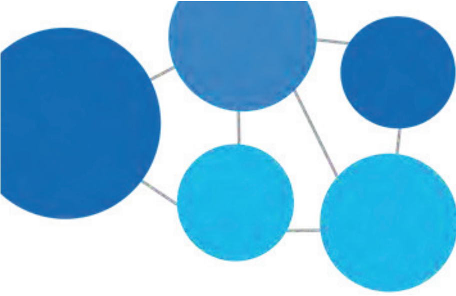

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# Report of the Evaluation Panel's Shortlisting Process

## Executive Summary

The purpose of this report is to present the Evaluation Panel's recommendations on which of the longlisted options for acute and community hospital services should be included on a shortlist for further examination.

The Programme Board is asked to discuss and decide on whether to approve the Panel's recommendations so that they may be forwarded for further approval by sponsor Commissioners and for endorsement, scrutiny or noting by stakeholder bodies (as set out in the Programme Execution Plan).

All of the options considered (except the 'Do Minimum') seek to implement the Clinical Design Report with its networks of care embracing both dispersed and consolidated services.

The Panel agreed the following recommendations.

1. **Urgent Care Centres (UCC) etc.**

   An initial four UCCs should be developed which should ideally be co-located with Local Planned Care facilities and Community Units. The locations for these centres should include:

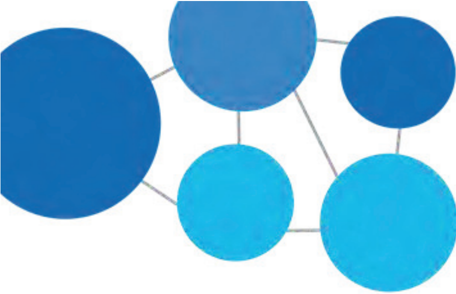
   - Royal Shrewsbury Hospital
   - Princess Royal Hospital, Telford, and
   - Two further centres (to be selected after further development and evaluation) from

| Bridgnorth | Oswestry |
|---|---|
| Ludlow | Whitchurch. |

2. **Emergency Centre (EC) and Diagnosis & Treatment Centre (DTC)**

   Six options should be selected for further development and evaluation:

   - EC and DTC on a New site;
   - EC on a New site, DTC at PRH
   - EC on a New site, DTC at RSH
   - EC at PRH, DTC at RSH




- EC at RSH, DTC at PRH
- Do minimum (existing dual site acute services maintained, provider and commissioner efficiency strategies implemented but no major services change).

The 'Do minimum' option was ranked last amongst all the options but is included as required by national guidance for comparison purposes.

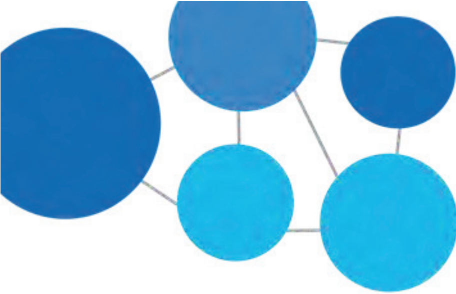
Within the options, the panel preferred the variants in which consultant-led obstetric activity (and associated neo-natal activity) is co-located with EC over equivalent variants in which this activity remains at PRH. Inpatient paediatrics would, in all change options, be co-located with EC.

Panel members undertook to keep the meeting's outcomes confidential until after the Board meeting on February 4th, in line with the Programme's confidentiality policy. This does not prevent members from reporting back to their nominating organisation so long as those receiving the information make the same undertaking. One member did not support the UCC proposal and submitted a minority report which has been made available to Board members separately.

## Background

Each sponsor and stakeholder organisation was given the opportunity to nominate a member of the Evaluation Panel. Some changes in membership had to be made through the course of the Panel's meetings. The final panel for the shortlisting process was comprised as follows:

| | |
|---|---|
| **Dr Bill Gowans, Vice Chair** | Shropshire Clinical Commissioning Group |
| **Chris Morris, Executive Lead for Nursing and Quality** | Telford & Wrekin Clinical Commissioning Group |
| **Victoria Deakins, Lead Therapist for North Powys** | Powys Local Health Board |
| **Mr Mark Cheetham, Scheduled Care Group Medical Director** | Shrewsbury and Telford Hospital NHS Trust |
| **Dr Emily Peer, Assistant Medical Director & GPSI** | Shropshire Community Health NHS Trust |
| **Pete Gillard** | Shropshire Patient Group |
| **Christine Choudhary** *(unable to attend)* | Telford & Wrekin Health Round Table |
| **Vanessa Barrett, Board Member** | Healthwatch Shropshire |
| **Kate Ballinger, Manager** | Healthwatch Telford & Wrekin |
| **Kerrie Allward, Better Care Fund Manager** | Shropshire Council |
| **Liz Noakes, Assistant Director and Director of Public Health** | Telford and Wrekin Council |
| **Mark Docherty, Director of Nursing, Quality & Clinical Commissioning** | West Midlands Ambulance Service NHS FT |
| **Dave Watkins, Locality Manager, North Powys** | Welsh Ambulance Services NHS Trust |
| **John Grinnell, Director of Finance** | Robert Jones & Agnes Hunt Hospital NHS FT |
| **Alison Blofield, Associate Clinical Director/Nurse Consultant** *(unable to attend)* | South Staffordshire & Shropshire Healthcare NHS FT |
| **Dr Jessica Sokolov** | Local Medical Committee/GP Federation |
| **Ian Winstanley, Chief Executive** | Shropshire Doctors' Cooperative Ltd. |





NHS England and Montgomeryshire Community Health Council declined to nominate members because of their subsequent assurance and scrutiny functions. The Chairs of the Join Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin were in attendance as observers.

The Panel's earlier work had included the development of a wide range of potential scenarios from which the longlist was created following the Panel's recommendation to Board. A number of pre-consultation public engagement events also informed the development and evaluation of options.

**The Long List**

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

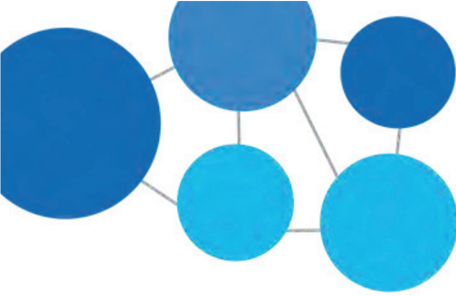
In December 2014, the Board agreed that there should be a differential approach to the identification of shortlists for the consolidated and dispersed elements of the proposed networks of care.

## Evaluation Criteria

The Evaluation Panel was also responsible for recommending the criteria against which longlisted options would be evaluated. A number of pre-consultation public engagement events also informed the development and weighting of the criteria.

Four criteria were proposed initially, to which Board added a fifth by separating out workforce considerations from wider quality impacts. The Board delegated to its Core Group the task of confirming the final set of measures to be used by the Programme Team to provide evidence for the Panel. These measures focused on evidence pertinent to the differentiation of acute scenarios rather than to the overall evaluation of programme proposals. That subsequent evaluation will only be possible once shortlisted options have been developed in more detail.

The agreed criteria are set out below with a brief explanation of the nature of the information provided to





the Panel. That information was presented in three tiers:

- **Tier 1** - an overall summary of acute options and obstetric variants, criterion by criterion, plus the programme Team's proposed approach to a shortlist for UCCs (see Appendices 1 & 2);
- **Tier 2** - a summary description of each option summarising all the measures available; and
- **Tier 3** – the underlying sources of information, including
  - The Clinical Design Report
  - Phase 1 Activity and Capacity Modelling
  - Latest Summary of Phase 2 Activity and Capacity Modelling
  - Baseline Impact Assessment Report
  - Reports on Pre-Consultation Engagement Activities
  - Feasibility Study Report
  - Financial Assessment of Feasibility Study (includes additional scenarios from long list)
  - Acute Services Template (setting out the views of acute clinicians of key co-location issues)
  - Summary Affordability Report
  - Commissioner Funding Scenarios
  - Accessibility analysis.

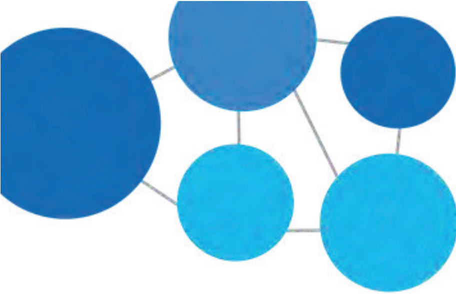
All three tiers are being made available to Board to inform its decision-making on shortlisting. They will subsequently be made available to the public (where not already published) to help people to form their own views on shortlisted options as part of ongoing pre-consultation engagement and impact assessment activities.

To enable a high-level view to be taken of equity impact, the information provided highlighted any adverse differential impacts on particular social groups. The Panel had requested that these groups should include Older People (75+), Children (0-5), people with Long Term Illness, people on Low Income and people with no access to a car or van. A summary of this information is attached as Appendix 3.

The weighting applied to the criteria was determined by the Panel, informed by public views. Members initially submitted their own weighting proposals, the results of which were presented to the Panel when it met. Following discussion, a final set of weightings was agreed. These are recorded against the criteria below which appear in ranked order.

**1. QUALITY – 29.4%**

Evidence for this criterion focused on





- The extent to which each option support the delivery of **key programme benefits** (which reflect health service need criteria). This was informed by the content of the Clinical Report and by the assessment of acute clinicians. Given that all change options respond to the Clinical Report, which sets out to design quality into the system, only a limited amount of information was available at this stage to support the differentiation of options. When options are fully developed they should be more amenable to a more detailed quality impact analysis.

- The impact on **patients with time-critical conditions** for the most serious cases conveyed by the ambulance service. The data provided was based on West Midlands Ambulance Service conveyance times. West Midlands Ambulance response time information was also made available to the Panel. Welsh Ambulance Service data has only recently become available and will be used to inform subsequent evaluation.

**2. ACCESSIBILITY – 26.5%**

The Clinical Model envisages the development of networks of care covering urgent and emergency care, planned care and long term conditions. At the present time it is not feasible to undertake detailed accessibility analysis on these networks, given the number of potential combinations of acute and community options. The system-wide impact will be assessed as part of the full evaluation later in the year. For the time being, the accessibility of consolidated acute services has to be looked at in isolation. This may unavoidably advantage the 'Do Minimum' option (Option 1) but this is not material at this stage given that this option is a required component of the shortlist in any case. The Programme Team expects that subsequent modelling will demonstrate improved overall accessibility for all other options once local facilities are factored in (UCC, LPC, CU). It is in these dispersed facilities that a significant amount of future activity is expected to take place, as demonstrated in the Phase 2 Activity and Capacity modelling. Whilst it has been possible to include theoretical public transport information for the New site, the provision of public transport would clearly be subject to change should a new site be constructed.

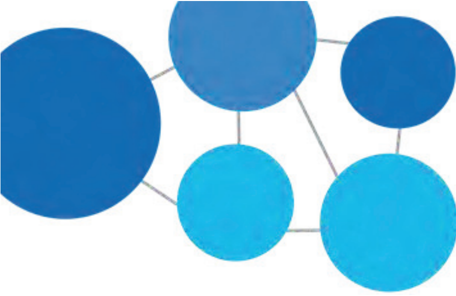
The travel time analysis provided was based on Phase 2 activity projections for 2018-19. These were derived by taking SaTH activity levels (using a 2012-13 baseline) and applying to these the expected impact of:

- Provider and commissioner efficiency strategies (as set out in Phase 1 activity and capacity modelling);

- Demographic change (using projections from the Office for National Statistics);

- The Clinical Design Report (as set out in Phase 2 activity and capacity modelling).

The measures reported cover emergency care (ambulance/car only) and planned care (car plus 3 public transport time windows – weekday morning, weekday evening and weekend morning) plus consultant-led obstetrics. Average travel times and distances reflect the potential impact of change (subject to patient choice) on patients and their carers/visitors, including where they may in future travel to out of area hospitals.



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## 3. WORKFORCE – 25.0%

This criterion (previously a component of the Quality criterion) was informed by the assessment of senior local acute clinicians about the advantages and disadvantages of the changes proposed under each option. Again, only a very high-level assessment is possible at this stage but there were three key factors:

- Options consolidating emergency care on a single site are expected to significantly improve recruitment and retention for EC and acute medicine;
- Options locating DTC and EC on separate sites are expected to be attractive for surgical recruitment as a result of separation of planned care services, resulting in a reduced impact from medical outliers; and
- Options with a greater proportion of new facilities are expected to be more beneficial for recruitment of staff.

## 4. DELIVERABILITY – 10.3%

Evidence under this criterion drew on the Programme's Feasibility Study work (both the original study and as subsequently expanded to cover all longlisted options).

The information provided included high level estates and financial information indicating the likely scale, duration and cost of the physical work required. It was highlighted that this information was not intended to propose final site configurations since these may evolve significantly during subsequent design phases.

In addition to this estates-based information, the Programme Team also provided a view on the likely acceptability of each option so far as it could reasonably be judged at this stage.

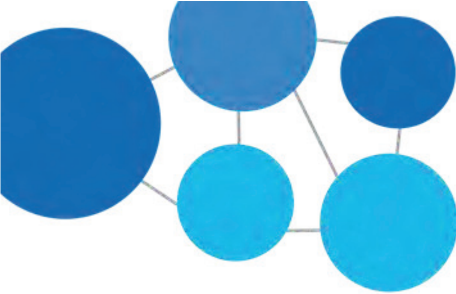
## 5. AFFORDABILITY – 8.8%

The Programme Board determined in December that no options could conclusively be identified as unaffordable on the basis of the information currently available. The affordability criterion was therefore treated in the same way as other criteria. The Panel was provided with:

- High-level estimates of acute costs from the expanded feasibility work;
- Estimates of the investment required in Urgent Care Centres;

Although the Panel were clearly not being asked to undertake an economic appraisal (which will form part of the next stage evaluation), it was invited to view options in the light both of wider demands on the resources of the Local Health Economy and of the relative inferiority of any options when benefits are compared with costs. This was in line with guidance in the DH Capital Investment Manual.

Four cost categories were reported in the summary documentation:



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- **25 Year Capital Costs**

  These costs set out both the initial capital cost of each option and the impact of future lifecycle costs over the following 25 years (in line with national guidance). This reflects the fact that, under the different options, differing proportions of the facilities will be operating in "New", "Refurbished" or "Retained" condition. Given the age of some of the existing estate, total replacement of some retained facilities is required within the 25 year period. Costs are discounted to current levels. They reflect the total cash investment required over the period. No assumption has been made about the source of this capital funding at this stage (e.g. public funds, private finance or a combination of the two).

- **Net Increase in Capital Charges**

  Capital funding resources are expected to come from outside the Local Health Economy but the relevant provider must be able to service the impact of that funding. This is expressed as an annual charge on the resources available to the provider. Net figures are provided in which the annual impact of new funding is offset by any savings from facilities no longer required under a particular option.

- **Total Change in Acute Revenue Costs**

  These are also annual costs borne by providers. In addition to the net increase in capital charges, these figures also reflect estimates of savings in maintenance energy and utility costs and savings in clinical efficiency (arising from a reduction in two-site working).

- **Estimated Overall Cost Change with 4 UCCs**

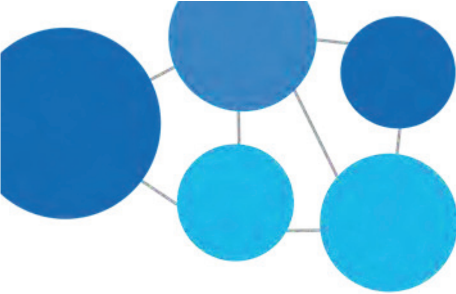
  These figures take the total change in acute revenue costs, remove the costs associated with urgent care activity which (under the options for change) would not be provided in an EC and add estimated costs for running 4 UCCs. This gives a view, therefore, on the potential net impact on the Local Health Economy of the Programme's proposals.

## Urgent Care Centres (UCC)

The Panel was presented with a proposal from the Programme Team about the potential make up of a shortlist for UCCs. This proposal built on clinical design work, patient and public engagement and financial, activity and travel time modelling. A proposal from Bishops Castle Patient Group was also made available.

The proposed shortlist sets out:

- The options considered for UCCs
- The philosophy and role for UCCs
- The staffing requirements for UCCs
- The proposed approach to developing UCCs.



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The proposed approach takes account of the need to understand in greater detail how UCCs would work, how they would relate to other components of the Clinical Model and how they would be staffed. The Programme Team had concluded that there was a need to proceed with caution and to adopt a prototyping approach in setting up an initial number of UCCs. This would allow testing of:

- Whether staff with the right skills can be recruited;
- Whether confidence in the model can be built amongst both patients and ambulance services;
- How a variety of patient pathways would be delivered in a networked EC/UCC model;
- How UCCs would link to 24/7 primary care services;
- What services envisaged in health hubs could be provided from UCCs;
- The need for co-location with beds (CUs) and certain planned care services (LPCs); and
- Whether the number and type of patients who would attend UCCs has been accurately estimated.

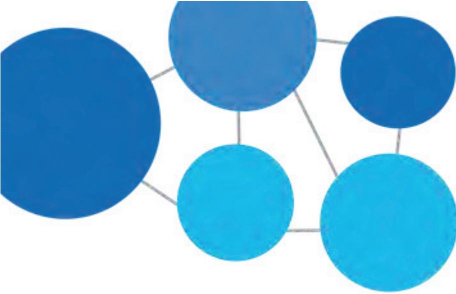
The Programme Team's recommendation was that four UCCs should be subject to prototyping initially: one each in Shrewsbury and Telford and two more in rural areas to test the quality, deliverability and viability of the models. Overall the catchment analysis suggests that the potential sites for the initial two remaining UCCs should be:

| Bridgnorth | Oswestry |
|---|---|
| Ludlow | Whitchurch. |

The consequence of shortlisting these sites would be to enable further detailed planning to be undertaken in relation to each of them to inform a subsequent evaluation of which sites offer the greatest benefits to the proposed prototyping approach. That evaluation will examine each site in the context of the overall networks of care in each option, enabling the kind of whole-system view that has not been possible to date.

In addition to the development and evaluation of shortlisted options, it is also proposed that further work is undertaken to scope the need and possibilities for providing additional services to support 24 hour seven day a week primary care services for smaller dispersed communities across Shropshire, including those served currently by community hospitals. For the avoidance of doubt, the aim of this work will be to increase rather than to reduce the range of services provided in more rural locations.

The Evaluation Panel accepted the proposed approach, subject to some amendments, and the shortlisted site options. The Programme Team's proposal, as amended by the Evaluation Panel, is attached as Appendix 1.



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## Emergency Centre (EC) and Diagnosis & Treatment Centre (DTC)

The Evaluation Panel received a presentation of the summary of acute options. It was then able to put detailed questions (covering all tiers of information provided) to a group of expert advisors who had been involved in the accessibility analysis, feasibility study, affordability analysis and pre-consultation public engagement.

At the conclusion of these detailed discussions the Panel was asked to undertake an initial scoring of each option (and obstetric variant). It was agreed that would be done individually and confidentially. Panel members awarded a score for each option/variant against each of the evaluation criteria using a scale of 0-7 (where 7 is a stronger score). Initial scores were collated, totalled then weighted to produce a single overall score for each option/variant. Sensitivity analysis was applied to show the effect of changing the weightings of the evaluation criteria. These initial results were reported to the Panel to inform further discussion on the evidence presented, and to begin to enable the Panel to consider which options would best form part of a balanced recommendation to the Board.

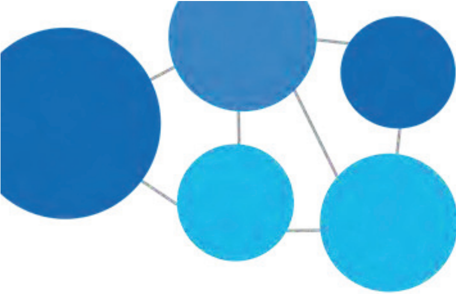
Following discussion, individual panel members were then given the opportunity to alter any of their initial scores if they wished to. The revised results were then presented and discussed. The following table summarises those results.

| Rank | Option Description (number) | Score | Difference from best | Gap |
|---|---|---|---|---|
| 1 | EC, DTC & Obs on new site (8a) | 71.9 | 0.0% | |
| 2 | EC/Obs at new site, DTC at RSH (5a) | 69.9 | 2.7% | 2.7% |
| 3 | EC/Obs at new site, DTC at PRH (4a) | 69.4 | 3.5% | 0.8% |
| 4 | EC/Obs at PRH, DTC at RSH (3) | 67.2 | 6.4% | 2.9% |
| 5 | EC/Obs at RSH, DTC at PRH (2a) | 65.9 | 8.3% | 1.9% |
| 6 | EC & DTC on new site, Obs at PRH (8b) | 63.8 | 11.2% | 2.9% |
| 7 | EC, DTC & Obs at PRH (7) | 63.2 | 12.1% | 0.9% |
| 8 | EC at new site, DTC at RSH. Obs at PRH (4b) | 61.9 | 13.9% | 1.8% |
| 9 | EC, DTC & Obs at RSH (6a) | 61.3 | 14.7% | 0.8% |
| 10 | EC at new site, DTC/Obs at RSH (5b) | 59.3 | 17.5% | 2.8% |
| 11 | EC at RSH, DTC/Obs at PRH (2b) | 56.4 | 21.5% | 4.0% |
| 12 | EC & DTC at RSH, Obs at RSH (6b) | 54.5 | 24.2% | 2.7% |
| 13 | Do Minimum (1) | 51.2 | 28.8% | 4.6% |

The Panel felt that the top five ranked options provided a good balance of feasible options for further development and evaluation alongside the ‘Do Minimum’ comparator.

Sensitivity analysis demonstrated that levelling the weightings did not significantly change the results, although Option 7 (EC and DTC at PRH) rose from 7th to 2nd because of the impact of increasing the relative affordability weighting on the lowest cost option. Option 8a moved from 1st to 6th. When the weighting for affordability is increased to about 25% (and other criteria maintain relative weightings) the most noticeable impact is the reduced performance of New site options which start to fall out of the top five.

A similar impact occurs results when are expressed in terms of cost per benefit point score. This analysis also



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reveals that removing affordability scores does not significantly affect the original weighted scores. Detailed tables are attached in Appendix 4.

## Next Steps

Programme Board is asked to discuss and decide whether to approve the shortlisting recommendations of the Evaluation Panel.

The outcome of the Board's decision-making will then be forwarded to Programme Sponsors and other key Stakeholders in line with the requirements of the Programme Execution Plan and as set out below.

| | Key Decision Documents | Programme Board | CCGs | Other Sponsors | Joint HOSC | Health & Wellbeing Boards | Assurance |
|---|---|---|---|---|---|---|---|
| 1 | Programme Execution Plan/Case for Change | Approve | Approve | Approve | Consider | Endorse Case for Change | Gateway 0 |
| 2 | Evaluation Criteria & Process | Approve | Approve | Endorse | Consider | n/a | Gateway 0 |
| 3 | Clinical Model of Care | Approve | Approve | Endorse | Consider | Endorse | Senate |
| 4 | Benefits Realisation Plan | Approve | Approve | Endorse | Consider | Endorse | Gateway 0 |
| **5** | **Selection of short list of Options** | **Approve** | **Approve** | **Endorse** | **Consider** | **Receive** | **Gateway 0** |
| 6 | Selection of Preferred Option | Approve | Approve | Endorse | Consider | Receive | Senate, Gateway 1 |
| 7 | Consultation Document | Approve | Approve | Respond | Consider | Respond | Gateway 2 |
| 8 | Decision on Preferred Option | Approve | Approve | Endorse | Consider | n/a | Gateway 2 |
| 9 | Outline Business Case(s) | Approve | Approve | Relevant Board to Approve | n/a | n/a | Gateway 2 |

Whilst the above processes are conducted, the Programme's Technical Team will continue to work on the development of options in the form they are agree at Programme Board.

The final shortlist will be subject to further pre-consultation engagement with patients and the public, linked to the Programme's Integrated Impact Assessment work.

The process for reaching the shortlist will be subject to both internal and external assurance. Internal assurance will be sought from the Assurance Workstream which will review the process prior to the Board meeting. External Assurance will be sought through the Health Gateway Review scheduled for February.