

<b>Sustainable Health Care in East Kent Joint Committee of NHS Clinical Commissioning Groups</b>		<b>Agenda Item:</b>		<b>019/19</b>	
<b>Date of Meeting:</b>	28 February 2019				
<b>Title of Report:</b>	Evaluation Process and Timeline				
<b>Author:</b>	Lorraine Goodsell				
<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 process. During stage 1 (application of hurdle criteria) and stage 2 (ranking criteria) of the evaluation process, a longlist of reconfiguration options have been evaluated to identify a medium (shortlist) of options. Stage 3 of the evaluation process (full and detailed evaluation) has now commenced. The preferred option will be consulted on with the patients and public of East Kent.</p> <p>Key components of the detailed evaluation, which will be overseen by an Evaluation Working Group, include:</p> <ul style="list-style-type: none"> <li>• Undertaking the analysis and compiling the evidence base for each of the five criteria (Clinical Sustainability, Accessibility, Implementable, Strategic Fit and Financial Sustainability)</li> <li>• From the analysis and evidence base - compiling an evaluation report for the medium list of options</li> <li>• Using the evaluation report to score each of the medium list of options. Scoring will be undertaken by members of an Evaluation Panel - which is scheduled for July 2019</li> </ul>					
<b>Recommendation:</b>					
<p>The Joint Committee is asked to:</p> <ol style="list-style-type: none"> <li>Review and comment on the evaluation process and timeline</li> <li>Approve the criteria that are part of stage 3 of the evaluation process (full and detailed evaluation) e.g. Clinical Sustainability, Accessibility, Implementable, Strategic Fit and Financial sustainability</li> <li>Review and comment on the sub criteria and the questions that make up the sub-criteria</li> </ol>					

**Governance**

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

# East Kent Transformation Programme

## Update on Evaluation Process and Timeline

Sustainable Health Care in East Kent Joint Committee

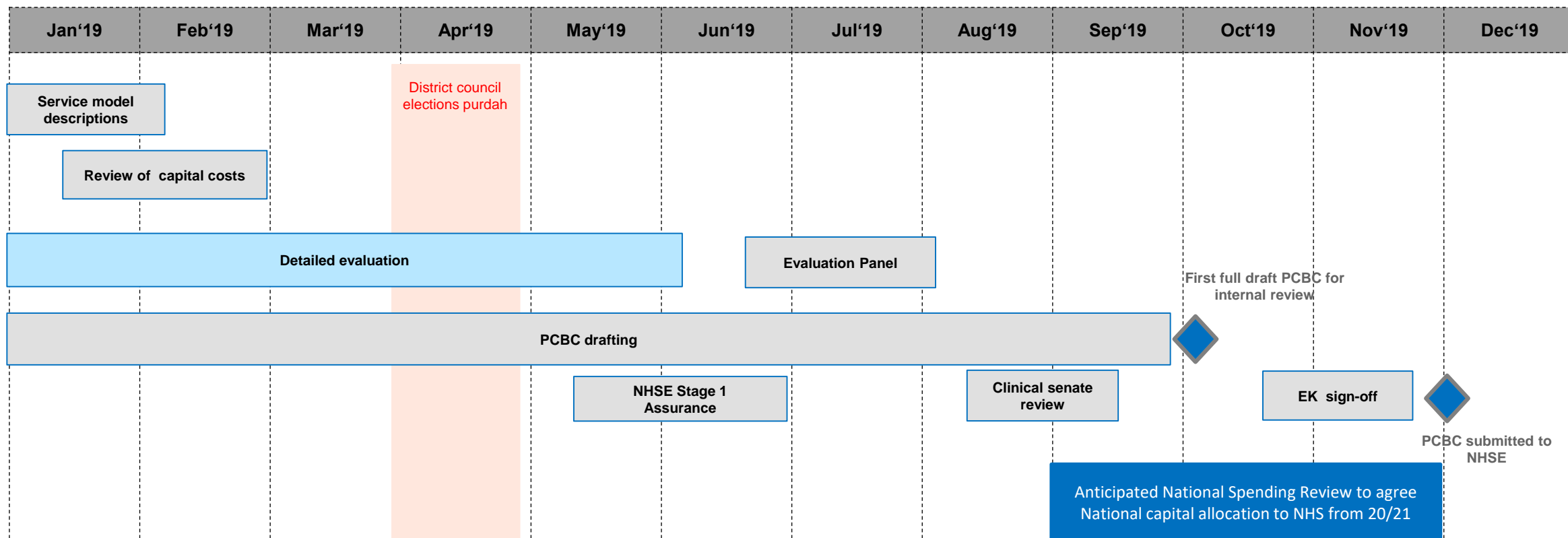
28 February 2019

Agenda item 019/19

# Evaluation Timeline

# High level programme plan and evaluation timeline

- Following detailed evaluation the timeline sees submission of the pre-consultation business case (PCBC) to NHS England in autumn 2019, noting the following items will impact on the date of consultation:
- After submission of the PCBC NHS England will undertake its stage 2 assurance process in line with their updated policy published in March 2018, “Planning, assuring and delivering service change for patients”, the duration of this will not be clear until submission
- NHS England have been clear that consultation cannot proceed until a source of capital for all shortlisted option(s) has been identified and it is anticipated that the next national spending review would be in the autumn of 2019.

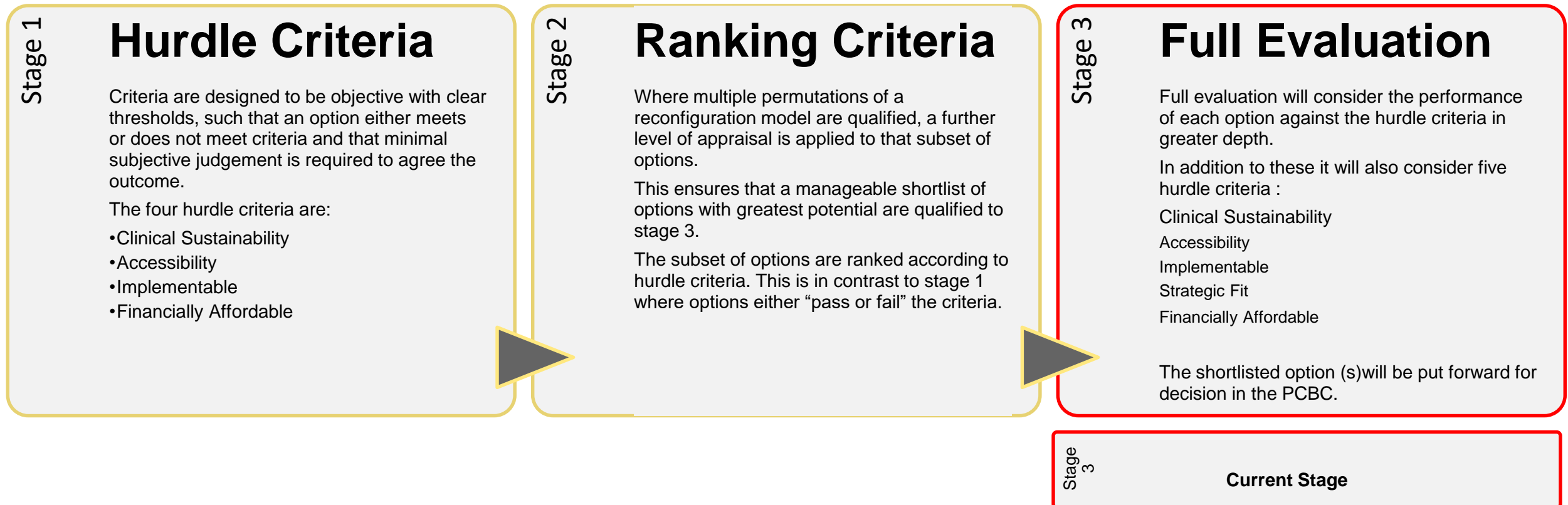


# Evaluation Overview

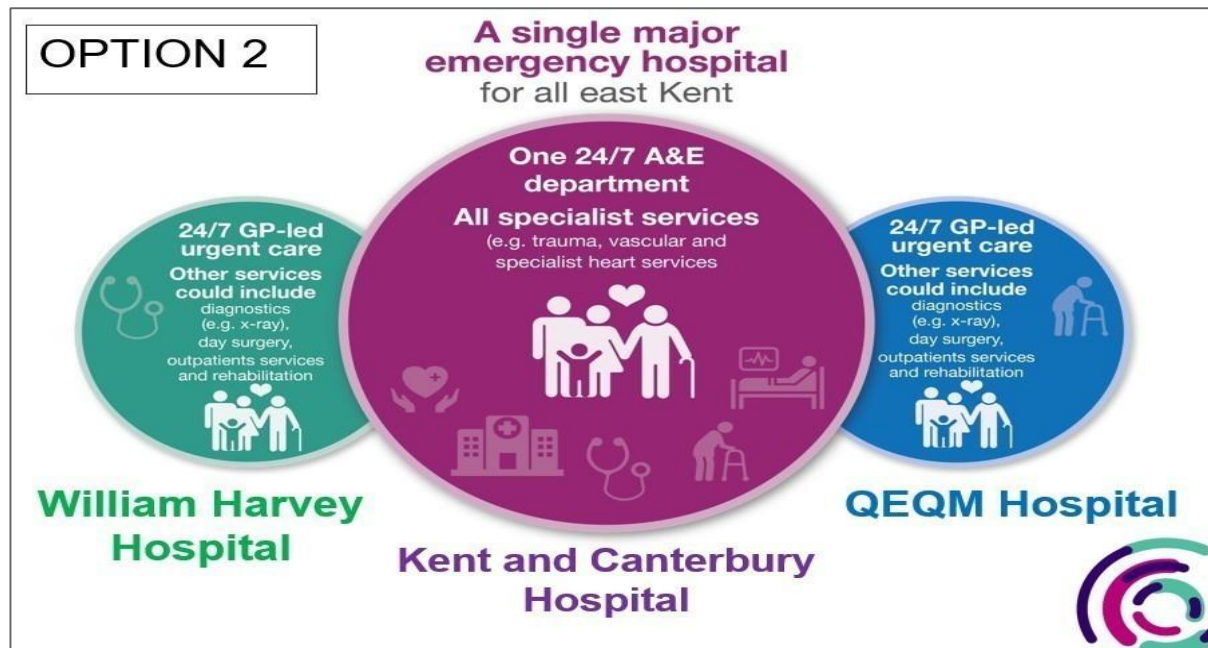
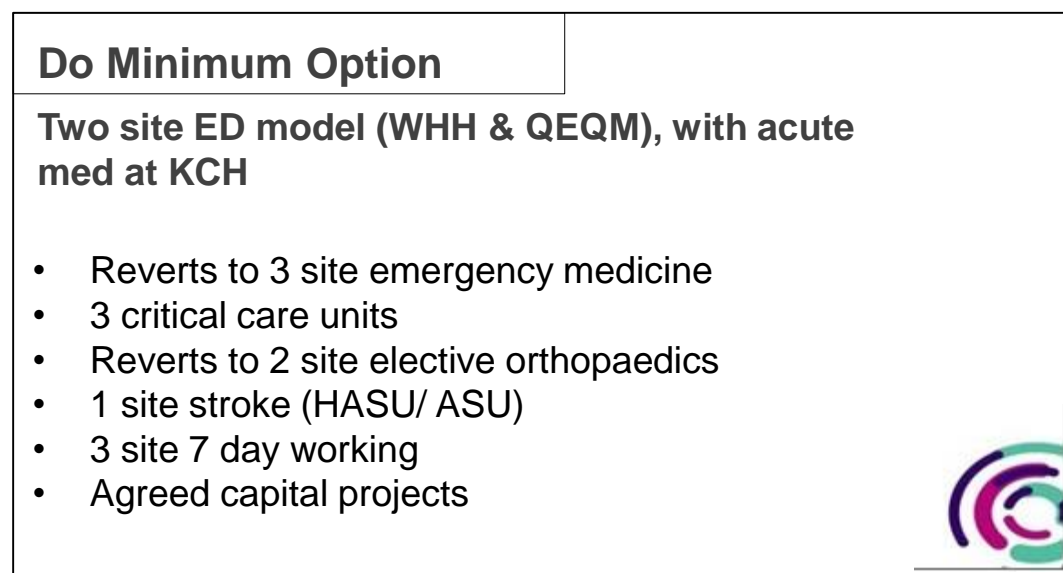
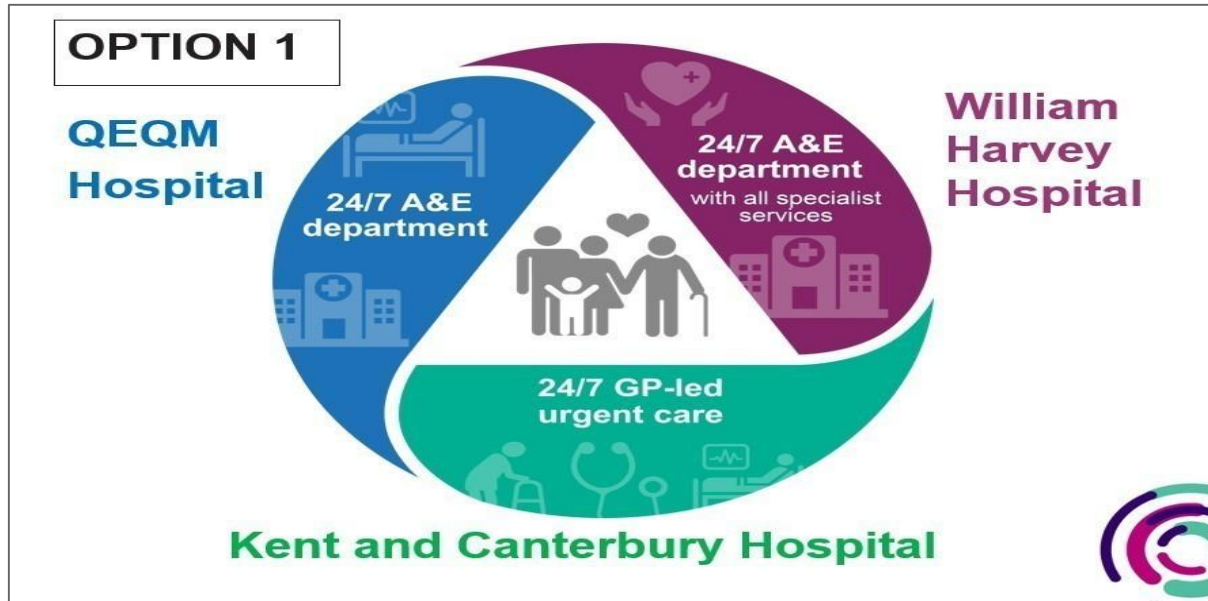
# Evaluation overview

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



# Overview of medium list of options





# Re- application of the hurdle criteria – medium list of options

# Re-application of the hurdle criteria

#	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> <li>Will capital be available for the option ?*</li> </ul>

- The hurdle criteria that were used in stage 1 of the evaluation process will be re -applied during the final detailed evaluation (stage 3)
- Using the latest available information - any of the medium list of options (including the do - minimum option) that does not pass the hurdle criteria will be removed from the options evaluation process
- An additional hurdle criteria for the final detailed evaluation stage has been included – ‘Will capital be available for the option’

# Evaluation Criteria

## The Detailed Evaluation process (final stage) is where each option is scored across five criteria

This evaluation is focused across five criteria, each with a number of sub-criterion (outlined below), which contain a set of specific evaluation questions to compare each option against the do minimum scenario;

1. Is the potential configuration option <b>clinically sustainable?</b>	2. Is the potential configuration option <b>accessible?</b>	3. Is the potential configuration option <b>implementable?</b>	4. Is the potential configuration option a <b>strategic fit?</b>	5. Is the potential configuration option <b>financially sustainable?</b>
1.1) Quality: workforce 1.2) Quality: effectiveness & safety 1.3) Quality: patient experience	2.1) Acute services 2.2) Local access	3.1) Time to implement 3.2) Delivery risks 3.3) Transition period	4.1) Long-term sustainability 4.2) Impact on neighbouring systems 4.3) Research, innovation & education	5.1) System affordability 5.2) Net present value 5.3) Income & expenditure performance

# The evaluation criteria that we propose to use in evaluating the medium list options (1)

Criterion	Sub-criteria	Evaluation questions
1. Is the configuration clinically sustainable and are able to deliver required quality standards?	1.1) Quality: workforce	In comparison with the 'do minimum' scenario, to what extent do the options: a) Allow each organisation to operate working patterns that are safe and compliant with regulatory standards? b) Impact on delivering a sustainable workforce, with the necessary clinical skills? c) Impact on -staff attrition across the system?
	1.2) Quality: effectiveness and safety	In comparison with the 'do minimum' scenario, to what extent do the options: a) Allow services to be configured in alignment with the Clinical Senate's recommended co-dependencies? b) Improve overall compliance with constitutional standards? c) Improve adherence to NHS policy (e.g. seven-day working and FYFV) and Royal College standards of care and conveyance standards? d) Deliver hospital sites that best meet the quality standards for safe buildings? e) Allow sufficient patient throughput to maintain clinicians skills, sustain services and optimise outcomes?
	1.4) Quality: patient experience	In comparison with the 'do minimum' scenario, to what extent do the options: a) Provide a better experience for patients as determined by nationally recognised and validated tools (i.e. Patient Reported Outcome Measures)?

## The revaluation criteria that we propose to use in evaluating the medium list options (2)

Criterion	Sub-criteria	Evaluation questions
<b>2. Is the potential configuration option accessible?</b>	<b>2.1) Acute Services</b>	<p>In comparison with the 'do minimum' scenario, to what extent do the options:</p> <ul style="list-style-type: none"> <li>• Enable the shortest acceptable travel times by service users of East Kent to get to hospital by ambulance, car (at off-peak and peak times and public transport) for the following services, in line with national or locally agreed standards:               <ol style="list-style-type: none"> <li>a) 60 min access to UEC services</li> <li>b) 60 min access to a trauma unit for stabilisation relative to the previous site designation (i.e. trauma Unit at WHH)</li> <li>c) patients can reach pPCI centre within 90 minutes</li> <li>d) 95% of East Kent patients can access a stroke unit within 60 minutes (to enable call to needle time within 120 minutes)</li> <li>e) 95% of the East Kent population can access vascular services within 60 minutes</li> </ol> </li> </ul>
	<b>2.2) Local access</b>	<p>In comparison with the 'do minimum' scenario, to what extent do the options:</p> <ol style="list-style-type: none"> <li>a) Allow the greatest majority of health and care that adheres to quality standards, to be delivered closer to home?</li> </ol>
<b>3. Is the potential configuration option implementable?</b>	<b>3.1) Time to implement</b>	Which option can be successfully delivered in the shortest times scale?
	<b>3.2) Delivery risks</b>	<p>In comparison with the 'do minimum' scenario, to what extent do the options present any risks of delays or failure to deliver owing to:</p> <ol style="list-style-type: none"> <li>a) Council planning or resource consent requirements?</li> <li>b) Number of delivery partners?</li> <li>c) Operational complexity and decant arrangements?</li> <li>d) Decisions regarding the Section 106 Agreement or Community Infrastructure Levy?</li> </ol>
	<b>3.3) Transition period</b>	<p>In comparison with the 'do minimum' scenario, to what extent do the options:</p> <ol style="list-style-type: none"> <li>a) Maximise value from investments made during the transition period to support the sustainability of vulnerable services (minimises sunk costs)?</li> <li>b) Enable the capital investment required to be phased over the transition period?</li> </ol>

## The evaluation criteria that we propose to use in evaluating the medium list options (3)

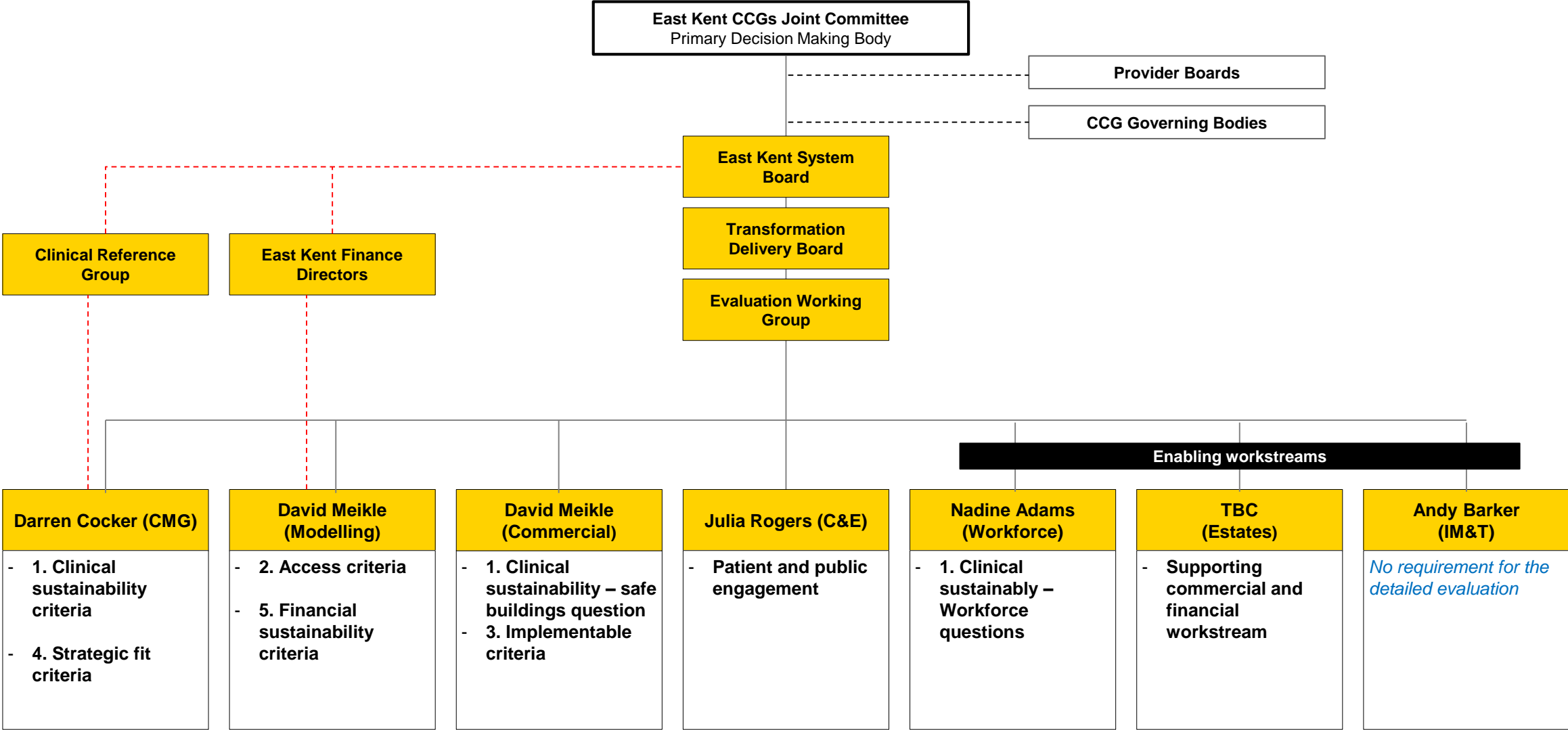
Criterion	Sub-criteria	Evaluation questions
4. Does the potential configuration option align strategically?	4.1) long-term sustainability	In comparison with the 'do minimum' scenario, to what extent do the options: a) Enable longer-term sustainability for the system (e.g. to avoid the need to reconfigure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

# Evaluation Governance



# Delivery of the detailed evaluation work programme will be overseen by the Evaluation Working Group and delivered by the Programme workstreams

Each workstream will have the opportunity to invite guests with relevant expertise and experience to support with the completion of the detailed evaluation.



# Key progress and next steps

# Detailed Evaluation - Key Progress

1. Agreed detailed evaluation criteria
2. Progressing analysis and evidence collection for each criteria
3. Initial drafting of future workforce requirements and clinical standards
4. Continued clinical engagement – e.g. EKHUFT strategy away day
5. Evaluation outputs are now being progress through programme governance  
(e.g. accessibility criteria and clinical sustainability criteria)

# Detailed Evaluation - Key Next Steps

Key milestones within detailed evaluation process;

1. Agree weighting & scoring approach end of March 2019
2. Complete analysis and evidence base for Evaluation Report May 2019
3. Clinical & Public Engagement events June 2019
4. Evaluation Report signed off through Programme Governance June 2019
5. Evaluation Panel July 2019
6. Evaluation outcome sign off by East Kent Joint Committee August 2019

# Evaluation weighting and scoring

Scoring Mechanism	
Numerical scale developed to assess the relative performance of each option against the do minimum (-3 to +3):	
-3	The option performs significantly worse than the do minimum and there is substantial evidence against the option
-2	The option performs poorly compared to the do minimum and there is some evidence against the option
-1	The option performs slightly worse than the do minimum but the case is weak and lacks substantial evidence
0	The option is comparable to the do minimum or there is no evidence to support an alternative option
+1	The option performs slightly better than the do minimum but the case is weak and lacks significant evidence
+2	The option performs well against the do minimum and there is some evidence in support of the option
+3	The option performs significantly better than the do minimum and there is substantial evidence in support of the option

- The proposed approach to weighting is equal weighting for each criteria
- The proposed approach for scoring is to use numerical scoring (including minus numbers)
- The weighting and scoring approach were further tested at Kent and Medway Patient and Public Advisory Group on 20<sup>th</sup> February

# Evaluation Process and Timeline – Appendix

28<sup>th</sup> February 2019

# Option Overview

# The list of sub-options totals four – three under UEC2 and a single option for UEC1

- Across UEC1 and UEC2 there is a total long list of four sub-options when you consider all elements of reconfiguration;
  - UEC1 remains a single permutation, fully encompassing the elective surgery options
  - UEC2 currently has three permutations when you overlay the elective surgery and preferred Midwife-led Birthing Unit option. The detail of this is outlined in the next sections of this pack.

## Sub-options overview:

- The 4 options have been broken down to show, across the 3 hospital sites, what the all encompassing options will include;

	UEC1	UEC2		
	Perm1	Perm2	Perm3	Perm4
K&CH	Integrated Care Hospital & Elective Surgery	Major Emergency Centre & Integrated Care Hospital	Major Emergency Centre & Integrated Care Hospital	Major Emergency Centre & Integrated Care Hospital
WHH	Major Emergency Centre & Integrated Care Hospital	Integrated Care Hospital & Elective Surgery	Integrated Care Hospital	Integrated Care Hospital & Elective Surgery
QEQM	Emergency Centre & Integrated Care Hospital	Integrated Care Hospital & Standalone Midwifery Led Unit	Integrated Care Hospital & Elective Surgery & Standalone Midwifery Led Unit	Integrated Care Hospital & Elective Surgery & Standalone Midwifery Led Unit



# Do Minimum: Two site ED model (WHH & QEQM), with acute med at KCH

**Do Minimum has the following key acute changes:**

- Reverts to 3 site emergency medicine
- 3 critical care units
- Reverts to 2 site elective orthopaedics
- 1 site stroke (HASU/ ASU)
- 3 site 7 day working
- Agreed capital projects

High level service description by site;

William Harvey Hospital	Kent & Canterbury Hospital	Queen Elizabeth Queen Mary Hospital
<p><b>Urgent Care:</b> ED, assessment areas and co-located UTC and Frailty Unit</p> <p><b>Surgery:</b> Planned and unplanned surgical specialties (except vascular and urology) and critical care,</p> <p><b>Acute Med:</b> Acute inpatient services for all medical specialties,</p> <p><b>Women's Services:</b> Obstetric Led unit, co-located MLU, gynae inpatient services</p> <p><b>Paediatrics:</b> Acute inpatient services, POSCU, NICU and paediatric surgery &amp; day cases</p> <p><b>Planned Ambulatory Care:</b> Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</p>	<p><b>Urgent Care:</b> UTC, Assessment inc. Frailty Unit, Diagnostics</p> <p><b>Surgery:</b> Critical care, Vascular and urology surgical specialties</p> <p><b>Acute Med:</b> Acute inpatient services for all medical specialties (except stroke)*</p> <p><b>Paediatrics:</b> Paediatrics day case surgery (excluding some specialties which are WHH only)</p> <p><b>Planned Ambulatory Care:</b> Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy, inpatient renal, inpatient clinical haematology services and radiotherapy</p>	<p><b>Urgent Care:</b> ED, assessment areas and co-located UTC and frailty unit</p> <p><b>Surgery:</b> Planned and unplanned surgical specialties (except vascular and urology) and critical care,</p> <p><b>Acute Med:</b> Acute inpatient services for all medical specialties (except stroke),</p> <p><b>Women's Services:</b> Obstetric Led unit, co-located MLU, gynae inpatient services including oncology</p> <p><b>Paediatrics:</b> Acute inpatient services, SCBU and paediatrics surgery &amp; day case (excluding some specialities which are WHH only)</p> <p><b>Planned Ambulatory Care:</b> Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</p>

How is this different compared to **current** service delivery?

WHH	
Services currently delivered on this site that no longer will be:	Services that will be delivered on this site that currently aren't:
	<ul style="list-style-type: none"> <li>- Urgent Treatment Centre</li> <li>- Hyper Acute Stroke</li> </ul>

KCH	
Services currently delivered on this site that no longer will be:	Services that will be delivered on this site that currently aren't:
<ul style="list-style-type: none"> <li>- Acute stroke*</li> </ul>	<ul style="list-style-type: none"> <li>- Urgent Treatment Centre</li> </ul>

QEQM	
Services currently delivered on this site that no longer will be:	Services that will be delivered on this site that currently aren't:
<ul style="list-style-type: none"> <li>- Acute Stroke</li> </ul>	<ul style="list-style-type: none"> <li>- Urgent Treatment Centre</li> </ul>

\* Stroke admissions and acute medicine and were temporarily removed from KCH in April 2017 and June 2017 respectively.

# Option 1: Two site ED model with WHH as the MEC

## Option 1 has the following key acute changes:

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

High level service description by site;

MEC: William Harvey Hospital	ICH: Kent & Canterbury Hospital	EC: Queen Elizabeth Queen Mary Hospital
<p><b>Urgent Care:</b> ED inc. Level 2 Trauma, assessment areas and co-located UTC and Frailty Unit</p> <p><b>Surgery:</b> Acute inpatient surgery for all surgical specialties and critical care,</p> <p><b>Acute Med:</b> Acute inpatient services for all medical specialties,</p> <p><b>Women's Services:</b> Obstetric Led unit, co-located MLU, gynae inpatient services including gynae-oncology</p> <p><b>Paediatrics:</b> Acute inpatient services, POSCU, NICU and paediatric surgery &amp; day cases</p> <p><b>Planned Ambulatory Care:</b> Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</p> <p><b>Specialist services:</b> centre for specialist services in east Kent</p>	<p><b>Urgent Care:</b> UTC, Assessment inc. Frailty Unit, Diagnostics</p> <p><b>Planned Ambulatory Care:</b> Outpatients, Adult Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</p> <p><b>Adult planned inpatient surgery:</b> Low risk Ortho, ENT, Breast, Urology and Gynae surgery</p>	<p><b>Urgent Care:</b> ED, assessment areas and co-located UTC and frailty unit</p> <p><b>Surgery:</b> Acute inpatient surgery (except vascular) and critical care,</p> <p><b>Acute Med:</b> Acute inpatient services for all medical specialties (except stroke),</p> <p><b>Women's Services:</b> Obstetric Led unit, co-located MLU, gynae inpatient services</p> <p><b>Paediatrics:</b> Acute inpatient services, SCBU and paediatrics surgery &amp; day case (excluding some specialties which are MEC only)</p> <p><b>Planned Ambulatory Care:</b> Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</p>

How is this different compared to **current** service delivery?

WHH	
Services currently delivered on this site that no longer will be:	Services that will be delivered on this site that currently aren't:
	<ul style="list-style-type: none"> <li>- Urgent Treatment Centre</li> <li>- Gynae-oncology</li> <li>- Urology</li> <li>- Vascular</li> <li>- Inpatient Renal services</li> <li>- Haemophilia services</li> <li>- Inpatient clinical haematology</li> <li>- Neurology</li> <li>- Hyper Acute Stroke</li> </ul>

KCH	
Services currently delivered on this site that no longer will be:	Services that will be delivered on this site that currently aren't:
<ul style="list-style-type: none"> <li>- Acute medical inpatient services (inc. stroke, cardiology etc.)*</li> <li>- Critical Care</li> <li>- Urology</li> <li>- Vascular</li> <li>- Paediatric Surgery</li> <li>- Inpatient Renal services</li> <li>- Haemophilia services</li> <li>- Inpatient clinical haematology</li> <li>- Neurology</li> </ul>	<ul style="list-style-type: none"> <li>- Urgent Treatment Centre</li> <li>- Low risk planned surgery</li> </ul>

QEQM	
Services currently delivered on this site that no longer will be:	Services that will be delivered on this site that currently aren't:
<ul style="list-style-type: none"> <li>- Gynae-oncology</li> </ul>	<ul style="list-style-type: none"> <li>- Urgent Treatment Centre</li> </ul>

\* Stroke admissions and acute medicine and were temporarily removed from KCH in April 2017 and June 2017 respectively.

## Option 2: One site ED model with K&CH as the MEC

### Option 2 has the following key acute changes:

- Changes to a single site emergency medicine
- 1 critical care unit
- TBC 1 or 2 site elective surgery (low risk)
- 1 site stroke (HASU/ ASU)
- Single site Obstetric and paediatric services
- Introduction of 1 standalone MLU
- 7 day working

High level service description by site;

ICH: William Harvey Hospital	MEC: Kent & Canterbury Hospital	ICH: Queen Elizabeth Queen Mary Hospital
<p><u>Urgent Care:</u> UTC, Assessment inc. Frailty Unit, Diagnostics</p> <p><u>Ambulatory Care:</u> Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</p> <p><u>Inpatient Services:</u> Step up/down beds and rehab services</p>	<p><u>Urgent Care:</u> ED inc. Level 2 Trauma, assessment areas and co-located UTC with a frailty unit</p> <p><u>Surgery:</u> All surgical specialties and critical care,</p> <p><u>Acute Med:</u> Acute inpatient services for all medical specialties,</p> <p><u>Women's Services:</u> Obstetric Led unit, co-located MLU, gynae inpatient services including oncology</p> <p><u>Paediatrics:</u> Acute inpatient services, POSCU, NICU and all paediatric surgery &amp; day cases</p> <p><u>Specialist services:</u> centre for specialist services in east Kent</p>	<p><u>Urgent Care:</u> UTC, Assessment inc. Frailty Unit, Diagnostics</p> <p><u>Ambulatory Care:</u> Outpatients, Day Surgery, Day treatments inc. chemotherapy, endoscopy and dialysis</p> <p><u>Standalone Midwifery Led Birthing Unit</u></p>

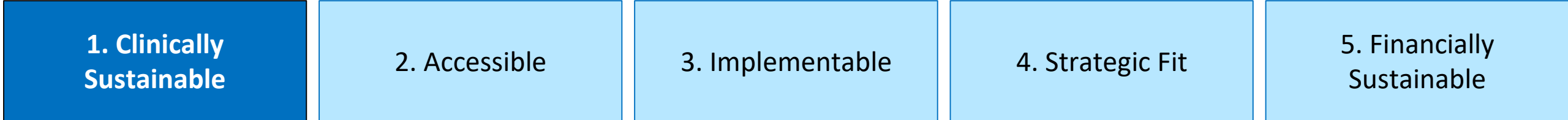
How is this different compared to **current** service delivery?

WHH	
Services currently delivered on this site that no longer will be:	Services that will be delivered on this site that currently aren't:
<ul style="list-style-type: none"> <li>- Emergency Department</li> <li>- Acute medical inpatient services</li> <li>- Inpatient unplanned surgery</li> <li>- Women's Health services (inc. maternity)</li> <li>- Paediatrics (inc. surgery, neonatal and acute inpatients)</li> <li>- Critical Care</li> <li>- Specialist services (inc. pPCI, H&amp;N Cancer)</li> </ul>	<ul style="list-style-type: none"> <li>- Urgent Treatment Centre</li> </ul>

KCH	
Services currently delivered on this site that no longer will be:	Services that will be delivered on this site that currently aren't:
<ul style="list-style-type: none"> <li>- A proportion of Day case surgery</li> </ul>	<ul style="list-style-type: none"> <li>- Urgent Treatment Centre</li> <li>- Emergency Department inc. Trauma</li> <li>- Inpatient unplanned and high risk planned surgery</li> <li>- Women's Health services (inc. maternity)</li> <li>- Paediatrics (inc. surgery, neonatal and acute inpatients)</li> <li>- <b>All</b> inpatient medical services (inc. pPCI, H&amp;N Cancer)</li> </ul>

QEQM	
Services currently delivered on this site that no longer will be:	Services that will be delivered on this site that currently aren't:
<ul style="list-style-type: none"> <li>- Emergency Department</li> <li>- Acute medical inpatient services</li> <li>- Inpatient unplanned surgery</li> <li>- Women's Health services (inc. maternity, gynae-oncology)</li> <li>- Paediatrics (inc. surgery, neonatal and acute inpatients)</li> <li>- Critical Care</li> </ul>	<ul style="list-style-type: none"> <li>- Urgent Treatment Centre</li> <li>- <b>A standalone MLU</b></li> </ul>

## Detailed information request for each criteria



## Clinically Sustainable: 1.1 Quality – Workforce (1)

1.1.1: Allow each organisation to operate working patterns that are safe and compliant with regulatory standards?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. For do minimum, Op1 and Op2, by specialty and workforce group, what are the recommended staffing levels in line with regulation?</li> <li>2. What alternative workforce models have been considered to be adopted as part of do minimum, Op1 and Op2?</li> <li>3. What is the expected impact (positive and negative) on requirements for each option compared to the baseline due to the changes to workforce model? Including impact on current vacancy rates and agency spend?</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• Clinical workforce standards and minimum requirements for all specialties and staff groups</li> <li>• Current rota and establishment information, for each specialty and workforce group inc. fill rates, % locums/agency and vacancy rates</li> <li>• Draft rota information for Op1 and 2 for each specialty and workforce group</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• Workforce model descriptions</li> </ul>

Next steps
Identify relevant specialties and staff groups that will be reviewed – ED, Acute Med (incorporates all medical specialties), Renal, Gen Surgery, Urology, Vasc, Paeds, Maternity, Trauma, Orthopaedics, Haematology, Gynaecology, Head and Neck, ?HCOOP, Critical care,
Define the workforce models taking into consideration the workforce related clinical standards and evolving skills-based roles (e.g. Acute Care Practitioners)
Define the recommended staffing levels in line with regulation for the workforce models under do min, opt 1 and opt 2 -> cross matched against the clinical standards
Map out rota requirements by specialty/ staff group for do min, opt 1 and opt 2
Cross match current workforce against rotas to determine – impact on total volume of workforce ,vacancy rates, locum/agency usage, and the gap
Describe the expected impact on the workforce requirements of each option compared with do-min – this will need to consider the ability to meet the proposed rotas within the context of the affordability and deliverability

## Clinically Sustainable: 1.1 Quality – Workforce (1)

1.1.2: Impact on delivering a sustainable workforce, with the necessary clinical skills, across the East Kent health and social care system?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. What are the current drivers for recruitment challenges and existing gaps in clinical skills across acute, out of hospital and social care services that exist under the do minimum option?</li> <li>2. What strategies that have been implemented to alleviate the challenges being experienced in recruiting to the required clinical skills and to what extent these have been successful?</li> <li>3. What is the expected impact (positive and negative) on recruitment and the identified skills gap, under each option?</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• High level skills gap analysis</li> <li>• Vacancies rates and gaps</li> <li>• Rebecca Brad – agency staff</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• Current drivers of recruitment challenges</li> <li>• Recruitment strategies</li> </ul>

Next steps
Analyse current vacancy, turnover rates and agency usage by specialty and staff groups
Review existing reports or analysis that will assist in understanding the drivers for the recruitment challenges
Review the strategic workforce plan to understand existing gaps in clinical skills
Summarise the steps taken to alleviate the challenges being experienced in recruitment and gaps in skills to date, and to what extent these have been successful – provide evidence of impact overtime (e.g. trend analysis) as available
Describe the expected impact on recruitment and the identified skills gap, under each option – taking into consideration the proposed workforce models

## Clinically Sustainable: 1.1 Quality – Workforce (2)

1.1.3: Impact on staff attrition across the system?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>To what degree are staff groups affected (by specialty) for each option compared to current position?</li> <li>Of the affected groups, what level of attrition is expected due to staff not relocating?</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>Using future workforce and clinical models quantify level of staff relocation by specialty and staff group</li> <li>Current attrition data by specialty and staff group</li> <li>Attrition data by specialty and staff group following large scale service change</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>Rationale, drivers and evidence for attrition due to staff not re-locating</li> </ul>

Next steps
Identify all specialties that are moving between sites
Identify the number of staff having to relocate by specialty and staff group
Review previous relocations within EKHUFT (acute medicine move, stroke, 2005 reconfiguration) to determine attrition levels by specialty and staff group
Define assumptions around attrition to be applied under opt1 and opt 2
Apply assumptions to each option to determine predicted attrition levels



## Clinically Sustainable: 1.2 Quality – Effectiveness & Safety (1)

1.2.1: Allow services to be configured in alignment with the Clinical Senate's recommended co-dependencies?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. Under do minimum, op1 and op2 demonstrate all co-dependencies are configured in line with the Clinical Senate recommendations</li> <li>2. Evidence to support any additional service changes outside of the Clinical Senate recommendations</li> <li>3. Review</li> </ol>
What data is required to answer these questions?	
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• Reconciliation of the future clinical models under do minimum, op1 and op2 against the clinical senate</li> <li>• Supporting evidence for any additional service changes</li> </ul>

Next steps
Review Clinical Senate report on co-dependencies and cross match this with do minimum, option 1 and 2
Identify the number of discrepancies between the report and do minimum, option 1 and option 2
Where a discrepancy exists collect evidence to support rationale for this
Summarise findings into report

## Clinically Sustainable: 1.2 Quality – Effectiveness & Safety (1)

1.2.2: Improve overall compliance with constitutional standards including conveyance standards?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. What are the current operational pressures faced by the Trust that are impacting ability to meet constitutional standards?</li> <li>2. How are these expected to change through the reconfiguration under op1 and op2?</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• Baseline current performance: RTT, A&amp;E, cancer, DM01 KPI data from the Trust</li> <li>•</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• By standard, rationale and evidence to demonstrate drivers for current operational pressures</li> <li>• Evidence for changes under op1 and op2 that will support improvement in ability to meet standards</li> </ul>

Next steps
Collect and analyse information on current and historical performance against constitutional standards (18 months worth of data)
Review performance reports sent to the Board to understand drivers for current performance
Interview with COO to understand drivers behind past performance, changes planned to improve this and what impact it is projected to have
By KPI, consider what service changes are planned under the options that may impact the current performance
Identify literature and case studies to support projected improvements in KPIs and summarise these
By KPI, describe how current performance is expected to change against do minimum for option 1 and option 2
Consider the ability to deliver the performance targets at what cost and

## Clinically Sustainable: 1.2 Quality – Effectiveness & Safety (2)

1.2.3: Improve adherence to NHS policy (e.g. seven-day working and FYFV) and Royal College standards of care?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. What is the current performance in adherence to the clinical standards?</li> <li>2. What are the current limitations in adherence to the standards and how are these expected to change for do minimum, op1 and op2?</li> <li>3. What is the expected change (+ve/-ve) in adherence to NHS policy standards through the reconfiguration under do minimum, op1 and op2?</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• Agreed list of clinical standards for each of the key areas of reconfiguration</li> <li>• Workforce models and rota information</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• By standard, rationale and evidence to demonstrate current adherence to standard</li> <li>• Evidence for changes under op1 and op2 that will support improvement in ability to meet standards</li> </ul>

Next steps
Linking in with HRBPs and workforce analysis under (1.1.1) demonstrate current adherence (do minimum) to standards – Criteria to be used: wholly meets, partially meets (>75%) (25-75) (<25%), does not meet – supporting narrative will be required on rationale for score and supporting evidence
Taking into consideration current limitations with meeting the standards, using the criteria above, score adherence with standards under op1 and op2

## Clinically Sustainable: 1.2 Quality – Effectiveness & Safety (2)

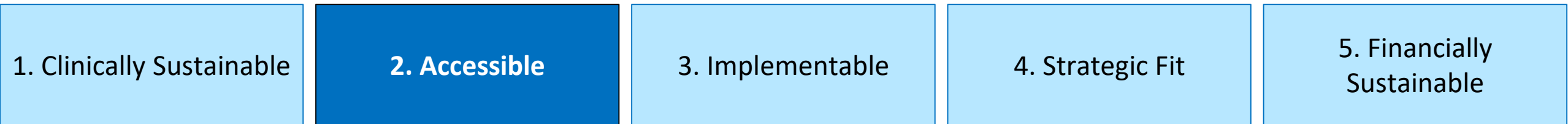
1.2.4: Deliver hospital sites that best meet the quality standards for safe buildings?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. What are the expected improvements to the quality buildings through the reconfiguration?</li> <li>2. To what degree will EKHUFT become more compliant with HBN guidelines through renovations?</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• Estate review of current buildings and expected % improvements associated with reconfiguration</li> <li>• Agreed list of HBN standards</li> <li>• Project plans that outline the expected improvements and end position of each hospital</li> <li>• Commercial call -</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• By standard, rationale and evidence to demonstrate current adherence to standard</li> <li>• Evidence for changes under op1 and op2 that will support improvement in ability to meet standards</li> </ul>

Next steps
Provide most recent estate condition survey results and backlog maintenance work programme and associated costing
For do minimum, op1 and op 2, present the % of the estate that is of an acceptable standard (definition TBC) and % of backlog maintenance to be addressed
Define the list of HBN standards to be used
Sign off agreed HBN standards
For do minimum, op1 and op 2, present % of HBN guidelines that will be adhered to

## Clinically Sustainable: 1.3 Quality – Patient Experience

1.4.1: Provide a better experience for patients as determined by nationally recognised and validated tools (i.e. Patient Reported Outcome Measures)?	
What questions are we trying to answer?	1. Will the option provide a better patient experience?
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• Baseline patient experience metrics; compliments to complaints, mixed sex breaches, complaint response timescales, FFT, overall PE % (from EKHUFT IPR Doc)</li> <li>• PROMs data</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• By metric, rationale and evidence to demonstrate drivers in current performance</li> <li>• Evidence and rationale for changes under op1 and op2 that will support improvement in ability to meet standards and improve patient experience</li> <li>• Thematic analysis of complaints</li> </ul>

Next steps
Define the patient experience metrics to be used
Sign off agreed patient experience metrics
Describe the expected impact with clear rationale and evidence for changes against patient experience metrics expected under option 1 and option 2 when compared with do minimum
Conduct thematic analysis of current and historical complaints to determine drivers
Consider how these drivers would be impacted by the reconfiguration under option 1 and option 2
Review historical data of complaint trends/ patterns following service moves to inform projected impact



## Accessible: 2.1 Acute Services

**2.1.1: Enable acceptable travel times by service users of East Kent to get to hospital by ambulance, car (at off-peak and peak times and public transport) for the following services, in line with national or locally agreed standards**

What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. For do minimum, Op1 and Op2 what are the volumes (%) of the population that will be able to access an ED, Trauma unit, pPCI, stroke &amp; Vascular services within 15,30,45 and 60mins?</li> <li>2. For do minimum, Op1 and 2 what is the impact of level of compliance for the locally agreed standards for each of the above?</li> <li>3. What is the impact on the maximum travel time compared to the do minimum? (For each option)</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• LSOA travel time analysis</li> </ul>
What qualitative evidence is required?	

### Next steps

Agree the outflows methodology to be used in conducting the travel time analysis

Run and present the analysis for question 1 above

Develop a response for questions 2 and 3 with a clear rationale and supporting evidence

## Accessible: 2.2 Local Access

### 2.2.1: Allow the greatest majority of health and care that adheres to quality standards, to be delivered closer to home?

What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. For do minimum, Op1 and Op2 what are the volumes (%) of the population that will be able to access services within 15,30,45 and 60mins?</li> <li>2. What is the impact on the maximum travel time for each service compared to the do minimum? (For each option)</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• LSOA travel time analysis at POD level</li> </ul>
What qualitative evidence is required?	

### Next steps

For all specialties impacted by the reconfiguration, conduct an analysis to determine the greatest volumes of the population across east Kent that will access services within 15, 30, 45 and 60 mins by car, ambulance and public transport – as per question 1

Develop a response to question 2 providing clear rationale and evidence





## Implementable: 3.1 Time to implement

### 3.1.1: What is the expected delivery timescale?

What questions are we trying to answer?	1. How long will the option take to complete from start to finish?
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>Project plans, Gantt charts and key milestones</li> </ul>
What qualitative evidence is required?	

### Next steps

Use commercial group to review project plans and agree a response to the question

## Implementable: 3.2 Delivery Risks (1)

3.2.1: Present any risks of delays or failure to deliver owing to: Council planning permission?	
What questions are we trying to answer?	1. For each option what are the potential reasons (risk) that council planning may be declined or delayed?
What data is required to answer these questions?	
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• Descriptions of the type and level of planning permission required for each option</li> <li>• Description of the implications that each option may pose to planning permission</li> </ul>

Next steps
Use commercial group to describe the type and level of planning permission required for each option
Use commercial group to identify the potential reasons that council planning may be declined/ delayed, the level of risk associated with this occurring under option 1 and option 2, and the mitigations that could be implemented

## Implementable: 3.2 Delivery Risks (1)

3.2.2: Present any risks of delays or failure to deliver owing to: Number of delivery partners?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. How many delivery partners are required to deliver do minimum, Op1 and Op2?</li> <li>2. For each option what are the potential risk factors that are linked to the delivery partners?</li> </ol>
What data is required to answer these questions?	
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• Description of the risk factors for engaging the likely developers taking into account financial health, size and management team, previous experience, track record of delivery and conflicting interests from a capacity perspective</li> </ul>

Next steps
<p>Use the commercial group to:</p> <ul style="list-style-type: none"> <li>• Define the numbers required under each option</li> <li>• Define the parameters linked to the risk profile of any developers</li> <li>• Describe the potential risk associated with the developers for option 1 and option 2</li> </ul>

## Implementable: 3.2 Delivery Risks (2)

### 3.2.3: Present any risks of delays or failure to deliver owing to: Operational complexity and decant arrangements?

What questions are we trying to answer?	<ol style="list-style-type: none"> <li>To what degree will delivery of these options impact on BAU running of services? (Scale, length etc.)</li> <li>What are the interim moves/plans during delivery timescale that will impact service delivery?</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>Project plans</li> <li>Current and future service models</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>Description of process to move service under op1 and op2</li> </ul>

### Next steps

Use the commercial group to:

- Review and agree on the number of steps in the plans to move each of the services in order to reach the end point
- Review and agree the number of services
- Review and agree on how critical the services are and the impact this may have on delivering to constitutional standards e.g. A&E (4-hour target) and RTT

## Implementable: 3.2 Delivery Risks (2)

3.2.4: Present any risks of delays or failure to deliver owing to: Decisions regarding the Section 106 Agreement or Community Infrastructure Levy?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. What is the impact of the Section 106 Agreement on do minimum, op1 and op2?</li> <li>2. For each option what are the potential risk factors that are linked to the Section 106 Agreement?</li> </ol>
What data is required to answer these questions?	
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• Section 106 Agreement</li> <li>• Description of the implications that the Agreement may pose to each option</li> </ul>

Next steps
Commercial group to review impact on Section 106 Agreement and implications of this on the options

## Implementable: 3.3 Transition period (1)

3.3.1: Maximise value from investments made during the transition period to support the sustainability of vulnerable services (minimises sunk costs)	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. What are the known short/medium term investments that are required for vulnerable services?</li> <li>2. How do the investments align (work towards, away etc,) to the future service model under do minimum, op1 and op2?</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• System Recovery Plan</li> <li>• Investment plans</li> <li>• Clinical and service models</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• Vulnerable service with rationale to understand drivers behind vulnerabilities</li> </ul>

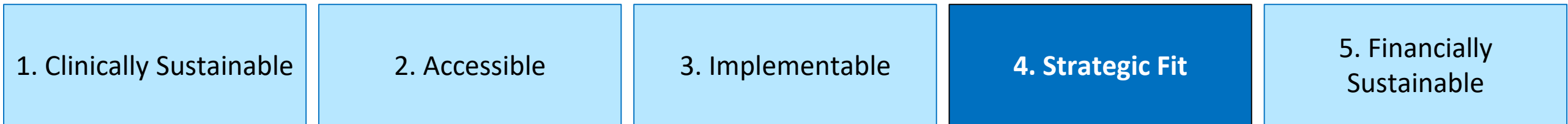
Next steps
Define the list of vulnerable services and reasons for this
Define the list of short/medium term investments required in those vulnerable services
For the list of investments, provide a description of what this is and the output to be delivered
Consider the applicability to option 1 or option 2, and how these align to the investments

## Implementable: 3.3 Transition period (2)

3.3.2: Enable the capital investment required to be phased over the transition period?	
What questions are we trying to answer?	1. When will capital investment be required for delivery of each option?
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>Project plans and investment plan for 'phases' of delivery</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>Rationale and supporting evidence to demonstrate investment timeframes</li> </ul>

Next steps
Commercial group to review question and investment plans required under each option in comparison with the do minimum
Commercial group to provide a response to question 1 above





## Strategic Fit: 4.1 Long-term sustainability

4.2.1: Enable longer-term sustainability for the system (e.g. to avoid the need to reconfigure in the next 5-7 years following implementation)?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. What are the drivers of longer-term sustainability</li> <li>2. To what degree does each option enable longer-term sustainability for the system (e.g. to avoid the need to reconfigure in the next 5-7 years following implementation)?</li> </ol>
What data is required to answer these questions?	
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• For do minimum, option 1 and 2, rationale, evidence and drivers for longer term sustainability for the system. Based on: NHS policies, guidance (e.g. Nuffield Trust and Delivering the Future Hospital) and Royal College Guidance on               <ol style="list-style-type: none"> <li>(a) medical training and trends towards increasing sub-specialisation and</li> <li>(b) trends in health care that may impact on sustainability in future, i.e. workforce shortages and technology</li> </ol> </li> </ul>

Next steps
Review and agree the key drivers of sustainability outlined: <ul style="list-style-type: none"> <li>• capacity, workforce – royal college guidelines, trends in health care, evidence of impact from planned interventions to reduce demand on secondary care across the health economy, national and international policy, Brexit</li> </ul>
Describe the impact of these drivers on the do minimum, option 1 and option 2

## Strategic Fit: 4.2 Impact on neighbouring systems

4.1.1: Impact on neighbouring systems and other providers through outward flows?	
What questions are we trying to answer?	1. Under each option what is the level of activity for each speciality that is expected to leave EK system?
What data is required to answer these questions?	Comparison of do minimum and option 1 and option 2 for: <ul style="list-style-type: none"> <li>• Travel time analysis</li> <li>• System wide assumptions</li> <li>• Activity levels by speciality that will leave the EK system</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• For option 1 and 2, rationale ,drivers and evidence for levels of activity for each speciality that is expected to leave the EK system</li> <li>• Evidence from changes to outward flows from previous service changes in EK (if applicable)</li> </ul>

Next steps
As per question 2.1.1, agree the outflows methodology to be used in conducting the travel time analysis and use the outputs of the travel time analysis to determine impact on neighbouring systems
Provide a response to question 1 above with clear rationale and evidence

## Strategic Fit: 4.3 Research & Education

4.1.1: Support research, education and innovation?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. To what extent will the do minimum, option 1 and option 2 support the delivery of the research programme the Trust aspires to achieve</li> <li>2. To what extent will the do minimum, option 1 and option 2 support adherence with mandatory standards for supervision and training</li> <li>3. To what extent will the do minimum, option 1 and option 2 enable innovation in practice</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• Mandatory standards for supervision and training of medical clinicians</li> <li>• For each option – plans for co-location of clinical activity and research teams, co-location of clinical specialties, efficiencies based on co-location of supporting nursing staff and principle / chief investigator roles, opportunities for collaboration and diversity of research</li> <li>• For each option – dedicated space for research activities</li> </ul>
What qualitative evidence is required?	<ul style="list-style-type: none"> <li>• STP/East Kent future clinical research and education plans (and alignment to option 1 and 2 if applicable)</li> <li>• Evidence for current adherence to research and education plans</li> <li>• Future strategy and planning documents for Medical School</li> </ul>

Next steps
Define the current research programme and its components, including any challenges currently being experienced
Describe the desired future research programme and how each option would facilitate this in comparison with the do minimum e.g.: <ul style="list-style-type: none"> <li>• Provide space for research activities</li> <li>• Provide links with the medical school and support placements to deliver the appropriate clinical roles</li> <li>• Support the development of new and flexible roles</li> </ul>
Define the mandatory standards for supervision and training by specialty
Describe the current performance against these for the do minimum, and how this would improve under each option



## Financially Sustainable: 5.1 Financially viable system

5.1.1: Support a financially viable system across East Kent?	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. What is the expected financial position for the system under the do minimum scenario?</li> <li>2. Compared to do minimum, what is the expected change to the systems financial position under op1 and op2?</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• Capacity &amp; demand modelling inc. patient flows</li> <li>• Account positions and I&amp;E modelling for system</li> </ul>
What qualitative evidence is required?	

Next steps
<p>Confirm final assumptions for each Do Minimum Inclusion, including:</p> <ul style="list-style-type: none"> <li>• Present, refine and sign off assumptions with / to the Modelling Group.</li> <li>• Present outputs to Directors of Finance Meeting.</li> </ul>
<p>Complete Local Care Intervention costings to understand the impact on all providers.</p>
<p>Complete Travel Time analysis to understand patient flows under each of the two options including:</p> <ul style="list-style-type: none"> <li>• Take Clinical Model Outputs to understand service provision at each site under both options.</li> <li>• Present discussion document to System Board for decision on whether patient flows can leave the East Kent system.</li> </ul>
<p>Model the financial position of each option to be compared against the do minimum, including:</p> <ul style="list-style-type: none"> <li>• Take Clinical Model and Travel Time Outputs to model capacity &amp; demand, inc. patient flows, for each option.</li> <li>• Calculate the financial impact of each option on providers account positions and I&amp;E modelling for the system.</li> <li>• Prepare comparison document showing the expected change to the systems financial position under each option.</li> </ul>

## Financially Sustainable: 5.2 Net present value

5.2.1: In line with the STP evaluation methodology, which option gives the best 30/64 year net present value? (whole of system lens, including capital costs)	
What questions are we trying to answer?	<ol style="list-style-type: none"> <li>1. What is the NPV expected for do minimum and op1 and op2 over the next 30 years?</li> <li>2. What is the NPV expected for do minimum and op1 and op2 over the next 64 years?</li> </ol>
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• Capacity &amp; demand modelling inc. patient flows</li> <li>• Account positions and I&amp;E modelling for system</li> </ul>
What qualitative evidence is required?	

Next steps
Present and sign off NPV methodology at Modelling Group and Director of Finance Meetings.
Using the outputs from 5.1 Financial Viable System, calculate the expected NPV for do minimum and both options over the next 30 years.
Using the outputs from 5.1 Financial Viable System, calculate the expected NPV for do minimum and both options over the next 64 years.
Prepare comparison document outlining the expected NPV of do minimum and each option over the next 30 and 64 years.

## Financially Sustainable: 5.3 I&E performance

### 5.3.1: Which option gives the best steady state I&E performance after year 10?

What questions are we trying to answer?	1. What is the expected income and expenditure for each organisation after the next 10years?
What data is required to answer these questions?	<ul style="list-style-type: none"> <li>• Capacity &amp; demand modelling inc. patient flows</li> <li>• Account positions and I&amp;E modelling for system</li> </ul>
What qualitative evidence is required?	

### Next steps

Using the outputs from 5.1 Financial Viable System, create comparison document showing the I&E position for each provider / organisation after the next 10 years.