25 MAY 2004 at approximately 7:45 pm

Civic Offices, St Nicholas Way, Sutton, SM1 1EA

To all members of the Joint Health Scrutiny Committee:

The following papers, which were not available for dispatch with the agenda, are attached. Please bring them with you to the meeting:

Item 4a. SITE SELECTION CRITERIA – ADDITIONAL INFORMATION

The NHS Trust have now circulated working papers 5-7, which update some of the previous working papers 1-4, that were circulated to the constituent authorities. The attached pack comprises:

♦ Original Introduction to working papers 1-4
♦ Original Working Paper 2 – Financial Considerations
♦ Working Paper 5 – Introduction and The Engagement Process
♦ Working Paper 6 – Site Selection Criteria with weightings
♦ Working Paper 7 – Sites for Critical Care Hospital

Working Papers 5, 6 and 7 replace the original papers 1, 3 and 4.
Clinical Services Strategy – Working Papers 1-4

Purpose of this Paper

This set of working papers is being issued in advance of a period of formal consultation, which will take place probably over a 14-week period, probably mid-July to end October 2004.

The formal consultation will be on a proposed reconfiguration of healthcare services associated with the creation of a network of Local Care Hospitals, supported by a Critical Care Hospital.

Ahead of this formal consultation, this set of working papers has been written to set out how the NHS intends to approach four issues:

- The processes of engaging public and patients (before, during and after consultation).
- Financial considerations
- The criteria against which sites will be chosen for both the Local Care Hospitals and the Critical Care Hospitals
- The weightings – if any – to be attached to each of the criteria

This set of working papers is not a formal consultation paper, but it is being published in the interests of openness. Any comments made will be considered if they are received by end April 2004.

Background

The Epsom/St Helier Trust has been talking to many people, patients and staff about the problems and opportunities it faces. This process was crystallised into a discussion document “A better future for your local health care”.

This document proposed that the Trust should aim for a significant decentralisation of services from its current two main sites (Epsom and St Helier) to a network of more local hospitals (location not specified, but possibly six in number). These local hospitals would provide most ‘booked services’ such as outpatient, day surgery, diagnostic tests; together with casualty services for less serious cases.

These Local Hospitals would be supported in their work by one Critical Care Hospital which would focus on casualty services for more serious cases, including in patients admitted as a result. Booked inpatient surgery would also take place at the Critical Care Hospital.

Maternity services would also be provided at the Critical Care Hospital (although subsequent comments raise the possibility that ‘low risk’ mothers might be cared for in units at some Local Care Hospitals).

Hospital Doctors would be expected to work from one or more Local Care Hospitals and the Critical Care Centre.
There was a reasonable measure of support for this concept, qualified by anxieties about the impact of having a single site dealing with serious casualties as opposed to the two sites which now exist.

**From Concept to Reality**

To make a reality of these ideas the NHS concluded there would need to be work on two fronts.

Firstly, on the 'clinical pathways' for patients - that is to say specifying for groups of illnesses just how the system would guide patients along the stages of diagnosis and treatment.

Secondly, work would need to take place on the reconfiguration of buildings which would be necessary.

The NHS therefore took the following steps:

- The 'clinical pathways' redesign which is at the heart of the programme, was formalised into a series of groups involving GPs as well as hospital doctors.

- There was an initial scoping of costs and benefits for the reconfiguration of services. This was formulated as a 'Strategic Outline Case' which was presented to NHS Boards in September and October 2003.

- The previous informal liaison between Epsom/St Helier Trust and its NHS partners was replaced with a formal co-ordinating Board of the two Primary Care Trusts (East Elmbridge and Mid Surrey and Sutton and Merton), the two Strategic HealthAuthorities (Surrey/Sussex and SW London) and, of course, Epsom/St Helier.

- A commitment was given to engage in formal consultation on the site for the Critical Care Hospital - with an open process beforehand to describe the appraisal criteria which would be used to propose a preferred option. This is the stage we have now reached.

**Appraisal Criteria and Weightings**

Working Paper 3 to this paper, therefore, is a working paper which sets out the criteria it is intended we should use; the rationale behind each one; and the way we expect to apply them. Working Paper 4 discusses whether each criterion should be equally weighted.

**Process and Timetable**

This paper needs to be seen in the context of the overall process, which is:

1. Preparing for the process of appraisal
2. The appraisal process, producing a preferred option
3. Formal Consultation on the preferred option
4. Consideration of the responses to the formal consultation
5. Outline Business Case
6. Full Business Case
7. Procurement

Working Paper 1 to this paper describes our current ideas and timetable for how to handle each of these 7 steps. Although not a formal consultation document in and of itself, we would nevertheless also welcome comments on this seven step process.

Financial Considerations

In the weeks since the publication of the Strategic Outline Case some commentators have raised the question of whether the concept is affordable – and as a consequence, whether we should go out to consultation at all on proposals.

That is not a view we currently share. Primary Care Trusts – who use tax funding to commission services – may indeed face problems of affordability. But this is because the number of cases they have to pay for is forecast to rise. From 2005 onwards they will have to pay for each case at a national fixed price – regardless of whether the Epsom/St Helier Trust costs are going up or down.

The Epsom/St Helier Trust will see a rise in its spending on capital charges because of the new developments. But if, as we expect, its caseload rises it will see a rise in income too.

Working Paper 2 sets out these arguments in greater depth.

It also commits us to re-examining the financial figures, and to putting them forward as part of the evidence to the June appraisal panel.

Summary of Key Questions

To summarise, we are particularly interested to hear views on the following:

1. Are the criteria sensible and fair?
2. Are there any criteria which ought to be there and are not?
3. Should all criteria carry equal weight? If not, which are the most important?
4. Are we making heavy weather of all this? We are striving hard to be transparent in the period prior to formal consultation. But is there a danger that the key issues actually get lost in the detail?

We would be interested to hear what the key issues are in people’s minds so that when we do engage in formal consultation during July – October, we can keep a focus on the important things.

Issued by the Programme Board on behalf of East Elmbridge and Mid Surrey
Comments by email to: info@msandmshealth.nhs.uk
Comments by post to: Keith Ford
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Financial Considerations figure in option appraisal in two ways, value for money and affordability. Both have elements of subjectivity and our current thoughts are set out below.

Value for Money is the test we will seek to apply to which mix of sites to use to create the LCH/CCH network. The perspective is that of an NHS Trust and their income and expenditure account.

Affordability is the test we will seek to apply to whether the LCH/CCH network is able to be afforded by the NHS. The perspective is that of a Primary Care Trust, and their funding stream.

Value for Money

Assessment of value for money is made by assessing benefits against cost. Assessing the options against the criteria produces a view of how each option ranks in terms of producing a benefit. The choice of which one to select as the preferred, value for money, option then has to bring cost into the equation.

It may be that the choice is to select the highest benefit option regardless of cost. But it may be that the second best set of benefits is only marginally inferior to the best - but is a lot cheaper, and is therefore best value for money.

In terms of our NHS appraisal of sites, we will be seeking to establish the relative capital cost of each option, and judge it against the benefits of each option.

Any difference in capital costs will have an impact on the revenue costs, since the LCH/CCH network will have to pay capital charges.

Most of the other revenue costs will, however, be assumed to be neutral as between sites. Staffing costs, drugs and medical equipment, food, cleaning, maintenance etc are costs which are likely to vary with the number of cases treated or the size of the facility, regardless of where it is located.

Affordability

The overall affordability of the LCH/CCH concept was set out in the Strategic Outline Case. It will need to be reworked for the Outline Business Case - partly as a matter of course (each stage in the Business Case process requires more detail) but partly because of changes in the policy context.

The following paragraphs are to share our thinking on the issues involved:

1. How much more work will have to be undertaken by the new network of LCHs supported by one CCH?

The Strategic Outline Case estimated by 2010 about 15% more work overall. We need to check these projections for reasonableness in the light of demographics and the NHS Plan targets for waiting lists - plus also our own target to keep people out of hospital.
2. **What is the income of the new network of LCH/CCH?**
Under a new system of Payment by Results, to be introduced in 2005, the income of LCH/CCH network will be the cases it treats multiplied by a nationally fixed price per case. Thus the income is no longer a matter of negotiation with Primary Care Trusts, and realistic forecasts of activity are key. 15% more activity brings 15% more income.

3. **What will the cost be of the new network of LCH/CCH?**
Because of the new ‘payment by results’ regime, the cost base of the new network will have to be constrained to the income levels forecast in steps 1 and 2 above. The decision for the managers/planners is how to configure services to live within that income.

The SOC was predicated on the fact that staffing is an increasingly scarce resource in the UK (and indeed, there is global competition for healthcare workers). Taken together with increasingly stringent rules on shift working, and junior doctor training, it was not sensible to assume that a 15% rise in caseload should be matched by a 15% rise in staffing in the same hospital configuration.

Instead the SOC models a modest increase in staffing levels using the extra funding from extra caseload to pay for extra capital charges (which in their turn pay for extra capital spending on new buildings in new settings to work more efficiently).

4. **Does that mean the reconfiguration is affordable?**
If these calculations are correct, then the CCH/LCH network is financially viable - i.e. its income can meet its expenditure. The calculations do need to be re-worked for the Outline Business Case since they will be scrutinised by DoH officials and potentially HM Treasury.

In particular at this stage of the Business Case process, what needs to be explored is the relative cost of each site option. As long as the extra caseload can be achieved, site selection which minimises capital spend is to be preferred to more expensive solutions - since this would reduce expenditure from capital charges without reducing income, and thus create a greater margin of safety in the calculation of financial viability.

5. **But can the NHS afford the total extra expense?**
That is a different sort of affordability. Prior to the new financial regime, the Primary Care Trusts were required to give their agreement to Business Cases - exercising a judgement about whether they could afford any extra expense (e.g. in Acute Care) in relation to the other demands on their budget (e.g. Primary Care, Mental Health).

Under the Payment by Results regime, that choice will not be open to them. If 15% more acute work is done - whether in a new LCH/CCH network or the old Epsom/St Helier reconfiguration - they will have to pay for it.

Since they can't negotiate what they pay per case, they can only reduce their total spend by reducing the number of cases that progress to acute hospitals.
6. **Should we build for 15% more patients?**

The earlier analysis raises two important questions:

- Which option is likely to give the best chance of controlling the volume of patients entering hospital for treatment?

- If the volume of patients treated does not rise by 15% where does this leave the financial viability of the LCH/CCH?

The current view of the NHS is that a LCH/CCH network is more likely than the current hospital configuration to offer PCTs the ability to control the volume of patients entering hospital for treatment and the length of time they stay when they are there. This is because the LCH network of outpatients and diagnostics closely interlinked with Primary Care is designed to move patients appropriately through the system.

If the LCH/CCH does exercise control and as result the volume of patients did not rise by 15%, then the income of the LCH/CCH would be less: but the size of facilities which would need to be built would be less (and so in consequence would capital cost and the revenue impact from capital charges).

There is a further policy initiative which alters the historic ground rules. Again from 2005, patients will be able to exercise choice. This will be over many dimensions of care, but in the context of the present appraisal the dimensions that matter will be their choice of hospital.

So, we are building for a future where either more or less than the current patients of Epsom/St Helier might choose to use the new LCH/CCH configuration.

Alternative scenarios of the financial viability need to be modelled.

**Conclusion**

Our intention at this stage is to concentrate on establishing the financial factors which would be influential in choosing between sites for a Critical Care Hospital using consistent assumptions.

But these assumptions need to be explored in the OBC – so we decide what size to make the new LCH/CCH network (or perhaps, how to create the flexibility to keep the options of size open as we see how the 2005 policy unfold as regards patient choice and payment by results).
INTRODUCTION TO WORKING PAPER 5 (WP5)

Revised 19th May 2004

On March 15th 2004, we issued Working Paper 1 which described the process we provisionally proposed to adopt, to culminate in decisions in December 2004 after public consultation. A number of views were received by the Programme Board, which we have considered carefully. Attached is WP5 which is a revised process (and therefore replaces WP1) which is our reflection on the issues set out below.

1. Some commentators expressed surprise that cost did not appear as one of the criteria.
2. A number of commentators have suggested that we were trying to achieve too much in one day on June 17th.
3. Some local authorities and MPs expressed a view that they should be entitled to scrutinise the data ahead of presentation on June 17th, and present data of their own.
4. The June 17th appraisal event was planned as an attempt to be transparent at a stage prior to consultation between mid July to end October, and therefore prior to any decision in December 2004. However, it has been interpreted by some – and portrayed to others as if an ‘irreversible decision’ will be made.

More fundamentally, some commentators queried the concept of a network of local care hospitals, supported by a single critical care hospital.

Taking this last point first, the arguments for this model were made in the Strategic Outline Case of November 2003 (and the various public engagement processes which preceded it). But the logic does need to be re-presented and re-evaluated during the formal consultation period mid July to end October, and we commit ourselves to doing this.

Furthermore, in the interests of transparency and openness, we plan to issue a working paper (ahead of formal consultation) which updates people on the ‘Model of Care’ – that is to say, the current estimation of the distribution of services between Local Care Hospital network and the Critical Care Hospital which supports it. The work of the 100 or so clinical professionals engaged in planning the distribution of services will continue to refine this.

Taking the four numbered points in order, our reflections are as follows.

1. The analysis of costs and affordability was always intended be a key part of the eventual decision in December 2004. It was not listed as a criterion because in a cost/benefit analysis, it stands alone on the cost side of the equation. In contrast the sum total of all the criteria comes together to form the benefits side of the equation. We are sorry if that was not clear from our Working Paper 2.

2. We accept we were asking too much of the panel on June 17th. There were three factors which were to have been considered by the panel on June 17th. These were Cost, the Local Care Hospital network, and data to appraise the location of the Critical Care Hospital.

We now plan to handle these matters differently. Each will be the subject of a Working Paper in this series, which we will introduce into the public domain in early June. We
will take comments on these Working Papers up to early July. This adds 4 weeks to the overall timetable – so formal consultation will run Sept – Nov, with a decision in Jan 05.

3. Since the date of June 17th is in many people’s diaries, we will retain that day as a ‘question and answer’ session on the Working Papers. If MPs and Local Authorities wish to present material on that day we will be inviting them to do so. This is in addition to any written comments they may choose to make by early July; and in addition to the formal consultation period.

4. We will no longer be asking an NHS panel to meet (on June17th or any other time) to make a recommendation. Any recommendation to PCT Boards will be made in the more conventional way by their NHS officials.

But we will probably seek to convene an NHS Panel in mid July to participate in a scoring process to rank each site option in terms of benefit.

We propose that this would take place under the observation of the joint local authority overview and scrutiny committees – but insofar as the panel’s deliberations will in any event be part of the material published with the formal consultation document, this may be an unnecessary complication. We shall seek the views of the Local Authority Scrutiny Committee on this.

The analysis of revenue costs and affordability will be undertaken by the Finance Directors of the relevant Trusts and presented, as is proper, to their organisations. It will be at that time, therefore, when the 2 PCTs will reach a view as to whether the costs/benefits are so clear cut as to conclude that there is a preferred option on which to consult, or whether consultation will take place on a range of options.

The analysis of capital costs will be undertaken by our professional advisors, E C Harris and partners. This will be presented to the relevant Trusts – preceded by one of this series of Working Papers.

This process means that all commentators have two bites of the cherry – one opportunity to comment on individual working papers ahead of formal consultation, and the second opportunity to comment on the combination of the working papers when brought together to form the consultation document.

In summary the steps are as follows:
(and shown on the attached diagram)

- mid March - Working Papers 1-4 were issued
- end April - comments received and considered
- mid May - WP6 issued (revised criteria and weights)
  - WP5 issued – this paper (revised process)

- Early June further working papers to be issued covering the proposed network of local care hospitals; the data on which to appraise the location of the Critical Care Hospital, and capital and revenue costs.

These working papers to be open for comment until early July (plus question and answer opportunity on 17 June).
• July NHS officials to consider comments received and frame a draft consultation paper to PCT Boards. (plus NHS panel mid July to undertake ‘benefits scoring’ exercise)

• The draft consultation document may indicate a preferred option (particularly if the analysis appears to lead to a clear position) or it may lay out the options without indicating a preference (particularly if the analysis does not lead to a clear cut position).

• Early August PCT Boards receive draft consultation paper and authorise release.

1st September 12 week consultation begins
series of listening events, open forums, meetings through Sept, Oct, Nov

• end November Consultation concludes
• December Comments considered
• January 2005 Boards to make a decision.
Seven steps are proposed

Having reflected on comments on Working Paper 1, this paper describes our revised intention and timetable for each of these.

Step 1

8.3 A best estimate will be made of how much decentralisation can be achieved, which will lead to an assessment of the type of services and workload to be handled by local care hospitals.

8.4 A proposed network of Local Care Hospitals for each PCT area will be formulated by each PCT. This will describe the range of facilities each network is expected to offer, relating to the population served by the PCT. Each PCT will assess how well the network meets the relevant criteria. This will be issued as Working Paper 9 and 10 early June.

8.5 The work of the Critical Care Hospital will be defined as that work which cannot be decentralised to Local Care Hospitals.

8.6 Four sites will be evaluated for a Critical Care Hospital – Epsom General: West Park: St Helier (with a sub-option of the playing fields opposite explored as to technical deliverability) and Sutton.

8.7 The benefits criteria against which site will be evaluated, and the weighting to be applied to the criteria was by an NHS panel revised on April 30th, and Working Paper 6 now sets out these (available mid May).

8.8 The data being collected to evaluate these options against the criteria will be published as Working Paper 12 (aim early June).

8.9 The cost implication of the local care hospitals network and the critical care hospital to support the network will be issued as Working Paper 13 – capital, and 14 - revenue (early June).
Step 2

8.3 The working paper listed in Step 1 will be available for comment over a four week period (early June to early July).

8.4 On 17th June 2004 a session will be held for Local Authorities Chief Officer/Leaders, MP’s and Chief Executives of neighbouring Trusts to meet the authors of the Working Papers and pose questions. This is in order to assist them in preparing any comments they may wish to make by early July. It does not replace the rights they have to comment during the formal consultation process.

2.3 In mid July NHS officials will consider the comments received and begin the process of drafting a consultation document.

2.4 In mid to late July an NHS panel will be convened to undertake a scoring exercise, rating each site option for the Critical Care Hospital against the criteria set out in Working Paper 6.

(This panel will have a much more limited remit than that envisaged for June 17th. It will not go on to assess each options benefit against cost, and it will not therefore arrive at a preferred option. The exposition of cost against benefit will appear in the formal consultation document itself.

If the analysis appears to show a clear cut best option, this may be suggested as the NHS preferred option – but if the analysis is less clear cut, then the NHS may simply lay out the range of options. In any event the decision will only be made after the end of the consultation and a period of reflection on comments).

8.3 In view of the more limited remit of the panel, we will aim for transparency mainly by publishing their scores as part of the consultation document – but we will also invite the joint local authority scrutiny committee to observe the panel discussion. The date for this panel meeting will therefore be set after discussion with those committee members.

Step 3

8.3 Having drafted the formal consultation document NHS officials will present this to two separate statutory Primary Care Trust Boards with recommendation by their two separate Chief Executives. Assuming endorsed by those Boards, it would be issued for consultation to begin 1st September 2004.

8.4 The formal consultation document will bring together the proposed model of care: the proposed local care hospitals network: options for the critical care hospital site (possibly indicating a preferred option in the light of cost considerations). It will be set out as follows:-
Chapter 1 - a restatement of the logic which led the NHS to conclude that the best option is a network of Local Care Hospitals supported by a Critical Care Hospital.

Chapter 2 - a proposal of the number and location of the Local Care Hospitals, describing the type of work to be undertaken in each of them.

Chapter 3 – an analysis in relation to the siting of the Critical Care Hospital, with supporting data.

Chapter 4 - a ‘before and after’ description of the location of major clinical services. (Technically speaking, it is this which is the subject of consultation).

8.5 Over a 12 week period, 1st September – end November, ‘open forums’ will be held. They would run through the day and evening to allow the public to attend on a ‘drop-in’ basis. In the forum there would be staff and exhibits about different aspects of the proposals e.g. the role of local care hospitals: the critical care hospital: A&E: maternity: diagnostics. More details will be available nearer the time from the two PCT’s concerned.

8.6 The two statutory boards referred to in paragraph 3.1 and 3.3 are those of the PCTs (EEMS and Sutton & Merton). They have the responsibility of consulting their public about service changes in their area regardless of which Trust is the provider.

The Trust providing the service – in this case Epsom/St Helier NHS Trust – is party to the consultation insofar as it will support the consultation process with information and staff to meet the public and respond to questions. When it comes to Business Case to implement any decision, then all those providing the services will be responsible for its production and submission to D of H.

3.5 Comments would also be accepted in writing.

Step 4

8.3 All responses will be considered by the Programme Board during December 2004 who will prepare a report for each of the NHS Boards (EEMS, S&M PCTs).

8.4 The Boards would meet in Jan 05 to consider the report and make their decision.

8.5 At this point, the joint local authority Overview and Scrutiny Committee could refer the matter to the Secretary of State if they were of the opinion that the consultation process had been flawed, or that the decision was not in the interest of the health service in their area.
Step 5

8.3 This step is contingent upon the decision reached in Step 4. If the NHS boards so conclude, they would authorise the Programme Board to prepare an Outline Business Case for their endorsement and submission to D of H officials (Feb 05 onwards).

8.4 The Outline Business Case is the key to securing approval to go ahead. If approved by DoH it authorises work to begin on a detailed design, leading to Full Business Case two years later (Feb 07).

Step 6

8.3 The Full Business Case (Feb 07) is the document which sets out the design solution and re-examines cost. Capital costs must have increased by no more than 10% since OBC, revenue costs must remain affordable to the PCTs.

Such a document could be two years after OBC, because of the level of detailed design work necessary - room numbers, sizes, drawings and elevations etc.

Step 7

7.1 Approval for the FBC permits the NHS to finalise procurement - either Public Sector funded or Private Finance Initiative. Contract signing could be six months after FBC approval. (Spring 07)

Keith Ford
Programme Director

18 May 2004
Working Paper 6 – Site Selection Criteria
Revised 19th May 2004

Introduction

The objective of the Clinical Services Strategy is ‘better care, closer to home’. To achieve this our aim is to create a network of Local Care Hospitals that would undertake high-volume scheduled services closer to home: outpatients, diagnostics and day care surgery. The network will be supported by a Critical Care Hospital which would undertake mostly unscheduled care – lower volume, but with round the clock availability.

The detailed specification of what can take place in Local Care Hospitals and what must be done in the supporting Critical Care Hospital will be the product of clinical advice. There are a large number of clinical professionals who have been meeting regularly over the last year, and will continue to meet to refine these plans. We expect to publish their current best estimate as part of the Working Papers leading up to formal consultation.

The network of Local Care Hospitals will be sited to serve population clusters. We intend to state the number of Local Care Hospitals and the population clusters or areas in which they will be located. Formal consultation in September-November will invite people to comment on whether or not that network could be improved upon. In proposing the network of Local Care Hospitals, each PCT will have regard to the criteria set out here.

The Critical Care Hospital is there to support the Local Care Hospitals in their work. We will be appraising three main options: the Epsom General Hospital site, the St Helier Hospital site and the Sutton Hospital site. We will also assess the technical suitability of the West Park site in Epsom as an alternative to the difficult task of developing a Critical Care Hospital whilst maintaining a functioning District General Hospital at Epsom General; and for a similar reason will assess the technical suitability of developing a Critical Care Hospital on the site of playing fields opposite St Helier (which assumes a hand-back of an equivalent land area from the existing St Helier site at the end of development).

This document sets out ten criteria against which the sites for a Critical Care Hospital should be evaluated. An explanation, some comments and also potential questions are listed for each one of the 10.

These criteria are the result of an initial set of ideas published in March 2004 (as Working Paper 3), modified in the light of comments received, and by a workshop facilitated by an expert in public sector economic appraisals. We have now taken the view that 3 of the initial set are ‘hurdle conditions’. That is to say they are important criteria that must be achieved before an option should even be considered. These are:

Fit with model of care
They are not however criteria that would be scored differentially between options. A fourth ‘hurdle condition has been added – Education, Training and Research.

One criterion has been added. We have accepted the view from a number of commentators that, as far as it can be measured, we should take account of the differential impact each option might have on reducing the health inequalities in the population we serve.

Three criteria have been modified. Accessibility has been split into ‘blue light’ ambulance access and patient and visitor access. Technical deliverability has been split into planning considerations and technical deliverability (excluding planning considerations). Impact on the Community has been split into two parts: short term disruption (ie through building works) and long term (the ongoing impact on the local population).

We have also now taken a view as to the weightings to be applied to each criterion, which we are expressing as percentages out of 100%.

The purpose of weightings is to assist judgement between options. If an option were to be rated the best on all 10 criteria, it would have the best benefits overall and there would be no need for weightings. (Although there would still be a question to be addressed about affordability).

But a more common position in appraisals is that some options are best on some criteria, whilst other options are best on other criteria. Forming a view as to which is the best overall mix of benefits requires them to be weighted for relative importance.

**PROPOSED CRITERIA**

The resultant criteria and weightings can be grouped under broad headings:-

**Hurdle conditions**

- Quality
- Fit with model of care
- Service capacity and national policies
- Education, Training and Research

**What is the right location?**

1. Visitor and patient access
2. Blue light access
3. Staff recruitment and retention

**Can it be achieved?**
This working paper sets out the way we are defining these criteria, which in turn leads to data being collected to evaluate the options against the criteria.

This is one of a series of Working Papers, which in time will underpin formal consultation from the beginning of September to the end of November 2004 – leading to a decision in January 2005.

Any comments on this Working Paper should be sent to Keith Ford (details below) Any such response does not prejudice the rights of the individual or organisation to comment during the formal consultation phase.

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Hurdle Conditions

All sites would be expected to reach minimum standards as regards:

Quality – Each site needs to be capable of accommodating a building designed to a quality standard environmentally, and designed to deliver services in a high quality manner.

Fit with model of care – Each site option needs to support the model of care which provides a network of Local Care Hospitals supported by a Critical Care Hospital.

Service Capacity and National Policies – Each site needs to be capable of being developed to the capacity required to deliver national policy targets.

Education, Training and Research – Each site needs to be capable of supporting patient and staffing levels commensurate with carrying out good quality education, training and research.

Our current view is that all the site options have a large enough ‘footprint’ to meet these conditions. We do not propose to collect specific data to discriminate between sites on any of these conditions.

CRITERIA

1.0 Visitor and patient access – weighting 14%

1.1 Definition

The journey time taken by patients and their visitors to attend the single critical care hospital.

1.2 Some context and explanation

Patient journeys will be for those who require scheduled inpatient care or who attend accident and emergency other than in a blue light ambulance. Visitor journeys will be those related to the patient attendance.

1.3 How this will be evaluated
Journey times will be estimated from the centre of each of 120 postcode sectors (capturing the majority of patients currently attending the Epsom & St. Helier University Hospitals NHS Trust) to various site options for the critical care hospital.

These times will be split by public transport and private transport, adjusted for percentage car ownership and population density in each postcode section.

The sites will therefore be compared one with another with relative ease of access for non-blue light attendances to the critical care hospital.

1.4 Comments

Accessibility is not a static concept. New roads, new bus routes and Tramlink extensions could all change the picture.

We intend to use current transport routes in this appraisal, and discount infrastructure still in the planning stage. However, we will undertake ‘sensitivity testing’. That is to say to rank the options on current information, and then calculate how much improvement in transport there would have to be to alter which option ranked best.

Although we intend to look at three main options, we will also calculate the optimal location. Our current expectation is that this would be impossible to achieve in an area as densely populated as this. However, it would be possible, during the consultation period, to explore the possibilities of acquiring this theoretical site should there be compelling reasons to pursue this as an option.

We are aware that the cost of public transport varies in different parts of the catchment area. However we do not believe that the location of an NHS facility should take this into account. This would require a sub-optimal investment decision by the NHS to redress different policy decisions on investment by transport authorities.

2.0 Blue light access – weighting 15%

2.1 Definition

Patients who are taken to the critical care hospital in an ambulance under blue light (emergency) conditions. This will exclude those who attend in an ambulance but not under emergency conditions.

8.3 Some context and explanation

Around 20% of patients attend the A&E by ambulance. For most patients, the critical time dimension is the speed of ambulance attending scene – hence targets set by DoH for this of 8 minutes. The most critical factor is the seniority and experience of the clinicians available on arrival at A&E. For this reason some patients bypass the nearest hospital in favour of a unit with specialist in neurosurgery, burns or trauma.

The speed of transmission to the nearest A&E is not normally a critical factor. In around 5% of ambulance journeys (1% of all attendances) the crews deem it desirable
to use ‘blue lights’ to aid their passage through the traffic. Where time is a critical factor, the phrase ‘golden hour’ is often used – conventional wisdom is that intervention by a doctor within one hour of the injury/trauma is highly desirable.

The overall patient time from injury scene to A&E door is not likely to breach an hour due to a single critical care centre as opposed to two A&E departments. Nevertheless, all other things being equal it is preferable that a location which keeps ‘blue light’ journey times to a minimum is to be preferred.

2.3 How will this be evaluated?

We will aim to analyse which site minimises the travel time from the post code sectors in the catchment to an A&E department, weighted by the number of people in each post code sector.

This acts as a proxy for the probability of a ‘blue light’ ambulance being required to travel from that post code sector. We shall seek the views of the relevant ambulance services as to whether any post code sector has a higher probability of requiring ‘blue light’ ambulance for reasons other than population density (eg traffic problems, industrial or retail complexes)

Our analysis will take account not only of those patients who will be taken to the critical care hospital, but also those taken to alternative sites. It therefore seeks to measure the optimal location for the whole catchment population.

3.0 Staff Recruitment and retention – weighting 10%

3.1 Definition

The ability to attract and retain good quality staff based on the site.

3.2 Some context and explanation

Staff recruitment and retention is a major issue, and increasingly the NHS is operating in a global market with, for example, US recruitment fairs being held in London to tempt nurses and others to the USA. There is free movement of labour within Europe and increasing competition to recruit from places such as the Philippines. Within the UK, various Trusts have added non-pay benefits, such as staff crèches and subsidised housing.

Issues such as training, education and research will all be important factors in helping to recruit and retain staff. The location of site and the network of local care hospitals could contribute to the success. In addition, the way the network overall works will have a major impact on the roles undertaken and therefore the quality of the jobs offered.

3.3 How this will be evaluated

We will ask Human Resource Directors to report on the current recruitment and retention statistics for each site, to see whether there is any significant difference. All
other things being equal, a site that offers better prospects of staff recruitment is to be preferred.

3.4 We will examine current data. Although there are potential changes to the pay structure (so called Agenda for Change) we do not consider it will be significant in altering the relative balance between sites.

4.0 **Technical deliverability (excluding planning considerations) – weighting 13%**

4.1 **Definition**

The technical factors that make it more or less likely that any option can be brought to fruition.

4.2 **Some context and explanation**

There are a number of factors that influence the ease of completing a building programme. These will include:

- Assembling the site – do we have square meterage and site capacity required and if not, how easy would it be to acquire?
- Adequate provision of utilities – gas, electrics, water etc.
- Buildability – do we have access to a clear site or do we have to build on a site that is fully functioning during building work? If so, how easy is it to decant the site prior to or during building?
- Access for contractors’ vehicles.
- Physical nature of the site – for example is it on a hill? Are there drainage problems etc?
- Timescale – different site options may have different timescales depending on the complexities

4.3 **How this will be evaluated**

Each site warrants a presentation by qualified professionals on all the relevant factors, together with an assessment of how easy or difficult it would be to overcome problems.

5.0 **Planning issues – weighting 12%**

5.1 **Definition**

An assessment of the probability of the design concept being able to proceed through the planning process without modification, without restrictions or caveats, and without delays through negotiations or appeals.

All other things being equal, a site with a smooth passage is to be preferred to one where difficulties would ensue.

5.2 **Some context and explanation**
All development will need discussion with Planning Authorities. At this stage it is an assessment of the probability of problems, which would be presented.

5.3 How will this be evaluated

The Planning Authorities themselves might present their views but this may be seen as prejudicing the outcome of the planning process. Alternatively the professional advisers to the project will present views based on their discussions and interpretations of published planning guidelines.

8 Strategic fit – weighting 10%

6.1 Definition

How well each option fits with, and contributes to, the strategic direction of service plans drawn up by Primary Care Trusts for the residents of the area.

How well each options fits with, and contributes to, the strategic directions of the plans of neighbouring NHS Trusts.

6.2 Context and explanation

PCTs are responsible for the direction of service plans in their area. The DoH requires that Business Cases have explicit confirmation that they are being developed in line with PCT plans.

In this case the PCTs are contributing to both the concept and implementation of the programme.

The principal issue for appraisal is whether any different potential location for the CCH is a better fit than any other with PCT plans.

6.3 How this will be measured

PCTs will provide a commentary on each option, as regards local residents interests.

The plans of neighbouring Trusts ought also to be consistent with the service plan of PCT’s, and in that sense it is for PCT’s to ensure that individual Trusts plans fit together.

However, it may be that there are aspects of individual Trusts plans which go beyond the direct interests of local residents (e.g. Education, Training and Research). Local Trusts will be invited to comment on this, in particular if any site location offers a better fit than another.

9 Strategic fit – weighting 10%

7.1 Definition
The impact the development of each site will have on the local community during the short term construction phase.

7.2 Some context and explanation

All developments, whether housing, retail or NHS, have an environmental impact during the construction phase. This can manifest itself as increased heavy traffic (noise and pollution), noise of building, antisocial aspects of building such as dust, and potential disruption to local services – for example short term cutting off of utilities (water, gas, electricity).

7.4 How this will be evaluated

For the most part these impacts are taken into account in conditions attached to planning consent for the eventual option.

However, we will also appraise sites explicitly against this criterion ourselves – using our professional advisors – prior to the selection of an option and submission of a planning application.

8.0 Impact on community (long term) – weighting 6%

8.1 Definition

The impact of the presence of a Critical Care Hospital within a particular area, on the residents of that area.

All other things being equal, an option perceived by local residents as having a positive impact is to be preferred to one perceived by local residents as having a negative impact.

8.2 Some context and explanation

All developments will have an impact. These impacts could be positive or negative. For instance, positive economic impact such as providing local jobs and staff spending money in local shops; negative environmental impact such as overspill parking on residential roads and the effect of people, staff, patients, ambulances and visitors, travelling to the site.

8.3 How will this be evaluated

We will aim to estimate footfall and vehicle movements for the Critical Care Hospital. With this information at appraisal stage we would seek views from local councillors as community representatives as to whether the presence of a Critical Care Hospital would be viewed positively or negatively. During the formal consultation period, the direct views of local residents be sought.

9.0 Health Inequalities – weighting 5%

9.1 Definition
The contribution that each site makes to reducing the health inequalities of the population.

9.2 Some context and explanation

In using this criterion, there is a presumption that the location of the critical care hospital will improve the health of deprived or sick people more by being located close to areas of relative health need.

This is not about the ‘draw’ effect a critical care hospital will tend to exert by increasing attendances the closer the patient is to the site.

9.3 How will this be evaluated

A literature search will be undertaken to identify any research that supports the presumption, and the views of public health professionals invited.

Geographic mapping of areas of health inequality will be available.

10 Future flexibility – weighting 10%

10.1 Definition

How well each option could cope with potential changes in technology, models of care and changes to medical practice.

10.2 Some context and explanation

This will be a major investment of public funds. The future is by definition uncertain, and the rate of change in medical practice and technology is rapid. The policy context (patient choice and payment by results) adds to that complexity. All other things being equal, sites, which offer the potential to accommodate changes after the opening date, are to be preferred to those that do not.

10.3 How this will be evaluated

Most flexibility will derive from building design and layout, regardless of the site location. However, there may be sites that offer greater potential for expansion (or contraction) by the nature of their site layout.

We will expect the professional advisors to comment.

Working Paper 7 - Sites for Critical Care Hospital

The NHS proposed to evaluate 3 sites. These were in NHS ownership and consequently could be expected to be easier to develop than any which required time to acquire, and which would not have planning permission on an ‘existing use’ basis as a hospital.

These were  
   Epsom General Hospital Site  
   Sutton Hospital Site  
   St Helier Hospital Site

To develop either Epsom or St Helier sites as a Critical Care Hospital would require a developer to work around an existing general hospital, maintaining its full functioning all the while. This is difficult and would extend the timescale and increase the risk of an operational failure at some point.

Whilst there might be some cost savings from using existing buildings, there could also be a cost penalty from the extended timescale.

The Programme Board have therefore asked that each of these sites have a sub-option examined.

In the case of St Helier, this would be to build on the playing fields opposite (currently Metropolitan Open Land owned by London Borough of Sutton); with a commitment to provide an equivalent area at the end of the build programme by laying out the current site as playing fields.

In the case of Epsom, there are adjoining Sports Fields, but not in NHS or local authority ownership. Here the sub-option would be to use the West Park site (to the west of Epsom town centre, formerly mental health and currently the location of the New Epsom and Ewell Cottage Hospital).

This site is currently owned by the Secretary of State for Health and is about to be transferred to the office of the Deputy Prime Minister for inclusion in a large scale land sales programme. The Chair of the Programme Board has written requesting that this transfer be deferred until the result of the formal consultation is known.

This is one of a series of working papers being released in early June 2004. The intention is they should form the basis of a formal consultation which will run from 1st September 2004 to 30th November 2004. The aim of early release is to enable comments to be received before the drafting of a formal consultation document begins in mid July.

Any comments on this Working Paper should be sent to:

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before 10th July 2004.

Any such response does not prejudice the rights of the individual or organisation to comment during the formal consultation period.