Report on the Shortlisting Process

The purpose of this report is to present the Programme Board's proposed shortlist of options and to summarise the process undertaken by the Evaluation Panel in developing its recommendations to the Board.

Sponsor organisations and other stakeholders are invited to consider these proposals as set out in the table below:

Key Decision Documents	Programme Board	CCGs	Other Sponsors	Joint HOSC	Health & Wellbeing Boards
Selection of Short List	Approve	Approve	Endorse	Consider	Receive

Executive Summary

The Programme Board received recommendations from the Evaluation Panel appointed by its sponsors and other stakeholders.

The Board had an extensive discussion of the Panel's recommendations in the light of all the evidence provided (including a minority report from a patient representative). Following this discussion the Board agreed the following acute services shortlist:

- Emergency Centre (EC) and Diagnostic & Treatment Centre (DTC) on a New site;
- EC on a New site, DTC at Princess Royal Hospital (PRH)
- EC on a New site, DTC at Royal Shrewsbury Hospital (RSH)
- EC at PRH, DTC at RSH
- EC at RSH, DTC at PRH
- Do minimum (existing dual site acute services maintained, provider and commissioner efficiency strategies implemented but no major services change).

The Board also agreed that there should be further debate on the best and safest configuration of obstetric services within these scenarios. This should include reviewing the clinical evidence and workforce models to understand whether obstetrics could operate on a site alongside a DTC, alongside an Emergency Centre or alongside either.

On Urgent Care Centres (UCCs) Programme Board agreed to proceed to work on:

- Prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and
- Exploring the most appropriate rural urgent care solutions in partnership with local communities and considering current facilities/services. All existing Minor Injuries Units will be considered as potential sites for Urgent Care Centres.

Next steps include:

- A further round of pre-consultation public engagement which kicks off with two 'pop-up shops', one in Telford Shopping Centre on 20/21 Feb and Shrewsbury Darwin Shopping Centre 27/28 Feb. Events in Powys are also being planned. Many more events will follow and will be publicised via the NHS Future Fit website;
- Detailed development of the shortlisted options (including estates, workforce and finance).

It is expected that the Board will be able to propose a preferred option later in the year. Formal Public Consultation would then commence from December 2015 (subject to the timing of national approvals).

Background

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

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

NHS England and Montgomeryshire Community Health Council declined to nominate members because of their subsequent assurance and scrutiny functions. The Chairs of the

Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin were in attendance as observers.

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

The Long List

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

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

Evaluation Criteria

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

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

The agreed criteria are set out below with a brief explanation of the nature of the information provided to the Panel. That information was presented in three tiers:

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

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

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

The weighting applied to the criteria was determined by the Panel, informed by public views. Members initially submitted their own weighting proposals, the results of which were presented to the Panel when it met. Following discussion, a final set of weightings was

agreed. These are recorded against the criteria below which appear in ranked order.

1. QUALITY – 29.4%

Evidence for this criterion focused on

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

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

2. ACCESSIBILITY – 26.5%

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

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

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

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

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

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

3. WORKFORCE – 25.0%

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

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

4. DELIVERABILITY – 10.3%

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

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

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

5. AFFORDABILITY – 8.8%

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

The Panel was provided with:

- High-level estimates of acute costs from the expanded feasibility work;

- Estimates of the investment required in Urgent Care Centres;

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

- **25 Year Capital Costs**

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

- **Net Increase in Capital Charges**

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

- **Total Change in Acute Revenue Costs**

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

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

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

Urgent Care Centres (UCC)

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

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

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

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

The Evaluation Panel accepted the proposed approach, subject to some amendments, although a minority report was submitted by one patient representative.

Both documents were made available to Programme Board which agreed to proceed to work on:

- Prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and
- Exploring the most appropriate rural urgent care solutions in partnership with local communities and considering current facilities/services. All existing Minor Injuries Units will be considered as potential sites for Urgent Care Centres.

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

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

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

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

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

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

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