

<b>Sustainable Health Care in East Kent Joint Committee of NHS Clinical Commissioning Groups</b>		<b>Agenda Item:</b>		<b>016/19</b>
<b>Date of Meeting:</b>	28 February 2019			
<b>Title of Report:</b>	Medium list assessment update (Application of Hurdle Criteria)			
<b>Author:</b>	Michael Ridgwell			
<b>Executive/ Lay Sponsor:</b>	Caroline Selkirk			
<b>This paper is for:</b> <i>(please X as applicable)</i>	Approval	Decision	Assurance	Information
	X		X	
<b>Are any members of the meeting conflicted?</b>	N	None identified: members to declare conflicts as necessary.		
<b>Is circulation restricted?</b> <i>(please X as applicable)</i>	No	Yes		
	X			
<b>Report summary/purpose:</b>				
<p>The East Kent Transformation Programme is continuing to progress with the development of a pre-consultation business case for the reconfiguration of its Urgent and Emergency Care (UEC) services. A key component of this work, is the evaluation of a longlist of reconfiguration options to identify a shortlist that will be consulted on with the patients and public of East Kent.</p> <p>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, inferring 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 2017.</p> <p>However, the capital cost of this option and timescale for delivery have increased since the initial medium list announcement and the option would not have met the original hurdle criteria. In addition, there were concerns about the sustainability of the two-site option being considered. Following the readiness assessment of the programme by 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. This also has assured commissioners that an economically more advantageous option, in comparison to this additional option, hasn’t been discounted at the hurdle evaluation stage.</p> <p>Amendments to the hurdle criteria were discussed by the joint committee at a workshop in July 2018. The paper is presented to the February 2019 joint committee to ratify this work. To conduct the re-evaluation of the options, a working group of the East Kent Transformation Programme was convened, consisting of key members from system partner organisations. A list of working group members can be found in the appendices of this document. In July there was a proposal for an independent review of the capital costs of option 9 (a single emergency site model with William Harvey Hospital). This review was taken forward and confirmed that the capital costs of option 9 did not meet the hurdle criteria for financial viability.</p>				

**Recommendation:**

The Joint Committee is asked to:

- a) Consider and sign-off the contents of the paper

**Governance**

The paper including appended reports has been reviewed by the Transformation Delivery Board, Clinical Review Group and System Board.

# East Kent Transformation Programme

## Medium list assessment update (hurdle criteria)

Sustainable Health Care in East Kent Joint Committee

28 February 2019

Agenda item 016/19

# Executive Summary (1)

## Overview

The East Kent Transformation Programme is continuing to progress with the development of a pre-consultation business case for the reconfiguration of its Urgent and Emergency Care (UEC) services. A key component of this work, is the evaluation of a longlist of reconfiguration options to identify a shortlist that will be consulted on with the patients and public of East Kent.

Following the completion of the previous first stage of evaluation (described in more detailed below), a proposal from a land developer (Quinn Estates) to provide a “hospital shell” on/adjacent to the Kent and Canterbury Hospital site for a single Major Emergency Centre was received, inferring 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 2017.

However the capital cost of this option and timescale for delivery have increased since the initial medium list announcement and the option would not have met the original hurdle criteria. In addition, there were concerns about the sustainability of the two-site option being considered. Following the readiness assessment of the programme by 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. This also has assured commissioners that an economically more advantageous option, in comparison to this additional option, hasn't been discounted at the hurdle evaluation stage.

Amendments to the hurdle criteria were discussed by the joint committee at a workshop in July 2018. The paper is presented to the February 2019 joint committee to ratify this work. To conduct the re-evaluation of the options, a working group of the East Kent Transformation Programme was convened, consisting of key members from system partner organisations. A list of working group members can be found in the appendices of this document. In July there was a proposal for an independent review of the capital costs of option 9 (a single emergency site model with William Harvey Hospital). This review was taken forward and confirmed that the capital costs of option 9 did not meet the hurdle criteria for financial viability.

## Evaluation Process

The process adopted by the programme has sought to provide a transparent framework for consideration of the longlist options, to determine a shortlist of options that have the greatest potential to deliver the objectives of the health economy and meet the needs of the population of East Kent and its periphery. The end to end evaluation process involves three key stages that our outlined in greater detail on the next page. This has been designed to enable the East Kent Transformation Programme to meet the following objectives:

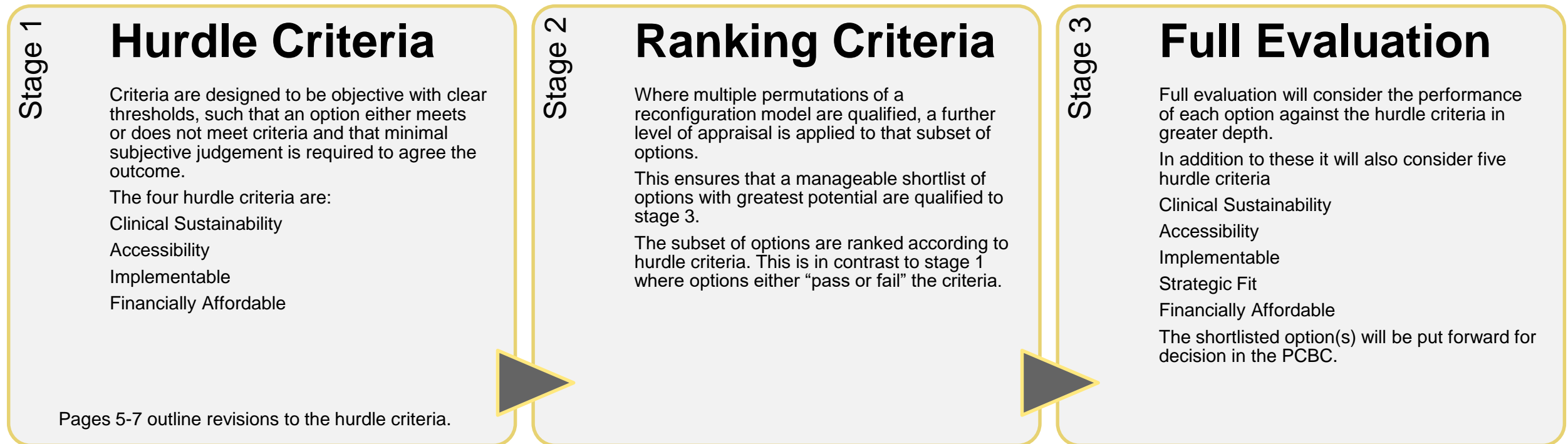
- Provide an objective and transparent framework for the assessment of all possible UEC reconfiguration options.
- Derive a manageable shortlist of options from the longlist of options.
- Ensure that shortlisted options would enable East Kent local health economy's objectives to be met.

# Executive Summary (2)

## Evaluation Process (continued)

The three key stages in the evaluation process are summarised below with more detail provided in the graphic at the bottom of the page:

- **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



# Executive Summary (3)

## Overview of all reconfiguration options

- Based on the 3 site types outlined in the previous slide; 5 reconfiguration models have been derived:

<p><b>Model 1: Two emergency sites</b></p> <ul style="list-style-type: none"> <li>▶ One site will be an MEC</li> <li>▶ One site will be a combined EC &amp; MedEC</li> <li>▶ One site will be a combined ICH and UCC</li> </ul>	<p><b>Model 2: Greenfield</b></p> <ul style="list-style-type: none"> <li>▶ A greenfield site will be designated as the new MEC</li> <li>▶ Existing 3 sites will be a combined ICH and UCC</li> </ul>	<p><b>Model 3: Single emergency site</b></p> <ul style="list-style-type: none"> <li>▶ One site will be an MEC</li> <li>▶ Remaining two sites will be combined ICH and UCC sites</li> </ul>	<p><b>Model 4: Close site</b></p> <ul style="list-style-type: none"> <li>▶ One site will be an MEC</li> <li>▶ One site will be a combine EC &amp; MedEC</li> <li>▶ One site will be closed</li> </ul>	<p><b>Model 5: Three emergency sites</b></p> <ul style="list-style-type: none"> <li>▶ One site will be an MEC</li> <li>▶ Remaining 2 sites will be a combined EC and MedEC</li> </ul>
---	--	--	---	---

- The long list of options has been developed based on the 5 different service configuration models outlined above (and permutations thereof).
- This ensures that all possible options have been considered but that through the hurdle criteria application we are able to arrive at a shortlist of options with the best potential to meet the objectives of the East Kent Transformation Programme.
- The resulting reconfiguration options based on permutations of the above models is outlined in the table below:

Site	Two emergency sites						Greenfield	Single emergency sites			Close site					Three emergency sites	
	Option 1 (two site)	Option 2 (two site)	Option 3 (two site)	Option 4 (two site)	Option 5 (two site)	Option 6 (two site)	Option 7 (green-field)	Option 8 (single site)	Option 9 (single site)	Option 10 (single site)	Option 11 (close a site)	Option 12 (close a site)	Option 13 (close a site)	Option 14 (close a site)	Option 15 (close a site)	Option 16 (close a site)	Option 17 (three site)
K&C	MEC	MEC	EC/MEDEC	ICH/ UCC	EC/MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	ICH/ UCC	MEC	MEC	Close	EC/MEDEC	Close	EC/MEDEC	MEC/ EC/ MedEC
WHH	EC/MEDEC	ICH/ UCC	MEC	MEC	ICH/ UCC	EC/MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	Close	EC/MEDEC	MEC	MEC	EC/MEDEC	Close	MEC/ EC/ MedEC
QEQM	ICH/ UCC	EC/MEDEC	ICH/ UCC	EC/MEDEC	MEC	MEC	ICH/ UCC	ICH/ UCC	ICH/ UCC	MEC	EC/MEDEC	Close	EC/MEDEC	Close	MEC	MEC	MEC/ EC/ MedEC
Green-field Site							MEC										

## Executive Summary (4)

### Reviewing the hurdle criteria

The original hurdle criteria was suitable within the previous context, however, there is recognition that the circumstances surrounding East Kent have changed since then. Most materially the capital envelope now being considered and the timeframe for delivery have both increased.

The risk of proceeding without amending them within the current context is that the three stage evaluation process could result in no viable option being shortlisted. This would be unhelpful in alleviating the pressures currently facing the East Kent system.

Reapplying the hurdle criteria to the long list of options, including revising the hurdle criteria, can be viewed as an example of the NHS “self-correcting” the process prior to consultation and decision-making.

We have sought to review the hurdle criteria in two key ways. Firstly, the ordering of the criteria to reflect the priorities of patients, the public and health system. Secondly, the criteria within each hurdle to ensure only those options with the greatest potential to deliver the objectives of the East Kent system are assessed in further detail in the second and third stage evaluation. The change in order of the hurdle criteria along with a supporting rationale, is displayed in the diagram on the following page. The revised hurdle criteria are outlined on the subsequent page.

# Executive Summary (5)

The original and revised ordering of the hurdle criteria

#	Original criteria order	Revised criteria order	Criteria Description
1	Is the configuration clinically sustainable?	Is the configuration clinically sustainable?	<ul style="list-style-type: none"> <li>No changes as this reflects the patients' and the system's perspective on importance</li> </ul>
2	Is configuration implementable?	Is the potential configuration option accessible?	Changed from criteria 3 to 2 to reflect patient's and the public's prioritisation of access.
3	Is the potential configuration option accessible?	Is the potential configuration option financial sustainable?	<ul style="list-style-type: none"> <li>Changed from criteria 5 to 3 to reflect the relative importance of this criteria</li> </ul>
4	Is the potential configuration option a strategic fit?	Is configuration implementable?	Changed from criteria 3 to 4 to reflect the relative importance of this criteria
5	Is the potential configuration option financially sustainable	Is the potential configuration option a strategic fit?	<ul style="list-style-type: none"> <li>This criteria will not be applied at the hurdle criteria stage as this does not provide a clear threshold for acceptance. This category will however become an important consideration in the full evaluation stage.</li> </ul>



# Executive Summary (6)

The table below summarises the new hurdle criteria. The detail of how these have changed from the previous hurdle criteria is outlined in the body of the document.

#	Criteria	Criteria Description
1	Is the potential configuration option clinically sustainable?	<ul style="list-style-type: none"> <li>• Does it deliver key quality standards?</li> <li>• Does it address any co-dependencies?</li> <li>• Will the workforce be available to deliver this and will it assist in addressing the workforce sustainability issues?</li> <li>• Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effective?</li> </ul>
2	Is the potential configuration option accessible?	<ul style="list-style-type: none"> <li>• <b>Urgent Care:</b> East Kent patients can access a trauma site within 60 minutes</li> <li>• <b>Trauma:</b> 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)</li> <li>• <b>Trauma:</b> the proportion of patients with <b>45min</b> access to a trauma unit is maintained or improved relative to the previous site designation (i.e. trauma Unit at WHH)</li> <li>• <b>Cardiac:</b> all Kent and Medway patients can reach pPCI centre within 90 minutes</li> <li>• <b>Stroke:</b> 95% of the East Kent population can access a stroke unit within 60 minutes (to enable call to needle time within 120 minutes)</li> <li>• <b>Vascular:</b> 95% of the East Kent population can access vascular services within 60 minutes</li> </ul>
3	Is the potential configuration option financially sustainable?	<ul style="list-style-type: none"> <li>• Will the option generate a cost of capital for the acute provider that is no more than £25m per annum?</li> </ul>
4	Is the potential configuration option implementable?	<ul style="list-style-type: none"> <li>• Will the option be implemented within a reasonable timescale i.e. no more than 12 years from completion of the public consultation?</li> </ul>
5	Is the potential configuration option a strategic fit?	

# Executive Summary (7)

## Stage 1 – hurdle criteria results

Through the application of the hurdle criteria, 11 of the 17 reconfiguration options were excluded. The rationale for excluding these options is summarised below and displayed on a table overleaf.

- Option **17** was excluded on the basis of clinical sustainability
- Options **5, 6** and **10** were excluded on the basis of accessibility being below agreed standards
- Options **7, 9, 10, 11, 12, 13, 14, 15, 16** and **17** were excluded on the basis of being financially unsustainable
- Using the Trust derived cost data the capital cost for option 9 (single UEC site at WHH) is such that it fails the financial sustainability hurdle and has been discounted. However the cost difference (~£260m) compared to option 8 (single UEC site at K&C) is significantly higher than expected, even after accounting for the effect of the developer's proposal. The rationale behind the cost differential has been provided by the Trust (appendix). Given the significance of the decision to rule out this option at this stage, a recommendation is being made to the Joint Committee to independently review the valuation and underpinning assumptions for this option (appendix). If this independent review indicates that the capital cost is lower and the option then meets the hurdle criteria, option 9 will be added to the shortlist taken into the third stage of the evaluation.
- Based on the above, options **1, 2, 3, 4, and 8** were qualified through to the second stage.

# Executive Summary (8)

## Stage 1 – ranking criteria results (continued)

Criteria	Options eliminated	Rationale
1) Clinical sustainability	17	Workforce spread over 3 sites is not sustainable due to (a) recruitment challenges (b) sufficient patient throughput to maintain clinicians skills and sustain services
2) Accessible	5, 6, 10,	MEC at QEQM takes trauma patients requiring stabilisation away from Major Trauma Centre (Kings College Hospital)
3) Financial sustainability	7, 9, 11, 12, 13, 14, 15 , 16	Option 13 would be the lowest cost close site option (least reprovision of service). Option 13 is above affordability threshold and therefore all close site options discounted. Option 7 and 9 were also above the affordability threshold and therefore are discounted as well.
4) Implementable	None	All options satisfy this criteria. In addition, Option 9 was qualified owing to lack of data available to assess the option.
Remaining Options	1,2,3,4, and 8	All hurdle criteria met

Site	Two emergency sites				Greenfield		Single emergency sites			Close site						Three emergency sites	
	Option 1 (two site)	Option 2 (two site)	Option 3 (two site)	Option 4 (two site)	Option 5 (two site)	Option 6 (two site)	Option 7 (green-field)	Option 8 (single site)	Option 9 (single site)	Option 10 (single site)	Option 11 (close a site)	Option 12 (close a site)	Option 13 (close a site)	Option 14 (close a site)	Option 15 (close a site)	Option 16 (close a site)	Option 17 (three site)
K&C	MEC	MEC	EC/MEDEC	ICH/UCC	EC/MEDEC	ICH/UCC	ICH/UCC	MEC	ICH/UCC	ICH/UCC	MEC	MEC	Close	EC/MEDEC	Close	EC/MEDEC	MEC/EC/MedEC
WHH	EC/MEDEC	ICH/UCC	MEC	MEC	ICH/UCC	EC/MEDEC	ICH/UCC	ICH/UCC	MEC	ICH/UCC	Close	EC/MEDEC	MEC	MEC	EC/MEDEC	Close	MEC/EC/MedEC
QEQM	ICH/UCC	EC/MEDEC	ICH/UCC	EC/MEDEC	MEC	MEC	ICH/UCC	ICH/UCC	ICH/UCC	MEC	EC/MEDEC	Close	EC/MEDEC	Close	MEC	MEC	MEC/EC/MedEC
Green-field Site							MEC										

## Executive Summary (9)

### Stage 2 Application of the ranking criteria

The rationale for having the stage 2 ranking criteria is to allow the configuration options with the same permutation of clinical model (e.g. a two UEC site clinical model) to be ranked against each other to identify the option(s) that provide the greatest potential to deliver the transformation programme objectives. This assists in creating a manageable medium list which can be comprehensively evaluated to the highest standard in stage 3.

All “two UEC site” options qualified from stage 1 of the appraisal process (options 1, 2, 3, 4) have undergone the stage 2 appraisal to determine the best two site option(s) to progress to full evaluation in stage 3. The same criteria is applied as in stage 1 (hurdle criteria) except in this evaluation the options are ranked relative to each other based on their ability to meet the criteria as opposed to either passing or failing the criteria as in stage 1.

In completing the application of the ranking criteria, all sub-criteria have been equally weighted, with the best ranking option(s) receiving 1 point, the second best ranking option receiving 2 points, and so on until all options have been scored. The table overleaf outlines the ranking sub-criteria that has been applied to options 1-4.

# Executive Summary (10)

## Stage 2 Application of the ranking criteria (continued)

Criteria	Sub-criteria	Approach to ranking
<b>1. Is the configuration clinically sustainable?</b> <i>(Rank 1 = Highest, 4 = Lowest)</i>	<b>1.1) Workforce available</b>	The option with the least adverse impact on workforce is the best ranked
	<b>1.2) Catchment population</b>	The option in which the EC/MedEC serves the largest population is the best ranked
<b>2. Is the potential configuration option accessible?</b> <i>(Rank 1 = Highest, 4 = Lowest)</i>	<b>2.1) Urgent Care</b>	The option that provides the greatest proportion of East Kent residents access to an emergency centre within 30 minutes is the best ranked
	<b>2.2) On-route to MTC</b>	The option with the MEC site located closest to the MTC is the best ranked
	<b>2.3) Trauma (45 min)</b>	The option with the largest percentage of East Kent residents able to access the MEC (trauma unit) within 45 minutes is the best ranked
	<b>2.4) Cardiac (90 min)</b>	The option with the lowest max travel time for Kent and Medway residents is the best ranked
	<b>2.5) Stroke (60 min)</b>	The option with the lowest maximum drive time for East Kent residents to the MEC site is the best ranked
	<b>2.6) Vascular (60 min)</b>	The option with the lowest maximum drive time for East Kent residents to the MEC site is the best ranked
<b>3. Is the potential configuration option financially sustainable?</b> <i>(Rank 1 = Highest, 4 = Lowest)</i>	<b>3.1) Lowest cost to implement</b>	The lowest cost option is the best ranked
<b>4. Is configuration implementable?</b> <i>(Rank 1 = Highest, 4 = Lowest)</i>	<b>4.1) Time to implement</b>	The shortest implementation timescale is the best ranked

# Executive Summary (11)

## Stage 2 – ranking criteria results

The results of the second stage evaluation are outlined in the table below:

- Option 4 is the best ranking two site option. Option 4 is therefore recommended to move to the third and final stage of the appraisal process to undergo a full evaluation alongside option 8.

Criteria	Sub-criteria	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
1. Is the configuration clinically sustainable? (Rank 1 = Highest, 4 = Lowest)	1.1 Workforce available	1	1	1	1
	1.2 Clinical Throughput	3	4	1	2
2. Is the potential configuration option accessible? (Rank 1 = Highest, 4 = Lowest)	2.1 Urgent Care	3	2	3	1
	2.2 Trauma (on-route to MTC)	1	1	1	1
	2.3 Trauma (45 min)	1	1	2	2
	2.4 Cardiac (90 min)	2	2	1	1
	2.5 Stroke (60 min)	1	1	2	2
	2.6 Vascular (60 min)	1	1	2	2
3. Is the potential configuration option financially sustainable? (Rank 1 = Highest, 4 = Lowest)	3.1 Lowest cost to implement	2	4	3	1
4. Is configuration implementable? (Rank 1 = Highest, 4 = Lowest)	4.1 Time to implement	1	1	1	1
<b>The sum of ranking positions</b>		16	18	17	14

- Option 4 is the best ranking two site option, followed by option 1, option 3 and option 2 as the worst ranked option.

## Executive Summary (12)

### Recommendations from the Joint Committee on Stage 1 of the evaluation criteria

- The key decisions taken in completing the application of the hurdle criteria to the longlist of UEC configuration options have been outlined in the table below along with their corresponding impact. The Joint Committee is asked to review and agree the following

Items for agreement by the Joint Committee	Impact of the decision
<ul style="list-style-type: none"> <li>Re-ordering of the hurdle criteria to reflect patient and public feedback on their priorities for health services, and respond to the previous steer from Joint Committee on timeframes for implementing the options</li> </ul>	<ul style="list-style-type: none"> <li>The order of the hurdle criteria is clinical sustainability, accessibility, financial sustainability, implementable and strategic fit</li> </ul>
<ul style="list-style-type: none"> <li>Not applying the strategic fit criteria at the hurdle criteria stage as it does not provide a clear threshold for acceptance or rejection</li> </ul>	<ul style="list-style-type: none"> <li>Only four the criteria are used at the hurdle stage (stage 1)</li> </ul>
<ul style="list-style-type: none"> <li>Changing the wording of the hurdle criteria taking into the changes in circumstances for the East Kent system</li> </ul>	<ul style="list-style-type: none"> <li>An increase in the number of options that passed the stage 1 hurdle criteria evaluation</li> </ul>
<ul style="list-style-type: none"> <li>Utilising option 13 (close K&amp;C) as a proxy for all 6 “close a site” options (11 to 16) as this represents the lowest net cost option across all close a site options</li> </ul>	<ul style="list-style-type: none"> <li>If option 13 passes or fails the hurdle criteria, then that result will also apply to Options 11, 12, 14, 15, 16.</li> </ul>
<ul style="list-style-type: none"> <li>Approach to applying the clinical sustainability hurdle criteria</li> </ul>	<ul style="list-style-type: none"> <li>Option 17 is excluded</li> </ul>
<ul style="list-style-type: none"> <li>Approach to applying the accessibility hurdle criteria</li> </ul>	<ul style="list-style-type: none"> <li>Options 5, 6 and 10 were excluded</li> </ul>
<ul style="list-style-type: none"> <li>Approach to applying the financial sustainability hurdle criteria</li> </ul>	<ul style="list-style-type: none"> <li>Options 7, 9, 10, 11, 12, 13, 14, 15, 16 and 17 were excluded</li> </ul>
<ul style="list-style-type: none"> <li>Approach to applying the implementable hurdle criteria</li> </ul>	<ul style="list-style-type: none"> <li>No impact of remaining options</li> </ul>
<ul style="list-style-type: none"> <li>Options <b>1, 2, 3, 4, and 8</b> qualify through to the second stage evaluation</li> </ul>	<ul style="list-style-type: none"> <li>The other 11 options are excluded at this stage</li> </ul>

## Executive Summary (13)

### Recommendations for the Joint Committee on Stage 2 of the evaluation criteria

- The key decisions taken in completing the application of the ranking criteria to the medium list configuration options have been outlined in the table below along with their corresponding impact. The Joint Committee is asked to review and agree these

Items for agreement by the Joint Committee	Impact of the decision
<ul style="list-style-type: none"> <li>• Rationale for conducting a second stage evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• The four “two UEC sites” options are reduced to a more manageable number for the stage 3 detailed evaluation</li> </ul>
<ul style="list-style-type: none"> <li>• Approach to ranking the options i.e. the question being asked in determining the rank of the options, and the weighting attributed to each sub-criteria</li> </ul>	<ul style="list-style-type: none"> <li>• The approach to ranking and weighting drive the outcome of second stage evaluation</li> </ul>
<ul style="list-style-type: none"> <li>• Approach to applying the clinical sustainability ranking criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Option 3 is the best ranked at this criteria</li> </ul>
<ul style="list-style-type: none"> <li>• Approach to applying the accessibility ranking criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Option 2 is the best ranked at this criteria</li> </ul>
<ul style="list-style-type: none"> <li>• Approach to applying the financial sustainability ranking criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Option 4 is the best ranked at this criteria</li> </ul>
<ul style="list-style-type: none"> <li>• Approach to applying the implementable ranking criteria</li> </ul>	<ul style="list-style-type: none"> <li>• All options are ranked equally at this criteria</li> </ul>
<ul style="list-style-type: none"> <li>• The “two UEC sites” options that qualify through to stage 3</li> </ul>	<ul style="list-style-type: none"> <li>• The other “two UEC sites” options are excluded at this stage</li> </ul>



# Application of Hurdle Criteria – Appendix

# Overview and purpose

## Readiness assessment and recommendations from EY

- As part of PCBC readiness assessment, EY conducted a high-level assessment of the option appraisal for Urgent and Emergency Care in June 2018. The report recommended:
  - Re-appraising the longlist of options for Urgent and Emergency Care (UEC) services to mitigate the risk of failure to reassess the options with a capital requirement similar to option 2 (after taking into account the Quinn Estates proposal) and assure NHS England that an economically more advantageous option hasn't been discounted. It would also consider viability issues being flagged on Option 1 (the two-site option)
  - Updating the hurdle criteria, taking into account the opportunity presented through Option 2, and the evolution of priorities for the East Kent system since the time the initial options appraisal was completed.
  - To apply the refined hurdle criteria to determine the medium list of options to move to more detailed evaluation

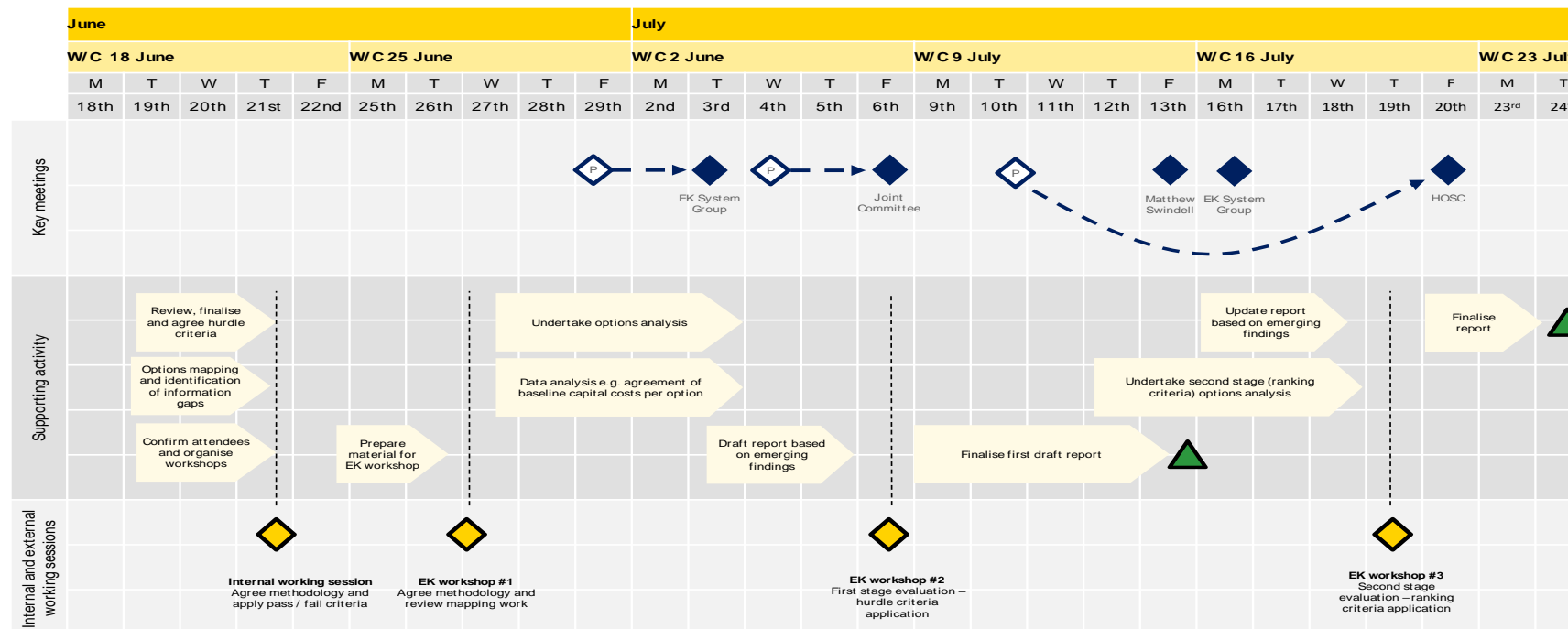
# A Working Group was established bringing together key system partners to rapidly conduct the re-appraisal of the UEC options

The scope of the Working Group has focused on three key areas:

- To develop and agree on a revised set of hurdle criteria
- To apply the revised hurdle criteria to the UEC options longlist and agree on the outcome of this
- To conduct the Stage 2 evaluation on the medium list of options to derive the shortlist of options for full evaluation
- To support with any analysis or technical/ clinical expert opinions required to successfully complete re-appraisal

In response to the request made by the Joint Committee a list attendees and summary of the each of the working sessions has been included in the appendix.

The Working Group worked to the plan below in 2018:








# Reconfiguration Options

# Reconfiguration options have been developed based on the Keogh model for urgent and emergency care settings

- The process for assembling a long list of potential reconfiguration options is described here
- EKUHFT currently operates 3 hospital sites
  - Willian Harvey Hospital (WHH)
  - Kent & Canterbury Hospital (K&C)
  - Queen Elizabeth and Queen Mother Hospital (QEQM)
- In developing potential options it is assumed that in the future the existing sites may be designated as any of the following
  - **MEC** – Major Emergency Centre with Specialist Services (MEC)
  - **EC / MedEC\*** – A combined Emergency Centre and Medical Emergency Centre. Further detailed assessment will be required to ascertain if the clinical workload and catchment population is sufficient to sustain a full EC or whether an augmented MedEC would be more sustainable. if any “two site” or “three site” options are shortlisted, this will need to be assessed in the full evaluation stage
  - **ICH / UCC** – A combination of Integrated Care Hospital and Urgent Care Centre
  - **Site Closure** – Cease to offer urgent of emergency services from this site
- These site types are based on the Keogh urgent care model. The Keogh site types are outlined in the next slide with specification of key services and features associated with each type of centre described by Keogh.
- In addition to conversion of existing sites; the possibility of a greenfield site is also considered in the options
- This results in a long list of 17 reconfiguration options which are outlined in this section of the report

# Overview Keogh urgent care model and site options in East Kent

		Site description and purpose	Services offered
MEC		<p><b>MEC - Major Emergency Centre with specialist services</b></p> <ul style="list-style-type: none"> <li>Larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist hyper-acute services</li> <li>Serving population of ~ 1-1.5m</li> </ul>	<ul style="list-style-type: none"> <li>Hyper-acute cardiac, stroke , vascular services</li> <li>Trauma unit</li> <li>Level 3 ICU</li> <li>Moving towards 24x7 consultant delivered A&amp;E, emergency surgery, acute medicine, inpatient paediatrics</li> <li>Full obstetrics and level 3 NICU</li> </ul>
		<p><b>EC - Emergency Centre</b></p> <ul style="list-style-type: none"> <li>Larger units, capable of assessing and initiating treatment for the overwhelming majority of patients but without all hyper-acute services</li> <li>Serving population of ~ 500-700K</li> </ul>	<ul style="list-style-type: none"> <li>Moving towards 24x7 consultant delivered A&amp;E, emergency surgery, acute medicine</li> <li>Level 3 ICU</li> <li>Inpatient paediatrics; obstetrics with level 2/3 NICU</li> </ul>
EC / MedEC		<p><b>MedEC - Medical Emergency Centre</b></p> <ul style="list-style-type: none"> <li>Assessing and initiating treatment for majority of patients</li> <li>Acute medical inpatient care with intensive care/HDU back up</li> <li>Serving population of ~ 250-300K</li> </ul>	<ul style="list-style-type: none"> <li>Consultant led A&amp;E</li> <li>Acute medicine and critical care/HDU</li> <li>Access to surgical opinion via network</li> <li>Possibly paediatrics assessment unit and possibly midwife-led obstetrics</li> </ul>
		<p><b>ICC - Integrated care hub with emergency care*</b></p> <ul style="list-style-type: none"> <li>Assessing and initiating treatment for large proportion of patients</li> <li>Integrated outpatient, primary, community and social care hub</li> <li>Serving population of ~ 100-250K</li> </ul>	<ul style="list-style-type: none"> <li>GP-led urgent care incorporating out of hours GP services</li> <li>Step up/step down beds possibly with 48 hour assessment unit</li> <li>Outpatients and diagnostics</li> <li>Possibly midwife-led obstetrics</li> </ul>
ICC / UCC		<p><b>UCC - Urgent care centre</b></p> <ul style="list-style-type: none"> <li>Immediate urgent care</li> <li>Integrated outpatient, primary, community and social care hub</li> <li>Serving population of ~ 50-100K</li> </ul>	<ul style="list-style-type: none"> <li>As with ICC above but no beds</li> </ul>

MEC = Major emergency centre; EC = Emergency centre; MedEC = Medical emergency centre; ICC = Integrated care centre; UCC = Urgent care centre

# Overview of all reconfiguration options

- Based on the 3 site types outlined in the previous slide; 5 reconfiguration models have been derived:

<p><b>Model 1: Two emergency sites</b></p> <ul style="list-style-type: none"> <li>▶ One site will be an MEC</li> <li>▶ One site will be a combined EC &amp; MedEC</li> <li>▶ One site will be a combined ICH and UCC</li> </ul>	<p><b>Model 2: Greenfield</b></p> <ul style="list-style-type: none"> <li>▶ A greenfield site will be designated as the new MEC</li> <li>▶ Existing 3 sites will be a combined ICH and UCC</li> </ul>	<p><b>Model 3: Single emergency site</b></p> <ul style="list-style-type: none"> <li>▶ One site will be an MEC</li> <li>▶ Remaining two sites will be combined ICH and UCC sites</li> </ul>	<p><b>Model 4: Close site</b></p> <ul style="list-style-type: none"> <li>▶ One site will be an MEC</li> <li>▶ One site will be a combine EC &amp; MedEC</li> <li>▶ One site will be closed</li> </ul>	<p><b>Model 5: Three emergency sites</b></p> <ul style="list-style-type: none"> <li>▶ One site will be an MEC</li> <li>▶ Remaining 2 sites will be a combined EC and MedEC</li> </ul>
---	--	--	---	---

- The long list of options has been developed based on the 5 different service configuration models outlined above (and permutations thereof).
- This ensures that all possible options have been considered but that through the hurdle criteria application we are able to arrive at a shortlist of options with the best potential to meet the objectives of the East Kent Transformation Programme.
- The resulting reconfiguration options based on permutations of the above models is outlined in the table below:

Site	Two emergency sites						Greenfield	Single emergency sites			Close site					Three emergency sites	
	Option 1 (two site)	Option 2 (two site)	Option 3 (two site)	Option 4 (two site)	Option 5 (two site)	Option 6 (two site)	Option 7 (green-field)	Option 8 (single site)	Option 9 (single site)	Option 10 (single site)	Option 11 (close a site)	Option 12 (close a site)	Option 13 (close a site)	Option 14 (close a site)	Option 15 (close a site)	Option 16 (close a site)	Option 17 (three site)
K&C	MEC	MEC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	ICH/ UCC	MEC	MEC	Close	EC/ MEDEC	Close	EC/ MEDEC	MEC/ EC/ MedEC
WHH	EC/ MEDEC	ICH/ UCC	MEC	MEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	Close	EC/ MEDEC	MEC	MEC	EC/ MEDEC	Close	MEC/ EC/ MedEC
QEQM	ICH/ UCC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	MEC	MEC	ICH/ UCC	ICH/ UCC	ICH/ UCC	MEC	EC/ MEDEC	Close	EC/ MEDEC	Close	MEC	MEC	MEC/ EC/ MedEC
Green-field Site							MEC										

# Reconfiguration Options (abridged)

- The table outlines the abridged options which were reviewed through the process.
- We recognise that of the “close site” options (11 to 16); option 13 would be the lowest net cost option as this option would:
  - entail the smallest amount of service displacement and thus cost of reprovision
  - generate the greatest revenue from sale of estates due to the higher land prices
- As a result, option 13 was considered a proxy for all close site options. This will enable the shortlisting process to be expedited whilst maintaining the rigour required of the process.
- This means that if option 13 passes or fails the hurdle criteria, then that result will also apply to Options 11, 12, 14, 15, 16.
- Options 11, 12, 14, 15, 16 have been hidden and will be assessed via the proxy option (13) as discussed in the previous slide.

Site	Option 1 (two site)	Option 2 (two site)	Option 3 (two site)	Option 4 (two site)	Option 5 (two site)	Option 6 (two site)	Option 7 (green-field)	Option 8 (single site)	Option 9 (single site)	Option 10 (single site)	Option 13 (close a site)*	Option 17 (three site)
K&C	MEC	MEC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	ICH/ UCC	Close	MEC/ EC/ MedEC
WHH	EC/ MEDEC	ICH/ UCC	MEC	MEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	MEC	MEC/ EC/ MedEC
QEQM	ICH/ UCC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	MEC	MEC	ICH/ UCC	ICH/ UCC	ICH/ UCC	MEC	EC/ MEDEC	MEC/ EC/ MedEC
Green-field Site							MEC					



# Reviewing the Hurdle Criteria

# Why review the hurdle criteria?

## Rationale

- There is recognition that the circumstances surrounding East Kent have changed since the time the original hurdle criteria was developed. For example, the Trust at the time was considering a much shorter timescale to have implemented a new UEC configuration, and the capital ask was smaller.
- While the original hurdle criteria may have been suitable within the previous context, the risk of proceeding without amending them within the current context is that the three stage evaluation process could result in no viable option being shortlisted. This would be unhelpful in alleviating the pressures currently facing the East Kent system.
- To mitigate the risk of this occurring, we have sought to review the hurdle criteria in two ways:
  - The order of the hurdle criteria to reflect the priorities of patients, the public and health system
  - The criteria within each hurdle to ensure only those options with the greatest potential to deliver the objectives of the East Kent system are assessed in further detail in the second and third stage evaluation

# The order of hurdle criteria has changed

In the diagram below, we have highlighted how the ordering of the hurdle criteria has changed and provided the rationale for doing so:

#	Original criteria order	Revised criteria order	Change in Order
1	Is the configuration clinically sustainable?	Is the configuration clinically sustainable?	<ul style="list-style-type: none"> <li>No change as this reflects the patients' and the system's perspective on importance</li> </ul>
2	Is configuration implementable?	Is the potential configuration option accessible?	<ul style="list-style-type: none"> <li>Changed from criteria 3 to 2 to reflect patients' and the public's prioritisation of access</li> </ul>
3	Is the potential configuration option accessible?	Is the potential configuration option financially sustainable?	<ul style="list-style-type: none"> <li>Changed from criteria 5 to 3 to reflect the relative importance of this criteria</li> </ul>
4	Is the potential configuration option a strategic fit?	Is configuration implementable?	<ul style="list-style-type: none"> <li>Changed from criteria 3 to 4 reflect the relative importance of this criteria</li> </ul>
5	Is the potential configuration option financially sustainable	Is the potential configuration option a strategic fit?	<ul style="list-style-type: none"> <li>This criteria will not be applied at the hurdle criteria stage as this does not provide a clear threshold for acceptance. This category will however become an important consideration in the full evaluation stage</li> </ul>

# Overview of new hurdle criteria

The table below summarises the new hurdle criteria. The detail of how this has changed from the previous hurdle criteria is outlined in the next section. The strategic fit hurdle is greyed out to highlight that it will not be used at this stage, but will be taken forward as a key hurdle in the full evaluation.

#	Criteria	Criteria Description
1	Is the potential configuration option clinically sustainable?	<ul style="list-style-type: none"> <li>Does it deliver key quality standards?</li> <li>Does it address any co-dependencies?</li> <li>Will the workforce be available to deliver this and will it assist in addressing the workforce sustainability issues?</li> <li>Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effective?</li> </ul>
2	Is the potential configuration option accessible?	<ul style="list-style-type: none"> <li><b>Urgent Care:</b> East Kent patients can access a trauma site within 60 minutes</li> <li><b>Trauma:</b> 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)</li> <li><b>Trauma:</b> the proportion of patients with <b>45min</b> access to a trauma unit is maintained or improved relative to the previous site designation (i.e. trauma Unit at WHH)</li> <li><b>Cardiac:</b> all Kent and Medway patients can reach pPCI centre within 90 minutes</li> <li><b>Stroke:</b> 95% of the East Kent population can access a stroke unit within 60 minutes (to enable call to needle time within 120 minutes)</li> <li><b>Vascular:</b> 95% of the East Kent population can access vascular services within 60 minutes</li> </ul>
3	Is the potential configuration option financially sustainable?	<ul style="list-style-type: none"> <li>Will the option generate a cost of capital for the acute provider that is no more than £25m per annum?</li> </ul>
4	Is the potential configuration option implementable?	<ul style="list-style-type: none"> <li>Will the option be implemented within a reasonable timescale i.e. no more than 12 years from completion of the public consultation?</li> </ul>
5	Is the potential configuration option a strategic fit?	

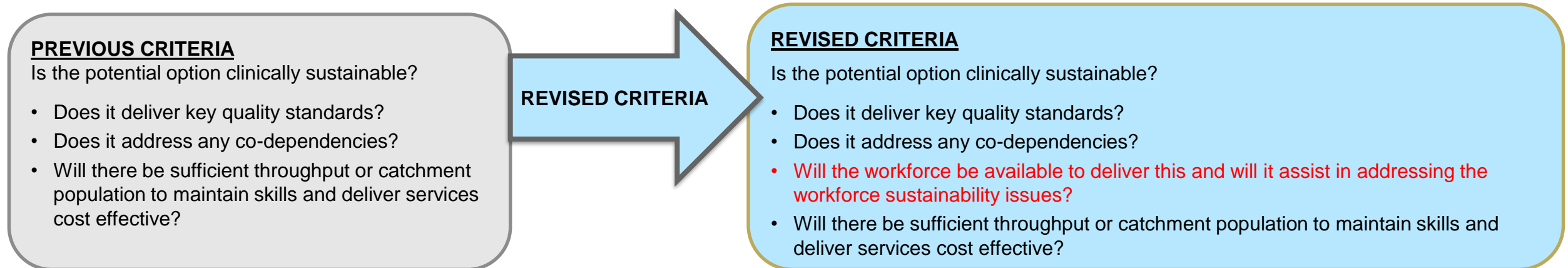
# Stage 1 Application of the Hurdle Criteria

# Hurdle 1

# Clinical Sustainability – hurdle application (1)

## Overview of changes and Rationale

- The workforce sub-criteria has been amended to incorporate the extent to which the option will contribute to addressing the workforce sustainability issues as previously applied under the strategic fit hurdle criteria.
- This allows all workforce related questions to be considered under a single hurdle criteria. Given that the workforce is critical to the sustainability of clinical services, it is best aligned with this criteria.



RED TEXT indicates change from previous criteria

## Clinical Sustainability – hurdle application (2)

### Sub-criteria: Does it deliver key quality standards?

- Ability to deliver quality standards at this stage of the assessment process will consider quality through the lens of catchment population and workforce sustainability.

### Sub-criteria: Does it address any co-dependencies?

- The specification for MEC and EC sites will follow the Keogh Model and SEC clinical senate service co-dependencies. Therefore, all options would meet this sub-criteria by design.

### Sub-criteria: Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effective?

- Keogh recommends a catchment population of 250k-300k for an emergency centre (EC) to have sufficient volume to maintain clinical competency and outcomes.
- The population of East Kent is approximately 695k.
- The table below outlines the average catchment population that would exist for different numbers of MEC/EC sites.

	3 Sites	2 sites	1 site
Average catchment population*	240	360	721
Minimum catchment population exists?	✓	✓	✓

### Conclusions

- All options could address the service co-dependencies
- Base on projected population growth, the catchment population is marginally below that required for 3 emergency centres

\* Base on projected East population of 721k people. Estimates do not account for potential outflow and inflow of patients to and from the periphery of East Kent



## Clinical Sustainability – hurdle application (3)

### Sub-criteria: Does it deliver key quality standards?

- Keogh recommends a catchment population of 1 to 1.5 million for a Major Emergency Centre with specialist services
- A number of specialist services are currently provided in east Kent, and these serve much larger populations
- Substantial numbers of people would travel over 2 hours for specialist services if they were not offered in east Kent, suggesting a MEC with specialist services is required

Service	Dartford & Gravesham	Medway	Tunbridge Wells	Maidstone	WHH	K&C	QEQM	Catchment
24 hours primary percutaneous coronary intervention (pPCI)	X	X	X	X	✓	X	X	1.7m
Urgent maxillo-facial surgery and oncology	X	X	X	X	✓	X	X	990k
Renal inpatients	X	X	X	X	X	✓	X	990k
Vascular	No arterial work	✓	minor	X	X	✓	X	710k <sup>1</sup>

### Conclusions

- A MEC would be clinically sustainable in East Kent based on the catchment population of East Kent and the periphery

\* Base on projected East population of 721k people. Estimates do not account for potential outflow and inflow of patients to and from the periphery of East Kent

## Clinical Sustainability – hurdle application (4)

**Sub-criteria: Will the workforce be available to deliver this and will it assist in addressing the workforce sustainability issues?**

- This criteria reviews the minimum workforce required at consultant and middle grade (ST4 and above) doctors to safely staff an emergency department and acute medicine unit (i.e. MEC or EC sites).

### Assumptions

- Minimum workforce requirements are based on application of Keogh clinical model for urgent and emergency care services.
- Actual WTE is used instead of establishment due to historically high vacancy rates, reflecting workforce challenges in this health economy.
- Actual WTE is based on a snapshot in time rather than annual average as this analysis is completed manually due to data availability.
- The impact of training and recruitment initiatives underway locally and nationally that seek to improve vacancy fill rates have not been factored in.
- Staffing requirement may be affected by changes in volume and intensity which is a likely result of reconfiguration, but these have not been factored in.

#	Workforce Standard	Current State		Minimum requirement (WTE)			
		Establishment (WTE)	Actual (WTE)	WTEs required per site	3 site model	2 site model	1 site model
1	ST4 & above doctor present in ED 24hrs, 7 days a week	30.7	13.7	?	?	?	?
2	Consultant Presence on ED floor 16 hrs/day, 7 days a week	22.5	14.9	12	X	?*	✓
3	Consultant Presence on AMU floor 12 hrs/day, 7 days a week*	26.7	21.4	10	X	✓	✓

\* AMU rota consists of Acute Physicians and Health Care of Older Person (HCOOP) consultants

\*\* criteria would be satisfied if full recruitment (100% vacancy fill rate) was achieved

# Clinical Sustainability – hurdle application (5)

## Sub-criteria: Will the workforce be available to deliver this and will it assist in addressing the workforce sustainability issues?

- **Single site options:** This option satisfies the clinical workforce sustainability criteria.
- Given the challenges highlighted above, there may be additional merit to consolidating urgent and emergency services with all supporting specialist services onto one site. This would improve management of on-call arrangements, which is easier with larger teams, and deliver operational efficiencies associated with managing the workforce across one site.
- **Two site Options:** Based on actual WTE, there is insufficient workforce to support two Emergency Departments but sufficient numbers to support an AMU. However improvement in vacancy rate would result in both ED and AMU being sustainable from a workforce perspective.
- However, the available data was based on a point in time, and the modelling work completed does not take into account any improvements in recruitment rates associated with the increased attractiveness of consultant posts following the reconfiguration of services in East Kent or the impact of recruitment and retention strategies in the health economy. This makes it difficult to draw any definitive conclusions at this stage.
- Repeating the analysis may reveal sufficient improvement, such that the two site options would be sustainable. This should track trends in vacancy fill rates and the impact of recruitment and retention strategies in the health economy
- **Three site Option:** A three site model would not be clinically sustainable from a workforce perspective even at 100% vacancy fill rate.

## Conclusions

- A three site option (option 17) does not meet the clinical workforce sub-criteria
- One site options would satisfy the clinical workforce sub-criteria
- Two site models could meet the hurdle criteria with improved vacancy fill rates

# Clinical Sustainability – hurdle application (6)

## RESULTS

- **Options 17**, would not satisfy hurdle criteria as the appropriate clinical workforce cannot be sustained over 3 sites and the catchment population is too small to sustain 3 sites.
- It is noted that the population of East Kent and the periphery is sufficient for a MEC to be clinically sustainable in East Kent.

Site	Option 1 (two site)	Option 2 (two site)	Option 3 (two site)	Option 4 (two site)	Option 5 (two site)	Option 6 (two site)	Option 7 (green-field)	Option 8 (single site)	Option 9 (single site)	Option 10 (single site)	Option 13 (close a site)*	Option 17 (three site)
K&C	MEC	MEC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	ICH/ UCC	Close	MEC/ EC/ MedEC
WHH	EC/ MEDEC	ICH/ UCC	MEC	MEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	MEC	MEC/ EC/ MedEC
QEQM	ICH/ UCC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	MEC	MEC	ICH/ UCC	ICH/ UCC	ICH/ UCC	MEC	EC/ MEDEC	MEC/ EC/ MedEC
Green-field Site							MEC					

KEY

Option does not satisfy the hurdle criteria

Option failed a prior hurdle criteria

### Conclusions :

- **Options 17** would not satisfy this hurdle criteria
- All remaining options satisfy this hurdle criteria

# Hurdle 2

# Accessible – hurdle application (1)

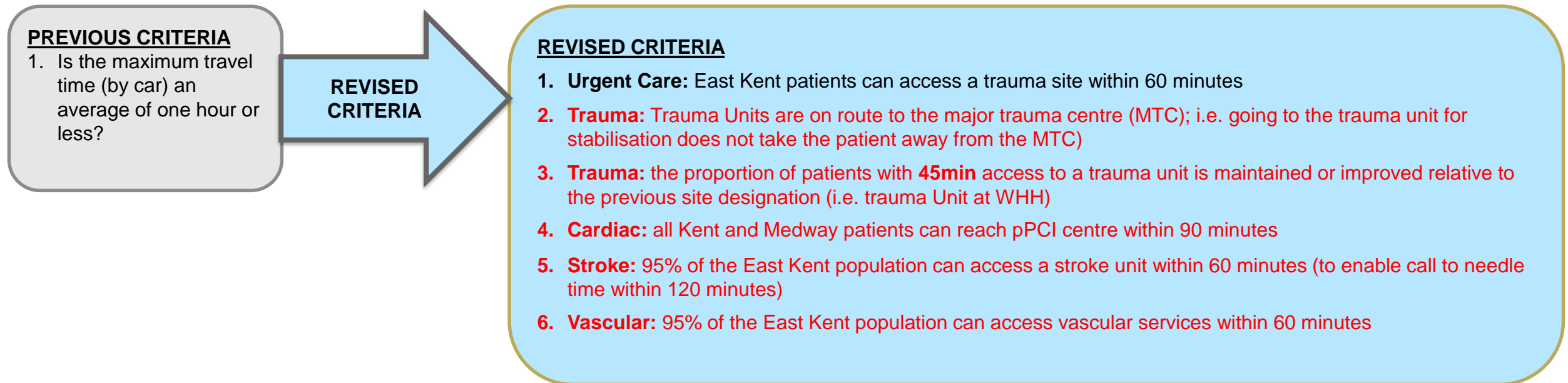
## Overview of changes and rationale

Accessibility was deemed by the public as a very important hurdle, after clinical safety, and as such has been prioritised above the implementable hurdle criteria.

The criteria has been expanded with the addition of the sub-criteria for access to key specialist services.

This builds on the original hurdle criteria identified under strategic fit, which sought to align with existing national designations, in two ways:

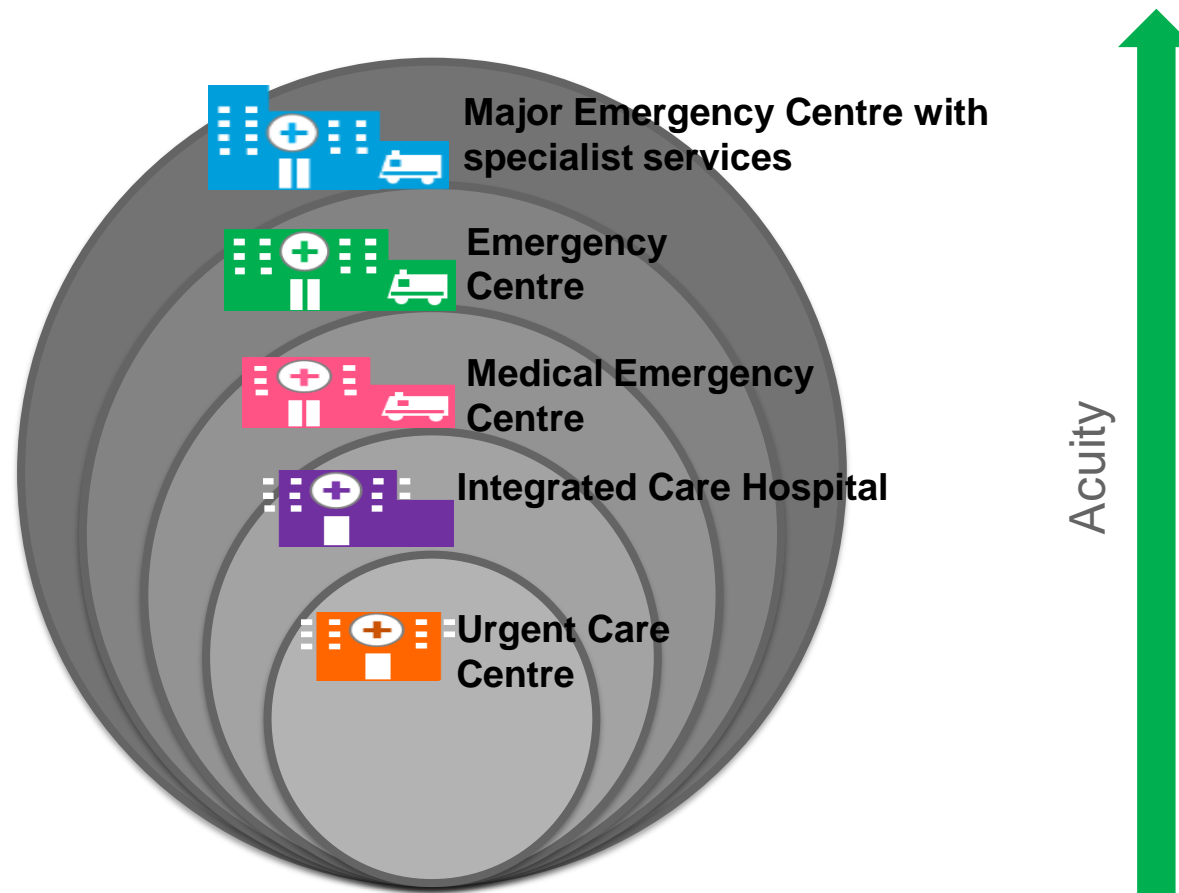
- Access standards as relating to vascular and stroke services are incorporated alongside access standards for trauma and primary PCI.
- The focus has shifted to remaining compliant with standards of care defined through previous designations as opposed to preserving the outcomes of previous designations. This is to enable comparable access irrespective of location chosen.



RED TEXT indicates change from previous criteria

## Accessible – hurdle application (2)

- The 5 types of site as outlined in the Keogh report are shown below in terms of increasing acuity and the specialist services contained within each site
- The reconfiguration options utilize variations on 3 types of site which are combinations of these 5 site types.
- The variations are 1) MEC, 2) EC /Med EC, 3) ICH /UCC



	MEC	EC	Med EC	ICH	UCC
Urgent Care	✓	✓	✓	✓	✓
Vascular	✓	X	X	X	X
Trauma Unit	✓	X	X	X	X
Stroke Unit	✓	X	X	X	X
Cardiac (pPCI)	✓	X	X	X	X

## Accessible – hurdle application (3)

### Hurdle application

- The expected outcomes on application of the hurdle sub-criteria are summarised below.

### Key Assumptions:

- Off-peak travel time by car is used as a proxy for ambulance (blue light) drive times. This assumption has been agreed with SECAMB
- Source data is basemap.

Sub-criteria	Criteria Descriptions	Outcome
2.1) Emergency Care	<ul style="list-style-type: none"> <li>• <b>East Kent</b> patients can access an emergency care centre within 60 minutes</li> </ul>	<ul style="list-style-type: none"> <li>• All options satisfy this criteria</li> </ul>
2.2) Trauma	<ul style="list-style-type: none"> <li>• Trauma Units are on-route to the major trauma centre (do not take patients away from MTC)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Options 5, 6, 10</b> would not satisfy the criteria</li> </ul>
	<ul style="list-style-type: none"> <li>• Proportion of patients with 45min access to a trauma unit for stabilisation is maintained or improved relative to the previous site designation (i.e. trauma Unit at WHH)</li> </ul>	<ul style="list-style-type: none"> <li>• All options satisfy this criteria</li> </ul>
2.3) Primary PCI	<ul style="list-style-type: none"> <li>• <b>Kent and Medway</b> patients can reach pPCI centre within 90 minutes</li> </ul>	<ul style="list-style-type: none"> <li>• All options satisfy this criteria</li> </ul>
2.4) Stroke	<ul style="list-style-type: none"> <li>• 95% of <b>East Kent</b> patients can access a stroke unit within 60 minutes (to enable call to needle time within 120 minutes)</li> </ul>	<ul style="list-style-type: none"> <li>• All options satisfy this criteria</li> </ul>
2.5) Vascular	<ul style="list-style-type: none"> <li>• 95% of the <b>East Kent</b> population can access vascular services within 60 minutes</li> </ul>	<ul style="list-style-type: none"> <li>• All options satisfy this criteria</li> </ul>



## Accessible – hurdle application (4)

### Sub-criteria:

- Trauma: The Proportion of patients with 45min access to a trauma unit for stabilisation is maintained or improved relative to the previous site designation (i.e. trauma Unit at WHH)

Single MEC Site based at	% patients within 45 min drive time	Peak of Maximum travel time	Outflow: # patients whose closest trauma centre is not EKHU
<b>WHH</b> <b>NB:</b> this is the current site		60 Mins	3,192 patients
<b>QEQM</b>		55 Mins	224,136 patients
<b>K&amp;C</b>		48 Mins	19,820 patients

### Results

- Trauma Unit at WHH is the current state
- Moving the trauma unit to QEQM or K&C would not worsen 45 minute access time to a trauma unit
- **Observations:** The current state (WHH as designated trauma centre) does not satisfy this hurdle criteria.

### **Conclusions**

- All options satisfy this hurdle criteria

SOURCE: Base map. Travel times, off-peak, by car (this is used as proxy for Blue light (ambulance) travel time)  
 Data presented is for the whole East Kent catchment population

# Accessible – hurdle application (5)

## Sub-criteria:

- Patients (across K&M) requiring PCI services will receive care within – 90 minutes ('Door To Balloon' time). Analysis outlines proportion of patients that are within 90 minute (average maximum drive time).

Single MEC Site based at	% patients within 90 min drive time	Peak of Maximum travel time	Outflow: # patients whose closest pPCI centre is not EKHUHT
<b>WHH</b> <b>NB:</b> this is the current site		60 Mins	452,668 patients
<b>QEQM</b>		80 Mins	1,030,410 patients
<b>K&amp;C</b>		64 Mins	615,542 patients

## Results

- No options would be excluded as a result of application of this hurdle criteria.
- Observations:** the nearest centre offering pPCI is outside of K&M for 452,688 patients in the current state. This would increase significantly if QEQM or K&C became the newly designated centres.

## Conclusions

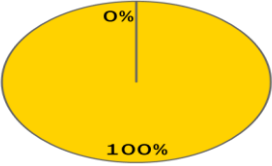
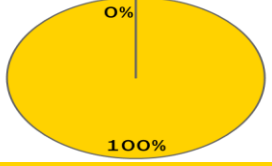
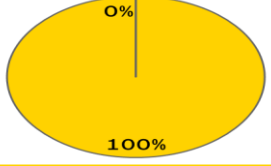
- All options satisfy this hurdle criteria

SOURCE: Base map. Travel times, off-peak, by car (this is used as proxy for Blue light (ambulance) travel time)  
 Data presented is for the whole Kent and Medway catchment population

## Accessible – hurdle application (6)

### Sub-criteria:

- **Emergency Care** : All patients can access an emergency centre within 60 minutes in Kent and Medway or the periphery.
- **Stroke**: 95% of **East Kent** patients 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

Single MEC Site based at	% patients within 60 min drive time	Peak of maximum travel time	Outflow: # patients whose closest pPCI centre is not EKHUHT
<b>WHH</b> <b>NB:</b> this is the current site		60 Mins	3,192 patients
<b>QEQM</b>		55 Mins	224,136 patients
<b>K&amp;C</b>		48 Mins	19,820 patients

### Results

- No options would be excluded as a result of application of this hurdle criteria

### **Conclusions**

- All options satisfy this hurdle criteria

SOURCE: Base map. Travel times, off-peak, by car (this is used as proxy for Blue light (ambulance) travel time)  
 Data presented is for the whole **East Kent** catchment population

## Accessible – hurdle application (7)

### RESULTS

- **Options 5, 6, 10**, would not satisfy hurdle criteria as major trauma patients requiring stabilisation would be taken away from the Major trauma centre. This is supported by the South East Trauma Network.
- Access times for Stroke, Vascular and pPCI were within respective accessibility thresholds for the concerned populations thus no options were eliminated on this basis.

Site	Option 1 (two site)	Option 2 (two site)	Option 3 (two site)	Option 4 (two site)	Option 5 (two site)	Option 6 (two site)	Option 7 (green-field)	Option 8 (single site)	Option 9 (single site)	Option 10 (single site)	Option 13 (close a site)*	Option 17 (three site)
K&C	MEC	MEC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	ICH/ UCC	Close	MEC/ EC/ MedEC
WHH	EC/ MEDEC	ICH/ UCC	MEC	MEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	MEC	MEC/ EC/ MedEC
QEQM	ICH/ UCC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	MEC	MEC	ICH/ UCC	ICH/ UCC	ICH/ UCC	MEC	EC/ MEDEC	MEC/ EC/ MedEC
Green-field Site							MEC					

#### KEY

Option does not satisfy the hurdle criteria

Option failed a prior hurdle criteria

### Conclusions :

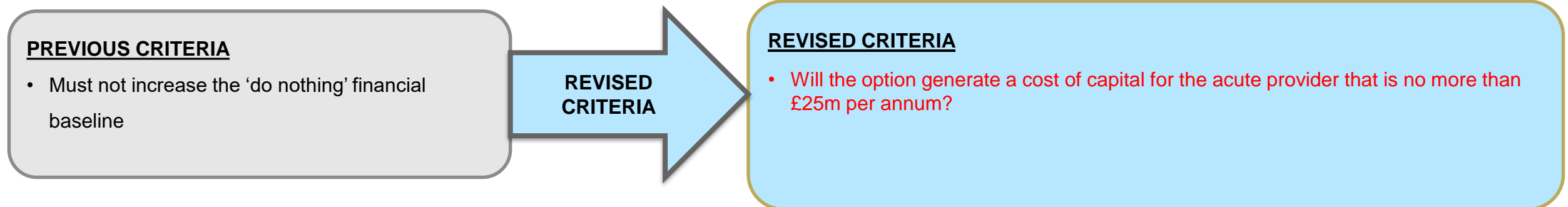
- Options 5, 6, 10 would not satisfy this hurdle criteria
- All remaining options satisfy this criteria

# Hurdle 3

# Financially Sustainable – hurdle application (1)

## Overview of changes and rationale

- Commissioners and providers will need to define the size of the capital investment that is affordable for the system. Commissioners will need to determine the absolute affordability across the system for the capital investment. However, to do this a level of detailed analysis is required on the options and out of hospital service models that is not available at this stage. System affordability of the shortlisted options will be considered further in the detailed evaluation stage.
- The Trust has defined the affordable capital cost and ongoing revenue costs to service the building. This is based on an assessment of what it considers deliverable based on historic CIP performance, the current pipeline of CIP initiatives and management capacity to deliver CIP benefits in relation to annual turnover. This produces a level of affordability of no more than 3.5% of turnover, equating to no more than £25m in cost of capital per annum, which would service a capital allocation of circa £300m.
- With the availability of information at this stage, the Trust's measure of affordability will be used as the financial sustainability hurdle criteria, and commissioner affordability will be considered in the detailed evaluation stage.



RED TEXT indicates change from previous criteria

# Financially sustainable – hurdle application (2)

**Sub-criteria: Are the revenue costs affordable?**

**Providers:**

- Affordability from the provider perspective is estimated based on the below:

**Affordability of reconfiguration<sup>1</sup>**

- Following the 2018/19 financial plan submission to NHSI, the Trust executive has undertaken a high level review of the potential financial benefits of EK reconfiguration, based on historic and emerging evidence from clinical teams. These opportunities would generate between £20m to £25m of potential cost efficiencies, which equates to circa 3.5% of consolidated turnover.
- The Trust is planning continued delivery of an annual CIP efficiency programme, with a particular focus on delivering a greater percentage of schemes with a recurrent impact. At the point of major reconfiguration, the Trust intends to have a reduced/ normalised CIP requirement of 2% aligned to current NHSI PbR tariff inflation assumptions.
- Affordability of reconfiguration, from a Trust perspective, includes a balance between what it considers deliverable in terms of scale with regard to clinical management capacity and also financially based on historic and planned CIP performance in relation to annual turnover. This produces **a level of affordability of no more than 3.5% of turnover, equating to circa £21-25m cost of capital per annum.**
- Based on this, the Trust believes the level of **affordable CIP is circa 5.5% which would service a capital allocation of circa £300m.** The cost of capital assumes no interest payments, but does include capital charges (3.5% PDC) and asset depreciation.

SOURCE: <sup>1</sup>East Kent Reconfiguration: Application of Hurdle criteria – Affordability paper. 04.07.2018

# Financially sustainable – hurdle application (3)

## Background information supporting the provider analysis

### Efficiency savings<sup>1</sup>

- The Trust has been successful in delivering material efficiency savings over the past five years. Achieving these levels of savings in each financial year requires management of a significant programme of Cost Improvement Plan (CIP) schemes and substantial associated clinical engagement.
- The Trust's historic CIP plans and delivery is outlined in the table below:

Financial years	CIP Plans		Actual CIP Delivered			
	Total	% of Consolidated Turnover	Total	Recurrent	Non Recurrent	CIP Plan % achieved
Yr	£000	%	£000	£000	£000	%
2013/14	30,000	6.0%	26,199	20,285	5,914	87%
2014/15	26,779	5.0%	19,240	15,400	3,840	72%
2015/16	14,719	2.8%	15,568	15,568	4,638	106%
2016/17	21,903	5.2%	18,799	11,251	7,549	86%
2017/18	32,336	5.5%	33,141	27,894	5,247	102%
2018/19 plan	30,000	5.1%	30,000	22,642	7,358	100%

## 2. Financial planning

- In determining the final 2018/19 Trust financial plan, the Trust Board led an assessment of the capacity of the organisation to generate efficiency savings in the current financial year. To achieve the Control total set by NHSI, the Trust would have had to develop and deliver Cost Improvement Plans (CIP) of nearing 7.7% of consolidated turnover.

SOURCE: <sup>1</sup>East Kent Reconfiguration: Application of Hurdle criteria – Affordability paper. 04.07.2018



# Financially sustainable – hurdle application (4)

## Background information supporting the provider analysis (continued)

### 2. Financial planning (continued)

- The Trust Board assessment included:
  - an evaluation of the financial risk, with possible mitigations, of not delivering such a large CIP programme, namely loss of £20.4m Provider Sustainability funding (PSF);
  - the level of clinical management capacity needed to deliver the multitude and scale of CIP schemes required to achieve this level of cost efficiency;
  - the number of ‘green’ schemes developed and in place for 2018/19 before the start of the financial year;
  - peer comparisons in terms of the level of CIP programme considered deliverable in any single financial year.
- The Trust Board concluded that, based on historic successful delivery and the capacity of the organisation to manage a CIP programme whilst continuing to deliver services, a CIP plan of circa 5% is deliverable and on an affordable trajectory.

SOURCE: <sup>1</sup>East Kent Reconfiguration: Application of Hurdle criteria – Affordability paper. 04.07.2018

# Financially sustainable – hurdle application (5)

## RESULTS

- The information provided by the Trust has estimated the capital cost and cost of capital for option 4, option 7, option 8, option 9 and option 13.
- Capital costs have been calculated at a high-level, taking into consideration building and equipment costs informed by OB1 forms provided by the Quantity Surveyor.
- The costs of capital have also been calculated at a high-level, taking into consideration depreciation and Public Dividend Capital (PDC) costs based on the assumptions below:
  - Depreciation – assumed useful economic life (UEL) of new build is 40 years, and equipment is 10 year (straight line method). This has excluded capital replacement costs as this would form part of the Trust’s annual capital programme
  - PDC – 3.5% PA payable on depreciated asset value over its UEL. Highest cost year has been calculated, as this will reduce in subsequent years as the assets depreciate
  - Capital funding – no additional interest cost assumed for capital expenditure outlay – repayable only through PDC

Source of estimate	Capital cost	Cost of capital (highest cost year calculated)	Outcome
EKUFT analysis of Option 4 (two site)	£224.7m	£14.7m	<b>Option 4</b> satisfies the hurdle criteria
EKUFT analysis of Option 7 (greenfield site)	£789.7m	£48.6m	<b>Option 7</b> does not satisfy this hurdle criteria
EKUFT analysis of Option 8: (single site)	£302.7m	£20.1m	<b>Option 8</b> satisfies the hurdle criteria
EKUFT analysis of Option 9 (single site)	£562.1m	£35.6m	<b>Option 9</b> does not satisfy this hurdle criteria, however, validation of the cost estimates is required
EKUFT analysis of Option 13 (close a site)	£518.6m	£32.8m	<b>Option 13</b> would not satisfy this hurdle criteria

## Financially Sustainable – hurdle application (6)

### RESULTS

- Applying the financial sustainability hurdle to these options result in option 4 and 8 satisfying the hurdle criteria, while options 9 and 13 do not. Further information on the drivers behind the cost differential between option 8 (single UEC site at K&CH) and option 9 (single UEC site at WHH) has been provided overleaf.
- Costing information for options 1-3 was not available at the time of the hurdle criteria application, therefore these options are assumed to satisfy the hurdle criteria at this stage. This will be further reviewed at the second stage of the evaluation.

Site	Option 1 (two site)	Option 2 (two site)	Option 3 (two site)	Option 4 (two site)	Option 5 (two site)	Option 6 (two site)	Option 7 (green-field)	Option 8 (single site)	Option 9 (single site)	Option 10 (single site)	Option 13 (close a site)*	Option 17 (three site)
K&C	MEC	MEC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	ICH/ UCC	Close	MEC/ EC/ MedEC
WHH	EC/ MEDEC	ICH/ UCC	MEC	MEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	MEC	MEC/ EC/ MedEC
QEQM	ICH/ UCC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	MEC	MEC	ICH/ UCC	ICH/ UCC	ICH/ UCC	MEC	EC/ MEDEC	MEC/ EC/ MedEC
Green-field Site							MEC					

#### KEY

Option does not satisfy the hurdle criteria

Option failed a prior hurdle criteria

#### Conclusions :

- Option 7, 9, & 13 would not satisfy this hurdle criteria.
- All remaining options satisfy this criteria.

# Financially Sustainable – hurdle application (7)

## Capital costs of option 9 (single UEC site at WHH)

- Following the completion of the capital cost analysis for the two, single UEC site options (8 – K&CH, and 9 – WHH), the Joint Committee and CCG leadership identified a significant difference (~£260m) in the capital cost between option 8 (~£302.7m) and option 9 (~£562.1m). A request was made to the Trust to provide more details on the rationale for this. A summary of the information supplied is provided below.
- Put simply, there are two primary drivers behind the capital costs of any options – the cost to build the shell and infrastructure, and the cost to fit out and refurbish the shell. The table below outlines the variation in costs across these two areas for options 8 and 9 (at the time of the review)

Option	Cost to build shell and infrastructure	Cost to fit out and refurbish the shell	Total cost
EKUFT analysis of Option 8: (single site)	Absorbed by Quinn Estates	£302.7m	£302.7m
EKUFT analysis of Option 9 (single site)	£277.5m	£284.5m	£562m

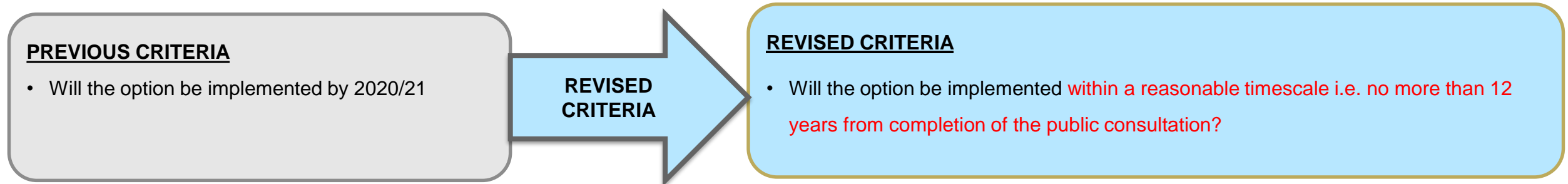
- The benefit received from the gift of a hospital shell from Quinn Estates, equates to a cost the NHS would have to incur of £277.5m in option 9. This higher cost is driven by a number of factors including, but not limited to:
  - A land purchase to create space for the new car park;
  - Installation of power to the building and acquired land;
  - Relocation of the helipad at WHH;
  - Management of older buildings which will not have been constructed as efficiently as K&CH leading to higher on costs; and
  - Departments have a higher percentage of super cost items such as theatres
- Incorporated within the capital costs for both options is the provisional location factor, which is higher for WHH (19%) than K&CH (15%). The location factors are set by BCIS, and reflects costs regionally (e.g. historical cost data shows Ashford is 4% more expensive than Canterbury).
- The cost to fit out and refurbish the shell in option 9 is slightly lower than option 8, because more estate could be re-used at WHH due to its current size.

# Hurdle 4

# Implementable – hurdle application (1)

## Overview of changes and rationale

- The time frame for implementation and delivery was originally revised from the medium term (2020/21) to a period of seven years to align with STP capital planning timeframes.
- However, following the feedback received from the Joint Committee on the potential constraints with a seven year timeframe, particularly when considering the council planning and approval lead times required, a longer period of time has been utilised i.e. 12 years.
- This time period has been selected based on our experience of the average capital build times (with examples provided overleaf).
- The time period commences following the completion of consultation, as opposed to a fixed date of delivery. This provides the flexibility needed in capital planning projects of this scale and supports system future proofing.
- Clear milestones will be needed to avoid slippage and ensure timely delivery of the overarching programme.



RED TEXT indicates change from previous criteria

## Implementable – hurdle application (2)

### Can the option be implemented within a reasonable timescale i.e. no more than 12 years from completion of the public consultation?




- Estimates of implementation timeline will be highly sensitive to factors such as; complexity of build; upheld challenge from jurisdictional review and/or build delays. We will however draw on analysis conducted in previous rounds and knowledge of recent NHS capital redevelopments to estimate likely implementation timelines.
- We do not have delivery timelines for options 1-3 but are comfortable that they can be delivered within the window of the other remaining options.

Source of estimate	Estimated Delivery timeline	Outcome
EKUFT analysis of Option 4 (two site)	3.5 years	<b>Option 4</b> satisfies the hurdle criteria
EKUFT analysis of Option 8: (single site)	4.5 years	<b>Option 8</b> satisfies the hurdle criteria
EKUFT analysis of Option 9 (single site)	5.5 years	<b>Option 9</b> satisfies the hurdle criteria
CF review of 3 recent new build hospitals	8.3-10.3 years (see next slide)	

### Conclusions

- All remaining options satisfy this criteria

## Implementable – hurdle application (3)

Hospital		Cost to build	# Beds	Cost per bed	Time to build	Total Time to deliver
Queen Elizabeth Birmingham (opened 2010)		£545m	1,215	£449,000	6 years	9 to 11 years
Queen Elizabeth Glasgow		£842m	900	£935,000	4 years	7 to 9 years
Royal Derby Hospital (opened 2009)		£334m	1,159	£288,000	6 years	9 to 11



## Implementable – hurdle application (4)

### RESULTS

- All remaining options are estimated to be implementable within the 12 year timeframe.

Site	Option 1 (two site)	Option 2 (two site)	Option 3 (two site)	Option 4 (two site)	Option 5 (two site)	Option 6 (two site)	Option 7 (green-field)	Option 8 (single site)	Option 9 (single site)	Option 10 (single site)	Option 13 (close a site)*	Option 17 (three site)
K&C	MEC	MEC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	ICH/ UCC	Close	MEC/ EC/ MedEC
WHH	EC/ MEDEC	ICH/ UCC	MEC	MEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC	ICH/ UCC	MEC	ICH/ UCC	MEC	MEC/ EC/ MedEC
QEQM	ICH/ UCC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	MEC	MEC	ICH/ UCC	ICH/ UCC	ICH/ UCC	MEC	EC/ MEDEC	MEC/ EC/ MedEC
Green-field Site							MEC					

#### KEY

Option does not satisfy the hurdle criteria

Option failed a prior hurdle criteria

### Conclusions :

- All remaining options satisfy this criteria



## **Stage 2 Application of the ranking criteria**

# Why have a second stage ranking criteria?

## Rationale

- As outlined in the evaluation process overview; if multiple permutations of a clinical model remain, those options can be ranked against each other in stage 2 to identify the option(s) that provide the greatest potential to deliver the transformation programme objectives.
- This fulfils the system leaders' responsibilities to ensure that costs for completion of the appraisal process and PCBC development are managed responsibly to deliver best value for public funds, whilst maintaining a reasonable number of options for the full evaluation
- The risk of qualifying a large number of options for the full evaluation stage is that the quality of full evaluation may be degraded due to the time and resource available to conduct the full evaluation. The benefit of this approach is to create a manageable shortlist of options which can be comprehensively evaluated to the highest standard.

## The ranking criteria will be applied to the four “two site” models

- The medium list of options qualified from the stage 1 hurdle criteria application are outlined in the table below:

Site	Option 1 (two site)	Option 2 (two site)	Option 3 (two site)	Option 4 (two site)	Option 8 (single site)
K&C	MEC	MEC	EC/ MEDEC	ICH/ UCC	MEC
WHH	EC/ MEDEC	ICH/ UCC	MEC	MEC	ICH/ UCC
QEQM	ICH/ UCC	EC/ MEDEC	ICH/ UCC	EC/ MEDEC	ICH/ UCC

- The medium list options consist of four “two site” options (1, 2, 3 and 4) and one “single site” option (8)
- As a result options 1,2,3 and 4 will be ranked against each other to determine the best two site option(s) to be qualified for full evaluation.
- The ranking criteria and their application is set out in the following slides.

# Recap of hurdle criteria

#	Criteria	Criteria Description
1	Is the configuration clinically sustainable?	<ul style="list-style-type: none"> <li>• Does it deliver key quality standards?</li> <li>• Does it address any co-dependencies?</li> <li>• Will the workforce be available to deliver this and will it assist in addressing the workforce sustainability issues?</li> <li>• Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effectively?</li> </ul>
2	Is the potential configuration option accessible?	<ul style="list-style-type: none"> <li>• <b>Urgent Care:</b> All East Kent residents can access a trauma site within 60 minutes</li> <li>• <b>Trauma:</b> 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)</li> <li>• <b>Trauma:</b> the proportion of residents with <b>45min</b> access to a trauma unit is maintained or improved relative to the previous site designation (i.e. trauma Unit at WHH)</li> <li>• <b>Cardiac:</b> all Kent and Medway residents can reach pPCI centre within 90 minutes</li> <li>• <b>Stroke:</b> 95% of the East Kent population can access a stroke unit within 60 minutes (to enable call to needle time within 120 minutes)</li> <li>• <b>Vascular:</b> 95% of the East Kent population can access vascular services within 60 minutes</li> </ul>
3	Is the potential configuration option financially sustainable?	<ul style="list-style-type: none"> <li>• Will the option generate a cost of capital for the acute provider that is no more than £25m per annum?</li> </ul>
4	Is configuration implementable?	<ul style="list-style-type: none"> <li>• Will the option be implemented within a reasonable timescale i.e. no more than 12 years from completion of the public consultation?</li> </ul>

# Approach to ranking the “two UEC site” options

- All “two UEC site” options qualified from stage 1 of the appraisal process will undergo the stage 2 appraisal to determine the best two site option(s) to progress to full evaluation in stage 3.
- The analysis from stage 1 will be used to rank the two site options relative to each other. They will not be applied as hurdle criteria with pass/fail thresholds as was the approach in stage 1 of the appraisal process.
- All sub-criteria will be equally weighted, with the best ranking option(s) receiving 1 point, the second best ranking option receiving 2 points, and so on until all options have been scored.

Criteria	Sub-criteria	Approach to ranking
1. Is the configuration clinically sustainable? <i>(Rank 1 = Highest, 4 = Lowest)</i>	1.1) Workforce available	The option with the least adverse impact on workforce is the best ranked
	1.2) Catchment population	The option in which the EC/MedEC serves the largest population is the best ranked
2. Is the potential configuration option accessible? <i>(Rank 1 = Highest, 4 = Lowest)</i>	2.1) Urgent Care	The option that provides the greatest proportion of East Kent residents access to an emergency centre within 30 minutes is the best ranked
	2.2) On-route to MTC	The option with the MEC site located closest to the MTC is the best ranked
	2.3) Trauma (45 min)	The option with the largest percentage of East Kent residents able to access the MEC (trauma unit) within 45 minutes is the best ranked
	2.4) Cardiac (90 min)	The option with the lowest max travel time for Kent and Medway residents is the best ranked
	2.5) Stroke (60 min)	The option with the lowest maximum drive time for East Kent residents to the MEC site is the best ranked
	2.6) Vascular (60 min)	The option with the lowest maximum drive time for East Kent residents to the MEC site is the best ranked
3. Is the potential configuration option financially sustainable? <i>(Rank 1 = Highest, 4 = Lowest)</i>	3.1) Lowest cost to implement	The lowest cost option is the best ranked
4. Is configuration implementable? <i>(Rank 1 = Highest, 4 = Lowest)</i>	4.1) Time to implement	The shortest implementation timescale is the best ranked

# Ranking Criteria Results



# Sub-criteria 1.1 – Workforce Availability

## Description

- **Sub-criteria:** To what extent is the workforce available to deliver this option and will the option assist in addressing the workforce sustainability issues

## Application

- All two site options will require the same overall workforce across EKUHFT so at this level of analysis the criteria does not allow for differentiation of the options.
- In addition to this, the analysis available at this stage of the evaluation does not provide the level of granularity required to draw any conclusions on variation in workforce availability by site.

## Assumptions

- Without considering the location of UEC site, all two site options will broadly require the same overall workforce

## Results

- This criteria does not provide any distinction between options thus all options have been ranked equally.

Site	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
Workforce availability	✓	✓	✓	✓
RANK	1	1	1	1

Best ranked option will receive 1 point

# Sub-criteria 1.2 – Catchment Population

## Description

- **Sub-criteria:** Will there be sufficient throughput or catchment population to maintain skills and deliver cost effective services?

## Application

- The Keogh model for urgent care recommends that the catchment population for a EC is 500 thousand.
- It is recognised that the East Kent population is smaller than the Keogh recommendation for 2 emergency centres. However it is noted that historic ED volumes across EKHHT are sufficient to support 2 emergency centres from a clinical workload perspective and the peninsular geography does merit 2 emergency centres to preserve access to services for the East Kent population.
- This criteria will examine to what extent each of the options are compliant with the Keogh recommendations for the catchment population of an EC site (i.e. closest to the recommended number of 500 thousand for an EC).
- The options will be ranked in order of which EC serves a catchment population that is most compliant with the Keogh recommendations.

## Assumptions

- The catchment population is defined as the population for whom the EC is their nearest emergency centre based on travel time by car.
- If an MEC is closer than the EC/MedEC then the patient is assumed to access the MEC directly
- Outflows are factored in (i.e. patients for whom their closest EC or MEC is another Trust are assumed to access emergency care there).

## Results

- Option 3 was the best ranking configuration with an MEC at WHH and the EC/MedEC at K&C.
- The next best options were option 4 followed by Option 1 then Option 2.

Site	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
Catchment population for the EC	265,347	199,185	474,093	312,240
RANK	3	4	1	2

Best ranked option will receive 1 point

# Sub-criteria 2.1 – Access to Urgent Care

## Description

- East Kent residents can access an emergency centre within 60 minutes.

## Application

- All options qualified to this stage provided the population an emergency centre (MEC or EC/MedEC) within 60 minutes. As such the options are assessed in terms of fastest accessibility to an emergency centre.
- This will be measured in terms of the proportion of East Kent residents who will be within 30 minutes (travel time by car) to their nearest emergency centre.

## Assumptions

- Both the MEC and EC/Med EC are considered emergency centres for the purpose of this analysis.
- Travel times are based on travel by car during off peak hours. This is the SECamb accepted proxy for ambulance travel time.
- Results presented are for the whole East Kent population.

## Results

- Option 4 is the best ranked option against this criteria providing 90% of East Kent residents with access to an emergency centre within 30 minutes (by car).
- Option 2 is the next best site followed by Options 1 and 3 which provide an equal level of access to an emergency centre

Site	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
% residents within 30 mins travel time to an emergency centre	77%	86%	77%	90%
RANK	3	2	3	1

Best ranked option will receive 1 point

## Sub-criteria 2.2 – Trauma centre is on route to the MTC

### Description

- 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.

### Application

- An MEC sited at either WHH or K&C would be on route to the MTC at King's Hospital London in accordance with the view of the South East Trauma Network. The travel time from the MEC to the MTC at King's Hospital London
- The application of this hurdle criteria would require further analysis to understand the distribution of travel times across the East Kent Geography in relation to the MTC and the proposed MEC site relative to residents' homes.
- Given the time and resource constraints, it is not feasible complete this analysis within the available timeframes.

### Assumptions

- The location of the EC/MedEC does not impact the scoring as the sub-criteria is only related to the site of the Trauma Unit (i.e. MEC).

### Results

- As per the view of the South East Trauma Network, all options are deemed to be on route to the MTC.
- This criteria does not provide any distinction between options thus all options have been ranked equally.

Site	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
<b>On route to the MTC</b>	Yes	Yes	Yes	Yes
RANK	1	1	1	1

Best ranked option will receive 1 point

## Sub-criteria 2.3 – Trauma centre access within 45 minutes

### Description

- **Sub-criteria:** the proportion of residents with **45min** access to a trauma unit is maintained or improved relative to the current site designation (i.e. trauma Unit at WHH)

### Application

- All options qualified to this stage maintained or improved current levels of access to a trauma centre. Therefore all options will be ranked in terms of:
  - Proportion of East Kent residents within 45 minute drive time to the trauma centre
  - The maximum drive time experienced by East Kent residents requiring a trauma centre

### Assumptions

- The location of the EC/MedEC does not impact the scoring as the sub-criteria is only related to the site of the trauma unit (i.e. MEC).
- Off-peak travel time by car is used to compare sites. This is the SECamb accepted proxy for ambulance travel time.

### Results

- Options 1 and 2 provide a greater proportion of East Kent residents access to a trauma unit within 45 minutes (99% versus 75%)
- Options 1 and 2 provide the fastest access to a trauma unit with maximum travel time at 48 minutes versus 60 minutes for options 3 and 4
- Options 1 and 2 are the best ranked options against this criteria

Site	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
<b>% residents within 45 minutes drive</b>	99%	99%	75%	75%
<b>Maximum travel time</b>	48 min	48 min	60 Min	60 Min
<b>RANK</b>	1	1	2	2

Best ranked option will receive 1 point

## Sub-criteria 2.4 – Cardiac (pPCI) access within 90 mins

### Description

- All Kent and Medway patients can reach pPCI centre within 90 minutes

### Application

- All options qualified to this stage provided the population an emergency centre within 90 minutes. The following 2 metrics are used to rank the options:
  - Maximum travel time that would be experienced by Kent and Medway residents
  - Outflow: the population for whom their closest centre for pPCI is not EKHFT

### Assumptions

- The location of the EC/MedEC does not impact the scoring as the sub-criteria is only related to the pPCI centre (i.e. the MEC).
- Off-peak travel time by car is used to compare sites. This is the SECamb accepted proxy for ambulance travel time.
- The population considered is all residents of Kent and Medway
- Patients are assumed to “outflow” to other centres offering pPCI (i.e. Brighton and Basildon and Thurrock hospitals) if those sites are closer than EKHFT

### Results

- Options 3 and 4 provide marginally faster access to a pPCI (60 minutes vs 64 minutes).
- Options 3 and 4 result in significantly fewer Kent and Medway patients accessing pPCI at other centres
- Option 3 and 4 rank the best on this sub-criteria

Site	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
<b>Maximum travel time</b>	64 min	64 min	60 min	60 min
<b>Outflow</b>	<b>615,542</b>	<b>615,542</b>	<b>452, 668</b>	<b>452, 668</b>
<b>RANK</b>	2	2	1	1

Best ranked option will receive 1 point

## Sub-criteria 2.5 – Stroke unit access within 60 minutes

## Sub-criteria 2.6 – Vascular unit access within 60 minutes

### Description

- 95% of the East Kent population can access a stroke unit within 60 minutes (to enable call to needle time within 120 minutes)
- 95% of the East Kent population can access vascular services within 60 minutes

### Application

- All options qualified to this stage provided the population access to a stroke unit and a vascular unit within 60 minutes.
- Specialist stroke and vascular units would be co-located with the MEC and thus travel times to the MEC are reviewed for both sites.

### Assumptions

- Travel times are based on off-peak travel times by car (which are considered a proxy for blue light (ambulance travel time)).
- It is assumed that the shorter the time to access a emergency centre the better outcomes.

### Results

- Options 1 and 2 provide the fastest access to specialist stroke and vascular units with maximum travel time at 48 minutes, and therefore rank the best.
- Options 3 and 4 provide slower access to specialist stroke and vascular units with maximum travel time at 60 minutes.

Site	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
% patients within 60 minutes	100%	100	100%	100%
Maximum travel time to MEC (minutes)	48	48	60	60
RANK	1	1	2	2

Best ranked option will receive 1 point

# Sub-criteria 3.1 – Financially sustainable?

## Description

- **Sub-criteria:** Will the option generate a cost of capital for the acute provider that is no more than £25m per annum?

## Application

- The options will be ranked according to the annual cost of capital with the option with lowest cost of capital being ranked highest

## Assumptions

- Capital costs and the revenue costs of capital have been calculated at a high-level, taking into consideration building and equipment costs (informed by OB1 forms provided by the Quantity Surveyor), and depreciation and Public Dividend Capital (PDC) costs, respectively.
- Depreciation – assumed useful economic life (UEL) of new build is 40 years, and equipment is 10 year (straight line method). This has excluded capital replacement costs as this would form part of the Trust’s annual capital programme.
- PDC – 3.5% PA payable on depreciated asset value over its UEL. Highest cost year has been calculated, as this will reduce in subsequent years as the assets depreciate.
- Capital funding – no additional interest cost assumed for capital expenditure outlay – repayable only through PDC.

## Results

- Option 4 has the lowest cost of capital and is ranked the best
- Option 1 is the next best followed by options 3 and 2 which fall outside of the £25m cost of capital ceiling.

Site	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
Capital Cost	£352m	£431m	£398m	£224m
Cost of Capital	£22.6m	£27.6m	£25.7m	£14.7m
RANK	2	4	3	1

All figures have been provided by EKHUFT

Best ranked option will receive 1 point



# Sub-criteria 4.1 – Implementable?

## Description

- **Sub-criteria:** Will the option be implemented within a reasonable timescale i.e. no more than 12 years from completion of the public consultation?

## Application

- All options have been qualified as being deliverable within the 12 year timeframe. The options will be ranked according to expected timeframe for delivery where the option with quickest delivery timescale will be ranked highest.

## Assumptions

- The high-level programmes to implement the options that have been provided by the Trust provide a realistic assessment of the timeframes required

## Results

- Option 4 has an estimated delivery time of 3.5 years, while options 1,2, and 3 have an estimated delivery time of just over 4 years.
- Given the high-level estimates that have been provided, and the close proximity between these, this criteria does not provide sufficient distinction between the options, thus all options have been ranked equally.

Site	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
Implementation timescale	4.08 years	4.08 years	4.08 years	3.5 years
RANK	1	1	1	1

Best ranked option will receive 1 point

## **Stage 2 Outcome Summary**

# Results: Option 4 was the best ranked “two UEC site” configuration

The results of the second stage hurdle criteria are outlined in the table below:

- Option 4 was the best ranking two site option.
- Option 4 will be qualified to the third and final stage of the appraisal process and undergo a full evaluation alongside option 8.
- Options 1, 2, and 3 will not be progressed or evaluated further as a two site option with greater potential already exists.

Criteria	Sub-criteria	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
1. Is the configuration clinically sustainable? (Rank 1 = Highest, 4 = Lowest)	1.1 Workforce available	1	1	1	1
	1.2 Clinical Throughput	3	4	1	2
2. Is the potential configuration option accessible? (Rank 1 = Highest, 4 = Lowest)	2.1 Urgent Care	3	2	3	1
	2.2 Trauma (on-route to MTC)	1	1	1	1
	2.3 Trauma (45 min)	1	1	2	2
	2.4 Cardiac (90 min)	2	2	1	1
	2.5 Stroke (60 min)	1	1	2	2
	2.6 Vascular (60 min)	1	1	2	2
3. Is the potential configuration option financially sustainable? (Rank 1 = Highest, 4 = Lowest)	3.1 Lowest cost to implement	2	4	3	1
4. Is configuration implementable? (Rank 1 = Highest, 4 = Lowest)	4.1 Time to implement	1	1	1	1
<b>The sum of ranking positions</b>		16	18	17	14

- Option 4 is the best ranking two site option, followed by option 1, option 3 and option 2 as the worst ranked option.

# Sensitivity analysis: applying the ranking criteria with equal weighting

- As per the “approach to ranking” slide (76), each sub-criteria has been attributed an equal weighting in completing the stage 2 evaluation.
- An alternative weighting strategy could be to apply an equal weighting to each criteria as opposed to sub-criteria. This would mean providing an average ranking based on the number of sub-criteria used in each criteria.
- The table below displays the overall ranking if this approach was taken. As shown, the ranking order remains consistent to previous slide with option 4 as the best ranked, followed by option 1, option 3 and option 2 as the worst ranked option.

Criteria	Sub-criteria	Option 1 K&C (MEC) WHH (EC/MEDEC) QEQM (ICH/UCC)	Option 2 K&C (MEC) WHH (ICH/UCC) QEQM (EC/MEDEC)	Option 3 K&C (EC/MEDEC) WHH (MEC) QEQM (ICH/UCC)	Option 4 K&C (ICH/UCC) WHH (MEC) QEQM (EC/MEDEC)
1. Is the configuration clinically sustainable? (Rank 1 = Highest, 4 = Lowest)	1.1 Workforce available	1	1	1	1
	1.2 Clinical Throughput	3	4	1	2
<b>Clinical sustainability sub-total</b>		<b>2</b>	<b>2.5</b>	<b>1</b>	<b>1.5</b>
2. Is the potential configuration option accessible? (Rank 1 = Highest, 4 = Lowest)	2.1 Urgent Care	3	2	3	1
	2.2 Trauma (on-route to MTC)	1	1	1	1
	2.3 Trauma (45 min)	1	1	2	2
	2.4 Cardiac (90 min)	2	2	1	1
	2.5 Stroke (60 min)	1	1	2	2
	2.6 Vascular (60 min)	1	1	2	2
<b>Accessible sub-total</b>		<b>1.5</b>	<b>1.3</b>	<b>1.8</b>	<b>1.5</b>
3. Is the potential configuration option financially sustainable? (Rank 1 = Highest, 4 = Lowest)	3.1 Lowest cost to implement	2	4	3	1
4. Is configuration implementable? (Rank 1 = Highest, 4 = Lowest)	4.1 Time to implement	1	1	1	1
<b>The sum of ranking positions</b>		<b>6.5</b>	<b>8.8</b>	<b>6.8</b>	<b>5.0</b>

# Recommendations to the JCCCG

# Recommendations to the JCCCG (1)

## Recommendations for the Joint Committee on Stage 1 of the evaluation criteria

- The key decisions taken in completing the application of the hurdle criteria to the longlist of UEC configuration options have been outlined in the table below along with their corresponding impact. The Joint Committee is asked to review and agree these:

Items for agreement by the Joint Committee	Impact of the decision
<ul style="list-style-type: none"> <li>Re-ordering of the hurdle criteria to reflect patient and public feedback on their priorities for health services, and respond to the previous steer from Joint Committee on timeframes for implementing the options</li> </ul>	<ul style="list-style-type: none"> <li>The order of the hurdle criteria is clinical sustainability, accessibility, financial sustainability, implementable and strategic fit</li> </ul>
<ul style="list-style-type: none"> <li>Not applying the strategic fit criteria at the hurdle criteria stage as it does not provide a clear threshold for acceptance or rejection</li> </ul>	<ul style="list-style-type: none"> <li>Only four the criteria are used at the hurdle stage (stage 1)</li> </ul>
<ul style="list-style-type: none"> <li>Changing the wording of the hurdle criteria taking into the changes in circumstances for the East Kent system</li> </ul>	<ul style="list-style-type: none"> <li>An increase in the number of options that passed the stage 1 hurdle criteria evaluation</li> </ul>
<ul style="list-style-type: none"> <li>Utilising option 13 (close K&amp;C) as a proxy for all 6 “close a site” options (11 to 16) as this represents the lowest net cost option across all close a site options</li> </ul>	<ul style="list-style-type: none"> <li>If option 13 passes or fails the hurdle criteria, then that result will also apply to Options 11, 12, 14, 15, 16.</li> </ul>
<ul style="list-style-type: none"> <li>Approach to applying the clinical sustainability hurdle criteria</li> </ul>	<ul style="list-style-type: none"> <li>Option 17 is excluded</li> </ul>
<ul style="list-style-type: none"> <li>Approach to applying the accessibility hurdle criteria</li> </ul>	<ul style="list-style-type: none"> <li>Options 5, 6 and 10 were excluded</li> </ul>
<ul style="list-style-type: none"> <li>Approach to applying the financial sustainability hurdle criteria</li> </ul>	<ul style="list-style-type: none"> <li>Options 7, 9, 10, 11, 12, 13, 14, 15, 16 and 17 were excluded</li> </ul>
<ul style="list-style-type: none"> <li>Approach to applying the implementable hurdle criteria</li> </ul>	<ul style="list-style-type: none"> <li>No impact of remaining options</li> </ul>
<ul style="list-style-type: none"> <li>Options <b>1, 2, 3, 4, and 8</b> qualify through to the second stage evaluation</li> </ul>	<ul style="list-style-type: none"> <li>The other 11 options are excluded at this stage</li> </ul>

- In addition to the above, it is recommended that the Joint Committee commission an independent review of the capital cost valuation and underpinning assumptions of option 9 (single UEC site at WHH). This is to better understand the rationale behind the cost differential between option 9 and option 8 (single UEC site at K&C)

# Recommendations to the JCCCG (2)

## Recommendations for the Joint Committee on Stage 2 of the evaluation criteria

- The key decisions taken in completing the application of the ranking criteria to the medium list configuration options have been outlined in the table below along with their corresponding impact. The Joint Committee is asked to review and agree these:

Items for agreement by the Joint Committee	Impact of the decision
<ul style="list-style-type: none"> <li>• Rationale for conducting a second stage evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• The four “two UEC sites” options are reduced to a more manageable number for the stage 3 detailed evaluation</li> </ul>
<ul style="list-style-type: none"> <li>• Approach to ranking the options i.e. the question being asked in determining the rank of the options, and the weighting attributed to each sub-criteria</li> </ul>	<ul style="list-style-type: none"> <li>• The approach to ranking and weighting drive the outcome of second stage evaluation</li> </ul>
<ul style="list-style-type: none"> <li>• Approach to applying the clinical sustainability ranking criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Option 3 is the best ranked at this criteria</li> </ul>
<ul style="list-style-type: none"> <li>• Approach to applying the accessibility ranking criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Option 2 is the best ranked at this criteria</li> </ul>
<ul style="list-style-type: none"> <li>• Approach to applying the financial sustainability ranking criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Option 4 is the best ranked at this criteria</li> </ul>
<ul style="list-style-type: none"> <li>• Approach to applying the implementable ranking criteria</li> </ul>	<ul style="list-style-type: none"> <li>• All options are ranked equally at this criteria</li> </ul>
<ul style="list-style-type: none"> <li>• The “two UEC sites” options that qualify through to stage 3</li> </ul>	<ul style="list-style-type: none"> <li>• The other “two UEC sites” options are excluded at this stage</li> </ul>

# Appendices



# Working Group Membership

Name	Role	Organisation
Anne Neal	Assistant Director of Strategic Development/Capital Planning	East Kent Hospitals University NHS Foundation Trust
Darren Cocker	Clinical Lead – Local Care	South Kent Coast Clinical Commissioning Group
Elizabeth Shutler	Director of Strategic Development/Capital Planning	East Kent Hospitals University NHS Foundation Trust
Keith Bourn	Assistant Director of Strategic Estates	East Kent Hospitals University NHS Foundation Trust
Kevin Tupper	Head of Finance	South Kent Coast Clinical Commissioning Group
Louise Dineley	East Kent Programme Director	East Kent CCGs
Mark Jones	General Practitioner	Canterbury & Coastal Clinical Commissioning Group
Matt Jones	Consultant Anaesthetist	East Kent Hospitals University NHS Foundation Trust
Melanie Hill	Head of Financial Planning	East Kent Hospitals University NHS Foundation Trust
Michael Ridgwell (Chair)	STP Programme Director	Kent and Medway STP
Nick Dawe	Chief Finance Officer	Canterbury & Coastal Clinical Commissioning Group
Oena Windibank	Local Care Director	Thanet Clinical Commissioning Group
Ray Savage	Business Manager	South East Coast Ambulance Service
Upaasna Garbharran	Consultant Geriatrician	East Kent Hospitals University NHS Foundation Trust

# Working Group meeting summaries (1)

## Meeting 1: Thursday 28<sup>th</sup> June 2018

### Key decisions & discussions:

- Agreement to use option 13 as a proxy for all close a site options
- Group requested that the three emergency sites option is re-introduced and the clinical sustainability hurdle criteria re-applied
- Group requested that travel time data was reviewed to determine if blue light travel times or a proxy for this was used
- Agreement to expand the accessible criteria to include stroke and maternity services in addition to trauma and primary PCI
- Group requested that a letter of advice was sought from the SELKaM Trauma Network on designation of trauma units across East Kent
- Agreement to change implementable criteria to a period of 7 years instead of a fixed date to allow for greater flexibility
- Agreement to change the financial sustainability criteria to include the Trust and Commissioner affordability
- Agreement to maintain strategic fit as category of hurdle criteria and explore alternative hurdle to be applied within this in the interim

## Meeting 2: Thursday 05<sup>th</sup> July 2018

### Key decisions & discussions:

- Group noted that whilst current clinical sustainability threshold does not discount a “two site” model; there are significant challenges that would need to be considered in the full evaluation stage
- Group requested confirmation based on clinical sustainability that an MEC in East Kent was clinically viable
- Group removed access to maternity services as a hurdle criteria as no agreed access thresholds existed. However full evaluation would need to consider impact on maternity services in relation to agreed outcomes of 2013 consultation
- Agreement to incorporate drive time standards for vascular as a sub-criteria within accessibility hurdle
- Agreement that while no hurdle criteria would be applied within the strategic fit category at this stage, it would be taken forward and applied in subsequent stages
- Financial affordability limited to provider affordability for the hurdle criteria stage. System affordability will be an important factor in full evaluation stage.
- Noted that full evaluation should consider impact on capital works backlog
- Agreement to undertake a second stage evaluation to differentiate between options if multiple permutations of the same delivery model are qualified through the appraisal process.

## Working Group meeting summaries (2)

### Meeting 3: Thursday 19<sup>th</sup> July 2018

#### Key decisions & discussions:

- Noting of the feedback provided by the System Board and Joint Committee on the stage 1 evaluation (hurdle criteria) and amendments made to the document to reflect this
- Agreement on the approach to the ranking criteria including the approach to weighting the sub-criteria equally
- Request to include the sensitivity analysis of using an alternative weighting approach i.e. weighting the criteria equally as opposed to the sub-criteria
- Agreement on the wording of the ranking sub-criteria following a couple of amendments to specify the residents being considered (i.e. East Kent or Kent and Medway) and the emergency centre being reviewed (i.e. MEC, EC/MedEC, ICH/UCC)
- Agreement on application of the ranking criteria
- Agreement that the best ranked option should be taken forward to the stage 3 evaluation (full evaluation)