

Greater Manchester Joint Commissioning Board

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Date: 18 December 2018
Subject: Standardising Acute and Specialised Care Programme – Evaluation Criteria
Report of: Stephen Kennedy, Financial Strategic Lead, GMHSC Partnership

PURPOSE OF REPORT:

(This report is categorised as relating to “Level B” business as set out in the JCB Terms of Reference – Section 10)

The Evaluation Criteria are an essential element of the Programme, spanning from the articulation of the Case for Change to the evaluation of shortlisted Models of Care options. This report summarises the context in which the Evaluation Themes and Metrics have been defined, how they have been developed, and how they will be applied and assessed. It also describes the process through which the proposed approach will be signed-off by representatives from across the Greater Manchester health system.

RECOMMENDATIONS:

The Greater Manchester Joint Commissioning Board is asked to:

-) approve the proposed approach to the evaluation of Models of Care options; and
-) endorse the Evaluation Criteria and Metrics suggested.

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1.0 INTRODUCTION AND BACKGROUND

- 1.1 People in Greater Manchester are admitted to hospital when their needs could be better met in the community. This continues to increase the pressure on our hospitals and means that our highly trained staff are not freed up to do what they do best: provide more specialist care to those who are most ill. Our population is changing so services need to adapt - more of the population has developed multiple long-term conditions, the focus has shifted from curing illnesses to helping individuals to live with chronic ill health closer to home.
- 1.2 There are variations in provision and standards of care across the region. Patients with the same severity of the same condition don't always have the same outcome and sometimes are more likely to stay in hospital for an unduly long time depending on which part of the hospital system in Greater Manchester they first attend.
- 1.3 Our services are under pressure to meet the rising needs every year, there is immense strain on resources, significant variation in our estate (i.e. our buildings and where we deliver services) in relation to location, age and quality of facilities, we face significant financial and workforce pressures. Change has to happen if we are to maintain the safety and quality of care in the future.
- 1.4 The 'Standardising Acute and Specialised Care Programme' is the third of five interlinking and co-dependent themes identified in the Greater Manchester (GM) Health and Social Care Partnership strategic plan '*Taking Charge*'.
- 1.5 The transformation priorities for the Programme were developed with clinicians, providers and commissioners over several months culminating in a proposal which was endorsed by the Association Governing Group, Provider Federation Board, and the Strategic Partnership Board Executive on the 19th September 2016. The following services are in scope of this Programme:
 -) Cardiology
 -) Respiratory
 -) Musculoskeletal/Orthopaedics
 -) Benign Urology
 -) Paediatric Surgery
 -) Breast Services
 -) Vascular
 -) Neuro-Rehabilitation
- 1.6 The decision making body for the Programme is the Greater Manchester Joint Commissioning Board, (JCB). This Board was established as part of the Greater Manchester Health and Social Care Devolution programme and has been meeting since 2015. More recently, work has been ongoing to give the Board formal Joint

Committee status, ensuring it is properly constituted to take decisions relating to the Programme.

2.0 INTRODUCTION TO THE EVALUATION CRITERIA

- 2.1 The Greater Manchester (GM) Standardising Acute and Specialised Care Programme is now well underway, with the Case for Change and Model of Care for each specialty nearing completion. Focus now needs to shift to the process of shortlisting and evaluating potential Models of Care options.
- 2.2 Evaluation Criteria are used to distinguish the relative merits between potential Models of Care options. Criteria can be applied as a 'principle', meaning an option must demonstrate it meets a certain standard (e.g. improvements to the quality of care). Alternatively, criteria can be applied as a Metric which measures how effectively an option achieves a desirable goal (e.g. reducing Providers' financial deficits).
- 2.3 Evaluation Criteria are typically defined at the outset of the work to define and assess Models of Care options, ensuring the process is both transparent and unbiased. These Criteria should cover key Themes linked to the Case for Change and any local drivers for the shaping of services. They provide a clear structure enabling stakeholders to assess the relative merits of shortlisted Models of Care options against local priorities.
- 2.4 We are currently developing an options evaluation model, this will present outputs showing the relative performance / preference of the short-list of Models of Care options against a subset of the Evaluation Criteria defined. Agreement of the Evaluation Criteria and the Metrics through which these will be assessed is essential to enable this work to be progressed.
- 2.5 This paper sets out how the proposed Evaluation Criteria have been developed, how they will be applied, and how they will be assessed.

3.0 DEVELOPMENT OF THE EVALUATION CRITERIA

- 3.1. The Evaluation Criteria should be fit for purpose, but not overcomplicated – previous experiences on similar programmes elsewhere have shown that Evaluation Criteria can quickly become unwieldy and difficult to assess.
- 3.2. Full details of the process followed to develop the Evaluation Criteria and the engagement with stakeholders across the GM health system are detailed in Appendix A.

3.3. Through this engagement process, seven Evaluation Themes were identified as important to consider in the evaluation of potential Models of Care options:

-) Quality of care for all
-) Access to care for all
-) Affordability and value for money
-) Workforce
-) Deliverability and sustainability
-) Research, innovation and education
-) Social value

3.4. Models of Care options will be assessed in the light of each Evaluation Theme, the process for this assessment is set out in the following sections.

4.0 APPLICATION OF THE EVALUATION CRITERIA

4.1. Evaluation Criteria are used to understand the likely relative merits between potential Models of Care options, measuring the extent to which each option meets important issues identified by stakeholders.

4.2. The Evaluation Criteria will be applied to the Models of Care options in three stages (as illustrated below).

	STAGE 1 MODEL OF CARE DESIGN CRITERIA	STAGE 2 SHORTLISTING CONSTRAINTS / HURDLE CRITERIA	STAGE 3 DETAILED EVALUATION CRITERIA
Quality of care for all	<ul style="list-style-type: none"> • promote clinical effectiveness • reduce wastefulness in patient care and resources • ensure delivery care care 	<ul style="list-style-type: none"> • adherence to clinical and professional codes of practice of no conflict 	NO FURTHER DETAILED EVALUATION CRITERIA CONSIDERED
Access to care for all	<ul style="list-style-type: none"> • attract patient choice 	<ul style="list-style-type: none"> • distribution of each specialty's provision across GM 	DETAILED EVALUATION CRITERIA DESCRIBED IN SECTION 6.3
Affordability and value for money			DETAILED EVALUATION CRITERIA DESCRIBED IN SECTION 6.3
Workforce			DETAILED EVALUATION CRITERIA DESCRIBED IN SECTION 6.3
Deliverability and sustainability		<ul style="list-style-type: none"> • use of existing private and infrastructure • consideration of practical commissioning decisions to individual designations 	DETAILED EVALUATION CRITERIA DESCRIBED IN SECTION 6.3
Research, innovation and education	<ul style="list-style-type: none"> • deliver an innovative service • offer good educational opportunities • encourage research through specialist centres 		NO FURTHER DETAILED EVALUATION CRITERIA CONSIDERED
Social value	<ul style="list-style-type: none"> • promote employment and economic sustainability • promote participation and citizen engagement 		NO FURTHER DETAILED EVALUATION CRITERIA CONSIDERED

- 4.3. **Stage 1: Model of Care Design Criteria** - fundamental 'principles' that all Models of Care must adhere to. These 'principles' focus on the quality / safety of services, patient choice, provision of research, innovation and education opportunities, and adherence to social values.
- 4.4. **Stage 2: Shortlisting Constraints / Hurdle Criteria** - a small set of Evaluation Criteria applied to the long-list of Models of Care options to generate a short-list for detailed review. These Evaluation Criteria will ensure the short-list of potential Models of Care options meet a set of 'principles' or sufficiently achieve goals sought by the Programme (Criteria applied in this way are sometimes referred to as 'Hurdle Criteria'). These Criteria will not be applied again in later stages since all options that progress into the short-list will meet these requirements. Typically, 4-12 options will progress to a short-list for more detailed evaluation.
- 4.5. **Stage 3: Detailed Evaluation Criteria** - a series of Metrics against which the shortlist of Models of Care options is measured. These are different to the Shortlisting Constraints / Hurdle Criteria as there is no minimum level required. Instead, the Metrics will highlight the relative merits between the Models of Care options by showing the extent to which each option meets the Evaluation Criteria.
- 4.6. The combined evidence from applying the Evaluation Criteria in these three stages will enable a holistic analysis of potential options against the 7 Evaluation Themes.
- 4.7. The concept of applying a weighting system to generate a single score across all Evaluation Criteria is not supported. Instead, discussions will be required to agree

the rationale for prioritising 1-3 Models of Care options from the short-list for more detailed consideration, business case development and implementation recommendations.

5.0 DEFINING THE CRITERIA THAT ALL MODELS OF CARE OPTIONS MUST MEET

5.1. The first stage in the shortlisting of options is performed during the design and development of the individual Models of Care, through clinical and patient engagement. Each Model of Care must fulfil the following requirements:

) Quality of care for all

- evidence improved clinical effectiveness relative to care provided today
- support consistent standards of care across Greater Manchester which will reduce variations in patient outcomes and inequalities
- ensure clinically safe care, evidenced by rigorous clinical testing and external validation

) Access to care for all

- offer patient choice

) Research, innovation and education

- deliver an innovative solution
- offer good educational opportunities
- encourage research through centralised services

) Social value

- promote employment and economic sustainability within GM
- promote participation and citizen engagement

5.2. The second stage consists of the application of Shortlisting Constraints / Hurdle Criteria focussing on:

-) Quality of care for all:** Are all the clinical interdependencies required to provide the specialty Model of Care met at the sites in this option? Will the delivery of each specialty be co-located on the same site as any other services that require this specialty?

) **Access to care for all:** Where a Model of Care is delivered across multiple sites, does the option provide a reasonable geographical distribution of services across GM?

) **Deliverability and sustainability:** Does this Model of Care option make good use of existing high quality or purpose-built estate and infrastructure, and good use of sites where services will have to be maintained due to prior commissioning decisions or national designations?

5.3. The application of these criteria will generate a short-list of potential Models of Care options. Before further evaluation takes place, the application of the Shortlisting Constraints / Hurdle Criteria and the resulting short-list will need to be validated by Theme 3 Board and JCB.

6.0 UNDERSTANDING RELATIVE MERITS: METRICS AGAINST WHICH THE SHORT- WILL BE MEASURED

6.1. Each shortlisted Model of Care option will be assessed using a further set of Metrics, to understand the relative merits between Evaluation Themes.

6.2. The Metrics below do not include further testing of the 'Quality of care for all', 'Research, innovation and education' or 'Social value' Evaluation Themes. Options can only be shortlisted if they deliver improvements to the Criteria within these Themes and they support all the clinical interdependencies required by the Models of Care. All Models of Care options will therefore have a uniform positive rating for these Evaluation Themes.

6.3. The table below sets out the detailed Metrics which will be used to assess each shortlisted Model of Care option against the remaining Evaluation Themes:

Evaluation Theme	Metric	Descriptor	Source	Rating basis
2. Access to Care for All	a. Travel times to access care	Impact on average travel times by private car and public transport	Travel time model	Lowest impact on average travel times receives positive rating
	b. Travel times for patients living in more deprived areas	Impact on average travel times by private car and public transport from LSOAs with IMD score less than 4	Travel time model	Lowest impact on average travel times receives positive rating
3. Affordability and Value for Money	a. Net Present Value	Discounted cash flows of the options	Model of Care Tool	Most positive NPV receives positive rating
	b. Capital Costs	Total value of capital required to implement the option. <i>This incorporates savings from avoiding backlog maintenance required in 'do nothing' and potential benefits received from estate disposals</i>	Model of Care Tool	Lowest capital required receives positive rating
	c. Transition Costs	One-off costs (excluding capital and receipts) required to implement the changes	Model of Care Tool	Lowest transition costs receives positive rating
	e. Impact on provider I&E at aggregate GM Level	Aggregate provider I&E surplus or deficit in 2022/23	Model of Care Tool	Highest aggregate I&E for GM above 'do nothing' receives positive rating
	f. Impact on I&E at Trust Level	Number of individual providers with I&E surplus or deficit in 2022/23	Model of Care Tool	Most individual trusts showing improvement above 'do nothing' receives positive rating
	g. Use of Estate - percentage unoccupied space	Proportion of acute provider estate estimated to be unoccupied in 2022/23. <i>Note - this is a proxy measure for stranded costs, area of land potentially freed up for sale and new housing opportunities which are correlated with this value.</i>	Model of Care Tool	Lowest total of unoccupied space below 'do nothing' receives positive rating

4. Workforce	a. Scale of Impact ____ _	Impact on Consultant Workforce requirements (see note below)	Workforce tool	Smallest number of consultant FTEs required receives positive rating ____ _
	b. Sustainability ____	Ability to attract and retain substantive workforce ____ _	WRG assessment	Most positive assessment receives positive rating ____
5. Deliverability and Sustainability	a. Expected time to deliver ____ _	The anticipated timeline and complexity for delivery	An assessment of likelihood of delivery within 3-5 years ____	Most positive assessment receives positive rating ____
	b. Co-dependencies with Other Strategies ____ _	The impact that the changes may have on sites where large-scale change is happening already.	An assessment of the impact and synergies with co-terminus work ____	Most positive assessment receives positive rating ____
	c. Scale of Change ____ _	The number of beds that will need to be moved to implement the change. <i>Note – this is a proxy measure for the level of complexity.</i> ____ _	Model of Care Tool ____	Lowest number of beds receives positive rating ____

N.B. Further workforce modelling will take place once the preferred Model of Care option has been agreed and progressed to business stage phase.

- 6.4. Each Model of Care option will have a series of positive and/or negative ratings against each of the Metrics above. An engagement process with GM stakeholders will inform the aggregation of the ratings within each Evaluation Theme into an overall rating for the Theme (e.g. taking aggregate viewpoint of travel time analysis for a Model of Care option to provide an overall rating for 'Access to care for all').

7.0 GOVERNANCE PROCESS

- 7.1. A Task and Finish Group was formed with representatives from across the GM health system, it was agreed that to be deemed a quorum, attendees must include as a minimum (including virtual contributions):

-) 2 x representatives from Commissioning organisations
-) 2 x Provider Transformation Leads (PTLs)
-) 1 x representative from a Local Authority
-) 2 x Theme 3 Leads

- 7.2. Members of the Task and Finish group were responsible for ensuring feedback and input was received from the elements of the GM health system which they represent.

- 7.3. This paper represents the output from the Task and Finish group proposing a set of Evaluation Criteria, Principles and Metrics using which the relative performance / preference of shortlisted Models of Care options will be shortlisted and assessed.

- 7.4. Final approval and sign-off will be required from:

-) Theme 3 Board (approved 6 December 2018)
-) Provider Federation Board (PFB, approved November 2018)
-) Joint Commissioning Board (JCB)

8.0 RECOMMENDATIONS

Members of the Greater Manchester Joint Commissioning Board are asked to:

-) approve the proposed approach to the evaluation of Models of Care options; and
-) endorse the Evaluation Criteria and Metrics suggested.

APPENDIX A

A draft set of Evaluation Criteria provided by McKinsey were used as a starting point for defining customised Evaluation Criteria reflecting the specifics of the Programme challenge in Greater Manchester:

INTRODUCTION: Preliminary Theme 3 Evaluation Criteria to consider

Criteria	Sub-criteria	Description
1 Quality of care for all	Clinical effectiveness	Improved future delivery against clinical and constitutional standards, access to skilled staff and specialist equipment, consistent delivery of best practice pathways and interventions
	Outcome variation and inequalities	Reduce variation in patient outcomes and health inequalities
	Patient and carer experience	Supports integration and co-ordination of pathways with Locality Plans, including alignment with Theme 2 plans Improved patient and carer experience with excellent communication and good outcomes
	Safety	Expected impact on excess mortality, serious untoward incidents
2 Access to care for all	Distance and time to access services	Impact on population weighted average travel times (blue light, off-peak car, peak car, public transport) to reflect average impact for emergency and elective treatment and total impact for more isolated populations
	Service operating hours	Ability of model to facilitate 7 day working and improved access to care out of hours
	Patient choice	Provides patients with choice in line with their rights in the NHS constitution
3 Affordability and value for money	Capital cost to the system	Capital requirements to achieve required capacity & quality
	Transition costs	One off costs (cost, capital & receipts) to implement changes
	Net present value	Total NPV of each potential option incorporating future capital and revenue/cost implications and compared on like for like basis Return on investment within four years (in order to access Transformation Funds)
	Stranded costs	Levels of under utilised estate
4 Workforce	Scale of impact	Potential impact on current staff and retraining required
	Sustainability	Likelihood to be sustainable from a workforce perspective, facilitating 7 day working and addresses any other recruitment challenges Expand time on non-substantive costs
5 Deliverability	Expected time to deliver	Fast of delivering change within 5-6 years
	Co-dependencies with other strategies	Alignment with other strategic changes (e.g. I1), any other national and local NHS strategies) and provides a flexible platform for the future

A Task and Finish Group was established with responsibility for developing the Programme Evaluation Criteria, specifically:

-) are there any generic Evaluation Criteria which are missing / not required / challenging to evaluate from a GM perspective?
-) are any changes to the wording of the Evaluation Criteria necessary to make them more appropriate to GM?
-) how do these compare to Evaluation Criteria used elsewhere?
-) are there elements identified in the Case for Change or Models of Care which are critical to the credibility / suitability of alternative Models of Care options?
-) what metrics will be used to compare the performance of shortlisted Models of Care options and how will they be assessed (i.e. quantitatively or qualitatively)?
-) who will be responsible for assessing each of the quantitative metrics and which individuals / groups will be required to enable discussions around metrics assessed qualitatively?

Engagement and input was also sought from numerous GM and Theme 3 governance groups representing key stakeholders. This paper incorporates feedback received from the following sources:

Date	Feedback provided by	Document reviewed	Feedback incorporated
27/07/18	Provider Federation Board (PFB)	v1.4 (v2.0)	[no feedback provided]
01/08/18	Finance and Estates Reference Group (FERG)	v1.4 (v2.0)	<ul style="list-style-type: none"> - consideration of estates criteria - impact on I&E at Trust/Provider level - inclusion of social value criteria
15/08/18	Theme 3 Exec	v1.4 (v2.0)	<ul style="list-style-type: none"> - establish Task and Finish Group to refine the Evaluation Criteria including: 2 x Provider Transformation Leads; 2 x Commissioner Leads; Theme 3 Programme Leads; and the Patient Engagement Lead
16/08/18	Theme 3 Board	v1.4 (v2.0)	<ul style="list-style-type: none"> - consideration of deliverability and governance
29/08/18	Task and Finish Group – Evaluation Criteria	v1.4 (v2.0)	<ul style="list-style-type: none"> - clinical effectiveness and outcome variation addressed within the Models of Care themselves - consideration of co-dependencies with other strategies (e.g. Theme 2)
19/09/18	Clinical Reference Group (CRG) - reviewed by the Chair and a subgroup of CRG members	v1.4 (v2.0)	<ul style="list-style-type: none"> - consideration of the use of existing estates and infrastructure (incl. stranded costs) - consideration of the deliverability of changes required - combination of Research and Innovation criteria - preservation of educational opportunities - consideration of ability to attract and sustain a substantive workforce
10/10/18	Workforce Reference Group (WRG)	v1.4 (v2.0)	<ul style="list-style-type: none"> - consideration of the impact on education and learning opportunities
03/10/18	Task and Finish Group – Evaluation Criteria	v3.0	<ul style="list-style-type: none"> - remove “protected characteristics” from the list of Evaluation Criteria
19/09/18	Task and Finish Group – Evaluation Criteria	v4.0	<ul style="list-style-type: none"> - inclusion of relevant elements of Greater Manchester Social Value Framework - split the application of Evaluation Criteria into 3 stages
10/10/18	Theme 3 Executive	v5.0	<ul style="list-style-type: none"> - remove patient and carer experience, as these are better considered later in the process

			- consideration of scale of change through the number of beds requiring relocation
17/10/18	Task and Finish Group – Evaluation Criteria	v5.0	- social value considered a Model of Care Design Criteria (Stage 1)

The Task and Finish Group consisted of the following individuals:

-) Hugh Mullen (Stockport), Jack Sharp (PTL / Salford), Richard Mundon (PTL / WWL), Darren Banks (PTL / Manchester FT), Pam Smith (Stockport)
-) Melissa Maguinness (Bolton CCG), Jen Riley (Bolton CCG), Karen Proctor (Salford CCG), Julie Crossley (Trafford CCG), Gillian Miller (Stockport CCG), Harry Golby (Salford CCG), Nadia Baig (Oldham CCG), Paul Lynch (Central Manchester CCG)
-) Sara Fletcher (Manchester HCC), Claudette Elliott (Manchester HCC)
-) Stephen Kennedy (GMHSCP), Christina Walters (GMHSCP), Jacqueline Robinson (GMHSCP), Peter Worthington (GMHSCP / PA Consulting), Sohrab Khan (GMHSCP / PA Consulting)

Attendance at individual Task and Finish Group meetings was:

-) 29/08/18 – Jen Riley, Christina Walters, Jacqueline Robinson, Stephen Kennedy, Sohrab Khan, Peter Worthington
-) 19/09/18 – Darren Banks, Jack Sharp, Harry Golby, Jacqueline Robinson, Stephen Kennedy, Sohrab Khan, Peter Worthington
-) 03/10/18 – Darren Banks, Jack Sharp, Hugh Mullen, Jacqueline Robinson, Stephen Kennedy, Peter Worthington
-) 17/10/18 – Karen Proctor, Darren Banks, Stephen Kennedy, Peter Worthington