ANNEX 6

Fit for the Future Public Consultation

Non-financial option appraisal

East Sussex Downs & Weald PCT
Hastings & Rother PCT

Lisa Compton, November 2007

Introduction

Following the work of the New Options Assessment Panel – and using its report as their starting point - board members from East Sussex Downs & Weald PCT and Hastings & Rother PCT conducted a formal (non-financial) appraisal of all the options remaining in the public domain after publication of the report of the New Options Assessment Panel. This included the four options proposed by the PCTs themselves and a total of eight other options proposed by other parties. This option appraisal took place in Lewes on Tuesday 13 November. It was chaired by an external facilitator and voting technology was supplied by an external contractor.

Methodology

In phase one of the non-financial option appraisal board members were asked to score each of the twelve options against four criteria previously agreed by board members. The four criteria are detailed in appendix one of this report. The full list of participating board members is appended as appendix two. All twelve options were scored against criterion one before the option appraisal moved on to criterion two. Board members were supplied with several key papers including a voting sheet to record votes, a sheet detailing the four criteria and an options sheet detailing the various options.

Board members were asked to give each option a score of one to ten for each criterion. Board members were invited to award a high mark if the option was felt to largely satisfy or deliver the relevant criterion and to award a low mark if the option was felt to barely satisfy or deliver the criterion. It was indicated to board members that the highest mark (10) should be awarded if the criterion was completely satisfied and the lowest mark (1) should be awarded if the criterion was not satisfied at all.

After each score had been recorded board members were invited to examine the spread of votes in order to establish whether there was broad consensus (across the two boards) about the relevant score or whether there was a range of opinions. If board members felt there was a lack of consensus they were allowed to explore the reasons for any such lack of consensus in a general discussion and were allowed to repeat the vote – after the discussion - if they chose to do so. Out of 48 separate votes (four criteria multiplied by twelve options) board members decided to repeat just two votes. The total maximum score obtainable by each option was 40 (four criteria multiplied by ten marks each).

Weighting

Phase two of the non-financial option appraisal involved weighting the various scores in order to achieve a final score. Board members had previously agreed that the four criteria were not of equal importance and that the scores for each of the criteria should be weighted. Prior to the option appraisal all board members had been invited to "weight" each criterion in percentage terms so that the four criteria together added up to a 100% weighting. The 22 individual weightings were then averaged in order to achieve a final weighting figure for each criterion.

This weighting exercise was conducted confidentially and board members taking part in the non-financial option appraisal were not told the results of the weighting exercise until they had cast all their option appraisal votes.

A total of 22 board members (i.e. every voting board member) took part in the weighting exercise and the result of the weighting exercise was as follows:

The range of weightings cast for each of the four options was:

CRITERION 1 – (clinical effectiveness and quality)	20% to 45%
CRITERION 2 – (health gain and demographics)	15% to 40%
CRITERION 3 – (sustaining two viable hospitals)	1% to 30%
CRITERION 4 – (access and choice)	10% to 35%

The two boards adopted notably similar positions with the average weightings for each criteria never differing (between the two boards) by more than about 3 percentage points.

The mean average weightings for the four criteria were:

CRITERION 1 – (clinical effectiveness and quality)	33.5%
CRITERION 2 – (health gain and demographics)	26.4%
CRITERION 3 – (sustaining two viable hospitals)	19.6%
CRITERION 4 – (access and choice)	20.5%

These weightings were agreed and adopted by the option appraisal panel when the option appraisal was complete.

Phase one scores (unweighted)

The unweighted phase one scores for each option were as follows:

	Option 1	Option 2	Option 3	Option 4	Option 5a	Option 5b	Option 6	Option 7	Option 10	Option11	Option12	Option 13
Criterion 1	6.7	6.7	7.4	7.6	5.3	4.5	6.7	6.7	6.9	6.8	5.6	3.9
Criterion 2	4.5	5.6	5.6	7.0	5.1	4.8	5.0	5.8	5.4	6.6	5.8	4.4
Criterion 3	5.0	5.8	5.8	6.4	5.1	5.0	4.6	5.1	4.4	5.0	5.1	5.1
Criterion 4	4.2	4.4	6.0	6.3	5.0	5.0	5.1	5.3	6.0	6.3	6.4	5.7
Total score	20.4	22.5	24.8	27.3	20.5	19.3	21.4	22.9	22.7	24.7	22.9	19.1
Initial ranking	10	7	2	1	9	11	8	=4	6	3	=4	12

Phase two scores (weighted) i.e. FINAL SCORES

The final (fully weighted) scores for each option were obtained by multiplying each score by the relevant weighting for that criterion derived from the average percentage weighting.

The relevant weightings were:

CRITERION 1 – (clinical effectiveness and quality)	33.5
CRITERION 2 – (health gain and demographics)	26.4
CRITERION 3 – (sustaining two viable hospitals)	19.6
CRITERION 4 – (access and choice)	20.5

For example the score for option 1 criterion 1 is 6.7 x 33.5 = 224.45. By adding up the four scores for each option we get a total number of "weighting points" for each option out of a possible grand total of 1000 weighting points for each option.

	Option 1	Option 2	Option 3	Option 4	Option 5a	Option 5b	Option 6	Option 7	Option 10	Option11	Option12	Option 13
Criterion 1	224.45	224.45	247.90	254.60	177.55	150.75	224.45	224.45	231.15	227.80	187.60	130.65
Criterion 2	118.80	147.84	147.84	184.80	134.64	126.72	132.00	153.12	142.56	174.24	153.12	116.16
Criterion 3	98.00	113.68	113.68	125.44	99.96	98.00	90.16	99.96	86.24	98.00	99.96	99.96
Criterion 4	86.10	90.20	123.00	129.15	102.50	102.50	104.55	108.65	123.00	129.15	131.12	116.85
Total score	527.35	576.17	632.42	693.99	514.65	477.97	551.16	586.18	582.95	629.19	571.80	463.62
Final ranking	9	6	2	1	10	11	8	4	5	3	7	12

Key points to note from the option appraisal statistics

- The rankings remained relatively consistent before and after the weighting exercise. 11 of the 12 options were within one place of their unweighted ranking once weighting was taken into account.
- In the weighted scoring, the top ranked option (option 4) was over 60 points ahead of the second ranked option.
- All six of the top ranking positions were held by options proposing consultant led maternity services on a single site.
- All three of the bottom ranking positions were held by options proposing consultant led maternity services on two sites.
- Three of the top four ranking positions favoured Hastings as the most appropriate site for consultant led maternity services.
- Seven options scored between 500 and 600 weighting points. Two scored below 500 points and three scored above 600 points.
- In the weighted scoring, the average score of the eight options proposing consultant led maternity services on a single site was over 90 weighting points higher than the average score of the four options proposing consultant led maternity services on two sites. (597.43 against 507.01)
- The average score (in weighting points) of the four options proposing consultant led maternity services on a single site in Hastings was almost 50 weighting points higher than the average score of the four options proposing consultant led maternity services on a single site in Eastbourne. (621.38 against 573.47)

Appendix one

Criteria

The final criteria agreed by the two boards as being appropriate for the option appraisal were as follows:

1. Clinical Effectiveness and Quality

Any option approved by the PCT boards should be capable of:

- Providing a safe, high quality service for mothers and babies with 60 hours of consultant presence on the labour ward
- Attracting and retaining good quality staff
- Dealing with complex care within East Sussex[1]
- Supporting care across the maternity spectrum from consultant-led care through midwife-led care to home birthing
- Ensuring that wherever maternity, neonatal or gynaecological emergencies arise, safe operational systems are in place to manage them

Key measures for this criterion would include:

- It would lead to fewer caesareans where clinically appropriate
- It would provide 1:1 care in labour
- It would allow an adequate paediatric and anaesthetic infrastructure

[1] Dealing with complex care within East Sussex improves access and helps ensure there is sufficient critical mass (>2500 births) for consultants to maintain their skills in dealing with high risk cases

KEY CONSIDERATIONS within the "clinical effectiveness and quality" criterion:

The option **should** provide the potential to increase the proportion of complex obstetric cases to be treated within East Sussex.

The option **should** provide the potential to move to 60 hours of consultant presence on the labour ward by 2009.

The option **should** provide the critical mass of births necessary to maintain skill levels and training.

The option **should** be able to meet all national and local safety regulations/guidance.

The option **should** provide sufficient availability of consultant and other specialist staff to safely deal with SCBU and gynaecological emergencies

2. Health Gain and Demographics

Any option approved by the PCT boards should be capable of:

- Improving health outcomes for mothers and babies across East Sussex
- Tackling health inequalities by improving the health outcomes of the most deprived, and so reduce the health inequalities gap
- Ensuring that services meet projected changes in population structure

Key measures for this criterion would include:

- It would enable high risk women to continue to be treated within East Sussex
- It would enable access to services for the most deprived communities

KEY CONSIDERATIONS within the "Health Gain and Demographics" criterion:

The option **should** provide early access to antenatal services that tackle deprivation risk indicators by targeting deprived communities

The option **should** improve outcomes for mothers, babies, and those requiring other services such as emergency gynaecology across East Sussex

The option **should** provide access to specialist care for women at high risk of adverse outcomes

3. Sustaining two viable hospitals

Any option approved by the PCT boards should be consistent with both hospitals (Hastings and Eastbourne) continuing to deliver emergency care.

Key measures for this criterion would include:

- The maintenance of 24 hour A&E on both sites
- The maintenance of intensive care capacity on both sites
- The maintenance of paediatric surgical and medical assessment on both sites
- The maintenance of relevant diagnostics on both sites
- The maintenance of training across both sites for major specialities
- The retention of core medical and surgical services on both sites

KEY CONSIDERATIONS within the "Sustaining two viable hospitals" criterion:

The option **should** enable each hospital to continue to maintain a 24/7 A & E service

The option **should** enable each hospital to continue to receive emergencies

4. Access and Choice

Any option approved by the PCT boards should be capable of:

- Strengthening the capacity to offer antenatal and postnatal care (meeting NICE Guidance standards) in the community
- Improving access to antenatal and postnatal care for deprived communities
- Guaranteeing, for all women within East Sussex, the choice of a home birth, birth in a midwife-led maternity centre or team care in a consultant led unit

Key measures for this criterion would include:

- Maximising the range of maternity, neonatal and gynaecological care available within the county and minimising the number of women and babies who receive their care out of the county
- Meeting the national choice guarantees described in Maternity Matters (choice of how to access maternity care, choice of type of antenatal care, choice of place of birth (home birth, birth in a midwife-led unit, birth in a consultant-led unit), choice of place of postnatal care)
- Preserving – and where possible extending - the range of specialty services on offer (e.g. antenatal screening tests currently only available outside the county)
- Supporting the delivery of 18 week waits in gynaecology
- Ensuring continued local provision of ambulatory and day care services in maternity and gynaecology care
- Minimising the inconvenience of longer journeys
- Reducing to zero the number of unplanned maternity unit and SCBU closures

KEY CONSIDERATIONS within the "Access and Choice" criterion:

The option **should** offer a practical choice - with sufficient capacity - between a home birth, birth in a centre under the care of a midwife or team care in a consultant led service

Appendix two

21 of the 22 voting members of the two boards (or their nominee as noted below) took part in the option appraisal with some members casting two votes because they were voting members on both boards. The attendance register of board members for the non-financial option appraisal was as follows:

	ABSENT / PRESENT
ESDW PCT	
John Barnes NED Chair	PRESENT
Rhiannon Barker NED	PRESENT
John Kay NED	PRESENT
Rita Lewis NED	PRESENT
Jack Barnes NED	PRESENT
Peter Douglas NED	PRESENT
Nick Yeo Chief Executive	PRESENT
Simon Eyre PEC Chair	PRESENT
Vanessa Harris	PRESENT
Diana Grice	PRESENT
Peter Finn (for Sarah Valentine)	PRESENT
H&R PCT	
Charles Everett NED Chair	PRESENT
Stuart Welling NED	PRESENT
Jeremy Birch NED	PRESENT
Tim Brammer NED	PRESENT
Peter Greene NED	ABSENT
Keith Glazier NED	PRESENT
Nick Yeo Chief Executive	PRESENT
Greg Wilcox PEC Chair	PRESENT
Vanessa Harris	PRESENT
Diana Grice	PRESENT
Peter Finn (for Sarah Valentine)	PRESENT

Appendix three

The options considered by the option appraisal process were as follows:

Option 1	Consultant led unit at Eastbourne District General hospital (EDGH). Midwife led unit (MLU) at Crowborough. No other MLUs in the area.
Option 2	Consultant led unit at the Conquest Hospital. Midwife led unit (MLU) at Crowborough. No other MLUs in the area.
Option 3	Consultant led unit at EDGH. MLU at Crowborough and at the Conquest Hospital.
Option 4	Consultant led unit at the Conquest Hospital. MLU at Crowborough and at EDGH.
Option 5a	2 Consultants led units, at EDGH and the Conquest Hospital. MLU at Crowborough. All consultant medical staffing model.
Option 5b	2 Consultants led units, at EDGH and the Conquest Hospital. MLU at Crowborough. Six consultants at each site, middle grade tier, no junior doctor tier.
Option 6	Consultant led unit at EDGH. MLU at Crowborough and at a point in-between Hastings and Eastbourne, serving the population of Hastings.
Option 7	Consultant led unit at the Conquest Hospital. MLU at Crowborough and at a point in between Hastings and Eastbourne serving the population of Eastbourne.
Option 10	Consultant led unit at EDGH. MLUs at Crowborough, Eastbourne and Hastings.
Option 11	Consultant led unit at the Conquest Hospital. MLUs at Crowborough, Eastbourne and Hastings.
Option 12	Consultant led units at EDGH and at the Conquest Hospital. Form of MLU at Crowborough and co-located with consultant led units. 5.5 consultants at each site, 7 middle grade staff and a full tier of first on calls.
Option 13	Consultant led unit at EDGH and at the Conquest Hospital. Integrated MLU at each site. Keep Crowborough but assess long term viability in the future. 5 consultants at each site, 8 middle grades as each site, 2 trainees at each site.

Please note options 8 and 9 were dealt with by the New Options Assessment Panel and were not considered at the option appraisal stage.