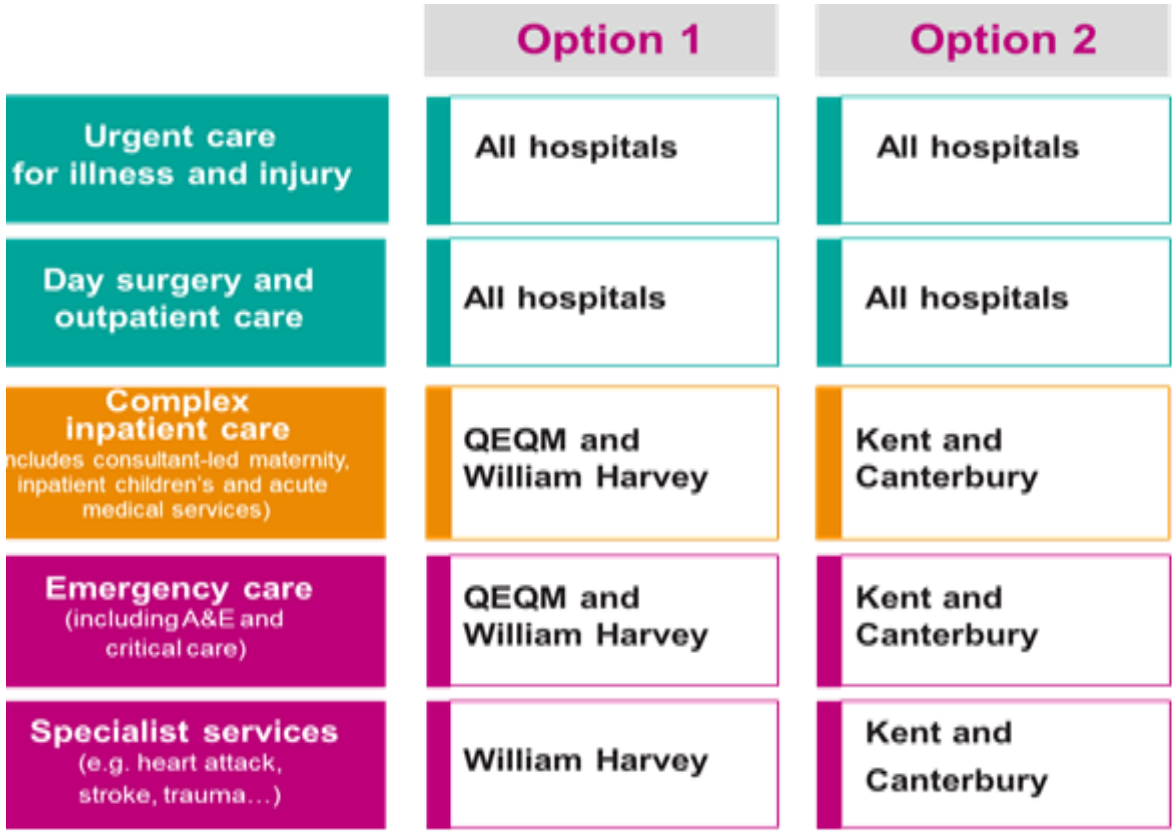
- The medium list of options included:

  Option 1: Two site ED model with William Harvey Hospital as the Major Emergency Centre

  Option 2: One site ED model with Kent & Canterbury Hospital as the Major Emergency Hospital

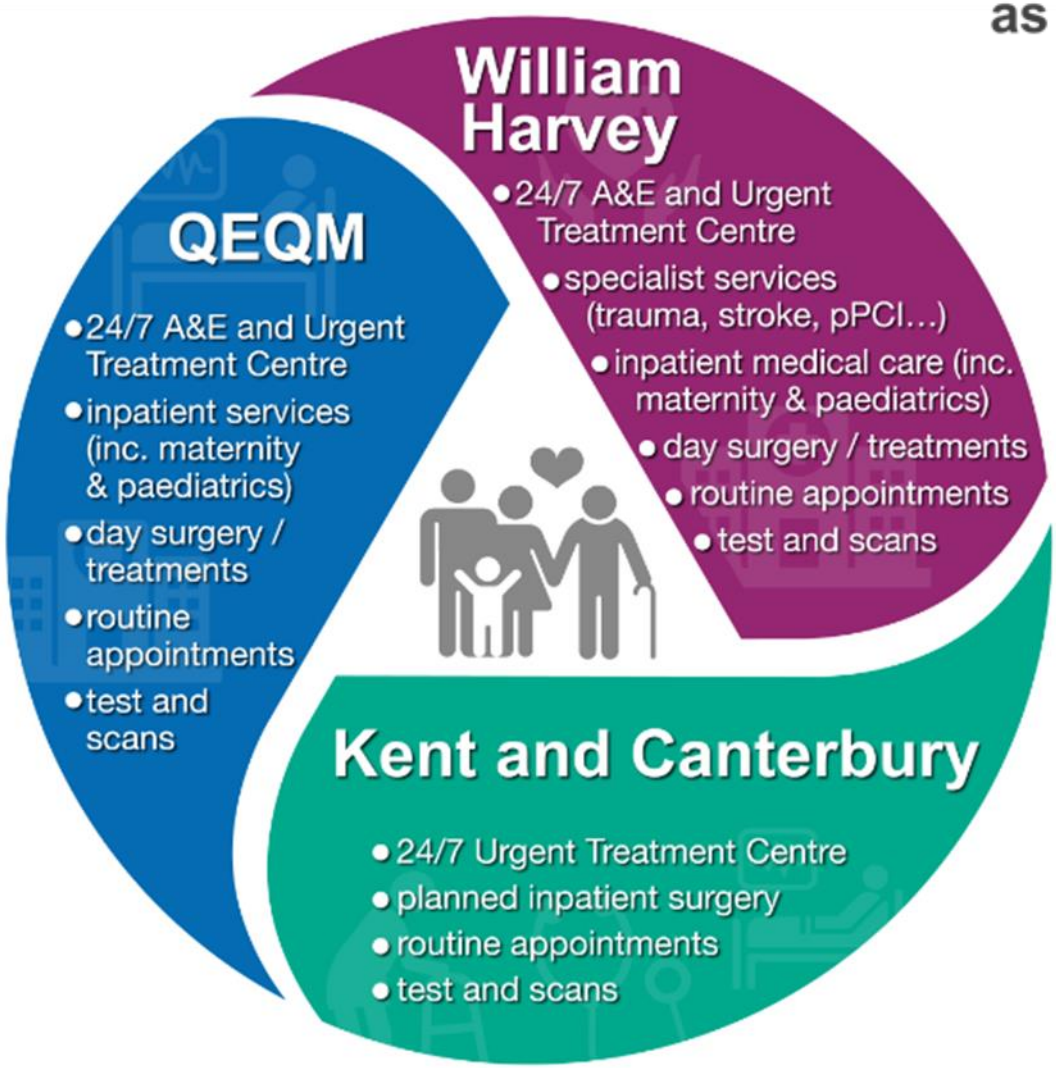
- During the final and detailed stage of the evaluation (stage 3) option 1 and 2 was also reviewed against a do – minimum option

Appendix 2 Options summary



Option 1

Two site emergency department model with William Harvey Hospital as the Major Emergency Centre

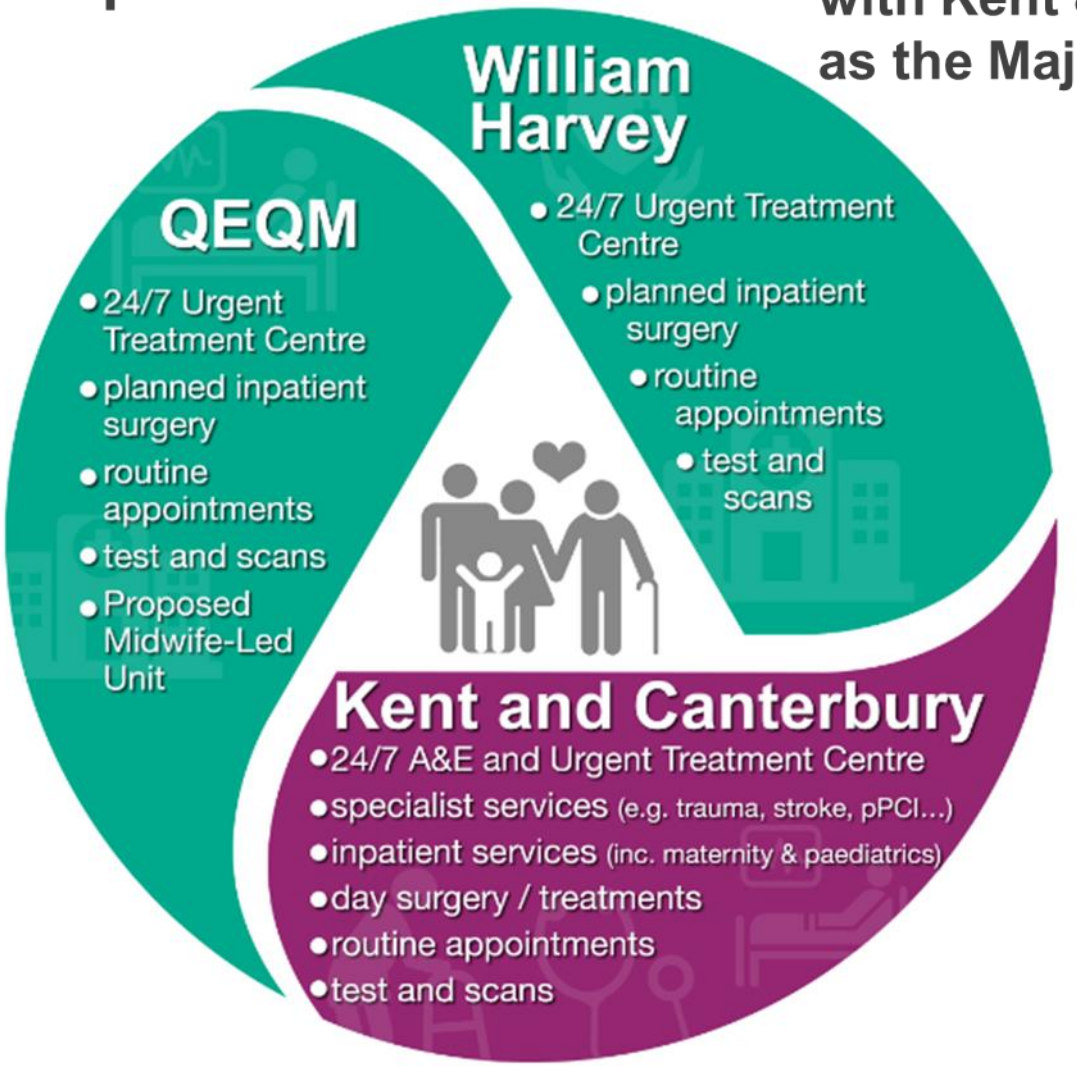


Option 1 has the following key acute changes:

- Permanent 2 site emergency medicine
- 2 critical care units
- 1 site elective surgery (low risk cases)
- 1 site stroke (HASU/ ASU)

Option 2

One site emergency department model with Kent & Canterbury Hospital as the Major Emergency Centre



Option 2 has the following key acute changes:

- Changes to a single site emergency medicine
- 1 critical care unit
- 1 or 2 site elective surgery (low risk cases) - to be confirmed
- 1 site stroke (HASU/ ASU)
- Single site obstetric and paediatric services
- Introduction of 1 standalone Midwife Led Unit at QEQM

Options summary

What is the ‘do-minimum’ option

Deciding whether to shortlist the options involved comparing them to a scenario without significant change. For this programme the do minimum has two elements:

Some planned improvements which would continue regardless of these proposals, including:

- delivery of 7 day working across the three sites
- establishing hyper acute stroke units in Kent & Medway
- do minimum includes changes or developments that are likely to happen within the next 12 years; including a range of agreed capital investment projects.

The modelling for do minimum scenario also needs to assume that some temporary changes made in recent years go back to their original model:

- Kent and Canterbury would return to taking emergency medicine admissions (but would not have a full A&E – the removal of full A&E services was formally consulted on previously)
- emergency medicine and critical care units at all three sites
- piloting of single site elective orthopaedic surgery reverts to two sites.

Options summary

Why compare against a ‘do-minimum’ option

The NHS Capital Investment Manual states:

The ‘Do-minimum’ option should be retained as a baseline in the shortlist since the implications of doing the minimum must be assessed and understood. It may be that a ‘do minimum’ option is not acceptable, or possible. However, the ‘do minimum’ option must then be included as a baseline so that the extra benefit and costs of other options can be measured against it. This will involve understanding the cost of merely maintaining the current level of service, over the full lifetime of the project. The effect of doing minimum might be that the life of the option is limited.

Significant resource input may be required just to maintain the status quo: that is, doing the minimum. Buildings or plant may have to come to the end of their useful life and may require replacement or upgrading. If the throughput of patients is increasing, maintaining service provision may take additional costs in staff, energy and other running expenditures.

Appendix 3
Evaluation criteria used in evaluating the medium list options

The evaluation criteria outlined on the following slides was used to score the medium list options against the 'Do-minimum'. While there is recognition that the 'Do-minimum' is not a sustainable option for the future, it is being used as the 'control' group to assist with objectively scoring both options. More detail on the 'Do-minimum' can be found in the next section.

Criterion	Sub-criteria	Evaluation questions
1. Is the configuration clinically sustainable and are able to deliver required quality standards?	**1.1) Quality: workforce**	In comparison with the 'do minimum' scenario, to what extent do the options: a) Allow each organisation to operate working patterns that are safe and compliant with regulatory standards? b) Impact on delivering a sustainable workforce, improving the recruitment and retention of suitably skilled staff across the East Kent health and social care system?
	1.2) Quality: Clinical recommendations and standards	In comparison with the 'do minimum' scenario, to what extent do the options: a) Allow services to be configured in alignment with the Clinical Senate's recommended co-dependencies? b) Improve adherence to NHS policy (e.g. seven-day working and FYFV) and Royal College standards of care and conveyance standards?
	1.3) Quality: patient experience and performance	In comparison with the 'do minimum' scenario, to what extent do the options: a) Provide a better experience for patients as determined by nationally recognised and validated tools (i.e. Patient Reported Outcome Measures)? b) Improves overall performance (i.e. RTT, A&E, and cancer) ? c) Deliver hospital sites that best meet the quality standards for buildings?

The evaluation criteria used in evaluating the medium list options

Criterion	Sub-criteria	Evaluation questions
2. Is the potential configuration option accessible?	**2.1) Emergency Travel Times**	In comparison with the 'do minimum' scenario, to what extent do the options: Enable emergency ambulance travel times to be in line with the following national / locally agreed standards. • 95% of the east Kent population can access an A&E department within 60 minutes. • The east Kent population can access a trauma unit for stabilisation within 60 minutes. • 95% of the Kent & Medway population can access the pPCI centre within 100 minutes (to enable a call-to-balloon time within 150 minutes). • 95% of the east Kent population can access a stroke unit within 60 minutes (to enable a call-to-needle time within 120 minutes). • 95% of the east Kent population can access vascular services within 60 minutes.
	2.2) Distance to hospitals	In comparison with the 'do minimum' scenario, to what extent do the options: (a) Enable the greatest number of people to receive appropriate hospital care at the site closest to home (b) Enable the greatest number of people from deprived communities to receive appropriate hospital care at the site closest to home
	2.3) Car/public transport travel times	In comparison with the 'do minimum' scenario, to what extent do the options: Enable patients requiring an inpatient stay and visitors (i.e. carers and relatives) to have the shortest travel times (a) By car (b) By public transport

The evaluation criteria used in evaluating the medium list options

Criterion	Sub-criteria	Evaluation questions
3. Is the potential configuration option implementable?	**3.1) Time to implement**	Which option can be successfully delivered in the shortest times scale?
	3.2) Delivery risks	In comparison with the 'do minimum' scenario, to what extent do the options present any risks of delays or failure to deliver owing to: a) Council planning or resource consent requirements? b) Number of delivery partners? c) Operational complexity and decant arrangements? d) Funding from external source to the NHS?
	3.3) Transition period	In comparison with the 'do minimum' scenario, to what extent do the options: a) Maximise value from investments made during the transition period to support the sustainability of vulnerable services (minimises sunk costs) b) Enable the capital investment required to be phased over the transition period?

The evaluation criteria used in evaluating the medium list options

Criterion	Sub-criteria	Evaluation questions
4. Does the potential configuration option align strategically?	**4.1) long-term sustainability**	In comparison with the 'do minimum' scenario, to what extent do the options: a) Enable longer-term sustainability for the system (e.g. to avoid the need to reconfigure in the next 5-7 years following implementation)
	4.2) Impact on neighbouring systems	In comparison with the 'do minimum' scenario, to what extent do the options: a) Impact on neighbouring systems and other providers through outward flow
	4.3) Research, innovation and education	In comparison with the 'do minimum' scenario, to what extent do the options: (a) Support research, education and innovation current and developing research and education? (b) Provide opportunities to develop innovative practice that improves patient outcomes?
5. Is the potential configuration option financially and economically sustainable?	**5.1) System affordability and I&E performance**	In comparison with the 'do minimum' scenario, to what extent do the options: a) Support a financially viable system across East Kent? b) Which option gives the best steady state I&E performance after year 10
	5.2) Net present value	In line with the STP evaluation methodology, which option gives the best 30/64 year net present value? (whole of system lens, including capital costs)
	5.3) Economic Impact	In comparison with the 'do minimum' scenario, to what extent do the options: a) Impact on employment opportunities within local communities