Report from Longlisting and Evaluation criteria workshop
17 June 2014

1. Introduction

The purpose of this report is to update the Programme Board on the outcome of the first two workshops of the panel brought together to develop a long list, evaluation criteria and, eventually, to propose a shortlist of options.

2. Attendance

There were a total of thirteen Panel Members present. The full list of attendees and absentees is shown at Appendix 1.

3. Process

The purpose of the day and its part in the overall programme process was set out and discussed.

The Future Fit Programme has progressed from the initial Call to Action 'case for change' to the agreement of a proposed Clinical Model developed through a large scale consensus – building exercise involving over 300 clinicians and members of the public considering the published evidence in the context of their local situation.

The Clinical Model is deliberately and appropriately 'location neutral' and also, in some instances, leaves open questions of scale and numbers of some of its components (e.g. urgent care centres ….where the model describes the function and says there will be 'some', leaving the best option to be determined). Nevertheless, the Clinical Model and the agreed objectives for Future Fit as a whole establish a number of key principles and requirements which could be delivered to a greater or lesser degree depending on which option is chosen.

The next stage of the Programme, therefore, is to develop a long list of options. Alongside this, there is the need to develop the criteria that will be used to differentiate between options and ultimately (after a short listing stage and further detailed work) to support the choice of the preferred option

The concepts of option creation and evaluation and cost benefit analysis were set out.

Participants were also provided with a mapped view of some key demographic data showing population densities and some demographic characteristics. The key physical components of the clinical model were then described as;

- Emergency Care Centre
- Diagnostic and Treatment Centre

- Community Units (corresponding to community beds and other services)
- Urgent Care Centres
- Local Planned Care
- Health Hubs

Together with information on the characteristics envisaged in the Clinical Model of those components.

It was pointed out by panel members that the model was open to interpretation. This was recognised and participants were informed that they were not bound by the Clinical Model, nor by any one interpretation of the Clinical Model. However, the panel should recognise that the Clinical Model had been developed through a large scale consensus building exercise involving over 300 clinicians and members of the public and that therefore it was reasonable to ask Panel Members to take guidance from the Clinical Model.

It was also pointed out the Clinical Model highlighted, for example, the need for 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.

4. WORKSHOP 1 – OPTION DEVELOPMENT

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. The Panel was also told that it did not have to assume that all options delivered the Clinical Model.

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.

4.1 Summary of option development discussion

The process of transcribing and analysing the written contributions is not yet completed. What follows is therefore a summary of the plenary feedback and a first analysis of the individual contributions.

In total 40 options were set out, all of which contained one Emergency Care centre and varying combinations of numbers, locations and co-locations of the other components of the model.

There was a general consensus that the options to be developed should fall within the parameters set out in the Clinical 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. However, some options, most frequently for Local Planned Care services and Health Hubs, other locations were proposed. In one option, other locations for Urgent Care Centres were suggested.

4.1.1 The Emergency Care 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 options the Emergency Care Centre was co- located with the Diagnostic and Treatment Centre, in other options they were on separate sites.

4.1.2 The Urgent Care Centres (UCC)

The number of Urgent Care Centres proposed ranged between one and eight. Most but not all options assumed a co-location of the Emergency Care centre with an Urgent Care Centre. The option which proposed a single UCC showed it co-located with the Emergency Care Centre.

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 options, however, had UCCs in one of the existing hospital sites and/or in some/all of the existing community hospital locations.

In most options UCCs were co- located with other services such as Local Planned Care, Community Units and Health Hubs.

4.1.3 Diagnostic and Treatment Centres (DTC)

Nearly all options proposed a single DTC. However, one option proposed five DTCs (this could be an interpretation error) as well as five Local Planned Care Centres (LPCs) and another option proposed three DTCs

Half of the options proposing a new build EC also proposed a co-located new build DTC.

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

- New build with the EC
- PRH
- RSH
- Oswestry

In options with a DTC on an existing hospital site most options did not co-locate the DTC with the EC, although this did occur more frequently as an option for the PRH site than for the RSH site.

4.1.4 Community Units (CUs)

The number of Community Units proposed ranged from 0 to 11 with most options proposing five, six or seven.

CU locations were widespread, most often in existing Community Hospital locations but also including existing hospital sites (although not on a new site EC). In some options CUs were located in Wales.

CUs were nearly always co-located with other services.

4.1.5 Health Hubs

Health Hubs did not feature in some options. 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 options showed HHs co-located with the EC, together with other services.

4.1.6 Local Planned Care (LPC)

Local Planned Care centres did not feature in some options. 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 of options had LPCs as standalone units

4.2 Plenary Discussion

Each group fed back a summary of the range of options they had discussed and the main issues that had arisen.

The key issues discussed were:

4.2.1 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 very limited in many parts of the County and that even where it did exist in greater volume 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.

4.2.2 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

4.2.3 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.

4.2.4 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.

4.2.5 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.

4.3 Conclusion of option development discussion

Members of the panel were thanked for their contribution. A summary of the options and the discussion would be fed back to members for their agreement and approval.

The work done by the panel to develop options would form the basis of a conversation with the wider public to inform the agreement of a final long list of options in September. The long list would need to be approved by the Programme Board at its meeting in mid-September.

5. WORKSHOP 2 – DEVELOPING EVALUATION CRITERIA

5.1 Context

The Panel were informed that there is a need to develop the criteria that will be used to differentiate between options and ultimately (after a short listing stage and further detailed work) to support the choice of the preferred option. For Future Fit to be authentic to its stated aims and ways of working, 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

The Panel were asked to start the debate on these 'non-monetary' criteria. Their considerations will be developed further including through public engagement prior to intended finalisation in September

5.2 The process of evaluating of options

As an introduction to its work, the Panel discussed some basic principles concerning the evaluation of options.

The process that is being undertaken in evaluating options is a form of Cost Benefit Analysis. It will seek to assess a range of options that can deliver the proposed Clinical Model (and , as a formal requirement, a 'do nothing' or 'do minimum' options that only might do so in part) and will do so by combining an assessment of financial and economic implications with an assessment of compliance with range of 'non-monetary' criteria which seek to encapsulate the hoped for qualitative benefits of the Programme . This process of assessment will of its

nature require judgements about future likelihood based on evidence and experience. It seeks through a process of scoring and weighting to deliver a rational and explicit means of selecting between options.

The way in which multiple criteria (financial and other) might be best considered and weighed against each other in reaching decisions was not discussed by the Panel. Further work is required to make recommendations on this to the Programme Board, work which will draw on the extensive literature on the discipline of Multi Criteria Analysis as well as approaches adopted in similar programmes elsewhere.

The Panel did discuss and agree, however, 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 nothing' 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 .

5.3 Developing an initial set of potential criteria

Note-The Panel on this occasion was not required to consider any financial criteria for option appraisal. These will be considered separately prior to bringing all potential criteria for Programme Board consideration in September 2014.
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 (appendix 2)
- The headings for option evaluation criteria that are suggested in guidance by the Dept of Health (appendix 2)
- 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…the 'list of 21' (appendix 3)

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.
This is a truly difficult topic!! It is not amenable to a simple 'right answer' and it requires serious consideration of technical and indeed philosophical questions. Members were encouraged throughout, therefore, 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.

5.4 The initial proposed 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 ahead of Programme Board deliberations in September. The output is summarised below:

Group A	Group B	Group C	Comment from plenary debate and further consideration of measurement
PATIENT ACCESS -range of service offer locally -transport -impact on highest/most frequent users	PATIENT ACCESS -distance -opening hours -cost incurred by patients	PATIENT ACCESS -delivering needs led equity	<u>Travel times</u> ,differentiating public transport -distinguish 'time critical care' from other -distinguish high users from incidental users

MEASURES OF CLINICAL QUALITY AND PATIENT EXPERIENCE	PATIENT OUTCOMES	CLINICAL QUALITY -delivery of clear defined tiered levels of care for everyone -delivery of multi-disciplinary teams that don't place drain on primary care/community	1 Emergency care outcomes for specific time critical conditions A marker measure….using MI; vascular; stroke etc 2 Risk of cancellation of planned procedure 3 Risk of developing hospital acquired infections in a planned procedure 4 Number of clinical 'handoffs' across whole system 5 A large patient panel (LTCs) asked to compare the current offer with the proposed future and score its relative benefit 6 Extent to which can support dispersed (local access) diagnostics
WORKFORCE SUSTAINABILITY/ 'STAFFABILITY'	WORKFORCE SUSTAINABILITY	WORKFORCE SUSTAINABILITY	1 improves attractiveness of posts and local careers 2 delivery of 'critical mass' of workforce (in part a variant on 1) 3 Fit with wider clinical networks 4 facilitates multi-disciplinary team working 5 Minimises avoidable workforce duplication

			6 Fit with established Professional/NICE Guidelines on staffing
INCREASING APPROPRIATE CARE CLOSER TO HOME			
PROMOTION OF HEALTH AND SOCIAL CARE ALIGNMENT			
DEGREE OF FUTURE PROOFING			
	OPTIMISES USE OF ESTATE (IMPROVES OVERALL QUALITY OF ENVIRONMENT OF CARE)	OPTIMISES USE OF ESTATE	Felt to be an important aspect of 'ease of delivery'
	OPTIMISES KEY SERVICE ADJACENCIES ACROSS HOSPITAL AND COMMUNITY		Felt to be a subset of 'CLINICAL QUALITY ' and 'SUSTAINABLE WORKFORCE' criteria
	IMPACT ON PATIENT SAFETY		Felt to be a subset of 'CLINICAL QUALITY'
		TIMING OF DELIVERY OF BENEFITS (QUICKER WINS)	Question as to whether a separate criteria or an important reminder that timing of benefits needs to be considered as a weighting factor for all options
			The Panel considered the list developed against the DH headings and were satisfied that all the elements were covered to an appropriate degree

5.5 Other Issues Raised

The Panel were concerned about the following in conducting a scored assessment of options against criteria:

- There were necessary preconditions for options to be even possible ….eg an integrated care record. It was essential that clear assumptions were stated on these by the Programme Board or by the Commissioners and other partners in order to allow the options to be properly appraised (especially as there remains a 'do nothing' option to consider). The list of areas discussed included : integrated care record; primary care capacity; social care availability ; what will happen in Wales;
- What assumptions should be made about future resource levels (some Panel members didn't accept the reasonableness of a 'no growth' assumption for 20 years)?
- What assumptions should be made about transport infrastructure in the future?
- What assumptions should be made about national policy, in particular in relation to the shape of emergency care (the Keogh Review)?

6. Next Steps

The outputs from the Panel's first consideration of options and criteria will now go through two parallel processes en route to consideration by the Programme Board in September :

- The Panel will receive a summary of its work
- The initial thinking will be tested as part of the public engagement process of Future Fit
- The Programme Office will synthesise the 40 options and the feedback from engagement into a smaller number of grouped options
- The Programme Office will develop the headline criteria and suggested sub-components with particular regard to precision of definition; formulation as a differentiating question; technical appraisal in terms of measurability;

The Panel will reconvene before September to receive outputs from these two processes and to refine further its recommendations to the Programme Board for final decision.

7. Conclusion and recommendations

The Panel broadly achieved that task set out for it. However, significant work is required by the Programme Team to synthesise options and develop suggestions for specific sub components of criteria.

The Programme board as asked to **accept** the progress made in developing options and criteria and to **agree** the next steps.

Ends

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Appendix 1

LONGLISTING/EVALUATION PANEL 17 JUNE SIGN-IN SHEET

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

Montgomeryshire CHC declined to nominate.

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Appendix 2

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Key Benefits

It is proposed that the criteria to be used in evaluating the short-listed options should be determined in advance by the Programme Board following a period of public engagement on a draft list proposed by the Evaluation Panel.

These criteria will need to reflect the programme's goals and objectives, as set out in the Programme Execution Plan:

a) Objective

To agree the best model of care for excellent and sustainable acute and community hospital services that meet the needs of the urban and rural communities in Shropshire, Telford and Wrekin, and Mid Wales.

b) Goals

The key benefits to be secured from the programme are:

- Highest quality of clinical services with acknowledged excellence in our patch;
- A service pattern that will attract the best staff and be sustainable clinically and economically for the foreseeable future;
- A coherent service pattern that delivers the right care in the right place at the right time, first time, coordinated across all care provision;
- A service which supports care closer to home and minimises the need to go to hospital;
- A service that meets the distinct needs of both our rural and urban populations across Shropshire, Telford & Wrekin and in Wales, and which anticipates changing needs over time;
- A service pattern which ensures a positive experience of care; and
- A service pattern which is developed in full dialogue with patients, public and staff and which feels owned locally.

In addition, the criteria should be informed by factors recommended by the DH and which are commonly used in non-financial appraisals:

• Access to services	• Meeting Policy Imperatives
• Clinical Quality	• Training, Teaching, Research
• Environmental Quality	• Effective Use of Resources
• Development of new/existing services	• Ease of Delivery.
• Strategic Fit	

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Appendix 3

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NHS

	EVALUATION CRITERIA	BENEFITS REALISATIONS CRITERIA
1. Improve care for you and your family?		
2. Promote independent living?		
3. Develop community capacity?		
4. Clearly define 'tiered' levels of care?		
5. Offer needs led and equitable access?		
6. Provide specialist care which achieves critical mass?		
7. Deliver generalist services and specialist assessment / follow up closer to home?		
8. Resolve or minimise transport issues?		
9. Empower patients by facilitating excellent Information, Self-management, Navigation and Advocacy?		
10. Enable a sustainable workforce with fully staffed clinical teams?		
11. Promote community mobilisation and partnerships?		
12. Empower communities to address the wider determinants of health?		
13. Redistribute existing funds with no new money?		
14. Integrate health and social care so they run 'in parallel'?		
15. Resolve or minimise transport issues?		
16. Empower patients by facilitating excellent Information, Self-management, Navigation and Advocacy?		
17. Enable a sustainable workforce with fully staffed clinical teams?		
18. Promote community mobilisation and partnerships?		
19. Empower communities to address the wider determinants of health?		
20. Redistribute existing funds with no new money?		
21. Integrate health and social care so they run 'in parallel'?		