



# Stroke Review Pre-Consultation Business Case

## Appendix N

### Medium list to shortlist of options

*Transforming health and social care in Kent and Medway* is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.



## Purpose of document

- This document aims to provide an explanation and rationale behind the evaluation process that informed the shortlisting of options for stroke as agreed by CCG Chairs and AOs
- The evaluation was an iterative process with input and review from multiple groups including the stroke Clinical Reference Group (CRG), Stroke Programme Board (SPB), the STP Clinical Board, STP Finance Group, and CCG Chairs and AOs, as well as a series of evaluation workshops (see appendix for attendees)
- Stroke ambassadors, patient representatives and the Stroke Association played a key role in evaluating the potential options
- The individual evaluations (++, + etc.) for all options have been developed through a process which is not purely scientific, however a clear rationale for each evaluation assigned is recorded in this document



## Background context: a medium list of 13 options emerged as a result of applying the agreed hurdle criteria

### Hurdle criteria

Is the potential configuration option clinically sustainable?

Is the potential configuration option implementable?

Is the potential configuration option accessible?

Is the potential configuration option a strategic fit?

Is the potential configuration option financially sustainable?

Hurdle criteria applied

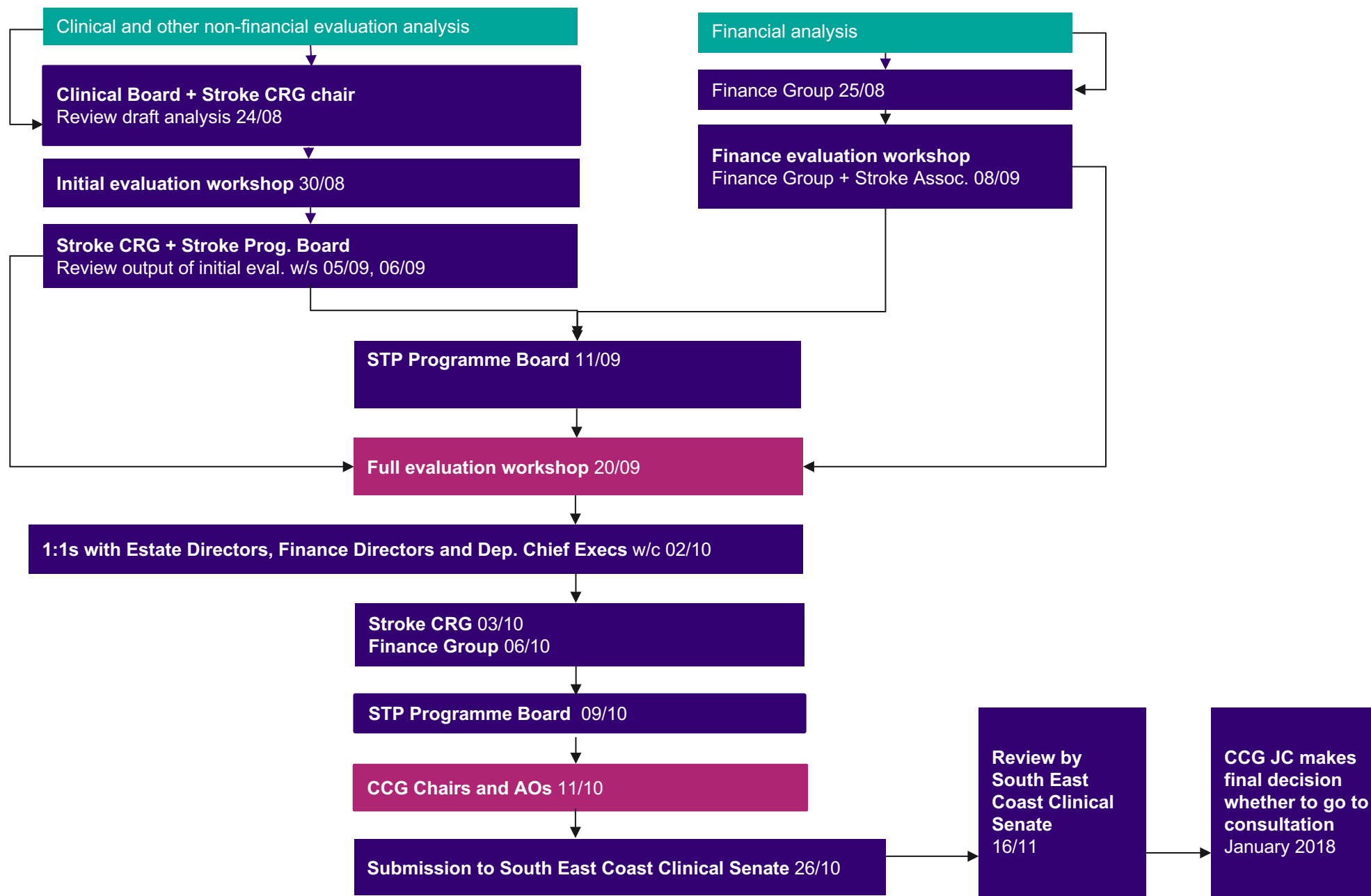
- 1) DVH, WHH, QEQM
- 2) MGH, MMH, QEQM
- 3) DVH, MMH, WHH
- 4) DVH, MMH, QEQM
- 5) DVH, MGH, WHH
- 6) DVH, MGH, QEQM
- 7) DVH, TWH, QEQM
- 8) MGH, MMH, WHH
- 9) TWH, MMH, QEQM
- 10) TWH, MMH, WHH
- 11) DVH, TWH, WHH
- 12) DVH, MGH MMH,
- 13) MGH, WHH, QEQM

### Key

Darent Valley Hospital (DVH)  
 Tunbridge Wells Hospital Pembury (TWH)  
 Maidstone General Hospital (MGH)  
 Queen Elizabeth The Queen Mother Hospital (QEQM)  
 William Harvey Hospital (WHH)  
 Medway Maritime Hospital (MMH)



## The following process was undertaken to reach a shortlist of options



## Each option on the medium list was assessed against the following five domains: Quality, Access, Workforce, Ability to deliver and Affordability

Criteria domain	Sub-criteria	Quantification measure	Example of quantification questions asked	
1	<b>Quality of care for all</b>	<ul style="list-style-type: none"> <li>Clinical effectiveness and responsiveness</li> </ul>	<ul style="list-style-type: none"> <li>Current provision of South East Coast Clinical Senate co-adjacencies</li> <li>Current provision co-adjacencies for mech. thrombectomy</li> <li>Current provision of requirements for a Major Emergency Centre</li> </ul>	<ul style="list-style-type: none"> <li>How many sites in this option provide trauma services on site?</li> </ul>
2	<b>Access to care for all</b>	<ul style="list-style-type: none"> <li>Time to access services</li> </ul>	<ul style="list-style-type: none"> <li>Ambulance blue light, (proxy used), travel time</li> <li>Private car, off peak, travel time</li> </ul>	<ul style="list-style-type: none"> <li>What % of the population have a travel time from home to HASU of less than 30 min in this option? (ambulance blue light and private car off-peak)</li> </ul>
3	<b>Workforce</b>	<ul style="list-style-type: none"> <li>Scale of impact</li> <li>Sustainability</li> </ul>	<ul style="list-style-type: none"> <li>Gap in workforce requirements</li> <li>Current vacancies</li> <li>Current turnover</li> </ul>	<ul style="list-style-type: none"> <li>How many more consultants are needed to deliver 24/7 care in this option?</li> <li>What are the average staff vacancies and turnover rates for the sites in this option?</li> </ul>
4	<b>Ability to deliver</b>	<ul style="list-style-type: none"> <li>Expected time to deliver</li> <li>Trust ability to deliver</li> </ul>	<ul style="list-style-type: none"> <li>Trust self-assessment of time expected to deliver service</li> <li>Trust willingness to deliver option (yes/no)</li> </ul>	<ul style="list-style-type: none"> <li>What is the estimated time it would take the trusts to deliver this option?</li> <li>Are the trusts willing to deliver this option?</li> </ul>
5	<b>Affordability and value for money</b>	<ul style="list-style-type: none"> <li>Financial benefit</li> </ul>	<ul style="list-style-type: none"> <li>Financial benefit (assessed using net present value)</li> </ul>	<ul style="list-style-type: none"> <li>What is the net present value at 10 years for this option?</li> </ul>

The final criteria and quantification measures were developed via an iterative process with input from the Stroke CRG, Stroke Programme Board, K&M STP Hospital Care workstream, STP Finance Group and evaluation workshop participants. A description of each measure used and the rationale behind using it is given in each section of this document. Several other quantification measures were tested but were removed on the grounds that they were not relevant for the review or did not differentiate (for further information please see appendix).

## Options evaluation – how was it undertaken?

- Individual sites were evaluated against each of the 11 sub-criteria and assigned an evaluation:



- A rationale for each of the individual site evaluations is provided within this document
- Each option was then assigned an evaluation against each of the 11 sub-criteria using the individual site evaluations within that option
- The aim of the options evaluation is to differentiate between options in order to enable a shortlisting proposal



# 1 Quality of care for all

## Evaluation question

- Does the option provide improved delivery against clinical and constitutional standards, and access to skilled staff and specialist equipment?

### Quantification measure

### Description

### Rationale as to why used

a

Current co-location with other co-adjacent services for a HASU (based on SEC Clinical Senate)

The South East Coast Clinical Senate has set out the clinical co-dependencies required for a hyper acute stroke unit (HASU), this includes those that must be co-located and those that would benefit from co-location (see appendix). Those that must be co-located, such as emergency medicine, critical care and physiotherapy are already available on all sites under all options so this evaluation only looks at those that would benefit from co-location.

Clinicians agreed that co-location with the trauma unit and/or vascular hub (centres for non-elective inpatient vascular surgery) is very beneficial as this supports access to interventional radiology and angiographic CT scanning 24 hours a day, 7 days a week. There are also some efficiencies to co-location with inpatient dialysis, neurology, nephrology and neurosurgery.

b

Self assessment of ability to provide optimal clinical co-adjacencies for mechanical thrombectomy

Mechanical thrombectomy is an emergency procedure used to remove a blood clot from a blood vessel (vein or artery). It requires advanced imaging to identify and support the removal of the clot in the brain (interventional neuroradiology). Clinicians agreed the key co-adjacency is interventional radiology, although similar skills and equipment are required to support pPCI.

It is a clinical aspiration to deliver mechanical thrombectomy from one K&M site in the future. Clinicians agreed that options including sites that could quickly develop the clinical co-adjacencies for mechanical thrombectomy should be evaluated more favourably.

c

Self assessment of ability to provide those services required for a Medical Emergency Centre (MEC) as defined by the Keogh model

The 2014 Keogh report set out a range of delivery models for urgent and emergency services. This included the major emergency centre with specialist services which has an unselected Emergency Department supported by on-site emergency surgery and a full obstetrics services.

Major emergency centres are expected to serve populations of around 1 to 1.5 million people. As there are around 1.8 million people in Kent and Medway, it would be expected that there would be at least two major emergency centres. As major emergency centres are expected to host HASU, clinicians agreed that options including sites that already have the clinical co-adjacencies for a major emergency centre would be evaluated more favourably.



# Provision of clinical co-adjacencies for a HASU, defined by the South East Coast clinical senate – site evaluations

How has the site evaluation been done?

- A pro forma was sent to Trusts, asking whether they currently provided the co-adjacent services for a HASU, as defined by the South East Coast Clinical Senate (please see appendix)
- Of these services clinicians agreed that co-location with the **trauma unit and/or vascular hub (centres for non-elective inpatient vascular surgery)** are the most beneficial as this supports access to interventional radiology and angiographic CT scanning 24 hours a day, 7 days a week
- Based predominantly on the current provision of the **trauma unit and/or vascular hub** this, each site was assigned an evaluation, (++, +, /, -, --)

	Is the site a vascular surgery centre	Availability of on site trauma services	Other services currently offered by networked service (i.e. NOT offered on site)	Agreed site evaluation	Rationale for evaluation	
WHH	No	Yes	Inpatient dialysis <sup>1</sup> IR <sup>1</sup> Neurology <sup>1</sup>	Nephrology <sup>1</sup> Neurosurgery	+	<ul style="list-style-type: none"> <li>• On-site availability of trauma</li> </ul>
QEQM	No	No	Clinical microbiology Inpatient dialysis <sup>1</sup> IR <sup>1</sup>	Neurology <sup>1</sup> Nephrology <sup>1</sup> Neurosurgery	-	<ul style="list-style-type: none"> <li>• Both vascular and trauma networked</li> <li>• Many other key services also not available on site e.g. inpatient dialysis, IR</li> </ul>
MMH	No	Yes	Nephrology Neurosurgery		+	<ul style="list-style-type: none"> <li>• On-site availability of trauma</li> </ul>
MGH	No	No	Neurosurgery Nephrology		/	<ul style="list-style-type: none"> <li>• Both vascular and trauma networked</li> <li>• However, of the other co-adjacencies, only neurosurgery and nephrology are not provided on site</li> </ul>
TWH	No	Yes	Inpatient dialysis Nephrology Neurosurgery		+	<ul style="list-style-type: none"> <li>• On-site availability of trauma</li> </ul>
DVH	No	No	Neurosurgery		/	<ul style="list-style-type: none"> <li>• Both vascular and trauma networked</li> <li>• However, of the other co-adjacencies, only neurosurgery is not provided on site</li> </ul>





1a

# Provision of clinical co-adjacencies for a HASU, defined by the South East Coast clinical senate – option evaluations

Option	1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH	13) MGH, WHH, QEQM	Sites not included in the option are greyed out
WHH	+		+		+			+		+	+		+	
QEQM	-	-		-		-	-		-				-	
MMH		+	+	+				+	+	+		+		
MGH		/			/	/		/				/	/	
TWH							+		+	+	+			
DVH	/		/	/	/	/	/				/	/		
<b>1a) Overall evaluation</b>	/	/	+	/	+	-	/	+	/	++	+	+	/	

## Rationale for overall evaluation

- Each Trust provided the information regarding their current provision of services
- The individual site evaluations were agreed as based on the rationale on the previous page
- The overall option evaluations are based on the combination of individual site evaluations within that option, with overall evaluation assigned as set out in the key

## Key

Combination of individual site evaluations			Overall evaluation
+	+	+	++
+	+	/	+
+	/	/	+
+	+	-	/
+	/	-	/
/	/	-	-

# Provision of optimal clinical co-adjacencies for mechanical thrombectomy – site evaluations

How has the site evaluation been done?

- Clinicians agreed the key co-adjacency is interventional neuro radiology, although similar skills and equipment are required to support Primary Percutaneous Coronary Intervention (pPCI)
- A further 5 secondary services or capabilities were identified as optimal clinical co-adjacencies for mechanical thrombectomy including (CT & CT angiogram; MRI angiogram; Interventional radiology suite with capability to use general anaesthetics/ sedation; Networked with a neurology centre; and Designated trauma unit). The sites have also been assessed on their provision of these
- Based on the current provision of these services, as provided and confirmed by the Trusts, each site was assigned an evaluation, (++, +, /, -, --)

	Available on site?		Onsite services or capabilities identified as beneficial to be co-located with mechanical thrombectomy		Agreed site evaluation	Rationale for evaluations
	Interventional neuro-radiology	Acute Cardiac pPCI				
WHH	No	Yes	<ul style="list-style-type: none"> <li>• CT &amp; CT angiogram</li> <li>• MRI angiogram</li> </ul>	<ul style="list-style-type: none"> <li>• Networked with a neurology centre</li> <li>• Designated trauma unit</li> </ul>	+	<ul style="list-style-type: none"> <li>• On site availability of pPCI</li> <li>• 4 secondary beneficial services or capabilities</li> </ul>
QEQM	No	No	<ul style="list-style-type: none"> <li>• CT &amp; CT angiogram</li> <li>• MRI angiogram</li> </ul>	<ul style="list-style-type: none"> <li>• Networked with a neurology centre</li> </ul>	-	<ul style="list-style-type: none"> <li>• 3 secondary beneficial services or capabilities</li> </ul>
MMH	No	No	<ul style="list-style-type: none"> <li>• CT &amp; CT angiogram</li> <li>• MRI angiogram</li> </ul>	<ul style="list-style-type: none"> <li>• IR suite with capability to use general anaesthetics/ sedation</li> <li>• Networked with a neurology centre</li> <li>• Designated trauma unit</li> </ul>	+	<ul style="list-style-type: none"> <li>• All 5 secondary beneficial services or capabilities</li> </ul>
MGH	No	No	<ul style="list-style-type: none"> <li>• CT &amp; CT angiogram</li> <li>• MRI angiogram</li> </ul>	<ul style="list-style-type: none"> <li>• IR suite with capability to use general anaesthetics/ sedation</li> <li>• Networked with a neurology centre</li> </ul>	/	<ul style="list-style-type: none"> <li>• 4 secondary beneficial services or capabilities</li> </ul>
TWH	No	No	<ul style="list-style-type: none"> <li>• CT &amp; CT angiogram</li> <li>• MRI angiogram</li> </ul>	<ul style="list-style-type: none"> <li>• IR suite with capability to use general anaesthetics/ sedation</li> <li>• Networked with a neurology centre</li> <li>• Designated trauma unit</li> </ul>	+	<ul style="list-style-type: none"> <li>• All 5 secondary beneficial services or capabilities</li> </ul>
DVH	No	No	<ul style="list-style-type: none"> <li>• CT &amp; CT angiogram</li> <li>• MRI angiogram</li> </ul>	<ul style="list-style-type: none"> <li>• IR suite with capability to use general anaesthetics/ sedation</li> <li>• Networked with a neurology centre</li> </ul>	/	<ul style="list-style-type: none"> <li>• 4 secondary beneficial services or capabilities</li> </ul>



# Provision of optimal clinical co-adjacencies for mechanical thrombectomy – option evaluations

Option	1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH	13) MGH, WHH, QEQM	Sites not included in the option are greyed out
WHH	+		+		+			+		+	+		+	
QEQM	-	-		-		-	-		-				-	
MMH		+	+	+				+	+	+		+		
MGH		/			/	/		/				/	/	
TWH							+		+	+	+			
DVH	/		/	/	/	/	/				/	/		
<b>1b) Overall evaluation</b>	/	/	+	/	+	-	/	+	/	++	+	+	/	

## Rationale for overall evaluation

- Each Trust provided the information regarding their current provision of services
- The individual site evaluations were agreed as based on the rationale on the previous page
- The overall option evaluations are based on the combination of individual site evaluations within that option, with overall evaluation assigned as set out in the key

## Key

### Combination of individual site evaluations

+	+	+	=	++
+	+	/	=	+
+	/	/	=	+
+	+	-	=	/
+	/	-	=	/
/	/	-	=	-

### Overall evaluation

++
+
+
/
/
-



# Provision of services required to constitute a Major Emergency Centre, defined by the Keogh model – site evaluations

How has the site evaluation been done?

- The services required for a Major Emergency Centre as defined by the Keogh model were identified
- A pro-forma was sent to the Trusts asking if they currently provide these services
- Based on the Trust information returned on current provision of these services, each site was assigned an evaluation, (++, +, /, -, - -)

Available on site (yes, no, networked (N/W))

	Acute Cardiac pPCI	A&E	Emergency Surgery	Full Obstetrics	Agreed evaluation	Rationale for evaluations
WHH	Yes	Yes	Yes	Yes	++	<ul style="list-style-type: none"> <li>• On site availability of pPCI</li> <li>• No other networked services</li> </ul>
QEQM	N/W	Yes	Yes	Yes	+	<ul style="list-style-type: none"> <li>• One networked service</li> </ul>
MMH	N/W	Yes	Yes	Yes	+	<ul style="list-style-type: none"> <li>• One networked service</li> </ul>
MGH	N/W	Yes	N/W	N/W	-	<ul style="list-style-type: none"> <li>• Three networked services</li> </ul>
TWH	N/W	Yes	Yes	Yes	+	<ul style="list-style-type: none"> <li>• One networked service</li> </ul>
DVH	N/W	Yes	Yes	Yes	+	<ul style="list-style-type: none"> <li>• One networked service</li> </ul>



SOURCE: Trust self-assessment, 24 August 2017, Carnall Farrar analysis (2017)

\*Note: The CRG recommend that, although a required service for a MEC, a level 3 NICU has marginal clinical relevance to a HASU so its availability is not considered in the evaluation

# Provision of services required to constitute a Major Emergency Centre, defined by the Keogh model –option evaluations

Option	1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH	13) MGH, WHH, QEQM	Sites not included in the option are greyed out
WHH	++		++		++			++		++	++		++	
QEQM	+	+		+		+	+		+				+	
MMH		+	+	+				+	+	+		+		
MGH		-			-	-		-				-	-	
TWH							+		+	+	+			
DVH	+		+	+	+	+	+				+	+		
<b>1c) Overall evaluation</b>	++	/	++	+	+	/	+	+	+	++	++	/	+	

## Rationale for overall evaluation

- Each Trust provided the information regarding their current provision of services
- The individual site evaluations were agreed as based on the rationale on the previous page
- The overall option evaluations are based on the combination of individual site evaluations within that option, with overall evaluation assigned as set out in the key

## Key for overall evaluation:

### Combination of individual site evaluations

++	+	+	=	++
++	+	-	=	+
+	+	+	=	+
+	+	-	=	/

### Overall evaluation

++
+
+
/



### Evaluation question

- Do any options keep to a minimum the increase in the total time it takes people to get to hospital by ambulance and car (at off-peak and peak times)?

#### Quantification measure

#### Description

#### Rationale as to why used

a

Ambulance blue light, (off peak proxy used), travel time

The % of K&M population (defined as the population whose current closest stroke services is within the K&M) who have a travel time from home to HASU of less than 30 mins and less than 45 mins at off-peak times (this was agreed as an appropriate proxy for blue light ambulance travel time by SECamb service)

Access to services is very important and was consistently mentioned during pre-consultation events with clinicians, patients and the public. Assessing the % of patients who will have an ambulance travel time of less than 45 mins and 30 mins is important within the context of 120 mins call to needle time for delivering thrombolysis. (It is assumed most patients will access HASU by ambulance)

b

Private car, peak, travel time

The % of K&M population (defined as the population whose current closest stroke services is within the K&M) who have a travel time from home to HASU of less than 30 mins and less than 45 mins at peak times.

Access to services is very important and was consistently mentioned during pre-consultation events with clinicians, patients and the public. Assessing the % of patients who will have a travel time of less than 45 mins and 30 mins is important within the context of 120 mins call to needle time for delivering thrombolysis but also for ease of visitor access

Please see the PCBC travel time appendix (Appendix P) for the methodology behind this

*The new model will deliver against the national requirement for 120 minutes call to needle. Whilst call to ambulance pick up and door to needle are a key part of this pathway, the most variable is door to door – therefore we are specifically reviewing travel time from door to door as part of the evaluation.*

# % population that can access sites within 30 mins and 45 mins travel time (blue light proxy) – options evaluation

Option	1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH	13) MGH, WHH, QEQM	As is*
<b>% Total pop access HASU within 30 mins</b>	79.5	74.9	73.4	71.4	74.2	71.7	71.7	76.2	80.2	82.2	76.9	62.6	85.8	96.3
<b>Agreed evaluation</b>	++	+	+	+	+	+	+	++	++	++	++	--	++	
<b>% Total pop access HASU within 45 mins</b>	98.5	94.9	91.0	93.0	91.3	94.8	92.6	91.3	95.7	92.0	91.9	81.6	99.0	99.0
<b>Agreed evaluation</b>	++	+	+	+	+	+	+	+	++	+	+	--	++	
<b>2a) Overall evaluation</b>	++	+	+	+	+	+	+	++	++	++	++	--	++	

<p><b>Key for % Total pop access HASU within 30 mins evaluation:</b></p> <ul style="list-style-type: none"> <li>=&gt;75% access within 30 mins <span style="background-color: #1f4e79; color: white; padding: 2px 5px;">++</span></li> <li>65-74.9% access within 30 mins <span style="background-color: #4a86e8; color: white; padding: 2px 5px;">+</span></li> <li>&lt;65% access within 30 mins <span style="background-color: #cfe2f3; color: black; padding: 2px 5px;">--</span></li> </ul>	<p><b>Key for % Total pop access HASU within 45 mins evaluation:</b></p> <ul style="list-style-type: none"> <li>=&gt;95% access within 45 mins <span style="background-color: #1f4e79; color: white; padding: 2px 5px;">++</span></li> <li>85-94.9% access within 45 mins <span style="background-color: #4a86e8; color: white; padding: 2px 5px;">+</span></li> <li>&lt;85% access within 45 mins <span style="background-color: #cfe2f3; color: black; padding: 2px 5px;">--</span></li> </ul>	<p><b>Key for overall evaluation</b></p> <p>Combinations of evaluation for 45 min and 30 min</p> <ul style="list-style-type: none"> <li><span style="background-color: #1f4e79; color: white; padding: 2px 5px;">++</span> <span style="background-color: #1f4e79; color: white; padding: 2px 5px;">++</span> = <span style="background-color: #1f4e79; color: white; padding: 2px 5px;">++</span></li> <li><span style="background-color: #1f4e79; color: white; padding: 2px 5px;">++</span> <span style="background-color: #4a86e8; color: white; padding: 2px 5px;">+</span> = <span style="background-color: #1f4e79; color: white; padding: 2px 5px;">++</span></li> <li><span style="background-color: #4a86e8; color: white; padding: 2px 5px;">+</span> <span style="background-color: #4a86e8; color: white; padding: 2px 5px;">+</span> = <span style="background-color: #4a86e8; color: white; padding: 2px 5px;">+</span></li> <li><span style="background-color: #cfe2f3; color: black; padding: 2px 5px;">--</span> <span style="background-color: #cfe2f3; color: black; padding: 2px 5px;">--</span> = <span style="background-color: #e91e63; color: white; padding: 2px 5px;">--</span></li> </ul> <p>Overall evaluation</p> <ul style="list-style-type: none"> <li><span style="background-color: #1f4e79; color: white; padding: 2px 5px;">++</span></li> <li><span style="background-color: #1f4e79; color: white; padding: 2px 5px;">++</span></li> <li><span style="background-color: #4a86e8; color: white; padding: 2px 5px;">+</span></li> <li><span style="background-color: #e91e63; color: white; padding: 2px 5px;">--</span></li> </ul>
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SOURCE: Basemap off-peak travel times 2015/16; ONS population figures 2015; Carnall Farrar analysis 2017. \*There are currently no HASUs on any of the 7 acute sites in K&M this refers to general medical assessment

# % population that can access sites within 30 mins and 45 mins travel time (peak driving) – options evaluation

Option	1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH,	13) MGH, WHH, QEQM	As is*
<b>% Total pop access HASU within 30 mins</b>	78.3	72.9	71.9	70.6	73.3	71.4	71.5	73.6	78.4	79.8	76.4	62.1	82.9	97.6
<b>Agreed evaluation</b>	++	+	+	+	+	+	+	+	++	++	++	--	++	
<b>% Total pop access HASU within 45 mins</b>	98.4	95.6	91.0	93.4	91.6	95.5	92.4	91.6	96.3	92.2	92.1	81.7	99.1	99.7
<b>Agreed evaluation</b>	++	++	+	+	+	++	+	+	++	+	+	--	++	
<b>2b) Overall evaluation</b>	++	++	+	+	+	++	+	+	++	++	++	--	++	

## Key for % Total pop access HASU within 30 mins evaluation:

=>75% access within 30 mins

++

65-74.9% access within 30 mins

+

<65% access within 30 mins

--

## Key for % Total pop access HASU within 45 mins evaluation:

=>95% access within 45 mins

++

85-94.9% access within 45 mins

+

<85% access within 45 mins

--

## Key for overall evaluation

Combinations of evaluation for 45 min and 30 min

++

++

=

++

++

+

=

++

+

+

=

+

--

--

=

--

Overall evaluation





## Workforce – sustainability and impact on local workforce

### Evaluation question

- Do the options vary in the need to employ extra stroke workforce?
- Where is it more difficult to recruit and retain staff?

#### Quantification measure

#### Description

#### Rationale as to why used

a

Number of staff required to run HASUs based on bed numbers under each option and best practice workforce requirements (only differentiator will be the number of consultants required to run rotas for larger units)

The number of stroke consultants will be different for different options as sufficient are required to staff a rota for 24 hours a day, seven days a week – the difference between this number of consultants required and the number in post is measured and evaluated (The number of nurses and allied health professionals required to run hyper acute and acute stroke units varies with the number of beds and, as the total number of beds are the same in all options, this therefore does not differentiate between options)

There are shortages in stroke consultants in K&M and nationally, therefore any options which require fewer consultants will be evaluated more favourably

b

Turnover rates by site (not stroke specific)

The average turnover rate for the last 3 years for all nursing and midwifery staff and medical staff by site

The ability of individual sites to retain staff working in hyper acute and acute stroke units can be indicated by turnover rates.

c

Vacancy rates by site (not stroke specific)

The average vacancy rate for the last 3 years for all nursing and midwifery staff and medical staff by site

The ability of individual sites to recruit staff working in hyper acute and acute stroke units can be indicated by turnover rates.



## Current consultant workforce for stroke by site

Trust	Site	Substantive no. of Whole Time Equivalents (WTEs) = 10 Programmed Activities (PAs)
MTW	MGH	0.9
MTW	TWH	0.7
MFT	MMH	2.5
EKHUFT	K&C	0.6
EKHUFT	QEQM	1.8
EKHUFT	WHH	1.8
D&G	DVH	1.6
<b>Total</b>	-	<b>9.9</b>



# Gap in workforce for consultants based on best practice requirements compared to in post staff

Option	1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH,	13) MGH, WHH, QEQM
K&M consultant gap, WTEs*	10	8	8	8	8	8	10	8	8	8	8	8	8
Additional consultants required at PRUH**	0	2	0	0	0	0	0	2	2	2	0	0	2.25
3a) Overall evaluation	-	-	/	/	/	/	-	-	-	-	/	/	-

## Notes

- As agreed at the workshop on 30/08, a neutral evaluation is used for the smallest consultant gap, with everything else negative to represent the recruitment challenge this poses
- This analysis takes into account the additional consultant workforce required to support activity outflows from K&M – this was requested at the workshop on 30/08
- The gap in K&M consultant staff has been calculated based on the assumption that the 9.9 WTE currently in post could fulfil some of the requirement
- The consultant requirement at the PRUH has been calculated based on a pro rata of activity volumes, therefore representing the additional consultants required rather than the gap against the total consultants currently in post at the PRUH

## K&M consultant gap + Additional consultants required at PRUH

$\geq 12$



$8 > X = 10$



$\geq 8$



## Overall evaluation

SOURCE: Provider information (2017); STP workstream analysis (2017); Clinical Standards, South East Stroke service specification (2017)

NOTES: \*Consultant requirements have been calculated based on a 1:6 rota for all units until the modelled predicted activity at a site is over 1,300 when a 1:8 rota has been used.

This is based on conversations with Frimley, this is for further discussion. This includes the extra staff that would be required at non-K&M sites based on patient out flows under some options \*\*BASP define a sliding scale for consultant DCC PA requirements in their 2011- 2015 document



## Vacancy rates by site for medical and nursing staff (not stroke specific) – average over the last three years

Site	Vacancy rates for nursing and midwifery staff (average for 2015-2017), % of establishment posts	Vacancy rates for medical staff (average for 2015-2017), % of establishment posts
DVH	11.41	7.70
TWH	16.87	2.03
MGH	19.83	11.35
MMH	24.00	20.00
QEQM	8.80	9.16
WHH	8.41	7.29

These are not specific for the stroke service

It was noted that hospital wide vacancy rates, where unusual circumstances may have applied, may not be indicator of future ability to recruit staff to HASU/ASU services



# 3b Vacancy rates overall evaluation

Option	1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH	13) MGH, WHH, QEQM	As is
Average vacancy rate for the 3 sites in the option (nursing & midwifery)	9.54	17.54	14.61	14.74	13.22	13.35	12.36	17.41	16.56	16.43	12.23	18.41	12.35	14.80
Agreed evaluation	++	--	/	/	+	+	+	--	--	--	+	--	+	
Average vacancy rate for the 3 sites in the option (medical)	8.50	13.50	11.66	12.28	8.78	9.40	6.30	12.88	10.40	9.77	5.67	13.02	9.27	9.50
Agreed evaluation	+	--	-	--	+	/	++	--	-	/	++	--	-	
3b) Overall evaluation	++	--	/	-	+	/	++	--	--	-	++	--	/	

**Key for evaluation against average vacancy rate for the 3 sites in the option (nursing & midwifery)**

- Turnover rate **significantly below** as is (<10) ++
- Turnover rate **below** as is (10<X<14) +
- Turnover rate **consistent with** as is (14<X<16) /
- Turnover rate **above** as is -
- Turnover rate **significantly above** as is (>16) --

**Key for evaluation against average vacancy rate for the 3 sites in the option (medical)**

- Turnover rate **significantly below** as is (<8) ++
- Turnover rate **below** as is (8<X<9) +
- Turnover rate **consistent with** as is (9<X<10) /
- Turnover rate **above** as is (10<X<12) -
- Turnover rate **significantly above** as is (>12) --

**Key Combinations of nursing and medical vacancy evaluation**

++	+	=	++
+	+	=	+
+	/	=	/
+	-	=	/
/	-	=	/

**Combinations of nursing and medical vacancy evaluation**

/	--	=	-
-	--	=	--
--	--	=	--

SOURCE: Trust workforce data (2015-2017); STP workforce team (2017)

## Turnover rates by site for medical and nursing staff (not stroke specific) - average over the last three years (1/4)

Site	Turnover rates for nursing and midwifery staff (average for 2015-2017), % of establishment posts	Turnover rates for medical staff (average for 2015-2017), % of establishment posts
DVH	10.18	9.48
TWH	6.51	3.82
MGH	7.05	3.32
MMH	13.10	4.02
QEQM	9.30	4.67
WHH	9.30	4.67

These are not specific for the stroke service

It was noted that hospital wide turnover rates, where unusual circumstances may have applied, may not be indicator of future ability to retain staff to HASU/ASU services



# Turnover rates overall evaluation

Option	1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH	13) MGH, WHH, QEQM	As is
Average turnover rate for Nursing and Midwifery for sites in option (%)	9.59	9.82	10.86	10.86	8.84	8.84	8.66	9.82	9.64	9.64	8.66	10.11	8.55	9.24
Agreed evaluation	-	-	--	--	+	+	+	-	-	-	+	-	+	
Average turnover rate for Medical staff for sites in option (%)	6.28	4.00	6.06	6.06	5.82	5.82	5.99	4.01	4.17	4.17	6.00	5.61	4.22	5.00
Agreed evaluation	--	++	--	--	-	-	--	++	++	++	--	-	+	
<b>3c) Overall evaluation</b>	<b>--</b>	<b>+</b>	<b>--</b>	<b>--</b>	<b>/</b>	<b>/</b>	<b>-</b>	<b>+</b>	<b>+</b>	<b>+</b>	<b>-</b>	<b>-</b>	<b>+</b>	

**Key for evaluation against average vacancy rate for the 3 sites in the option (nursing & midwifery)**

Turnover rate <b>significantly below</b> as is (<8)	++
Turnover rate <b>below</b> as is (8<X<9)	+
Turnover rate <b>consistent with</b> as is	/
Turnover rate <b>above</b> as is (<9X<10.5)	-
Turnover rate <b>significantly above</b> as is (>10.5)	--

**Key for evaluation against average vacancy rate for the 3 sites in the option (medical)**

Turnover rate <b>significantly below</b> as is (<4.2)	++
Turnover rate <b>below</b> as is (4.2=X<5)	+
Turnover rate <b>consistent with</b> as is	/
Turnover rate <b>above</b> as is (5<X<6)	-
Turnover rate <b>significantly above</b> as is (>=6)	--

**Key Combinations of nursing and medical vacancy evaluation Overall evaluation**

++	-	=	+
+	+	=	+
+	-	=	/
+	--	=	-
-	-	=	-
-	--	=	--
--	--	=	--

SOURCE: Trust workforce data (2015-2017); STP workforce team (2017)

## Evaluation question

---

- How easy will it be to deliver change?
- How able/willing to deliver are the Trusts in question for each option?

### Quantification measure

### Description

### Rationale as to why used

---

a

Trust self-assessment of time to deliver based on the new capacity required

Trusts were asked to assess how long it would take to them to deliver the option based on the capacity required: 0 – 6 months; 6 – 12 months; 12 – 18 months and 18+ months

It is important that change can be delivered as quickly and easily as possible so that the benefits from the change can be gained as soon as possible.

b

Self certify ability to deliver each Trust by option

Trusts were asked if they would be willing to deliver the option, taking into account issues e.g. management capacity to deliver change, the ability of a Trust to run hyper acute and acute stroke units on two sites (where applicable), and ability to attract the workforce from other site

It is important that the Trusts want to and feel able to deliver the change





# Expected time and ease to deliver (incl. PRUH)– options evaluation

Option	1)	2)	3)	4)	5)	6)	7)	8)	9)	10)	11)	12)	13)
<b>Site 1</b>	DVH	MGH	DVH	DVH	DVH	DVH	DVH	MGH	TWH	TWH	DVH	DVH	MGH
Time to deliver (mnths)	12-18	6-12	6-12	6-12	6-12	6-12	12-18	0-6	6-12	6-12	12-18	6-12	6-12
Evaluation	-	/	/	/	/	/	-	+	/	/	-	/	/
<b>Site 2</b>	WHH	MMH	MMH	MMH	MGH	MGH	TWH	MMH	MMH	MMH	TWH	MGH	WHH
Time to deliver (mnths)	18+	0-6	0-6	12 - 18	6-12	12 -18	6-12	0-6	12 -18	6-12	6-12	6-12	18+
Evaluation	--	+	+	-	/	-	/	+	-	/	/	/	--
<b>Site 3</b>	QEQM	QEQM	WHH	QEQM	WHH	QEQM	QEQM	WHH	QEQM	WHH	WHH	MMH	QEQM
Time to deliver (mnths)	18+	18+	18+	18+	18+	18+	18+	18+	18+	18+	18+	12-18	18+
Evaluation	--	--	--	--	--	--	--	--	--	--	--	-	--
<b>External sites option</b>	0-6	18+	0-6	0-6	0-6	0-6	0-6	0-6	18+	18+	0-6	0-6	18+
Time to deliver (mnths)	0-6	18+	0-6	0-6	0-6	0-6	0-6	0-6	18+	18+	0-6	0-6	18+
Evaluation	+	-	+	+	+	+	+	+	-	-	+	+	-

<b>4a) Overall evaluation</b>	-	-	/	-	/	-	-	+	-	-	-	/	-
-------------------------------	---	---	---	---	---	---	---	---	---	---	---	---	---

**Key for individual sites time to deliver (months)**

0-6 12-18 (18+ for external)

6-12 18+

PRUH bed numbers are smaller and so have a lower impact on overall evaluation

**Combination of individual site evaluations Overall evaluation**

				=	
				=	
				=	
				=	
				=	

SOURCE: Trust self-assessment, 24 August 2017, Carnall Farrar analysis (2017)

1) Currently based on assumption from PRUH that any change would take 2-3 years to implement 2) PRUH timescales are 0-6months because activity flows from PRUH in these options 3) PRUH bed numbers are smaller and so have a lower impact on overall evaluation

# Trust willingness to deliver – options evaluation

Option	1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH,	13) MGH, WHH, QEQM
	DVH	MGH	DVH	DVH	DVH	DVH	DVH	MGH	TWH	TWH	DVH	DVH	MGH
Willing to deliver? Site 1	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
	WHH	MMH	MMH	MMH	MGH	MGH	TWH	MMH	MMH	MMH	TWH	MGH	WHH
Willing to deliver? Site 2	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO
	QEQM	QEQM	WHH	QEQM	WHH	QEQM	QEQM	WHH	QEQM	WHH	WHH	MMH	QEQM
Willing to deliver? Site 3	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO
<b>4b) Overall evaluation</b>	--	++	++	++	++	++	++	++	++	++	++	++	--

- Trusts were asked to fill in a pro-forma confirming whether or not they were willing to deliver each option based on a yes/no response
- The pro forma was signed by the Chief Executive and Medical Director of each Trust respectively
- East Kent Hospitals University Trust felt unable to deliver 2 sites with HASU/ASU
- The information collected through the pro forma was directly reflected in the options evaluation
- The responses for options 12 and 13 were confirmed with Trusts

**Key**

**Combinations of individual site evaluations**

YES	YES	YES	=	++
YES	NO	NO	=	--



## Evaluation question

---

- Which options will give the greatest financial benefit assessed using net present value over the next 10 years?

## Quantification measures

---

- a • Highest financial benefit assessed using net present value after 10 years (capital costs are a component of NPV so not considered independently)



# 5a Financial benefit

Option	1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH,	13) MGH, WHH, QEQM
NPV (10yr, £k)	(10,732)	16,855	17,666	24,449	12,107	8,529	(10,047)	14,379	17,232	16,086	16,283	27,959	(1,540)
5a) Overall evaluation	--	+	+	++	+	/	--	+	+	+	+	++	-

- **Net present value** is a calculation to see whether the amount invested today in the new model of care results in an improvement to the amount stroke services cost in the future as compared to today

Key	10ys NPV Criteria (£000)	Overall evaluation
	>24,000	= ++
	14,000-24,000	= +
	8,000-14,000	= /
	-2,000 -10,000	= -
	<-2,000	= --

# Full evaluation matrix

		1) DVH, WHH, QEQM	2) MGH, MMH, QEQM	3) DVH, MMH, WHH	4) DVH, MMH, QEQM	5) DVH, MGH, WHH	6) DVH, MGH, QEQM	7) DVH, TWH, QEQM	8) MGH, MMH, WHH	9) TWH, MMH, QEQM	10) TWH, MMH, WHH	11) DVH, TWH, WHH	12) DVH, MGH, MMH	13) MGH, WHH, QEQM
1	Quality													
	• SEC co-adjacencies	/	/	+	/	+	-	/	+	/	++	+	+	/
	• Co-adjacencies for mech. thrombectomy	/	/	+	/	+	-	/	+	/	++	+	+	/
	• Req. for MEC	++	/	++	+	+	/	+	+	+	++	++	/	+
2	Access													
	• Blue light, proxy	++	+	+	+	+	+	+	++	++	++	++	--	++
	• Private car, off peak	++	++	+	+	+	++	+	+	++	++	++	--	++
3	Workforce													
	• Gap in workforce requirements	-	-	/	/	/	/	-	-	-	-	/	/	-
	• Vacancies	++	--	/	-	+	/	++	--	--	-	++	--	/
	• Turnover	--	+	--	--	/	/	-	+	+	+	-	-	+
4	Ability to deliver													
	• Expected time to deliver	-	-	/	-	/	-	-	+	-	-	-	/	--
	• Trust ability to deliver	--	++	++	++	++	++	++	++	++	++	++	++	--
5	Finance													
	• Net Present Value (NPV at 10 yrs, £m)	--	+	+	++	+	/	-	+	+	+	+	++	-


# Appendix



## Terms of Reference: Initial evaluation workshop 30/08 (1/2)

The purpose of this meeting is to:

1. Review the supporting analysis to enable an assessment of the options against each of the agreed evaluation criteria (**clinical and non-financial only**)
2. Make an assessment of the options against each of the evaluation criteria and assign draft evaluations (++, +, /, -, --)

- This workshop is the first opportunity to **engage on and get input into the emerging evaluation** of the medium list of options for stroke against **clinical / non-financial criteria**
  - The CCGs are in the process of reviewing with a view to endorse the hurdle criteria, medium list of options and evaluation criteria – as such, **the current options and evaluation criteria are not set in stone**, but will be used as a basis for discussion and input today
  - The outputs of both workshops will be brought together in a full evaluation session, where the options can be considered in the round
  - Following review and feedback from the SE Clinical Senate in October, the CCGs will then take the final decision about the most viable options and whether to go out to consult on these
  - This may include options not discussed today if more information on other potential options comes to light over the next couple of months
- 

## Terms of Reference: Initial evaluation workshop 30/08 (2/2)

- Both voting participants and contributors are able to participate fully in discussions
- A voting participant from each table should provide feedback to the room in the plenary sessions
- In the event of being unable to reach consensus, the room will move to a vote. Only voting participants can take part in the vote. This addresses potential perceived conflicts of interest.

### Voting participants (for assigning evaluation):

- CCG Clinical Chairs, Accountable Officers and CFOs (or nominated deputy)
- NHS England representative
- Patient representatives (including PPAG members)
- Healthwatch (Kent and Medway)
- Stroke Association representative
- Directors of Public Health (KCC and MUA)
- Directors of Adult Social Care (KCC and MUA)
- Kath Pasco (Independent Advisor, K&M Stroke CRG)
- Tony Rudd (National Clinical Director for Stroke, NHS England)
- Patricia Davies (K&M Stroke SRO)
- Oena Windibank (K&M Stroke Programme Director)
- Shelley Whittaker (K&M Stroke Comms & Eng Lead)

### Invited as contributors:

- JHOSC Chair and Vice Chair
- K&M acute trust Medical Directors and Finance Directors
- SECAMB representatives
- Nominated CRG representative (one from each trust – including acute and community trusts)
- K&M Clinical Board members (including mental health trust and community trust representatives, as well as acute trust MDs and SECAMB representatives – see above)
- CCG Clinical Chairs and Accountable Officers from Bexley CCG and Bromley CCG
- KCH NHS FT representative





## List of workshop attendees (30/08)

Name	Organisation	Scoring participant or contributor
Sally Allen	West Kent CCG	Voting participant
Rebecca Bradd	STP Workforce Programme Lead	Contributor
Jim Cross	Stroke Ambassador	Voting participant
Patricia Davies	Stroke Review SRO	Voting participant
Michelle Gatehouse	Dartford & Gravesham NHS Trust	Contributor
Tara Galloway	Stroke Association	Voting participant
David Hargroves	East Kent Hospitals University Foundation Trust	Contributor
Dr Liz Lunt	NHS Dartford, Gravesham and Swanley CCG	Voting participant
Ian Hutchison	Carnall Farrar	Contributor
Stuart Jeffrey	Medway CCG	Voting participant
Rachel Jones	NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG	Voting participant
Helen Lovelock	STP Workforce Workstream	Contributor
Peter Maskell	Maidstone and Tunbridge Wells NHS Trust	Contributor
Jeffrey Overton	South East Coast Ambulance Service NHS Foundation Trust	Contributor
Kath Pasco	Frimley Health	Voting participant
Andrew Scott-Clark	Kent County Council	Voting participant
Mark Spencer	Carnall Farrar	Contributor
Sarah Vaux	Medway CCG	Voting participant
David Whiting	Medway Council	Voting participant
Shelley Whittaker	Stroke Review Communications and Engagement Lead	Voting participant
Oena Windibank	Programme Director	Voting participant
Kirti Mukherjee	Medway NHS Foundation Trust	Contributor
Samuel Sanmuganathan	Medway NHS Foundation Trust	Contributor
Rihanna Roderick	South East Coast Ambulance Service NHS Foundation Trust	Voting participant



## Terms of Reference: Full evaluation workshop 20/09 (1/2)

The purpose of this meeting is to:

- Review the medium list of potential site-specific grouping options for acute stroke services in K&M
- Review the previous evaluation by the workshops on 30 August and 8 September, the Stroke CRG and the Stroke Programme Board
- Reach agreement on the individual evaluation assessments, taking into account wisdom that may not come through in the analysis
- Agree the evaluation matrix with a view to excluding less viable options
- Consider the combination of evaluations so as to recommend a shortlist of possible site combinations that should be recommended for consultation



## Terms of Reference: Full evaluation workshop 20/09 (2/2)

- Both voting participants and contributors are able to participate fully in discussions
- A voting participant from each table should provide feedback to the room in the plenary sessions
- In the event of being unable to reach consensus, the room will move to a vote. Only voting participants can take part in the vote. This addresses potential perceived conflicts of interest.

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- Shelley Whittaker (K&M Stroke Comms & Eng Lead)

### Invited as contributors:

- JHOSC Chair and Vice Chair
- K&M acute trust Medical Directors and Finance Directors
- SECAMB representatives
- Nominated CRG representative (one from each trust – including acute and community trusts)
- K&M Clinical Board members (including mental health trust and community trust representatives, as well as acute trust MDs and SECAMB representatives – see *above*)
- CCG Clinical Chairs and Accountable Officers from Bexley CCG and Bromley CCG
- KCH NHS FT representative



## Terms of Reference: Full evaluation workshop 20/09 (2/2)

- Both voting participants and contributors are able to participate fully in discussions
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### Invited as contributors:

- JHOSC Chair and Vice Chair
- K&M acute trust Medical Directors and Finance Directors
- SECAMB representatives
- Nominated CRG representative (one from each trust – including acute and community trusts)
- K&M Clinical Board members (including mental health trust and community trust representatives, as well as acute trust MDs and SECAMB representatives – see *above*)
- CCG Clinical Chairs and Accountable Officers from Bexley CCG and Bromley CCG
- KCH NHS FT representative



## Evaluation workshop attendees (20/09) (1/2)

Name	Role	Organisation
Steve Fenlon	Medical Director	Dartford and Gravesham NHS Trust
Michelle Gatehouse	Stroke Service Co-ordinator	Dartford and Gravesham NHS Trust
Lorraine Clegg	Finance Director	Dartford and Gravesham NHS Trust
Rachel Jones	Chief Officer	Dartford, Gravesham and Swanley CCG
David Hargroves	Stroke Consultant	East Kent Hospitals University NHS Foundation Trust
Nick Gerrard	Finance Director	East Kent Hospitals University NHS Foundation Trust
Louise Dineley	Programme Director	East Kent Strategic Programme Board
Steve Innet	Chief Executive	Kent Healthwatch
Katy Davies	Clinical Lead for Stroke	Maidstone and Tunbridge Wells NHS Trust
Sarah Vaux	Chief Nurse	Medway CCG
Samuel Sanmuganathan	Stroke Consultant	Medway NHS Foundation Trust
Diana Hamilton-Fairley	Medical Director	Medway NHS Foundation Trust
Tracey Cotterill	Finance Director	Medway NHS Foundation Trust
James Williams	Director of Public Health	Medway Unitary Authority
Claire Hall	Clinical Education Lead	South East Coast Ambulance Service NHS Foundation Trust
Jim Cross	Stroke Ambassador	Stroke Association
Tara Galloway	Interim Lead for South East Coast	Stroke Association
Oena Windibank	Programme Director	Stroke Review
Patricia Davies	SRO	Stroke Review
Sally Allen	Head of System-Wide Commissioning	West Kent CCG



## Evaluation workshop attendees (20/09) (2/2)

Name	Role	Organisation
Ruth Linklater	Strategic Development Manager	East Kent Hospitals University NHS Foundation Trust
Matthew Trainer	Managing Director	Kings College Hospital NHS Foundation Trust
Ray Savage	Kent Account Manager	South East Coast Ambulance service
Ian Ayres	Accountable Officer	West Kent CCG
Ibrahim Balogun	Stroke Consultant	East Kent Hospitals University NHS Foundation Trust
Sarah Overton	Head of Strategy	Maidstone and Tunbridge Wells NHS Trust
Richard Brailey	Deputy Chief Finance Officer	Medway CCG
Lisa Clinton	Deputy for comms and engagement lead	Stroke Review
Sarah MacDermott	Deputy Clinical Chair	Dartford, Gravesham and Swanley CCG
Helen Lovelock	Programme Manager	STP Workforce w/s
Photis Garipis	Service Manager for Neurosciences and Stroke	Kings College Hospital
Hannah Farrar	Partner	Carnall Farrar
Bev Evans	Partner	Carnall Farrar
Mark Spencer	Principal	Carnall Farrar
Ellie Davies	Analyst	Carnall Farrar
Ian Hutchison	Senior Analyst	Carnall Farrar
Alice Caines	Manager	Carnall Farrar
Liz Knight	Principal	Carnall Farrar



## Terms of Reference: Stroke options shortlisting workshop (11/10)

The purpose of this meeting is to:

- Have a shared understanding of the evaluation process and outcomes to date
- Review the recommendations from CRG regarding the quality evaluation
- Review the recommendations from Finance Group regarding the finance evaluation
- Confirm the evaluation matrix
- **As CCGs, the bodies that will be going out to consult, agree the shortlist of options**
- Align on next steps



## Workshop attendees (11/10)

Name	Role	Organisation
Ashley Scarff	Deputy Chief Officer	NHS High Weald Lewes Havens CCG
Simon Perks	Accountable Officer	Ashford CCG and NHS Canterbury and Coastal CCG
Ian Ayres	Accountable Officer	NHS West Kent CCG
Caroline Selkirk	Accountable Officer	NHS Medway CCG
Patricia Davies	Accountable Officer	DGS/Swale CCG
Hazel Carpenter	Accountable Officer	Thanet and South Kent Coast CCG
Navin Kumta	Chair	Ashford CCG
Nick Dawe	Chief Finance Officer	Ashford CCG and NHS Canterbury and Coastal CCG
Peter Green	Chair	Medway CCG
David Baines	Deputy Director of Finance	East Kent Hospital University NHS Foundation Trust
Glenn Douglas	CEO	Maidstone and Tunbridge Wells NHS Trust
Jonathan Bryant	Chair	South Kent Coast CCG
Shekh Motin	Chief Finance Officer	Medway CCG
Simon Lundy	Clinical Lead	Ashford and Canterbury CCGs
Jonathan Bates	Chief Finance Officer	CCG Thanet and SICC
Steve Orpin	Director of Finance	MTW
Sarah Macdermott	Deputy Chair	DGS CCG
Hannah Farrar	Partner	Carnall Farrar
Bev Evans	Partner	Carnall Farrar
Mark Spencer	Principal	Carnall Farrar
Ellie Davies	Analyst	Carnall Farrar
Jamie Leverton	Consultant	Carnall Farrar
Charlotte Osborne	Analyst	Carnall Farrar
Liz Knight	Principal	Carnall Farrar <a href="#">(first 30 mins by phone)</a>



# Evaluation criteria: rationale for removal of quantification measures (1/3)

Criteria	Sub-criteria	Evaluation question	Quantification measure	Rationale if not measured/ used in final matrix
1 Quality of care for all	• Clinical effectiveness and responsiveness	• Does the option provide improved delivery against clinical and constitutional standards, access to skilled staff and specialist equipment?	<ul style="list-style-type: none"> <li>• Current co-location with other co-dependent services for a HASU (based on SEC Clinical Senate), including provision of inpatient rehabilitation</li> <li>• Self assessment of ability to provide optimal clinical co-adjacencies for mechanical thrombectomy</li> <li>• Self assessment of ability to provide those services required for a Medical Emergency Centre (MEC) as defined by the Keogh model</li> <li>• Percentage who can access services within 30 mins and within 45 mins (blue-light)</li> <li>• Number of patient transfers</li> </ul>	<p>All trust pro-formas gave the same information regarding current availability of rehab so it was non-differentiating</p> <p>All access is considered under the access criterion</p>
	• Patient and carer experience	• Which options would provide a better experience for patients?	<p>Would expect these to be improved similarly for all options under new model of care therefore do not differentiate between options</p>	<p>There would be no repatriation following a HASU stay, the closest ASU for patients accessing a non-K&amp;M site would still be outside K&amp;M</p>
	• Safety	• What is the expected impact on excess mortality, serious untoward incidents and patient harm?		
	2 Access to care for all	• Time to access services	• Do any options keep to a minimum the increase time it takes people to get to hospital by ambulance, car (peak times)	<ul style="list-style-type: none"> <li>• Private car – Percentage who can access services within 30 mins and within 45 mins, peak</li> <li>• Private car – Percentage who can access services within 30 mins and within 45 mins, off peak</li> <li>• Public transport – peak travel times (Percentage who can access within 2 hours)</li> </ul>
• Service operating hours		• What is the ability of model to facilitate 7 day working and improved access to care out of hours?	<p>Would expect these to be the same for all options under new model of care therefore agreed no to differentiate between options (w/s 30/08)</p>	
• Compliance with Competition and Markets Authority (CMA)		• Which options would give people in Kent the greatest choice of hospitals for each service under consideration across the greatest number of trusts?	<p>Patient feedback was that that choice was not an important factor in acute stroke care – patients would access closest site via ambulance</p>	

## Evaluation criteria: rationale for removal of quantification measures (2/3)

Criteria	Sub-criteria	Evaluation question	Quantification measures	Rationale if not measured/ used in final matrix
3	Workforce	<ul style="list-style-type: none"> <li>Scale of impact</li> </ul>	<ul style="list-style-type: none"> <li>Number of staff impacted by the proposed option including impact of Agenda for Change</li> </ul>	<p>Participants at w/s 30/08 agreed this was useful for planning purposes but not differentiating as it was unclear whether or not staff would move</p>
		<ul style="list-style-type: none"> <li>Sustainability</li> </ul>	<ul style="list-style-type: none"> <li>Number of consultants required (all other workforce will be the same as only considering 3 site options)</li> </ul>	
		<ul style="list-style-type: none"> <li>Impact on local workforce</li> </ul>	<ul style="list-style-type: none"> <li>Number of staff impacted by the proposed option including impact of Agenda for Change</li> </ul>	
5	Ability to deliver	<ul style="list-style-type: none"> <li>Expected time to deliver</li> </ul>	<ul style="list-style-type: none"> <li>Vacancy rates and turnover by site</li> </ul>	<p>All trust pro-formas gave the same information regarding current availability of rehab so it was non-differentiating</p>
		<ul style="list-style-type: none"> <li>Co-dependencies with other strategies</li> </ul>	<ul style="list-style-type: none"> <li>Trust self-assessment of time to deliver based on the new capacity required (Pro-forma)</li> <li>Availability of community rehabilitation and social services</li> </ul>	
		<ul style="list-style-type: none"> <li>Trust ability to deliver</li> </ul>	<ul style="list-style-type: none"> <li>Fit with national initiatives</li> <li>Fit with local strategies in place or in-development (Pro-forma)</li> </ul>	<p>Found to be non-differentiating</p>
		<ul style="list-style-type: none"> <li>How easy will it be to deliver change within 5 years?</li> </ul>	<ul style="list-style-type: none"> <li>Trust self assessment</li> </ul>	<p>Participants at the w/s 30/08 felt this was subjective and difficult to score. It was agreed that whilst this was important information, it was non differentiating. In some cases, Trust strategies might be defined by the situation of the HASU sites.</p>
		<ul style="list-style-type: none"> <li>How well does each align with other strategic changes and provide a flexible platform for the future?</li> </ul>	<ul style="list-style-type: none"> <li>How able / willing to deliver are the Trusts in question for each option?</li> </ul>	



# Evaluation criteria: rationale for removal of quantification measures (3/3)

Criteria	Sub-criteria	Evaluation question	Quantification measures	Rationale if not measured/ used in final matrix
5 Affordability and value for money	• Capital cost to the system	• Which options would have the lowest capital costs (cost of buildings and equipment)?	<ul style="list-style-type: none"> <li>• Estimated capital costs for new additional capacity, including the number of new beds required for each site; impact on wider capacity e.g. A&amp;E, critical care; cost of additional equipment e.g. CT scanner, etc.</li> </ul>	It was agreed at the Financial Evaluation w/s 08/09, that since capital charges is calculated as a % of capital investment required the evaluation of capital charges would be duplicative of that of capital investment requirements
	• Revenue costs to the system	• Which options will have the lowest revenue costs	<ul style="list-style-type: none"> <li>• Increased cost of staff based on number of consultants and nurses required</li> </ul>	
	• Transition costs	• Which options would have the lowest cost of transferring services between hospitals?	<ul style="list-style-type: none"> <li>• Consideration of double running costs, training, potential redundancies</li> </ul>	It was agreed at the Financial Evaluation w/s 08/09, that workforce is non-differentiating
	• Financial benefit assessed using net present value technique	• Which options will give the best financial benefit (assessed using net present value) over the next 10 years?	<ul style="list-style-type: none"> <li>• Lowest NPC / highest NPV, relative to 'do nothing' by:               <ul style="list-style-type: none"> <li>- Understanding the total investment requirements including commissioner and provider (up front capital investment, ongoing replacement capex, one-off transition costs, any workforce costs)</li> <li>- Understanding the total potential benefits including commissioner and provider (consolidation savings, net change to fixed costs, capital receipts)</li> </ul> </li> </ul>	



# The South East Coast Clinical Senate has set out the clinical co-dependencies required for a HASU

Service should be co-located in the same hospital

Emergency medicine
Acute and General Medicine
Elderly Medicine
Respiratory Medicine
Urgent GI Endoscopy
Critical Care (adults)
Gen Anaesthetics
Acute Cardiology
X-ray and diagnostic ultrasound
CT
MRI
OT
Physio
Acute (Liaison) Mental Health

Service should come to patient (patient transfer not appropriate), but could be provided by visiting/inreach from another

Nephrology
Palliative Care
Neurology
Speech and Language
Dietetics

Ideally on same site but could alternatively be networked via robust emergency and elective referral and transfer protocols

Ophthalmology
General Surgery
Trauma
Orthopaedics
Hub Vascular Surgery
Neurosurgery
Critical Care (paediatric)*
Acute Stroke Unit
Inpatient dialysis
Acute Paediatrics
Nuclear Medicine
IR
Clinical and lab microbiology
Urgent diagnostic haematology
Acute inpatient rehabilitation

