DRAFT Evaluation Criteria (Version 5) Amended to Include Stakeholder Feedback from NBT, UHBW, and Patient Representatives at 3rd March 2021

Evaluation criteria	Defined as
 **1 Quality of Care**	1.1 Clinical effectiveness 1.2 Patient and carer experience 1.3 Safety (e.g. workforce rotas)
 **2 Access to care**	2.1 Impact on patient choice 2.2 Distance, cost and time to access services 2.3 Service operating hours
 **3 Workforce**	3.1 Scale of impact 3.2 Impact on recruitment, retention, skills
 **4 Value for money**	4.1 Operating Costs to the system (Workforce costs and other direct costs) 4.2 Capital cost to the system 4.3 Transition costs required 4.4 Net present value (10, 20 and 60 year)
 **5 Deliverability**	5.1 Expected time to deliver 5.2 Co-dependencies with other strategies/strategic fit

1

Sub-criteria: Quality of Care

Evaluation criteria	Questions to test
▪ Clinical effectiveness	▪ Will this option lead to people receiving equal or better quality care in line with national guidance standards or best practice? ▪ Will this option improve outcomes of care, including mortality, independence and quality of life? ▪ Will this option result in more effective prevention? ▪ What impact will this option have on health inequalities in relation to health outcomes? ▪ Will this option lead to more people being treated by teams with the right skills and experience? ▪ Will this option sustain or even improve the current quality of care received by non-stroke patients?
▪ Patient and carer experience	▪ Will this option improve continuity of care for patients? (e.g., reduce number of hand offs across teams / organisations, increase frequency of single clinician / team being responsibility for a patient)? ▪ Will this option enable greater opportunity to link with voluntary / community sector health and wellbeing services? ▪ Will this option improve quality of environment in which care is provided? ▪ Does this option strengthen the *(opportunities for*) communication with patients and their carers about their individual condition in particular, about a planned discharge?
▪ Patient safety	▪ Will this option allow for patient transfers/emergency intervention within a clinically safe time-frame? Will travel time impact on patient outcome? ▪ Will this option offer reduced levels of risk (e.g., staffed 24/7 rotas, provide networked care, implement standardization)?

2

Sub-criteria: Access to Care

Evaluation criteria	Questions to test
▪ Impact on patient choice	▪ Does this option increase or decrease choice for patients? ▪ Does this option improve equitable access to services? ▪ Will this option make it easier for people to understand which services they can access when and where? ▪ Will this option account for future changes in the population size and demographics? ▪ Will this option provide sufficient capacity within the services to meet demand?
▪ Distance, cost and time to access services	▪ Will this option increase/reduce travel time and/or cost for patients to access specific services? ▪ Will this option involve patients travelling more/less frequently, change the number of journeys to access urgent medical intervention? ▪ Will this option reduce/increase patients' waiting time to access services? ▪ Will this option increase/reduce travel time and/or cost for carers and family? ▪ Will this option support the use of new technology to improve access?
▪ Service operating hours	▪ Will this option improve operating hours for the service? ▪ Does the option reduce the risk of unplanned changes and improve service resilience? ▪ Does the option maintain or enhance the ability of the service to adapt to planned or envisaged future changes?

3

Sub-criteria: Workforce

Evaluation criteria	Questions to test
Scale of impact: existing staff: • The HASU and ASU • The sub-acute workforce • The non-stroke workforce • All staff groups	▪ Will this option improve the resilience of current staff (e.g. recruitment, retention) ▪ Will it support the talent management of existing staff e.g. enable maintenance and /or enhancement of skills, competencies, career pathways, enable them to work at the maximum capability of their role ▪ Is the staff travel, relocation or retraining required in line with organisational change principles? ▪ Will this option have a disproportionate impact on staff with protected characteristics
Scale of impact: future workforce	▪ Is it possible to develop the workforce model required to deliver the option e.g. skills base, new competencies, new roles etc against the anticipated timeline for implementation? ▪ Will it support the financial sustainability of the workforce e.g. reduction in agency spend ▪ Will this option enable accountability and governance structures to support staff? ▪ Will this option increase multi-disciplinary/cross-organisational & system working/greater diversity & inclusion?

5

Sub-criteria: Deliverability

Evaluation criteria	Questions to test
▪ Expected time to deliver	▪ Is this option deliverable within 3 years? ▪ How quickly could this option deliver benefits?
▪ Co-dependencies	▪ Is this option compatible with the Healthier Together STP vision? ▪ Does this option enable the system to maximise the role of and adapt to new technologies? ▪ Will this option be co-dependent on other models of care / provision being put in place and if so, are these deliverable within the necessary timeframe? ▪ Will the wider system be able to deliver on this change including the community and voluntary sector? Can the additional capacity requirements be delivered? Will it destabilize any other providers in a way that can not be managed? ▪ Does the system have access to the infrastructure, capacity and capabilities to successfully implement this option in particular, a reduced length of acute stay with sufficient capacity outside of the acute trusts to support it ? ▪ Are there identified negative impacts for non-stroke patients that cannot be mitigated?

4 Sub-criteria: Finance/Value for Money

Questions to test

- The Stroke Strategic Business Case is based on two hypotheses:
  - Ensuring quickest access to specialist clinicians & interventions (potentially longer travel times offset by 24hour availability of specialist care) improves patient outcomes and reduces long term costs of healthcare
  - Rehabilitation out of bedded-hospital care improves patient outcomes and reduces long term costs of healthcare
- Long list options all involve the transfer of activity between acute providers and/or the transfer of activity from acute sector to community sector
- Due to imminent changes to the basis for calculating provider income for health services (incl. stroke pathway activity) all analysis is based on the cost to each provider of delivering the services, how this is contracted will depend on the NHS finance and contracting regime at the point of implementation.
- Demographics mean that demand for stroke services are growing, and change will take a number of years to transition therefore costs should be modelled over a 5 year time horizon; including modelling a 5 year do nothing scenario including national efficiency assumptions
- Acute Hospital beds remains the most scarce resource in the BNSSG health economy, therefore options that reduce demand for beds have a particular premium associated with their opportunity costs
- The largest economic benefits are expected to be reduced costs of social care and continuing healthcare from improved acute care; and the likelihood of returning to work following stroke. These benefits will be referred to in the narrative of the business case; however these benefits are assumed to be outside the scope of finance and value for money tests due to complexity regarding the Health vs. Social Care funding routes.

4

Sub-criteria: Finance/Value for Money

Evaluation criteria	Questions to test
▪ Operating costs	▪ What would be the workforce costs to the system of each option? ▪ What would be the total direct costs (Workforce, Diagnostics, Therapies, Clinical Administration, Drugs, Clinical Supplies, Ambulance and Patient Transport)? ▪ What is the full system cost as a result of the proposed changes?
▪ Capital cost to the system	▪ What would the capital costs be to the system of each option, including refurbishing or rebuilding capacity in other locations? ▪ Can the required capital be accessed and will the system be able to afford the necessary financing costs?
▪ Transition costs	▪ What are the transition costs (e.g., relocating staff, training and education costs)?
▪ Net present value	▪ What is the 10, 20 and 60 year NPV (net present value) of each option, taking into account capital costs, transition costs and operating costs?