East Kent Transformation Programme

Evaluation Panel Briefing Pack

August 2019
Introduction (1)

Purpose

The purpose of this report is to:
• Outline the process undertaken by the East Kent Transformation Programme ‘the Programme’ in the development of PCBC for the acute reconfiguration options to date
• Provide the Evaluation Panel members and relevant stakeholders with an understanding of the detailed evaluation process
Introduction (2)

Overarching process for the completion of the Pre-Consultation Business Case (PCBC)

As outlined in the diagram below, the current stage of the East Kent Transformation Programme is undertaking the detailed evaluation of the medium list of options and drafting the PCBC.

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<tbody>
<tr>
<td>Vision</td>
<td>Case for Change</td>
<td>Development of Service Models</td>
<td>Development of Hurdle Criteria</td>
<td>Identify Full Evaluation Criteria</td>
<td>Identify Long List of Options</td>
<td>Application of Hurdle Criteria</td>
<td>Detailed Work-up of Medium list of options</td>
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<tr>
<td>Detailed Evaluation of Medium List of Options</td>
<td>Development and drafting of the PCBC</td>
<td>Submission of PCBC to NHS Investment Committee</td>
<td>Decision to Consult taken by CCG Joint Committee</td>
<td>Public Consultation</td>
<td>Evaluation of Consultation Discussions &amp; Responses</td>
<td>Development of a Decision Making Business Case</td>
<td>Decision by CCG Joint Committee on Final Option</td>
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Current stage of EK programme
Over the past 12-18 months detailed work has been completed in developing the PCBC

Work across EKHUFT, other provider organisations (KCHFT, KMPT, KCC) & the commissioners has been completed to progress towards the submission of the PCBC.

Key achievements have been:

1. Completion of hurdle & ranking evaluation criteria;
2. Full engagement with CCGs;
3. Defining Local Care Initiatives;
4. Initial public engagement events;
5. Defined clinical models of care across acute & integrated care;
6. Development of future workforce requirements
7. Independent review of clinical standards
8. Commercial risk assessment of developer option (Quinn Estates)
9. Economic Impact Assessment
10. Detailed analysis of final stage of evaluation
## Content

1. Understanding the case for change and developing the long list of reconfiguration options  
   2. The Evaluation process  
   3. Development and application of hurdle criteria  
   4. Understanding the medium list of options  
   5. Development of the detailed evaluation criteria  
   6. The ‘Do minimum’ option  
   7. Developing analysis and outputs for Evaluation Panel  
   8. The Evaluation Panel  
   9. Next Steps
1. Understanding the case for change and developing the long list of reconfiguration options
Why change is needed

Four in 10 emergency hospital admissions could be avoided with better support.

Specialist hospital teams cannot run a full service, seven days a week.

At any one time, 300 people are in a hospital bed who could be recovering faster with the right support at home or in community services.

We have real challenges recruiting enough consultants, GPs, nurses and therapists.

A significant proportion of clinical areas are in old buildings needing improvement.
How we want to improve care

- More care closer to home
- Routine hospital care remains local
- Certain specialist hospital services should be located in one hospital to improve your care and recovery
- Planned operations should take place in a separate hospital
The case for change and long list of options

In east Kent, there is one trust (east Kent Hospitals Foundation Trust - EKHUFT) providing services across three main acute sites.

(William Harvey Hospital - WHH, Queen Elizabeth the Queen Mother Hospital - QEQM and Kent and Canterbury Hospital - K&C), offering many similar services.

In considering the reconfiguration options for the acute Trust, the starting position was that each service could be provided on:

• 3 sites
• 2 sites
• 1 site
• 0 sites

This assisted with the development of the longlist of 17 acute reconfiguration options.
2. The Evaluation Process
The Evaluation Process

The end to end evaluation process involves three key stages

Objectives

Key objectives of the evaluation process include:

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

The three key stages of the evaluation process

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

Models of care
- Help shape breadth of possible options

Long list
- 17 potential options

Filter
- Fixed point criteria
  - applied to all potential options

Hurdle criteria
- applied to long list

Medium list
- 2 potential options

Evaluation criteria
- applied to medium list

Shortlist
- To be confirmed

Consult public
- Final option(s)
  - to take to public consultation and included in the PCBC

August 2016 to November 2017
November 2017 to September 2019
September 2019 onwards
PCBC and business case process (1)

Purpose of the PCBC

• The Pre-Consultation Business Case (PCBC) is a technical document that provides our national regulators with all of the evidence they need to assess our proposals for service change and agree in principle if funding is available.

PCBC and consultation

• The PCBC is a published document but it is not intended to be the main mechanism through which proposals are explained to the public.
• The consultation document is a public-facing document that sets out the proposals and their implications and asks specific questions to help to test and refine these proposals.

Business Case process

• Following consultation, the Decision-Making Case Business Case (DMBC) will validate the consultation outcome and help the Joint Committee decide whether to progress with the recommended preferred option.
• The PCBC is the first of a series of business cases before implementation of service change. The Full Business Case (FBC) is the final business case.
Evaluation and the PCBC (1)

- Vision
- Case for change
- Models of Care
- Service Delivery Models

Development of PCBC

- Long List of options
- Hurdle Criteria
- Medium List of Options
- Final evaluation

Evaluation

- Benefits from evaluation
- Evaluation Panel Report
- Equality Impact Assessment*

Final PCBC

* The Equality Impact Assessment describes the impact of service changes on relevant diverse groups.
Evaluation and PCBC (2)

What’s included in the evaluation

The evaluation process predominately focuses on the options appraisal of acute hospital reconfiguration. This is because there’s the same improvements to local care for all options. Therefore local care will not be a differentiator across the options.

What’s included in the Pre-Consultation Business Case (PCBC)

Acute hospital service changes, improvements to local care and clinically developed models of integrated care are key aspects of the PCBC.

For the PCBC to be approved by NHSE England - the PCBC must provide robust evidence that it meets key tests for reconfiguration. This includes demonstrating acute bed changes will not adversely impact patients and ensuring local workforce will in place.

The PCBC will also include an Equality Impact Assessment. This is an assessment of the impact of service changes on relevant diverse groups.
3. Development and application of hurdle criteria
Application of hurdle criteria

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

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

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

• Reapplying the hurdle criteria to the long list of options, included revising the hurdle criteria (see slide 5)
### The Hurdle Criteria

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

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

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

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

• The medium list of options included:
  
  **Option 1**: Two site ED model with William Harvey Hospital as the Major Emergency Centre
  
  **Option 2**: One site ED model with Kent & Canterbury Hospital as the Major Emergency Hospital

• During the final and detailed stage of the evaluation (stage 3) option 1 and 2 will also be reviewed against a do – minimum option
4. Understanding the medium list of options
## Options summary

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
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<tbody>
<tr>
<td><strong>Urgent care</strong></td>
<td>All hospitals</td>
<td>All hospitals</td>
</tr>
<tr>
<td>for illness and injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Day surgery and</strong></td>
<td>All hospitals</td>
<td>All hospitals</td>
</tr>
<tr>
<td><strong>outpatient care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Complex</strong></td>
<td>QEQM and William Harvey</td>
<td>Kent and Canterbury</td>
</tr>
<tr>
<td><strong>inpatient care</strong></td>
<td>(includes consultant-led maternity, inpatient</td>
<td></td>
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<tr>
<td></td>
<td>children’s and acute medical services)</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency care</strong></td>
<td>QEQM and William Harvey</td>
<td>Kent and Canterbury</td>
</tr>
<tr>
<td>(including A&amp;E and</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>critical care</strong></td>
<td>William Harvey</td>
<td></td>
</tr>
<tr>
<td><strong>Specialist services</strong></td>
<td>William Harvey</td>
<td>Kent and Canterbury</td>
</tr>
<tr>
<td>(e.g. heart attack,</td>
<td></td>
<td></td>
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<td><strong>stroke, trauma...</strong>)</td>
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Options summary

Two site ED model (WHH & QEQM), with acute medicine 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
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)
Option 2

Option 2 has the following key acute changes:

- Changes to a single site emergency medicine
- 1 critical care unit
- 1 or 2 site elective surgery (low risk) - to be confirmed
- 1 site stroke (HASU/ASU)
- Single site obstetric and paediatric services
- Introduction of 1 standalone MLU
5. Development of the detailed evaluation criteria
The evaluation criteria that will be used in evaluating the medium list options (1)

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

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Sub-criteria</th>
<th>Evaluation questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the configuration clinically sustainable and are able to deliver required quality standards?</td>
<td>1.1) Quality: workforce</td>
<td>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, and the required support staff across the East Kent health and social care system? c) Impact on recruitment and staff attrition, for all staff groups (including support staff) across the system? d) Impact on employment opportunities within local communities</td>
</tr>
<tr>
<td></td>
<td>1.2) Quality: Clinical recommendations and standards</td>
<td>In comparison with the ‘do minimum' scenario, to what extent do the options: a) Allow services to be configured in alignment with the Clinical Senate’s recommended co-dependencies? b) Improve adherence to NHS policy (e.g. seven-day working and FYFV) and Royal College standards of care and conveyance standards?</td>
</tr>
<tr>
<td></td>
<td>1.3) Quality: patient experience and performance</td>
<td>In comparison with the ‘do minimum' scenario, to what extent do the options: a) Provide a better experience for patients as determined by nationally recognised and validated tools (i.e. Patient Reported Outcome Measures)? b) Improves overall performance (i.e. RTT, A&amp;E, and cancer)? c) Deliver hospital sites that best meet the quality standards for buildings?</td>
</tr>
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</table>
The evaluation criteria that will be used in evaluating the medium list options (2)

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Sub-criteria</th>
<th>Evaluation questions</th>
</tr>
</thead>
</table>
| 2. Is the potential configuration option accessible? | 2.1) Emergency Travel Times | In comparison with the ‘do minimum’ scenario, to what extent do the options:
Enable emergency ambulance travel times to be in line with the following national / locally agreed standards:
- 95% of the east Kent population can access an A&E department within 60 minutes.
- The east Kent population can access a trauma unit for stabilisation within 60 minutes.
- 95% of the Kent & Medway population can access the pPCI centre within 100 minutes (to enable a call-to-balloon time within 150 minutes).
- 95% of the east Kent population can access a stroke unit within 60 minutes (to enable a call-to-needle time within 120 minutes).
- 95% of the east Kent population can access vascular services within 60 minutes. |
| | 2.2) Distance to hospitals | In comparison with the ‘do minimum’ scenario, to what extent do the options:
(a) Enable the greatest number of people to receive appropriate hospital care at the site closest to home
(b) Enable the greatest number of people from deprived communities to receive appropriate hospital care at the site closest to home |
| | 2.3) Car/public transport travel times | In comparison with the ‘do minimum’ scenario, to what extent do the options:
Enable patients requiring an inpatient stay and visitors (i.e. carers and relatives) to have the shortest travel times
(a) By car
(b) By public transport |
The evaluation criteria that will be used in evaluating the medium list options (3)

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Sub-criteria</th>
<th>Evaluation questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Is the potential configuration option implementable?</td>
<td>3.1) Time to implement</td>
<td>Which option can be successfully delivered in the shortest times scale?</td>
</tr>
</tbody>
</table>
|           | 3.2) Delivery risks | In comparison with the ‘do minimum’ scenario, to what extent do the options present any risks of delays or failure to deliver owing to:  
  a) Council planning or resource consent requirements?  
  b) Number of delivery partners?  
  c) Operational complexity and decant arrangements?  
  d) Funding from external to the NHS? |
|           | 3.3) Transition period | In comparison with the ‘do minimum’ scenario, to what extent do the options:  
  a) Maximise value from investments made during the transition period to support the sustainability of vulnerable services (minimises sunk costs)d  
  b) Enable the capital investment required to be phased over the transition period? |
The evaluation criteria that will be used in evaluating the medium list options (4)

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Sub-criteria</th>
<th>Evaluation questions</th>
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<tbody>
<tr>
<td>4. Does the potential configuration option align strategically?</td>
<td>4.1) long-term sustainability</td>
<td>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)</td>
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<td></td>
<td>4.2) Impact on neighbouring systems</td>
<td>In comparison with the ‘do minimum’ scenario, to what extent do the options: a) Impact on neighbouring systems and other providers through outward flow</td>
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<tr>
<td></td>
<td>4.3) Research, innovation and education</td>
<td>In comparison with the ‘do minimum’ scenario, to what extent do the options: (a) Support research, education and innovation current and developing research and education? (b) Provide opportunities to develop innovative practice that improves patient outcomes?</td>
</tr>
<tr>
<td>5. Is the potential configuration option financially sustainable?</td>
<td>5.1) System affordability</td>
<td>In comparison with the ‘do minimum’ scenario, to what extent do the options: a) Support a financially viable system across East Kent?</td>
</tr>
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<td></td>
<td>5.2) Net present value</td>
<td>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)</td>
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<tr>
<td></td>
<td>5.3) I&amp;E performance</td>
<td>Which option gives the best steady state I&amp;E performance after year 10?</td>
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6. The ‘Do-minimum’ option
The ‘Do-minimum’ option (1)

The NHS Capital Investment Manual states:

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

Significant resource input may be required just to maintain the status quo: that is, doing the minimum. Buildings or plant may have to come to the end of their useful life and may require replacement or upgrading. If the throughput of patients is increasing, maintaining service provision may take additional costs in staff, energy and other running expenditures.
The ‘Do-minimum’ option (2)

Deciding whether to shortlist the options means comparing them to a scenario without significant change.

Some planned improvements continue, including:

- Delivery of 7 day working across the three sites
- Establishing hyper acute stroke units in Kent & Medway
- Do minimum includes changes or developments that are likely to happen within the next 12 years.

In the do minimum scenario some temporary changes made in recent years go back to their original model:

- Kent and Canterbury would return to taking emergency medicine admissions (but would not have a full A&E)
- Piloting of single site elective orthopaedic surgery reverts to two sites
7. Developing the analysis and outputs for the Evaluation Panel
Developing the analysis and outputs for the Evaluation Panel

**May**

4. **Templates completed by EKHUFT**
   - Templates completed and submitted to EY and the PMO
   - **EKHUFT**: Clinical Sustainability excl. Workforce
   - Implementable, Strategic Fit, Accessibility
   - **STP Workforce Lead**: Workforce
   - **EY**: Financial Sustainability
   - Deadline: 29th May (non-workforce)
   - Deadline: 14th June (workforce and finance)

5. **Templates reviewed by EY**
   - EY feedback will be shared with EKHUFT who will provide further information and updates to the templates as required
   - EY review: 5th June (non-workforce)
   - EY review: 19th June (workforce and finance)

**June**

6. **Review of templates by Evaluation Assurance Group**
   - EY to present outcome of review and updated templates to the Evaluation Assurance Group
   - The programme will provide further feedback to EKHUFT and request further information and updates to the templates as required.
   - Information and updated templates will be required within 7 days
   - 6th June (non-workforce)
   - 20th June (workforce and finance)

7. **Review and endorsement of templates by workstreams**
   - Templates scrutinised by workstreams aligned to each criteria
   - Workstream members will be assigned specific templates to review in detail
   - The programme will provide feedback to EKHUFT and request further information as required
   - Information will be required within 7 days
   - 13th June - 15th August

   - Final templates and cover report detailing revision prepared by the PMO and EY presented to Evaluation Working Group for endorsement
   - The programme will provide feedback to EKHUFT and request further information as required
   - Information will be required within 7 days
   - The programme will update templates based on information received
   - Report summarising feedback from the engagement event presented by Communications lead to Evaluation Working Group for review and endorsement
   - Final endorsement by: 21st August

9. **Endorsement of Evaluation Panel Report by TDB and SB**
   - The two evaluation panel reports and engagement event feedback report will be presented to the Transformation Delivery Board and System Board for review and endorsement
   - The programme will provide feedback to EKHUFT and request further information as required
   - Information will be required within 7 days
   - The programme will update templates based on information received
   - 9th September – endorsed at TDB and SB

10. **Evaluation Panel**
    - **Evaluation panel**
    - 4/9 Accessibility and Strategic Fit criteria
    - 11/9 Implementable and Finance
    - 18/9 Clinical Sustainability

**Current stage**
8. Evaluation Panel
Evaluation panel members - key responsibilities

The Evaluation Panel will consist of the current voting members of the East Kent Joint Committee. Each constituent CCG has three voting members (from the CCG Governing Body). The panel will be supported by SME on each criteria.

- Each individual panel member’s role is to help the panel arrive at the best decision for East Kent health and care system
- You are not expected to have canvassed locally for opinions
- Recognise the scoring event is “one piece in the puzzle” to evaluate the shortlisted options for a formal consultation
- Recognise reconfiguration of acute services will need changes to be made in out of hospital services, the scoring will focus on acute reconfiguration
- Both evaluation panel members and contributors are able to participate fully in discussions. Only the panel members will score
- Respect others while participating in the group discussion
- Reach a consensus on the scoring
Overview of the scoring methodology (1)

- Both options scored against the do minimum (not each other)
- Do minimum is scored as zero in all criteria
- Panel must come to shared decision on score for each sub criteria

<table>
<thead>
<tr>
<th>Score</th>
<th>Definition</th>
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<tbody>
<tr>
<td>+3</td>
<td>performs significantly better than the do minimum</td>
</tr>
<tr>
<td>+2</td>
<td>performs well against the do minimum</td>
</tr>
<tr>
<td>+1</td>
<td>performs slightly better than the do minimum</td>
</tr>
<tr>
<td>0</td>
<td>comparable to the do minimum or there is insufficient information to support differential scoring</td>
</tr>
<tr>
<td>-1</td>
<td>performs slightly worse than the do minimum</td>
</tr>
<tr>
<td>-2</td>
<td>performs poorly compared to the do minimum</td>
</tr>
<tr>
<td>-3</td>
<td>performs significantly worse than the do minimum</td>
</tr>
</tbody>
</table>
Overview of the scoring methodology (2)

The evaluation process will score the five criteria equally and a total overall score between -45 and +45 will be awarded to each option.

There are five criteria in total, each of which has three sub-criteria. Each sub-criterion will receive a score of between -3 and +3. This will aggregate into a score of between -9 and +9 for each of the five main criterion.

The Do Minimum will always score zero.

<table>
<thead>
<tr>
<th>#</th>
<th>Criteria</th>
<th>Sub - criteria</th>
<th>Range of scoring*</th>
</tr>
</thead>
</table>
| 1   | Clinical Sustainability         | 1.1 Workforce  
                                  | 1.2 Clinical standards and recommendations 
                                  | 1.3 Patient experience and performance | -9 to +9          |
| 2   | Accessibility                   | 2.1 Emergency travel times  
                                  | 2.2 Distance to hospitals  
                                  | 2.3 Car and public travel times | -9 to +9          |
| 3   | Implementable                   | 3.1 Time to implement  
                                  | 3.2 Delivery Risks  
                                  | 3.3 Transition Period          | -9 to +9          |
| 4   | Strategic Fit                   | 4.1 Long term sustainability  
                                  | 4.2 Impact on neighbouring systems 
                                  | 4.3 Research and education    | -9 to +9          |
| 5   | Financial Sustainability        | 5.1 System affordability  
                                  | 5.2 Net Present Value  
                                  | 5.3 I&E performance           | -9 to +9          |

**Equal weighting for each criterion**

**Equal weighting for each sub criteria**

| Range of scoring for each sub criteria question | -3 to +3 |

-45 to +45
The Evaluation Panel will review the evaluation reports and score the options based on the scoring mechanism

**Define the ask**

Key input: There will be evaluation reports for option 1 and option 2 and reports for each of the 5 criteria. Therefore 10 reports will be endorsed by the Transformation Delivery Board and System Board.

Once the evaluation reports have been endorsed by the Transformation Delivery and System Boards, the Evaluation Panel will review the evaluation reports in detail:

- The Evaluation Panel will have a set of briefings in advance on of receiving the information to prepare for this.

**Scoring Mechanism**

- The Evaluation Panel will then be asked to score each option at sub-criteria level.
- Each sub-criteria will receive a weight of 6.7% and each criteria will receive a weight of 20% to ensure equal weighting across the breadth of the criteria.
- The range of scoring for each sub-criteria is between -3 to +3.

**Final Scoring**

- Each option will be scored against the Do Minimum and the Evaluation Panel will score one criteria at a time. For example, Option 1 will be scored against the Do Minimum for the entire Clinical Sustainability Criteria, followed by Option 2 against the Do Minimum.
- To avoid scoring bias, the ‘first’ option to be scored against the Do Minimum will be rotated.

Key output: The overall scores will be reflected in the master scoring sheet.
Evaluation panel – approach to the meetings and content provided

• Three Evaluation Panel days will be held on the 4th, 11th and 18th September, each from 9am to 5pm. The table below shows the criteria that will be scored on each day:

<table>
<thead>
<tr>
<th>Panel Dates</th>
<th>4th September</th>
<th>11th September</th>
<th>18th September</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td>• Strategic fit • Accessible</td>
<td>• Implementable • Financial sustainability</td>
<td>• Clinical sustainability</td>
</tr>
</tbody>
</table>

• Each criteria will have three sub-criteria that will need to be scored individually. As described on the previous slide, to support the Panel with scoring, evaluation reports, patient and public feedback from engagement events, and content experts close to the detail of the evaluation reports will be available

• For each sub-criteria, content experts will have the opportunity to present the findings in the report to the Panel. This will be followed by a period of discussion and questions

• At the point in time the Panel is ready to score, non-voting members will be asked to leave the room, and the chair will facilitate the Panel in reaching a consensus on the score for the option under consideration
Example of master score sheet for options 1 and 2

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Sub-criteria</th>
<th>Do Minimum score -3 / +3</th>
<th>Option 1 score -3 / +3</th>
<th>Do Minimum score -3 / +3</th>
<th>Option 2 score -3 / +3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Sustainability</strong></td>
<td>1.1 Workforce</td>
<td></td>
<td></td>
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<td></td>
<td>1.2 Clinical standards and recommendations</td>
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<td></td>
<td>1.3 Patient experience and performance</td>
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<td></td>
<td><strong>Total clinical sustainability</strong></td>
<td></td>
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<tr>
<td><strong>Accessibility</strong></td>
<td>2.1 Emergency travel times</td>
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<td></td>
<td>2.2 Distance to hospitals</td>
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<td>2.3 Car and public travel times</td>
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<tr>
<td></td>
<td><strong>Total accessibility</strong></td>
<td></td>
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<tr>
<td><strong>Implementable</strong></td>
<td>3.1 Time to implement</td>
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<td>3.2 Delivery Risks</td>
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<td>3.3 Transition Period</td>
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<td></td>
<td><strong>Total implementable</strong></td>
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<tr>
<td><strong>Strategic Fit</strong></td>
<td>4.1 Long term sustainability</td>
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<td>4.2 Impact on neighbouring systems</td>
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<td></td>
<td>4.3 Research and education</td>
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<td></td>
<td><strong>Total strategic fit</strong></td>
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<tr>
<td><strong>Financial Sustainability</strong></td>
<td>5.1 System affordability</td>
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<td></td>
<td>5.2 Net Present Value</td>
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<td>5.3 I&amp;E performance</td>
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<td></td>
<td><strong>Total financial sustainability</strong></td>
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<td><strong>Overall score</strong></td>
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</table>
9. Next Steps
Drafting of the PCBC will continue and the first full draft of the PCBC will be reviewed by the Transformation Delivery Board on 25th September 2019

Sections of the PCBC that are being drafted are:

1. Vision and strategy
2. Introduction to the PCBC
3. Health and care economy in East Kent
4. Stakeholder engagement
5. Case for change
6. Vision and models of care
7. Benefits framework
8. Options appraisal
9. Impact of preferred options(s)
10. Implementation Plan (including Medium Term/Interim Plan)
11. Quality assurance and approvals
12. Plans for consultation
Overview of next steps

Scoring options

- Scoring panel meets in September
- Completion of evaluation outcome report

Finalising shortlist for consultation

- Final drafting of pre-consultation business case (PCBC)
- South East Clinical Senate review proposals
- Endorsement of PCBC by programme
- Submission of pre-consultation business case to NHSE
- Consult public

Decision making and implementation

- Review feedback from consultation and any further information
- Confirm preferred option
- Prepare full business case
- Implement