

Surrey Downs CCG, Sutton CCG and Merton CCG

Committees in Common

Improving Healthcare Together: 2020-2030

Agenda

**21st June 2018, 18.00 – 19.45,
120 The Broadway, Wimbledon, SW19 1RH, Meeting Room 6.2 and 6.3**

Convenor:

Jonathan Perkins

Time	Item	Decision	Lead	Paper
18.00	1. Welcome, introductions and apologies	N/A	Convenor	
18.05	2. Register of declared interests	For action	Convenor	
18.10	3. Terms of Reference for Surrey Downs, Sutton and Merton Clinical Commissioning Groups Committees in Common	For approval	Convenor	1
18.20	4. Items for decision a) Improving Healthcare Together 2020-2030: Issues paper b) Improving Healthcare Together 2020-2030: Issues paper technical annex: case for change, clinical model and development of potential solutions c) Improving Healthcare Together 2020-2030: Communications and engagement plan	For approval For approval For approval	Andrew Demetriades Andrew Demetriades/ CCG Clinical Chairs Andrew Demetriades	2, 3 and 4
19.15	5. Any other business	N/A	Convenor	N/A
19.20	6. Questions from the public Purpose to: respond to any pre-submitted questions from the Public and if time permits questions from the floor. Members of the public are encouraged to submit questions at least 24 hours before the meeting.	For discussion	Convenor	N/A
19.45	7. Close	N/A	Convenor	N/A

Report Cover Sheet Committees in Common Improving Healthcare Together: 2020-2030

Date of Meeting: 21st June 2018

Agenda No: 3

ENCLOSURE: 1

<p>Title of Document: Committees in Common Terms of Reference for Surrey Downs, Sutton and Merton Clinical Commissioning Groups.</p>	<p>Purpose of Report: To seek approval for the Terms of Reference for Surrey Downs CCG, Sutton CCG and Merton CCG Committees in Common.</p>
<p>Report Authors: Programme Team</p>	<p>Lead Director: Andrew Demetriades, Joint Acute Sustainability Programme Director</p>
<p>Executive Summary: In January 2018, Merton, Sutton and Surrey Downs Clinical Commissioning Groups (CCGs) approved the governance structure for the Improving Healthcare Together: 2020-2030 programme and agreed to use CCG 'Committees in Common' (CiC) arrangements for the purpose of collaborative decision making with regard to the programme.</p> <p>In May 2018, Merton, Sutton and Surrey Downs CCGs presented a Committees in Common paper to approve the process and framework for establishing CCG CiC in relation to the Improving Health Together 2020-2030 programme.</p>	
<p>Key issues to note are: None</p>	
<p>Recommendation: The Committees in Common is asked to:</p> <ul style="list-style-type: none"> • Approve the Committees in Common Terms of Reference for Merton, Sutton and Surrey Downs CCG in relation to the Improving Health Together: 2020-2030 programme. 	
<p>Committees which have previously discussed/agreed the report: The process for establishing a Committees in Common was approved by: Merton Governing Body on 2nd May 2018 Sutton Governing Body on 3rd May 2018 Surrey Downs Governing Body on 3rd May 2018</p>	
<p>Financial Implications: The financial implications of any potential solutions will be conducted in due course as part of the Programme.</p>	
<p>Equality Impact Assessment: An equality impact assessment (Phase 1) has been commissioned for the Improving Healthcare Together: 2020-2030 programme</p>	
<p>Information Privacy Issues: None</p>	
<p>Communication Plan:</p>	

A communications and engagement plan for the acute sustainability programme has been developed in draft and will be approved by the Committees in Common.

Surrey Downs CCG, Sutton CCG and Merton CCG

COMMITTEES IN COMMON

Improving Healthcare Together: 2020-2030

Draft Terms of Reference

June 21st 2018

1. Introduction and establishment of a Committees in Common

The three Clinical Commissioning Groups (CCGs) for Merton, Sutton and Surrey Downs have agreed the establishment of the Improving Healthcare Together: 2020-2030 Committees in Common (or CiC) arrangement for the purpose of collaborative decision making for the programme. The governing body of each of the CCGs has agreed to participate in this CiC arrangement and each CCG Committee has delegated authority to make decisions about the matters within the scope of this CiC on behalf of its own CCG and without the need to be ratified by its Governing Body.

2. Statutory framework

Each of the CCGs provides in its Constitution a mechanism that allows specified functions to be delegated to a designated committee, which may meet with delegated committees of other CCGs in a CiC arrangement.

The intention of this approach is to enable consensual decision making to take place across a number of CCGs whilst maintaining the integrity of each statutory organisation's governance. Where the CiC is unable to reach a unanimous decision, then this will be recorded in the meeting minutes, and the CiC convener will close the meeting to allow for further discussion within Governing Bodies.

3. Scope

This CiC arrangement is established to enable the participating CCG Committees to consider the same issues at the same time in relation to any significant change to the commissioning of acute services at Epsom and St Helier University Hospitals Trust.

The CiC will be responsible for ensuring that key decisions are taken in relation to the programme including the planning and delivery of engagement activities, the pre-consultation business case development and any future consultation requirements.

4. Membership of individual CCG Committees

Each CCG will appoint a Committee (a "CCG Committee") including the following members:

- The CCG's Clinical Chair (voting)
- An additional Clinical member (voting)
- A lay member (voting)
- A managerial member (voting)

In attendance for each CCG will be:

- The Managing Director of the CCG
- A Health-watch representative from each CCG area
- A public engagement representative from each CCG

Each CCG may also nominate deputies who may act as alternate members of the relevant CCG Committee to the extent a member is unable to attend a meeting. A nominated deputy shall have the same background experience (clinical, lay, and managerial) as the person unable to attend.

5. Appointment of CiC Convenor

- a) The CCG Governing Body Chairs shall not appoint a Chair but shall instead appoint an individual with responsibility for convening meetings (the "Convenor"). The Convenor shall not be a member of the CiC or of any CCG Committee and therefore he/she will not be part of the decision-making process; the Convenor shall, however support the CiC in trying to reach a consensus for each decision.
- b) The term of office for the CiC Convenor will be for the time the CiC is in operation. In the event that the Convenor is unable to continue in this role, the CCG Chairs will appoint a new Convenor.

6. Procedure

- a) CiC meetings will be held in public, except where all individual committees resolve to exclude the public on the grounds of the confidential nature of the business to be discussed, in the interests of public order or because they consider that it would otherwise not be in the public interest for the public to be admitted to all or part of a meeting.
- b) The CCGs retain their own powers to exercise their own decision making accountability in line with their statutory responsibility and will exercise their powers with the other CCGs through the meeting of the CiC. As such, each CCG Committee, with full delegated authority from its own Governing Body, will bind its own CCG so that when the CCG Committees meet as the CiC, the decisions made by consensus at the CiC are finite.
- c) The CiC Convenor is responsible for agenda setting, overseeing meeting arrangements and maintaining order. The Convenor will use reasonable endeavours to assist the CCG Committees to resolve any differences and will from time to time establish the views of each CCG Committee and whether a consensus has been reached by that CCG Committee.
- d) The Convenor, at the request of one or more CCG Committee, may call additional individuals or experts to attend meetings on an ad hoc basis to inform discussions as appropriate.
- e) The Convenor, with the members of the participating CCG Committees, will agree a schedule of meetings to reach decisions on issues within its scope as set out in section 3. This schedule may be amended as required.
- f) All administration support for the CiC will be provided by the programme team.
- g) CiC papers will be circulated to CiC members one week prior to the meeting.
- h) CiC meetings will be advertised on Surrey Downs CCG, Sutton CCG and Merton CCG websites, one week prior to the CiC meeting.
- i) The minutes of each CiC meeting will consist of individual sets of minutes for each CCG Committee with exactly the same content. The CiC will formally verify the minutes at their next meeting.

- j) The decisions of each of the three CCG Committees will be recorded in the minutes.
- k) The CCG clinical chairs will hold the casting vote for each CCG Committee.
- l) It will be permissible for individual members of a CCG Committee to join the meeting remotely by telephone conference call or other digital or electronic means, subject to agreement by the Convenor that arrangements for them to contribute effectively in the meeting and with their own CCG Committee are in place.

7. Reporting Arrangements

- a) Each Committee will present the agreed minutes to its Governing Body.
- b) The individual CCG CiC Committee Chairs will, in addition, provide a written summary report to each Governing Body following each meeting of the CiC business. This should highlight: issues, decisions, risks and assurance.

8. Conflicts of interest

- a) Each CCG Committee is expected to comply fully with the guidance issued by NHS England on management of Conflict of Interest and to ensure that the individuals attending have completed all three modules of the NHS England Conflict of Interest Training.
- b) Each CCG Committee will ensure the declaration and management of any conflicts of interest by ensuring the relevant CCG register is up to date. In addition, a verbal declaration should be made at the start of each meeting in relation to any conflict relevant to the discussion.
- c) Any person in attendance who is invited to speak will be required by the Convenor to state if they know of any conflict of interest that may require consideration of the matter in hand. Any person in attendance should also make written declarations before the meeting.

Report Cover Sheet Committees in Common Improving Healthcare Together: 2020-2030

Date of Meeting: 21st June 2018

Agenda No: 4

ENCLOSURE: 2

Title of Document: Improving Healthcare Together 2020-2030: Issues paper	Purpose of Report: For approval
Report Authors: Programme Team	Lead Director: Andrew Demetriades, Joint Acute Sustainability Programme Director
Executive Summary: The issues paper is the main public facing document with which the engagement programme will be launched. It summarises the key challenges faced by the local health community and explains why change is necessary. Specifically, it summarises the case for change, the provisional clinical model, development of potential solutions and supporting engagement plan. This document will be published and is intended to be a document that will be widely circulated and read by members of the public.	
Key issues to note are: <ul style="list-style-type: none"> • All documentation is draft subject to approval by Committees in Common. • All documentation has been written at a point in time, reflecting information (including sources and references accessed) as of the date of publication. • All documentation may change based on new or additional information which is made available to the programme. 	
Recommendation: The Committees in Common is asked to: <ul style="list-style-type: none"> • Approve the Improving Healthcare Together 2020-2030: Issues paper 	
Committees which have previously discussed/agreed the report: This paper has been reviewed by governance groups across the programme including the Clinical Advisory Group and Programme Board.	
Financial Implications: The financial implications of any potential solutions will be conducted in due course as part of the Programme.	
Equality Impact Assessment: An Equality Impact Assessment (Phase 1) has been commissioned for the Improving Healthcare Together: 2020-2030 programme.	
Information Privacy Issues: None	
Communication Plan: A draft communications and engagement plan for the Improving Healthcare Together 2020-2030: has been developed and will be approved by the Committees in Common.	



Improving Healthcare Together 2020-2030

NHS Surrey Downs, Sutton and Merton CCGs

Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups

Issues Paper



Surrey Downs

Clinical Commissioning Groups



Sutton

Clinical Commissioning Groups



Merton

Clinical Commissioning Groups

Contents

Foreword	03
A compelling case for change	04
Our clinical vision for care: prevention, integration and acute services	06
Developing potential solutions	11
How to get involved	18



Foreword

We, the clinical leaders for NHS Surrey Downs, Sutton and Merton clinical commissioning groups (CCGs), are a body of experienced local GPs who lead the organisations responsible for planning care for our patients and communities. We want to ensure the very best quality of care is available to our patients and communities, and that it is sustainable into the future from buildings which are fit for purpose.

To do this, we have come together to resolve the long-standing healthcare challenges with our *Improving Healthcare Together 2020-2030* programme. We believe there is a compelling set of reasons why change has to happen now and we want to share these with you.

We have been working with our clinical colleagues across local healthcare organisations to develop our view of how healthcare needs to be delivered in the 2020s and beyond. We need to plan for the future and we want to share this early thinking with you.

At the heart of our vision is wanting to keep you well, and for as much care to be delivered as close to your home as possible. We want to do this in a joined-up way with GPs and clinicians from hospitals, community and mental health organisations, working together alongside social care practitioners and the voluntary sector.

We also need to ensure that when you are seriously unwell or at risk of becoming seriously unwell, you have access to the highest quality care, available at any time of day or night and on any day of the week.

We are committed to keeping hospital services within the combined geographies of the three

clinical commissioning groups and so we are not proposing any solutions which will result in hospital-based services being moved from our area.

We have looked at all the different ways we could deliver this vision and address our challenges and we have come to a provisional view that there are three ways we could do this. It is important to state that we have made no decisions on which solution is best.

What we are certain of is that if we do not resolve these issues now, we will not be able to maintain all the services we currently provide locally and which our population need.

In this document, and the information we have published on our website, we want to share how we have got to these three potential solutions. This is the start of our conversation with you about this, and we are looking forward to hearing your views. Following your feedback, we are aiming to have a public consultation in early 2019 when we have a view on our preferred solution. We want to involve you throughout this process and for everyone to have the opportunity to have their say.

We look forward to hearing from you.

Yours faithfully,

[subject to CiC approval]

Dr Russell Hills
Clinical chair of
NHS Surrey Downs CCG

[subject to CiC approval]

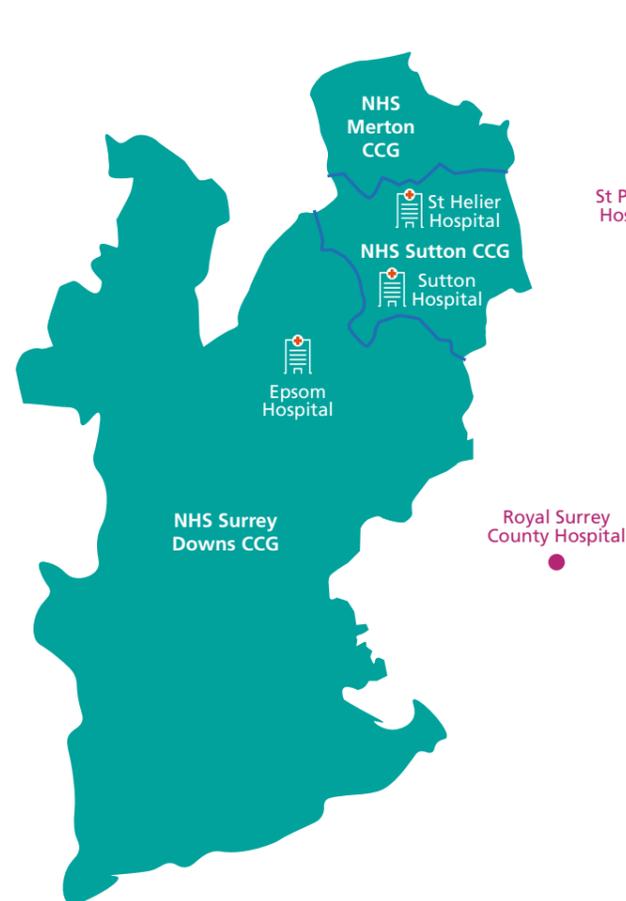
Dr Jeffrey Croucher
Clinical chair of
NHS Sutton CCG

[subject to CiC approval]

Dr Andrew Murray
Clinical chair of
NHS Merton CCG

A compelling case for change

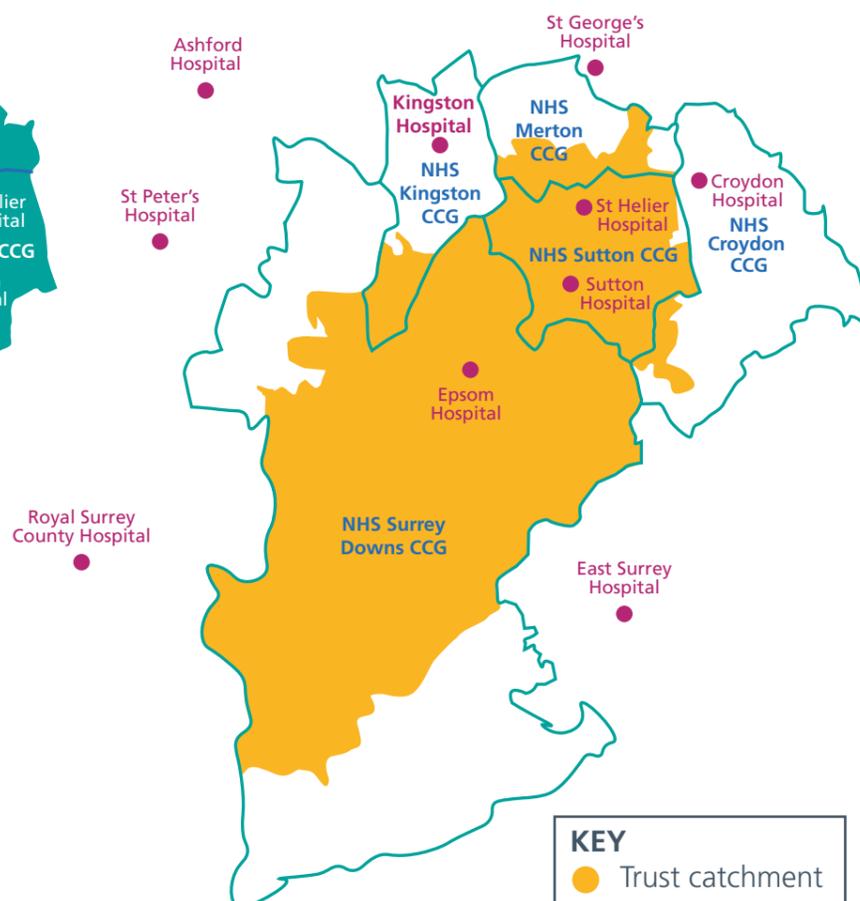
Geography of CCGs



Our three CCGs cover the catchment area of Surrey Downs, Sutton and Merton, known as the 'combined geographies', shown on this map. There are approximately 720,000 residents in our combined geographies and a number of healthcare providers are based here.

For some time, we have been exploring ways to address long-term issues of sustainability in our combined geographies. As many people will be aware, this has often focused on Epsom and St Helier University Hospitals NHS Trust so this map shows the catchment area it serves.

Catchment area for Epsom and St Helier University Hospitals NHS Trust



Last year, Epsom and St Helier engaged with its patients and communities on what its next steps should be in providing care sustainably into the future and asked us, as commissioners, for our view. We reviewed the work of Epsom and St Helier and we agree that we are facing three big challenges which mean a growing need for change. Collectively, we need to address these three main issues, which are:

Improving clinical quality

Our role as commissioners is to set clinical standards for care, assess objectively how these standards can best be met and then hold providers to account to deliver the standards. In line with national best practice, in 2017 we as commissioners defined clear clinical standards

for six acute services. These standards set out expected senior staffing levels. We asked all our providers of patient care whether they believe they can meet these quality standards and all except Epsom and St Helier said they could. Therefore the Trust is a key focus of this discussion.

Based on the standards agreed in South West London, there is a shortage of consultants in emergency departments, acute medicine and intensive care. The Trust is not meeting the Royal College of Emergency Medicine guidance for consultant cover and this is something recently identified by the Care Quality Commission (CQC) the regulator of services, when it inspected acute services. Additionally, there is also a shortage of middle grade doctors and nursing staff.

The work which has been done across all of our CCG geographies to date indicates that there is not a need to look more broadly at changes to acute hospital services in our local area, other than those at Epsom and St Helier.

Providing healthcare from modern buildings

The buildings of Epsom and St Helier, in particular, were built before the NHS was founded and are ageing. They are not designed for modern healthcare, an issue repeatedly highlighted by the CQC, including in its latest report (May 2018). Epsom and St Helier has a very significant and critical backlog of maintenance and the deterioration of the estate is affecting the day-to-day running of clinical services and patients' experience.

Achieving financial sustainability

The Trust has an underlying financial deficit which is getting worse each year. In 2013/14 it was around £7million and in 2017/18 it has increased to around £37m. This growing deficit is driven by unavoidable increases in costs for clinical workforce including temporary staff, increasing costs for estates maintenance and decreasing opportunities for changing the way we work. The financial position will continue to worsen unless changes are made.



Conclusion

These three challenges faced in our local healthcare system will not only affect the experience of our patients and the quality of patient care, but also have the potential to affect the outcomes for patients. Moreover, these challenges each impact each other, as shown in the diagram below. If we do not solve each of these problems we will not be able to provide high quality healthcare into the future.



We would like you to consider the following question:

In addition to solving the clinical quality, financial deficit and poor quality buildings in our local NHS, are there any other challenges you think we may need to solve?

Our clinical vision for care: prevention, integration and acute services

As a group of local GPs, we have considered from a clinical perspective how to address the challenges our local healthcare system faces. We want to resolve these challenges and believe that the best way to do this is by looking at how to deliver care in the future. We are doing this with our clinical partners from other healthcare providers in the area.

We aim to prevent as much ill health as possible and ensure services are appropriate, joined up, high quality and meet the necessary quality standards when healthcare is needed.

Looking at the long-term healthcare needs of our population, we have identified local aims for the future of healthcare.

These aims are:

- Delivering care as close to patients' homes as possible
- Ensuring high standards of healthcare across all our providers
- Maintaining the provision of major acute services within our combined geographies
- Improving the health of our populations

This will be achieved through:

- Greater prevention of disease
- Improved integration of care
- The delivery of enhanced standards in major acute services

The NHS's direction of travel was set out in its 2014 *Five Year Forward View*. This focus is consistent with our aims and is the basis of the priorities established by our sustainability and transformation partnerships. These are:

We need to avoid people becoming ill wherever possible, either by preventing diseases in the first place or preventing existing conditions deteriorating.

Integration is key to ensuring continuity of care and delivery of care closer to patients' homes.

Making progress with integrating care in each of our three areas.

Integrating care, which means 'joining up' health and care services so they work effectively together, requires a completely different approach and there are examples of where we are doing this. All three CCGs have plans to integrate services and provide care which is more proactive rather than reactive. The boxes below show some examples of this.

Sutton Health and Care

Sutton Health and Care (SHC) delivers integrated health and social care services for patients with long-term, complex needs in two ways. Firstly, preventative and proactive care to support people staying well in the community. Secondly, reactive care, to avoid admissions and accelerate discharge for the frail, older population. It is a joint venture between the London Borough of Sutton, the hospital trust, the mental health provider and Sutton GP Services (a federation of GP practices in Sutton). SHC has ambitious plans to extend integrated services to cover all ages and patient groups which would benefit from organisations working closer together to deliver their care, as close to home as possible.

Sutton CCG also pioneered the 'red bag scheme'. This sees residents from nursing homes bring a specially packed red bag to hospital, which means patients arrive with a discharge plan already in place, as well as clothes to go home in, meaning quicker and easier discharge.

Epsom Health and Care

Epsom Health and Care @home has been established to provide extra support and care within a patient's home to support those who have two or more long-term conditions to live as independently as they can and to prevent them from needing a hospital admission.

It also works to see patients over the age of 65 discharged earlier from hospital and, where possible, cared for at home rather than in hospital. This is a joint venture between acute services, GPs and Surrey County Council. The @home service has seen a reduction in patients needing to stay the night and excellent feedback from patients and carers.

Merton Health and Care Together

The Merton strategy for integrated community and primary care focuses on local teams working together to take action to prevent patients who are frail or have complex conditions from becoming unwell in the first place. It also sees a rapid response for vulnerable patients who become unwell, with measures in place to ensure patients are discharged from hospital at the right time.

East Merton has seen GP practices work in teams to give patients better access to care, undertake 'social prescribing' and initiatives to look after the wellbeing of residents.

Merton has also been working closely with local A&E departments to help them determine which patients may have urgent rather than emergency care needs, and provide the right care.

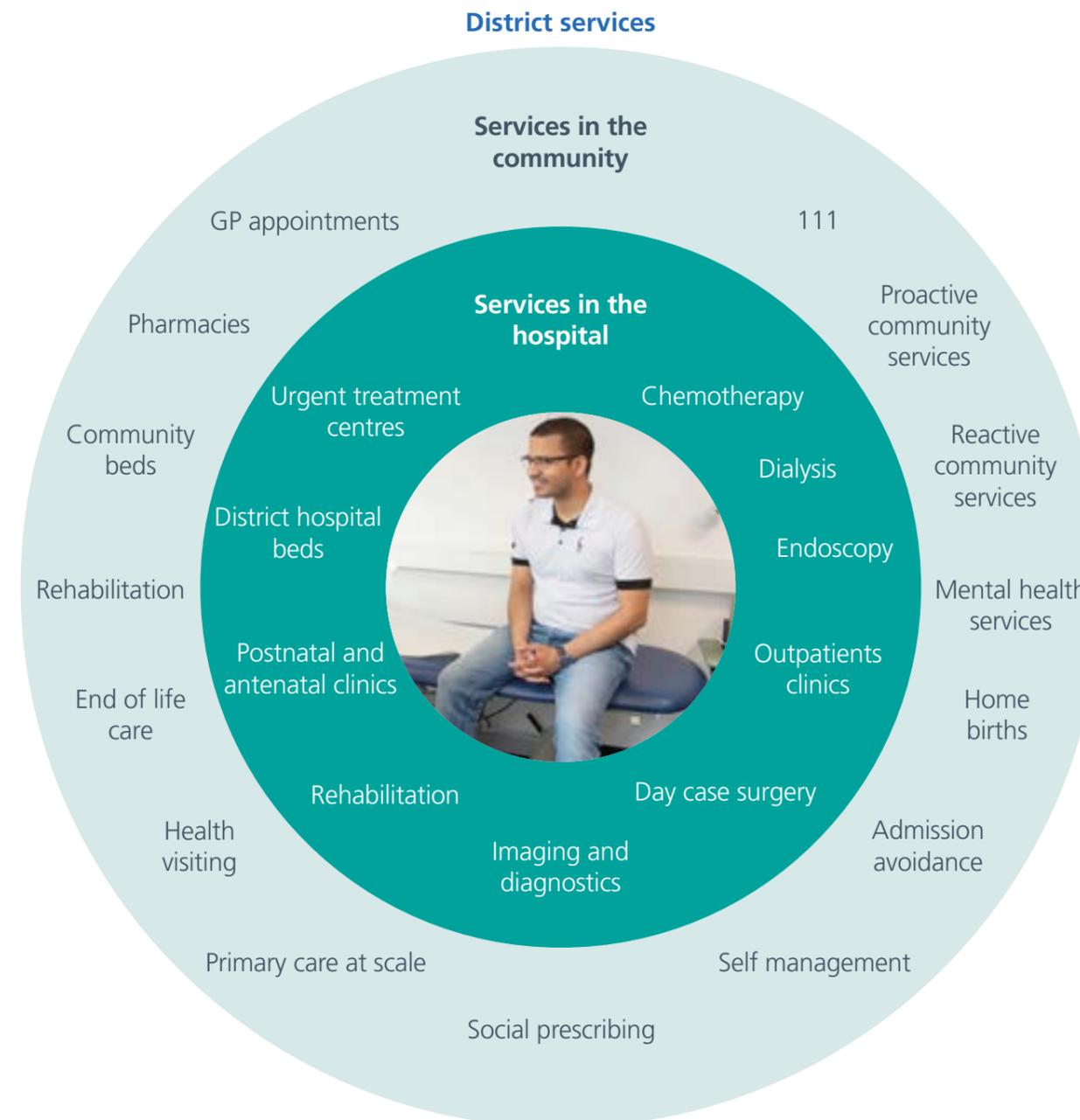


Our emerging clinical model focuses on two types of services: district services and major acute. This builds on the work we have been doing on integrated care and all the services where we can provide high-quality care for you.

Most health services in the local area will not change. The majority of services, including those for patients who do not need lifesaving, emergency, or unplanned care, will be unaffected by any potential changes.

District services are services which are provided locally. These are services which patients are likely to require more frequently, and in each area there is a local strategy which is working to ensure they are co-ordinated and integrated with community, primary, social and voluntary care. Where there is not a case for change for these services, they would continue to develop in line with current plans.

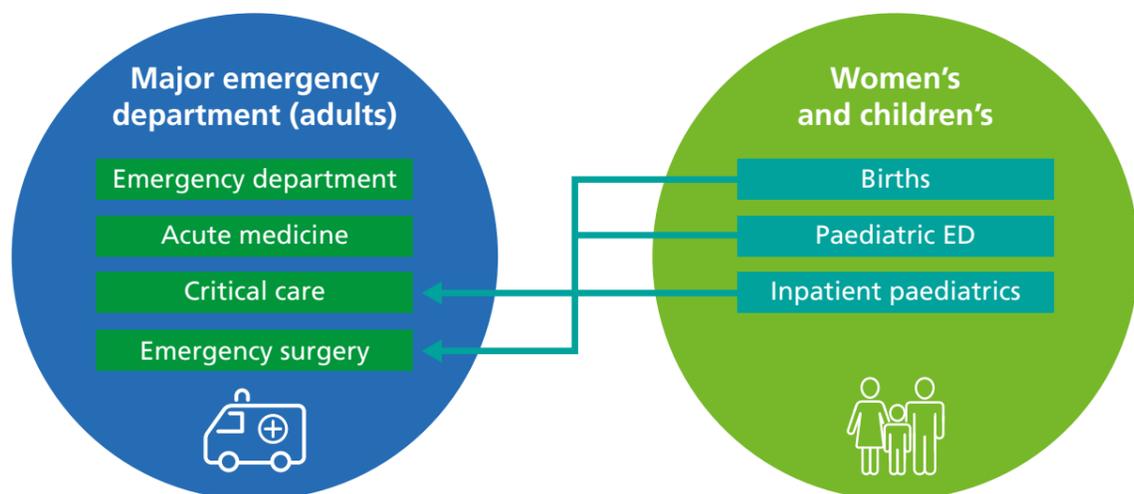
District services include urgent treatment centres, outpatients, day case surgery, low-risk antenatal and postnatal care, imaging and diagnostics, and district beds. District services and how they relate to other services are shown in the diagram opposite:



Major acute services are often needed if you are very unwell. These major acute services include emergency departments, acute medicine, critical care, emergency surgery, obstetrician-led births, paediatric emergency departments and paediatric inpatients. These services all depend on the use of intensive care services and specialist input for patients who are the highest risk and sickest. There are other 'co-dependencies' between services (meaning that they have to be located together) which are shown on the diagram on the following page.

We believe these six major acute services may need to change so that people who are very unwell, or at risk of becoming very unwell, get the right support straight away from senior specialist staff.

Co-dependent major acute services



Clinical evidence shows that, for some conditions, bringing services and the most experienced doctors (consultants) together means better care for patients and those with life-threatening conditions such as major trauma or stroke. It also means we can deliver the clinical standards, which means better survival rates and improved outcomes for our patients.

This table shows the number of senior specialist doctors currently needed by our services.

Service	Total requirement consultant (two sites)	Current consultant staffing	Gap (two sites)
Emergency department	24	14	10
Obstetrics	22	26	-
Emergency general surgery	10	10	-
Paediatrics	24	26	-
Acute medicine	24	11	13
Intensive care	9	7	2

The Trust has already moved its emergency surgery and critical care to St Helier Hospital, which has improved care for patients. Emergency fractured neck of femur (broken hip) services have been brought together at St Helier Hospital and now see significantly better outcomes for elderly patients than the national average. This means that less people die as a result of breaking their hip. These improvements have been possible because, by having a single team on one site, the Trust has been able to ensure that patients have access to the right specialist. This is why we think change may be needed – because we believe it will improve clinical standards and care for patients.

We would like you to consider the following question:

Do you think our vision for healthcare services is the right vision for this area?

Developing potential solutions

To find potential solutions to our challenges, we have looked at how our case for change can be addressed. We have explored how our clinical vision for care can be delivered and how our hospitals can be maintained into the future. We have focused on this process in two different ways:

Firstly, we have focused on major acute services only, as there is a need for significant changes in these services. District services, which comprise the majority of healthcare provided on our hospital sites, do not face the same issues and can continue to be developed through local strategies, which includes looking at delivering care in a more integrated way.

As highlighted below, we are also doing work as part of this programme to analyse the different needs of communities across the Trust catchment, and in particular how relative levels of deprivation affect those needs and the ability to access services.

Secondly, we have focused only on changes within our combined geographies. Our focus has been on major acute services, so we have been looking at how many hospital sites can deliver care in line with the quality standards for major acute services. However, if these changes impact on other providers including other hospitals, this would be considered as part of a detailed analysis of ways services can be delivered.

Based on this, we have then made further considerations. We have looked at how potential solutions might develop into a long list of ideas for solving our health and care challenges. This is intended to capture a wide range of potential solutions so we can then consider whether they meet the needs of local people and address the problems we are facing.

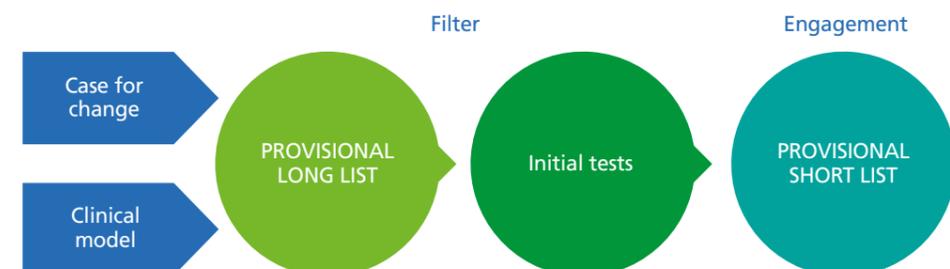
We have considered how many major acute hospitals we have in our geographies, which major acute services these hospitals provide, whether workforce from outside the area could be used to supplement rotas, and which sites could be used to deliver major acute services.

All the combinations of these factors leads to 73 potential solutions. This forms our provisional long list of ideas for solving our challenges.





Our long list is refined by testing these potential solutions against three initial tests, which are in line with our case for change and include whether services are maintained in our combined geographies. This is shown in this diagram.



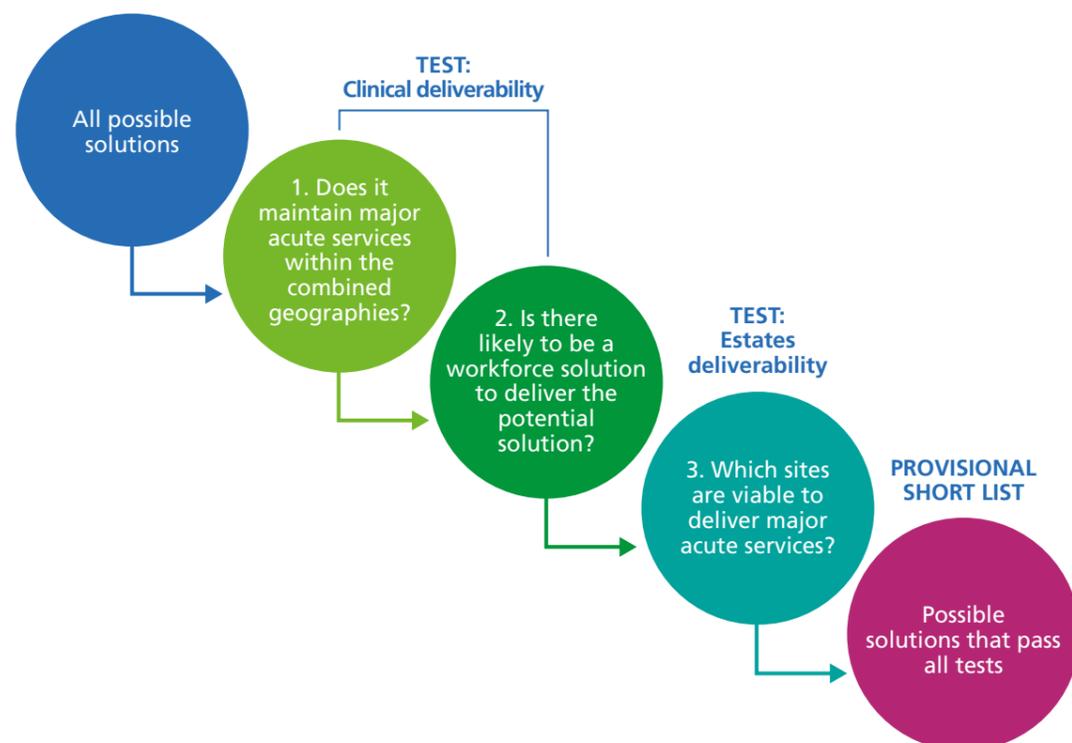
We have applied three initial tests to this long list to reach a provisional shorter list we can consider in detail. The most important of these tests is whether a solution fits in with our collective commitment to maintaining services within our combined geographies. Our other two tests are about whether we can deliver the solution based on the available workforce and the quality of the estate.

The initial tests we have applied are:

1. Does the potential solution **maintain major acute services within the combined geographies**? This is a key commitment for us and any potential solution must maintain all major acute services within our combined geographies.
2. Is there likely to be a **workforce solution** to deliver the potential solution? This includes ensuring any potential solution meets our standards for the quality of major acute services with the available workforce.
3. From which **sites** is it possible to deliver major acute services? This considers whether different sites are feasible for the delivery of major acute services.



Applying these tests, shown in this diagram, sequentially reduces the long list:



- After the first test, **any potential solution that does not offer all major acute services within the combined geographies is eliminated** (e.g. no major acute hospitals or only providing major adult emergency department services within the combined geographies). This provisionally results in 50 potential solutions.
- After the second test, workforce limitations and the six acute services which need to be located together mean that **any potential solution with more than one major acute site and any potential solution relying on external workforce is eliminated**. This provisionally results in four potential solutions – a single major acute site from one of four sites, including the possibility of a new site. Detail on this analysis is included in the technical annexe which we have published.
- After the third test, where we looked at other locations in our geographies, **only existing sites appear feasible**. This provisionally results in three potential solutions.

We will compare these solutions with the concept of continuing as we are.

There are therefore three potential solutions in our provisional short list.

This provisional short list includes:

- Locating **major acute services at Epsom Hospital**, and continuing to provide all district services at both Epsom and St Helier Hospitals.
- Locating **major acute services at St Helier Hospital**, and continuing to provide all district hospital services at both Epsom and St Helier Hospitals.
- Locating **major acute services at Sutton Hospital**, and continuing to provide all district services at both Epsom and St Helier Hospitals.

This table shows the number of senior specialist doctors which are needed by a service when they are brought together in one place, compared with two.

Service	Current consultant staffing	Total requirement (two sites)	Total requirement (one site)	Gap
Emergency department	14	24	12-16	0
Obstetrics	26	22	12-16	0
Emergency general surgery	10	10	10	0
Paediatrics	26	24	12-16	0
Acute medicine	11	24	12	1
Intensive care	7	9	9	2

To build on the engagement work already done by Epsom and St Helier with patients and our communities, further public engagement is taking place on our provisional short list of three potential solutions, which we have described in this document. Any views on this provisional short list will be taken into account in the next phase of work, which will be informed by the views gained through this engagement.

The case for change makes clear that we need to consider our plans for the future and explore the ways in which the issues we face can be addressed. We are clear that any potential

solutions must address the three main issues of clinical quality, estates and financial sustainability, while supporting our broader plans for healthcare locally. Further work is required, and we will continue to explore:

- How the clinical model can change to address our challenge of clinical quality and ensure that care is integrated and standards for major acute services are met
- The potential solutions which deliver this clinical model to our populations while addressing our challenges of workforce, estates and financial sustainability

Other important things to consider

As part of this work, there are a number of other important considerations for our patients and their families and carers. We will consider pieces of work as we progress further. These include:

- **Travel and access**
What kind of journey would patients have, and what kind of distance would they need to travel, in order to access care? What public and patient transport would be available or needed?
- **Impact on deprived communities**
We will consider how potential changes might affect communities within our local

area which are affected by deprivation, such as poverty, poor education or housing, all of which can affect health and wellbeing.

- **An equality impact analysis**
This will consider the impact of any change on our communities, including people with protected characteristics.



We have already started looking into these important elements of how care is accessed, using experts to analyse work which has already taken place.

We would like you to consider the following question:

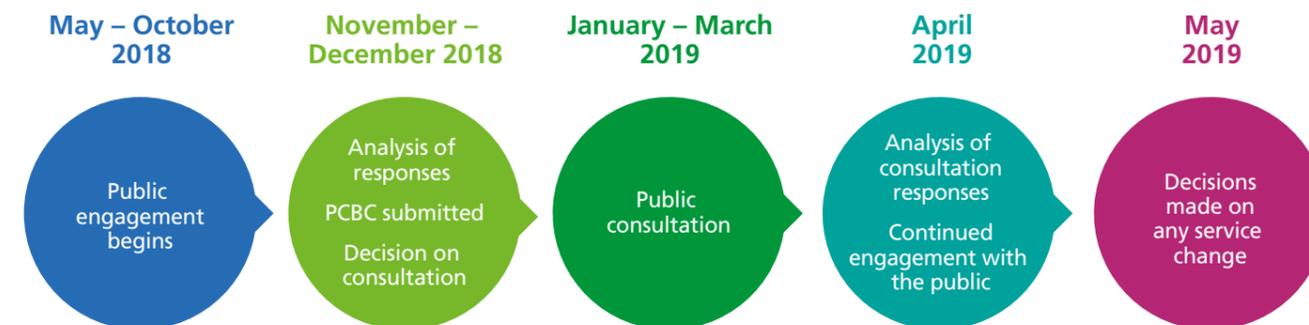
Do you think we should consider any other initial tests – apart from those described in this document – as we develop the long list of ideas into a short list?

Next steps

There is lots of work to be done on our challenges in healthcare, and a number of key issues which need to be considered. During this phase of engagement, we intend to listen to and talk with our communities through a number of engagement activities. This document is the start of the engagement process.

We also have a stakeholder reference group for local patient, community and other organisations which will be sharing thoughts and ideas. Additionally, we are undertaking a number of activities to make sure people know about this programme and can tell us their thoughts.

Potential timeline



During this engagement period, we will publish the equality impact and deprivation analyses referred to above. We will also be seeking stakeholder input to the issues set out in this document. In the future, we will also be seeking your views on any potential evaluation criteria we might use to evaluate any shortlisted solutions. However, we will as CCGs consider all feedback from stakeholders, patients, staff and the wider public before proceeding with any future review of potential solutions.

After that phase, the next phase of the programme will be to take all this information into account as we create a series of options for how we might change the way deliver care. We will continue to involve our local communities and other important stakeholders to ensure we receive feedback to inform our thinking.

If significant change is proposed, then we would draft a document which asks for the funding needed to undertake this work called a pre-consultation business case (PCBC) for approval by NHS England and if approved we would consider proceeding to consultation.

We would like you to consider the following questions:

Do you have any questions about the process we are proposing to follow or any suggestions for improving it?

Can you think of any other ways of tackling the challenges described in this document, within what the document describes as possible?

What are the best ways for involving our patients and community in developing ideas to address the challenges described in this document?

How to get involved

It is vital that this programme talks with local communities who may be affected by changes to services in the area. As lead clinicians working to improve healthcare into the future, we and our colleagues want to hear from local patients, their families and carers to establish their thoughts, feelings and ideas about local healthcare and how it can be improved.

We will be publishing details of upcoming engagement activities. We would also like to ask you some questions in response to this document. Most of these questions appear throughout this *Issues Paper* – we have collated them here for you to consider.

Please send us your answers to these questions, or any other thoughts, questions or comments, using the contact details on the back cover of this document.

1. In addition to solving the clinical quality, financial deficit and poor quality buildings in our local NHS, are there any other challenges you think we may need to solve?
2. Do you think our vision for healthcare services is the right vision for this area?
3. Do you think we should consider any other tests – apart from those described in this document – as we develop the long list of ideas into a short list?
4. Do you have any questions about the process we are proposing to follow or any suggestions for improving it?
5. Can you think of any other ways of tackling the challenges described in this document, within what the document describes as possible?
6. What are the best ways for involving our patients and community in developing ideas to address the challenges described in this document?
7. Would you like to receive the regular electronic update newsletter we propose to publish? If so, please let us know. Our contact details are on the next page.





Improving Healthcare Together 2020-2030

NHS Surrey Downs, Sutton and Merton CCGs

Please send us your thoughts, questions or comments.
Contact details below.

Online:

[To follow after CiC approval]

By email:

[To follow after CiC approval]

In writing:

[To follow after CiC approval]



[To follow after CiC approval]



[To follow after CiC approval]

This document is available in large print, audio and other languages on request.

Report Cover Sheet Committees in Common Improving Healthcare Together: 2020-2030

Date of Meeting: 21st June 2018

Agenda No: 4

ENCLOSURE: 3

<p>Title of Document: Improving Healthcare Together 2020-2030 Issues paper technical annex: Case for Change, Clinical Model and Development of Potential Solutions</p>	<p>Purpose of Report: For approval</p>
<p>Report Authors: Programme Team</p>	<p>Lead Director: Andrew Demetriades, Joint Acute Sustainability Programme Director</p>
<p>Executive Summary:</p> <p>This <i>Technical Annex</i> sits alongside the <i>Issues Paper</i>, and details the key challenges facing our healthcare system and describes why change is necessary. It details an emerging clinical model for our combined geographies based on clinical standards and evidence based best practice, and sets out a provisional short list of potential solutions we intend to consider further following the launch of the engagement programme.</p> <p>The purpose of this <i>Technical Annex</i> is therefore threefold:</p> <ol style="list-style-type: none"> 1. To set out the case for change: The case for change describes the key challenges faced by the local health economy – and in particular by Epsom and St Helier University Hospitals Trust – and explains why change is necessary. It also describes the current provision of healthcare in the local area, the needs of the local population and our vision for the future of local healthcare. 2. To describe the clinical model: The emerging clinical model has been developed to meet local needs for our combined geographies based on clinical standards and evidence based best practice. It includes the model for urgent and emergency care, planned care, maternity and paediatrics. 3. To set out the framework used to develop potential solutions: The framework describes the standard approach we have used to understand the potential solutions to deliver the emerging clinical model. This document describes a long list and applies a series of initial tests to reach a provisional short list. 	
<p>Key issues to note are:</p> <ul style="list-style-type: none"> • All documentation is draft subject to approval by Committees in Common. • All documentation has been written at a point in time, reflecting information (including sources and references accessed) as of the date of publication. All documentation may change based on new or additional information which is made available to the programme. 	
<p>Recommendation:</p>	

The Committees in Common is asked to:

- Approve the *Technical Annex*

Committees which have previously discussed/agreed the report

This paper has been reviewed by governance groups across the programme including the Clinical Advisory Group and Programme Board.

Financial Implications:

The financial implications of any potential solutions will be conducted in due course as part of the Programme.

Equality Impact Assessment:

An Equality Impact Assessment (Phase 1) has been commissioned for the Improving Healthcare Together: 2020-2030 programme.

Information Privacy Issues:

None

Communication Plan:

A draft communications and engagement plan for the Improving Healthcare Together 2020-2030: has been developed and will be approved by the Committees in Common.

DRAFT

**IMPROVING HEALTHCARE TOGETHER 2020-2030
ISSUES PAPER TECHNICAL ANNEX:
CASE FOR CHANGE, CLINICAL MODEL AND
DEVELOPMENT OF POTENTIAL SOLUTIONS**

Surrey Downs, Sutton and Merton CCGs

June 2018

EXECUTIVE SUMMARY

We (NHS Surrey Downs Clinical Commissioning Group, NHS Sutton Clinical Commissioning Group and NHS Merton Clinical Commissioning Group) have been exploring how to meet the healthcare needs of our populations in a sustainable way.

The purpose of this document is threefold:

1. **To set out the case for change:** The case for change describes the key challenges faced by the local health economy – and in particular by Epsom and St Helier University Hospitals Trust – and explains why change is necessary. It also describes the current provision of healthcare in the local area, the needs of the local population and our vision for the future of local healthcare.
2. **To describe the clinical model:** The clinical model has been developed to meet local needs for our combined geographies based on clinical standards and evidence based best practice. It includes the model for urgent and emergency care, planned care, maternity and paediatrics.
3. **To set out the framework used to develop potential solutions:** The framework describes the standard approach we have used to understand the potential solutions to deliver the emerging clinical model. This document describes a long list and applies a series of initial tests to reach a provisional short list.

We have collectively identified the main issues and opportunities in delivering healthcare to our populations. We are focused on addressing issues that affect our combined geographies. Wider changes or acute services reconfiguration across South West London, Surrey or individual CCGs are out of scope of the programme. The programme will work within the context of the other emerging initiatives and will consider any further initiatives as they arise. We will also assess the impact of changes on the acute providers outside our combined geographies.

Our case for change describes the key challenges faced by the local health economy

As commissioners of healthcare across Surrey Downs, Sutton and Merton, we are clear that we must ensure that the needs of our populations are met and support improved health of our populations, both currently and in the future. This includes rapid access for urgent care needs, consistency in care for long-term conditions and access to specialists for the sickest patients or those most at risk.

To meet these needs, we have a vision for future healthcare:

- **Preventing illness**, including both preventing people becoming sick and preventing illness getting worse.
- **Integrating care** for those patients who need care frequently and delivering this integrated care as close to patients' homes as possible.
- **Ensuring high quality major acute services** by setting clear standards for the delivery of major acute emergency, paediatric and maternity services.

We have identified a number of barriers to delivering this vision. In particular, we have three main challenges with our main acute provider, Epsom and St Helier University Hospitals NHS Trust (ESTH):

- **Delivering clinical quality:** ESTH is the only acute trust in South West London that is not clinically sustainable in the emergency department and acute medicine due to a 25 consultant shortage against our standards. Additionally there are shortages in middle grade doctors, junior doctors and nursing staff. The Care Quality Commission has highlighted workforce shortages across its two sites as a critical issue.
- **Providing healthcare from modern buildings:** Our acute hospital buildings are ageing and are not designed for modern healthcare. Over 90% of St Helier Hospital is older than the NHS and it

has the 16th highest backlog maintenance in the country; its condition has been highlighted by the Care Quality Commission as requiring improvement.

- **Achieving financial sustainability:** The cost of maintaining acute services across two hospital sites is a major driver of the system's deficit. In particular, by 2025/26, ESTH may need c. £33m of additional annual funding above that which is likely to be available, based on current services. This is a major challenge to the sustainability of the local health economy.

Our clinical model describes how we will deliver healthcare in the future to meet local needs

We have set out an emerging clinical model to meet the needs of our populations and deliver our vision. This improved clinical model is based on clinical standards and evidence based best practice. It includes the model for urgent and emergency care, planned care, maternity and paediatrics.

This model has been developed by our Clinical Advisory Group, which has a membership drawn from acute and non-acute clinical leaders from across the Surrey Downs, Sutton and Merton area. Additionally, this emerging model has been refined both by working groups of clinicians and other stakeholders from across primary and secondary care including through two clinical workshops involving stakeholders from across the area.

As our challenges are local, this emerging clinical model focuses only on the combined geographies of Surrey Downs, Sutton and Merton. Wider changes, such as the clinical model for South West London and Surrey, are out of scope. However, the impact of local changes on other providers will be considered as part of detailed analysis.

Our clinical model aims to integrate care across all settings. However, our focus here is on the future of hospital care, where we have specific challenges.

We need to deliver more integrated, locality-based community care for patients. This is intended to provide care closer to home where possible and ensure that, if needed, hospital care is timely, high quality and provided within facilities that are fit for purpose.

As such, a whole systems approach needs to be taken for the consideration of potential solutions for Surrey Downs, Sutton and Merton, encompassing all settings of care. This is the focus of our individual and collective strategic plans.

As we have a specific challenge with the provision of hospital services, this document focuses on the provision of **district hospital** and **major acute** hospital care based on their reliance on critical care services (hospital services that provide monitoring and/or treatment for the sickest or highest risk patients and include intensive care units, high dependency units and post-anaesthesia care units).

- **Major acute services** are defined as those services that reliant on the presence of critical care and/or services that critical care is dependent on. These are services that the only the highest risk and sickest patients require from a healthcare service.
- **District hospital services** are defined as services that do not require critical care and/or services that critical care is dependent on. They have close links with other health and care services and are becoming more integrated, including across community, mental health and primary care.

Major acute services are dependent on the physical presence of critical care.

Major acute services include emergency department, acute medicine, emergency surgery, critical care, obstetrician-led births, emergency paediatrics and inpatient paediatrics.

These major acute services can be organised in multiple ways. Within our clinical model, we have considered two clusters of services:

- **Major emergency department (adults):** Emergency department, acute medicine, emergency surgery and critical care.
- **Women's and children's services:** Obstetrician-led births, emergency paediatrics and inpatient paediatrics.

The cluster of major emergency department (adults) services must be co-located to offer a viable major emergency department. Women's and children's major acute services (obstetrician-led births, emergency paediatrics and inpatient paediatrics) are typically closely linked; for example, clinical rotas are often shared. Women's and children's services also require a major emergency department due to their dependency on critical care and emergency surgery for women.

In addition to the changes to major acute services, the emerging clinical model outlines developments in a number of other hospital services. This includes:

- Urgent treatment centres
- District hospital beds
- Non-obstetrician maternity services
- Elective surgery

Urgent treatment centres are important district hospital services to maintain access for patients requiring urgent medical attention.

National guidance requires that our existing urgent care centres (located at St Helier Hospital and Epsom Hospital) are developed into urgent treatment centres, which offer a broader range of diagnostics and treatment for patients presenting with urgent care needs.

As per the national guidance, these urgent treatment centres will be staffed by a multidisciplinary team, led by general practitioners. We will also explore the potential of co-location with general practice out-of-hours services to support the delivery of both services.

National guidance mandates that urgent treatment centres are open for a minimum of 12 hours a day, 7 days a week. Our urgent treatment centres, as defined by this emerging clinical model, will meet all national standards, including these standards for access. We will continue to review the appropriate opening hours of our urgent treatment centre.

Inpatients who do not need critical care can be treated in district hospital beds.

We have ambitious plans to treat more patients in their own homes and/or in the community through the development of district care services. These enhancements are expected to reduce the demand for inpatient beds across the combined geographies.

Nevertheless, we will still need hospital beds in the future. Based on our initial work, we do not expect the total number of beds in our combined geographies to change significantly; more work is needed to explore this further.

While major acute hospital beds will be used for our sickest and highest risk patients, multiple bed audits have identified a cohort of c. 47–60% of existing inpatients who require a hospital bed but do not require any of the major acute services. While further work is required to define the specific types of patient within this cohort, the needs of these patients could include: active, short-term rehabilitation; ongoing therapy assessment; intravenous therapy; and/or further assessment and monitoring (e.g. activity charts).

Our clinical model plans to manage these patients via district hospital beds, which are a different type of bed designed to better meet the needs of this patient cohort.

We will define this cohort further as our work develops, but we expect three pathways into these district hospital beds:

- Direct admission from primary care or an urgent treatment centre.
- Step down from the major acute site.
- Step-up from a community multi-disciplinary team for patients with short-term escalating medical needs.

At both Epsom and St Helier hospitals, these patients are already being treated in a different manner as inpatients. In the emerging clinical model these beds would remain at each site with a new model of care.

For women planning to give birth in our combined geographies, a choice of home birth, midwife-led birth and obstetrician-led birth will be maintained.

For women giving birth, choice is important – this has been reiterated by the most recent national guidance, which requires that women are supported to give birth in their preferred choice of location, whether at home, in a midwife-led unit or in an obstetrician-led unit.

Obstetrician-led births are a major acute service and are described above.

For home births, we will continue to offer support to women and promote this as a viable choice for women where this option is appropriate. There is an established a home birth team, aiming to increase the uptake of home births from current levels. This will involve having open discussions with women about their options for birth and providing educational material on the maternity journey so that they are able to make an informed decision.

For midwife-led births, the needs of our local population and the configuration of local maternity services means that our emerging thinking is that midwife-led units should be alongside obstetrician-led units. Key considerations include:

- Currently, midwife-led births comprise c. 15–20% of all hospital births and are delivered via alongside midwife-led units. Having units located alongside obstetrician-led units enables effective use of midwives, who can operate across both units.
- Transfer rates from midwife-led births can be c. 21% due to complications with the mother and/or the baby. These mothers and/or babies would then require an obstetrician, a neonatal doctor and/or other major acute services (e.g., emergency surgery, emergency gynaecology). Co-locating midwife-led units with obstetrician-led units ensure these services are on the same site and long inter-hospital transfers are avoided.
- In the local area, we have a significant number of midwife-led units available nearby, including at Kingston, St Peter's, St George's, Croydon, West Middlesex, Royal Surrey County, and Chelsea and Westminster hospitals. All of these units are currently co-located with an obstetrics unit.

Based on these considerations, our emerging thinking is that it is more appropriate in our local area to maintain midwife-led units alongside obstetrician-led units.

For elective surgery, daycases can be delivered as a district hospital service. However, inpatient elective surgery requires a post-anaesthesia care or high dependency unit.

Most elective surgery is performed as a daycase, which can safely be delivered without needing significant support. In 2017, 23,703 daycases were performed in our local geographies, comprising 66% of all elective surgical activity.

For inpatient elective surgery, post-anaesthesia care or high dependency units may be required for some patients. Of the 12,328 inpatient elective surgical cases performed in our combined geographies in 2017, 584 (4.7%) required a high dependency unit during their stay.

Therefore, inpatient elective surgery will need to be co-located with an existing post-anaesthesia care or high dependency unit (e.g., a major acute critical care unit or an existing dedicated post-anaesthesia care or high dependency unit).

Our emerging clinical model has considered a range of district services, which will continue to be delivered.

District services are hospital-based services that patients may require frequently. This can include, for example, urgent treatment centres, district hospital beds, outpatient clinics, dialysis, chemotherapy, daycase surgery and some inpatient care; some of these services are discussed above.

These services can continue to develop as described by existing plans. Central to this are our aims for the integration of services across primary, community and hospital care, building on our existing work to deliver enhanced services to our populations.

This emerging clinical model forms the basis of our planning for potential solutions for our combined geographies. It will be tested with the public and clinical senates and may be refined if additional evidence emerges.

We are considering potential solutions to address our challenges and deliver our vision

We have used a standard approach to understand the potential solutions to deliver the emerging clinical model. This includes developing a long list and applying a series of initial tests to reach a provisional short list.

This process has been informed by previous engagement with the public on potential solutions to the issues we face and extensive discussion within the local area, including amongst clinicians, commissioners, providers and regulators. This includes previous public engagement on potential scenarios for Epsom and St Helier University Hospitals Trust, which was completed to support the development of their *Strategic outline case for investment in our hospitals 2020-2030*.

We are at the beginning of our process. Each element of this process will be tested with the public – this includes the long list, initial tests and provisional shortlist. In addition, the long list and provisional short list may be refined if further evidence is forthcoming.

Our development of potential solutions explores ways our case for change can be addressed, our clinical model can be delivered and our hospitals maintained into the future. We have focused this process in two ways.

- **First, we have focused on major acute services only**, as there is a need for significant changes in these services. District hospital services, which comprise the majority of healthcare provided on our hospital sites, do not face the same issues and can continue to be developed as described in our existing plans, including our plans to deliver care in a more integrated way.
- **Second, we have focused only on changes within our combined geographies**. However, if these changes impact on other providers, this would be considered as part of detailed analysis of ways they can be delivered.

Based on this, we have then considered how potential solutions might vary to develop a long list of potential solutions. This is intended to capture a wide range of potential solutions – consideration of their viability is a subsequent step. We have considered:

- **How many major acute hospitals are provided in the combined geographies?** Possible solutions include sites providing district hospital services alongside up to two sites delivering major acute services. Although no major acute hospital sites would not align with our commitment to maintaining major acute services within our combined geographies, it has been included for completeness.
- **Which major acute services do these hospitals provide?** There are two potential configurations of major acute services: major acute hospital(s) could provide adult major emergency department(s) only or provide major adult emergency department(s) alongside women's and children's services.
- **Is workforce from outside the area used to supplement rotas?** Possible solutions include relying only on workforce within our local area and using workforce from nearby providers to supplement rotas.
- **Which sites could be used to deliver major acute services?** Possible solutions include using existing acute hospital site(s) (i.e., Epsom, St Helier and/or Sutton Hospital site) and/or using a new site within our combined geographies.

All the combinations of these factors leads to 73 potential solutions. This forms our provisional long list.

Our long list is refined by testing the viability of potential solutions against three initial tests, including whether services are maintained in our combined geographies.

We have applied three initial tests, aligned to our case for change, to this long list to reach a shorter list we can consider in detail. The most important of these concerns our collective commitment to maintaining services within our combined geographies, so long as a viable potential solution is available. Our other two tests concern deliverability based on available workforce and estates.

The initial tests we have applied are:

1. Does the potential solution **maintain major acute services within the combined geographies**? This is a key commitment for us and any potential solution must maintain all major acute services within our combined geographies.
2. Is there likely to be a **workforce solution** to deliver the potential solution? This includes ensuring any potential solution meets our standards for the quality of major acute services with the available workforce.
3. From which **sites** is it possible to deliver major acute services? This considers whether different sites are feasible for the delivery of a major acute hospital.

Applying these tests sequentially reduces the long list:

- After the first test, **any potential solution that does not offer all major acute services within the combined geographies is eliminated** (e.g., no major acute hospitals or only providing major adult emergency department services within the combined geographies). This provisionally results in 50 potential solutions.
- After the second test, workforce limitations and co-dependencies mean that any potential solution with more than one major acute site and any potential solution relying on external workforce is eliminated. This provisionally results in four potential solutions – a single major acute site from one of four sites (Epsom Hospital, St Helier Hospital, Sutton Hospital, or a new site within our combined geographies).
- After the third test, **only existing sites appear feasible**. This provisionally results in three potential solutions.

In addition, our provisional short list includes a ‘do minimum’ – continuing with existing service provision at both Epsom Hospital and St Helier Hospital.

There are therefore four potential solutions in our provisional short list.

Our provisional short list includes:

- **The ‘do minimum’**: Continuing current services at Epsom Hospital and St Helier Hospital.
- **A single major acute site at Epsom Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
- **A single major acute site at St Helier Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
- **A single major acute site at Sutton Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.

This provisional short listing process and supporting evidence will be tested with the public before further analysis is completed. This will then form part of a full options appraisal to support a pre-consultation business case.

The case for change makes clear that we need to consider our plans for the future and explore the ways that the issues we face can be addressed. We are clear that any potential solutions must address the three main issues of clinical quality, estates and financial sustainability, while supporting our broader plans for the system. Further work is required, and we will continue to explore:

- How the clinical model can change to address our challenge of clinical quality and ensure that care is integrated and standards for major acute services are met.
- The potential solutions that deliver this clinical model to our populations while addressing our challenges of workforce, estates and financial sustainability.

The public will be involved throughout the process. As a first step, we are publishing an *Issues Paper* as a starting point for engagement and discussion with the public.

Following engagement, we will then commence further analysis of the provisional shortlist of potential solutions as part of a pre-consultation business case, considering the full implications of any changes, including clinical benefits, travel times and access, patient volume and flows, workforce impacts, impacts on other providers and financial impacts (including revenue and capital). Alongside this, we will complete specific analyses of deprivation and the impact of any changes on equalities.

The pre-consultation business case will be considered by the three clinical commissioning groups who will ultimately make any decisions, in line with the regulatory framework. No decisions have been made at this point, and before we make any decisions, there will be full public consultation and the decisions will take account of the feedback received from the public.

DRAFT

PURPOSE OF THIS DOCUMENT

This *Technical Annex* sits alongside the *Issues Paper*, and details the key challenges faced our healthcare system and describes why change is necessary. It details an emerging, sustainable clinical model for our combined geographies based on clinical standards and evidence based best practice, and sets out a provisional short list of potential solutions we intend to consider further following testing with the public.

This document has been written at a point in time, reflecting information (including sources and references accessed) as of the date of publication. The document, including its related analysis and conclusions, may change based on new or additional information which is made available to the programme.

The case for change brings together the clinical and wider factors affecting healthcare for the area of the three combined clinical commissioning groups.

- It describes the current provision of healthcare in the local area, the healthcare needs of our populations and our aims for healthcare in the future. It describes the challenges to achieving these aims, focusing on Epsom and St Helier University Hospitals Trust.
- It sits alongside other documents such as both the South West London and the Surrey Heartlands sustainability and transformation partnership plans and focuses on the challenges facing the particular combined geography of Surrey Downs, Sutton and Merton clinical commissioning groups.
- It does not seek to identify issues that are not particular to the region defined by the three combined CCGs, including acute services in Surrey Heartlands or South West London.

The emerging clinical model describes district services, major acute services, co-dependencies, patient pathways and the process being undertaken to develop the clinical model.

- It has been developed locally by our Clinical Advisory Group and its subgroups, with inputs from a number of other stakeholders.
- It is intended to describe the services that will be provided to meet local needs and the co-dependencies between them. It sets out the benefits framework of potential changes and patient pathways, including 'as is', key changes and the 'to be' with the potential impact on patients.
- It is not intended to describe a detailed model at specialty level. It will not analyse the financial implications and requirements of the clinical model. This will follow once the clinical model is defined and potential ways to deliver it are identified.

The initial framework for the development of potential solutions is intended to summarise our work in seeking to explore potential changes, assuming the case for change is successfully made.

It summarises a provisional long list of possible changes, the hurdle criteria for establishing a short list, a provisional short list and the evaluation criteria. It is intended to:

- Describe the ways in which we can address our case for change, deliver our clinical model and maintain our hospitals into the future.
- Identify a small number of initial tests to reduce the number of potential solutions to a shorter list that can be analysed in more detail. It describes the potential solutions that pass our initial tests based on the evidence currently available and sets out the further work we will undertake on this shorter list of potential solutions.

- The framework does not conduct a detailed options appraisal of preferred solutions, nor estimate the costs and benefits of different preferred solutions. It does not identify a preferred solution for our combined geographies.

Public engagement has taken place throughout the development of this *Technical Annex*. This includes an established Stakeholder Reference Group and the involvement of Healthwatch. Through engagement with stakeholders over the coming months, we will seek to receive further feedback on the case for change, clinical model and development of potential solutions. At every stage of the process we will consider the views of patients and the public.

DRAFT

SCOPE OF THIS DOCUMENT

We are focused on addressing issues that affect our combined geographies, while aiming to retain major acute services in geography and secure investment for the area. Wider changes or acute services across South West London, Surrey Heartlands or individual clinical commissioning groups are out of scope of the programme. The programme will work within the context of the other emerging initiatives and will consider any further initiatives as they arise. We will also assess the impact of potential changes on the acute providers outside our combined geographies.

Our sustainability and transformation partnerships are working together to address a wide range of issues and opportunities, including transforming the provision of care more generally. These plans are clearly described in both our sustainability and transformation plans and are described further in this document.¹

As part of this planning, specific issues were identified at Epsom and St Helier University Hospitals Trust, aligned with previous discussions about its long-term sustainability (see Section 1.5). The South West London Sustainability and Transformation Partnership concluded that three of the four acute trusts in South West London are clinically sustainable, but there is a specific need to address issues at Epsom and St Helier University Hospitals Trust; therefore there is no case for system-wide acute services reconfiguration.² Similarly, Surrey Heartlands Sustainability and Transformation Partnership identified a specific need to find a solution for estates at Epsom and St Helier University Hospitals Trust and requested national support to realise this but did not identify any case for acute services reconfiguration across the region.³

For these reasons, Surrey Downs, Sutton and Merton Clinical Commissioning Groups have come together to explore the issues around the sustainability of Epsom and St Helier University Hospitals Trust hospitals. We are not considering wider changes to services or acute services reconfiguration across South West London or Surrey Heartlands. Parallel programmes, including ongoing implementation of our sustainability and transformation partnership plans, are expected to deliver the wider changes needed in the system.

Whilst we are keen to hear feedback from people who live in other parts of South West London and Surrey, we are not proposing any changes to where you are likely to access acute health care services from most of Croydon and Kingston; Richmond and Wandsworth; Guildford and Waverley; Staines-upon-Thames, Sunbury-on-Thames, Chertsey, Weybridge and Woking; nor geographies in East Surrey. We do recognise, however, that our potential changes may impact health care providers in these areas, and we will consider these as the programme progresses.

¹ This includes: *South West London Five Year Forward Plan* (October 2016) <https://www.swlondon.nhs.uk/wp-content/uploads/2016/11/SWL-Five-Year-Forward-Plan-21-October-2016.pdf>; *South West London Health and Care Partnership: One Year On* (November 2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>; *Surrey Heartlands Sustainability and Transformation Plan* (June 2016); *Surrey Heartlands Sustainability and Transformation Plan* (October 2016) <http://www.surreyheartlands.uk/wp-content/uploads/2017/04/surrey-heartlands-stp-october-2016.pdf>

² *South West London Five Year Forward Plan* (October 2016) <https://www.swlondon.nhs.uk/wp-content/uploads/2016/11/SWL-Five-Year-Forward-Plan-21-October-2016.pdf>.

³ *Surrey Heartlands Sustainability and Transformation Plan* (October 2016) <http://www.surreyheartlands.uk/wp-content/uploads/2017/04/surrey-heartlands-stp-october-2016.pdf>

CONTENTS

1	CASE FOR CHANGE	13
1.1	Background	13
1.2	Needs of our populations	14
1.3	Healthcare in the local area	18
1.4	Our aims	24
1.5	Our challenges and opportunities	32
1.6	The need for change	41
2	CLINICAL MODEL	42
2.1	Process	42
2.2	Clinical model	44
2.3	Urgent and emergency care	54
2.4	Paediatrics	62
2.5	Maternity	66
2.6	Planned care	73
2.7	Conclusion	78
3	DEVELOPMENT OF POTENTIAL SOLUTIONS	79
3.1	Our approach	79
3.2	Our requirements	81
3.3	Identifying potential solutions	83
3.4	Initial tests for potential solutions	86
3.5	Applying initial tests	91
4	NEXT STEPS	99
5	APPENDIX	100
5.1	Lists of potential solutions	100

1 CASE FOR CHANGE

1.1 Background

As commissioners of healthcare in the local area, we (NHS Surrey Downs Clinical Commissioning Group, NHS Sutton Clinical Commissioning Group and NHS Merton Clinical Commissioning Group) have been exploring the best way to meet the healthcare needs of our populations in a sustainable way.

This has included working with neighbouring clinical commissioning groups (CCGs), working together as sustainability and transformation partnerships (STPs) to identify priorities for the delivery of high quality, affordable and sustainable care. We sit across two STPs, Surrey Heartlands and South West London (SWL), and have clear plans to improve healthcare in these regions.⁴

As part of this work, we identified specific issues with the long-term sustainability of healthcare in our combined geographies (i.e., the geographic areas covered by the three CCGs). Specifically, there are issues with clinical quality, estates and finance that create a need for us to consider how healthcare should change.

These issues specifically affect the major acute trust in our combined geographies, Epsom & St Helier University Hospitals NHS Trust (ESTH).

This need has led to the production of this case for change, which focuses on the issues at ESTH.

1.1.1 Building on previous work

We are looking to build on recent work that ESTH has undertaken.

Following a number of attempts to resolve long-term issues of sustainability in the combined geography, in 2017, with our support as commissioners, ESTH published a strategic outline case (SOC) for investment in its hospitals.⁵ This document described ESTH's view of its challenges. As commissioners, we accepted it has an issue to address and agreed to further work to explore the future for healthcare locally.

To address the issues the system faces, we need to ensure there is a clear case for change and consensus among commissioners and providers that something must change. We have developed a programme to ensure this consensus is maintained across the system.

⁴ This includes: *South West London Five Year Forward Plan* (October 2016) <https://www.swlondon.nhs.uk/wp-content/uploads/2016/11/SWL-Five-Year-Forward-Plan-21-October-2016.pdf>; *South West London Health and Care Partnership: One Year On* (November 2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>; *Surrey Heartlands Sustainability and Transformation Plan* (June 2016); *Surrey Heartlands Sustainability and Transformation Plan* (October 2016) <http://www.surreyheartlands.uk/wp-content/uploads/2017/04/surrey-heartlands-stp-october-2016.pdf>

⁵ *Strategic outline case for investment in our hospitals 2020-2030* (2017) <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93jijm4n8158.pdf>

1.2 Needs of our populations

The populations across Surrey Downs, Sutton and Merton have a range of different needs for health and social care services, which should be considered when developing future plans. For example, some people need intensive care and support, whilst others use services less regularly. This need depends on several factors, including population demographics such as age and deprivation; as well as whether people are living with one or more long term health condition, such as diabetes, asthma, or a mental illness. It is also important to understand how the needs of local people are likely to change, to ensure the future care system can be designed in the right way.

Our population is growing and getting older. For example, since 2014, the population has grown by 4% in Surrey and 5% in Sutton and Merton, and is expected to continue in to the future; and in Surrey in particular, the share of the population which is over 65 is high and increasing. We need to ensure that the future care system can be designed and targeted in the right way to meet the needs of our growing and ageing populations.

1.2.1 Population health needs

People in Surrey Downs, Sutton and Merton are generally more affluent and have better outcomes than the rest of England⁶, although there is significant variation.

The populations across Surrey Downs, Sutton and Merton vary significantly, although outcomes across all three areas are generally better than the average for England.⁷

- Surrey Downs has a comparatively older and less ethnically diverse population, living in more rural areas, and is similarly more affluent than the England average. While outcomes are better than the England average, there is some variation, including cancer survival rates.⁸
- In Sutton, health outcomes are better than the average in England, and the borough is affluent on average, however there are health inequalities and significant pockets of deprivation within the borough, which drive differences in life expectancy.
- In Merton, the population is older and health outcomes are similarly better than the London and England average, however there are significant social inequalities which mean that the life expectancy gap between the most and least deprived areas is six years for men and four years for women.⁹

1.2.2 Healthcare needs of different groups

Some people have more health and social care needs than others. People in Surrey Downs, Sutton and Merton require different levels of health and social care.

The majority of the population in Surrey Downs, Sutton and Merton are generally healthy and only need access to health and social care services on an occasional basis. However, some groups of people need more care than others – this is common across England and is influenced by factors such as a person's age, underlying health and income. For example, nationally, it costs twice as much

⁶ For example, average gross disposable household income per head in each of Sutton, Merton and Surrey Downs is in the top quartile of local councils in the UK. *Regional gross disposable household income (GDHI) by local authority in the UK (2017)* <https://www.ons.gov.uk/economy/regionalaccounts/grossdisposablehouseholdincome/datasets/regionalgrossdisposablehouseholdincomegdhibylocalauthorityintheuk>

⁷ For example: assessments of the healthcare needs of local populations, including joint strategic needs assessments (JSNAs) maintained by local authorities. *The Merton Story – Key Issues in Merton* <https://www2.merton.gov.uk/Merton-story-final.pdf>; *Sutton Population Fact Sheet (2017)* https://data.sutton.gov.uk/sutton_jsna/; *Surrey Downs: Surrey Downs CCG Health Profile (2015)* http://www.surreydownsccg.nhs.uk/media/144405/sdccg_health_profile_2015.pdf

⁸ For example: 56% of the population is of persons aged between 20–64 years and 20% are aged 65 years and over.

⁹ *South West London Health and Care Partnership: One Year On (2017)* <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>

to treat a 65 year old than a 30-year old, and is even higher for older age groups, and this is similar across Surrey Downs, Sutton and Merton.¹⁰ Understanding the distribution of health and social care needs helps us to ensure that the future care system can be designed and targeted in the right way to meet these varying needs.

Most people living in Surrey Downs, Sutton and Merton are generally in good health and use health and social care services less regularly.

Most people living in Surrey Downs, Sutton and Merton are generally in good health and use services less regularly – for example visiting the GP for a common illness, or having a minor operation. A continuation of good health can be supported and encouraged through awareness and prevention campaigns, and information can be provided to support self-care where appropriate. High quality health and social care services need to be easily accessible when they are needed.

People are living longer which means they need more care.

Almost 2 in 10 people in Surrey Downs is over 65, and more than 1 in 10 people in Sutton and Merton, and this is expected to increase.¹¹ The number of very elderly people is also high, with around 2% of people in Surrey Downs, Sutton and Merton over the age of 85.

The ageing population means the need for health and social care services is much greater, as older people are more likely to develop long term health conditions such as diabetes, heart disease and dementia; and are more at risk of strokes, cancer and other health problems. Nationally, 58% of people over 60 have a long term condition compared to 14% under 40.¹² Across Surrey Downs, Sutton and Merton, health and social care expenditure is significantly used for people aged over 65, despite representing only 20% in Surrey Downs of the population and 10-15% of the population in Sutton and Merton.

Older people also find it difficult to access services (especially if it involves significant travel), future services therefore need to be designed to ensure that high quality services are easily accessible for this group.

The number of people with multiple long term conditions is increasing, meaning a greater focus on preventative and proactive support is required.

Around 15 million people in England have a long-term condition¹³, and across Surrey Downs, Sutton and Merton, a number of these conditions are particularly prevalent, including¹⁴:

- Asthma (c. 5%);
- Diabetes (c. 5% for Surrey Downs and c. 6% for Sutton and Merton);
- Chronic heart disease (c. 3% for Surrey Downs, 2% for Sutton, and 2.5% for Merton);
- Cardiovascular disease (c. 1%);
- COPD (c. 1% for Surrey Downs and Merton, and 1.5% for Sutton);
- Dementia (c. 1%, with a slightly higher prevalence in Surrey Downs); and
- Hypertension (high blood pressure) (c. 14% for Surrey Downs, 11% for Sutton, 12% for Merton).

The ageing population means that the number of people living with long term conditions is likely to increase. There are also other risk factors, including higher rates of teenage pregnancies; alcohol

¹⁰ UK health and social care spending <https://www.ifs.org.uk/uploads/publications/budgets/gb2017/gb2017ch5.pdf>

¹¹ Population estimates <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates>

¹² Long Term Conditions Compendium of Information: Third Edition (2012) <https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition>

¹³ Long Term Conditions Compendium of Information: Third Edition (2012) <https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition>

¹⁴ Quality and Outcomes Framework (QOF) - 2016-17 (2017) <https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/quality-and-outcomes-framework-qof-2016-17>

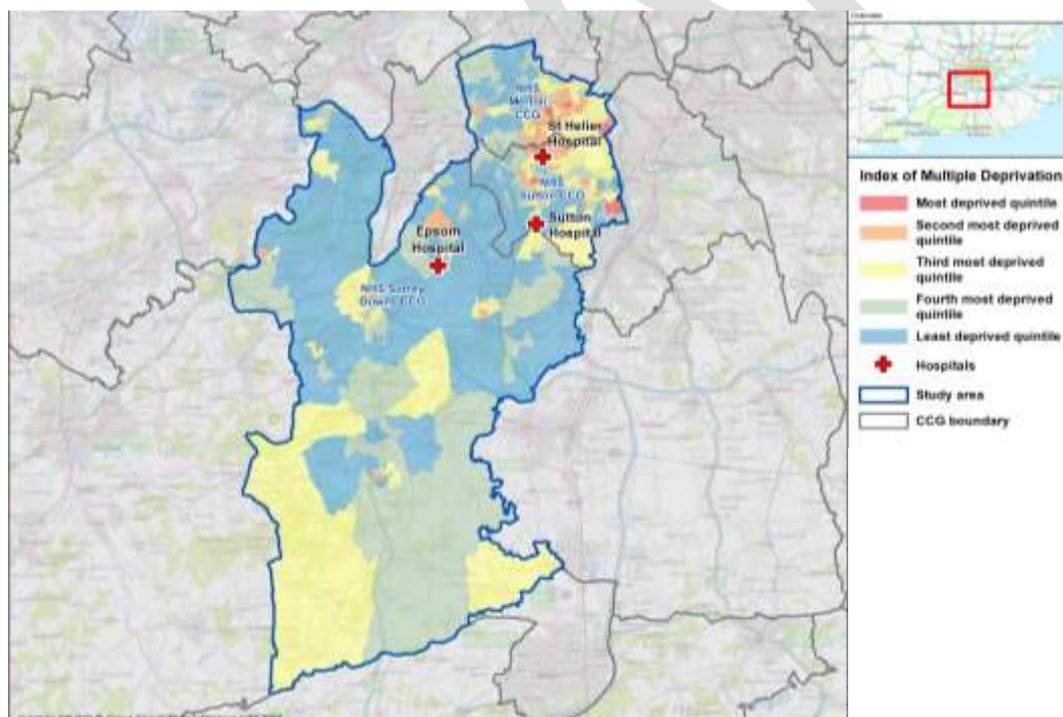
consumption; and obesity and smoking, which mean the number of people living with long term conditions is likely to increase.

People living with long term conditions tend to need access to greater care to support the management of their condition, and are also at risk of hospital admission and requiring access to a range of other services. People living with long term conditions are therefore more likely to benefit from care which is more joined up, or integrated. Future health and social care services need to be designed to meet these needs, whilst ensuring that public health and prevention programmes are strengthened to reduce the risk factors. For example, two thirds of deaths from cardiovascular disease could be avoided through improved prevention, earlier detection and better treatment in primary care.¹⁵

Health inequalities and significant pockets of deprivation, particularly in Sutton and Merton, mean there are people with much higher levels of need in some areas.

Although health outcomes across Surrey Downs, Sutton and Merton are generally better than the England average, there are more deprived communities, particularly in parts of Sutton and Merton including the areas around St Helier Hospital, where around 5% of lower-layer super output areas (LSOAs) – small sub-areas within a council area – are in the most deprived 20% of all LSOAs. There are fewer deprived communities in Surrey, where around 90% of its LSOAs are in the least deprived half of all areas of the country.¹⁶

Figure 1: Levels of deprivation across Surrey Downs, Sutton and Merton¹⁷



Future health and social care services need to be designed to ensure that the needs of the most deprived communities are met.

¹⁵ *Surrey Heartlands Sustainability and Transformation Plan* (October 2016) <http://www.surreyheartlands.uk/wp-content/uploads/2017/04/surrey-heartlands-stp-october-2016.pdf>

¹⁶ The Index of Multiple Deprivation (IMD) is an overall relative measure of deprivation constructed by combining seven domains of deprivation. LSOAs (Lower-layer Super Output Areas) are small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. There are 32,844 Lower-layer Super Output Areas (LSOAs) in England. *English indices of deprivation* (2015) <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

¹⁷ *English indices of deprivation* (2015) <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

Mental illness is becoming increasingly common, particularly in parts of Sutton and Merton, and we need to do more to achieve parity between physical and mental health.

Mental illness is relatively common in Surrey Downs, Sutton and Merton. For example almost 1 in 10 local people aged over 18 have reported experiencing depression.¹⁸ People with a serious mental illness are more likely to die at an earlier age.

Those with a mental health illness are also more likely to have poor physical health. For example, depression is associated with a greater risk of developing heart disease and lower cancer survival rates.

Local health and social care services need to prioritise high quality services for people with a mental illness, especially those who also have poor physical health. In addition, it is important that mental health has equal priority with physical health and that mental wellbeing forms a key part of prevention programmes.

There are many people with cancer who need rapid access to high quality services.

More than one person in three will develop cancer at some time in their lives, and one in four will die of the condition. Cancer can develop at any age, but it is most common in older people. Cancer is prevalent in around 2% of the population in Merton and Sutton and around 3% of the population in Surrey Downs.

Local health and social care services need to make sure that people with cancer have rapid access to high quality services.

¹⁸ *Depression Reported Prevalence: Disease Register, Estimated Population 18yrs +, Quality and Outcomes Framework (QOF) (2015/16)*

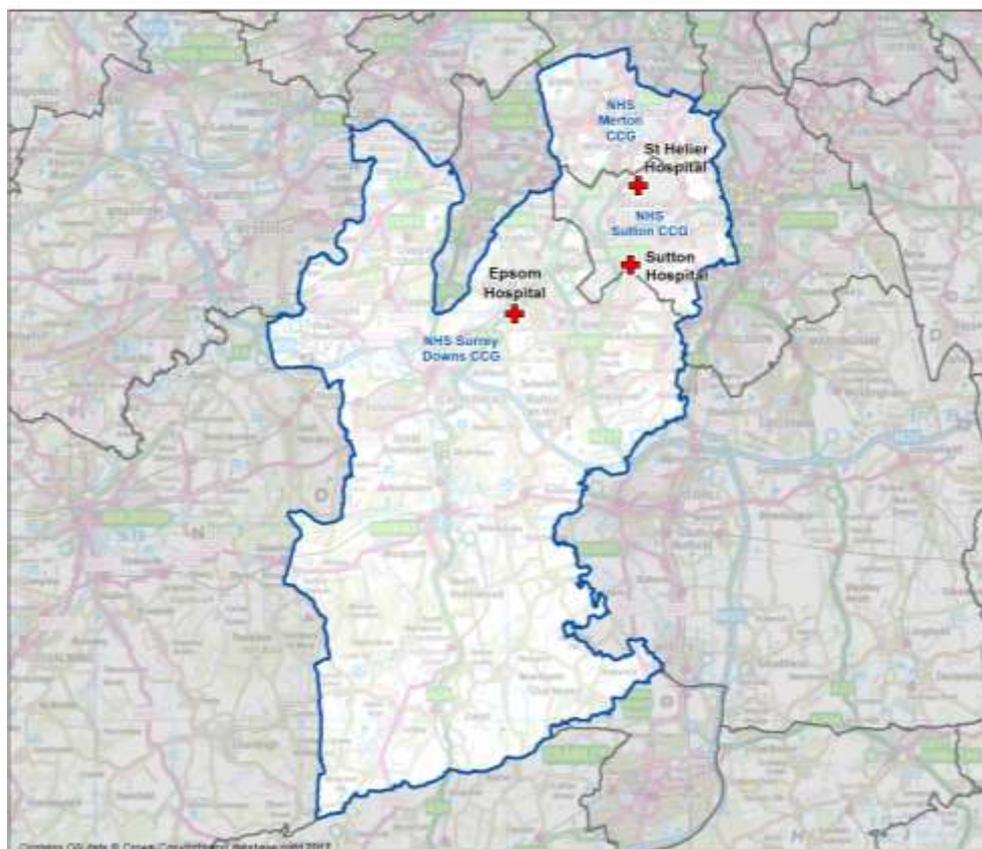
1.3 Healthcare in the local area

1.3.1 Commissioning landscape

We are responsible for securing the provision of quality healthcare services for the populations of Surrey Downs, Sutton and Merton.

Surrey Downs, Sutton and Merton CCGs are located across SWL and Surrey. They commission healthcare services for a combined population of 720,000 people. The geographic areas covered by the three CCGs are referred to as our 'combined geographies' (see Figure 2).

Figure 2: Combined geographies of Surrey Downs, Sutton and Merton¹⁹



We are part of two different STPs, both of which are relevant to this case for change and our plans for the future:

- Surrey Downs CCG is part of the Surrey Heartlands STP together with Guildford & Waverley and North West Surrey CCGs.
- Sutton and Merton CCGs are part of the South West London STP together with Croydon, Kingston, Richmond and Wandsworth CCGs.

Our populations are served and represented by different local authorities:

- Surrey Downs CCG lies within Surrey County Council, and covers the whole of Epsom & Ewell Borough Council and Mole Valley District Council as well as parts of Elmbridge Borough Council and Reigate & Banstead Borough Council.
- Sutton CCG is coterminous with the London Borough of Sutton (Sutton Council).
- Merton CCG is coterminous with the London Borough of Merton (Merton Council).

¹⁹ Improving Healthcare Together 2020-2030 analysis

1.3.1.1 Local context

Local priorities match these national priorities and include specific improvements in key disease pathways.

Aligned to the *NHS Five Year Forward View*²⁰ (FYFV), our STPs have identified key areas of focus, which include²¹:

- Cancer
- Mental health
- Cardiovascular
- MSK
- Maternity
- Learning disabilities
- Children and young people
- Health prevention and promotion
- Primary care
- Urgent and emergency care
- Local communities
- Workforce
- Technology
- Buildings and estate

To achieve improvement in these areas, each STP has key principles it is working to.

In Surrey Heartlands, these are:

- Achieve consistent clinical pathways and remove unwarranted variation.
- Deliver a system which is sustainable and designed to deliver quality, efficiency and access in care.
- Secure buy-in for change and personal responsibility for health.
- Speak with one voice and act with one mind.

In SWL, these are:

- A local approach works best for planning.
- Care is better when it is centred around a person, not an organisation.
- Bottom-up planning at borough level, based on local people's needs.
- Strengthening our focus on prevention and keeping people well.
- The best bed is your own bed.

1.3.2 Current service provision

1.3.2.1 Primary care

Primary care is central to the delivery of effective healthcare to the local population in the community. It is important identifying and addressing the needs of the local population. The *General Practice Five Year Forward view* for the NHS was published in 2016 and represented a step change in the level of investment and support for primary care. It recognised that primary care has been relatively underfunded and that a strengthened version of primary care is essential to the wider sustainability of the NHS, and that primary care is increasingly more open to new ways of working, including expanding service offerings.²²

There are 79 practices across Surrey Downs, Sutton and Merton CCGs, covering a population of 729,000.

²⁰ *NHS Five Year Forward View* (2014)

²¹ *South West London Health and Care Partnership: One Year On* (November 2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>; *Surrey Heartlands Sustainability and Transformation Plan* (October 2016) <http://www.surreyheartlands.uk/wp-content/uploads/2017/04/surrey-heartlands-stp-october-2016.pdf>

²² *General Practice Forward View* (2016) <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

Table 1: Practices across Surrey Downs, Sutton and Merton ²³

	Number of practices	Number of patients
Merton	22	226,827
Sutton	25	194,512
Surrey Downs	32	307,540

Surrey Downs has the highest ratio of patients to GPs at 2,063 patients per GP, followed by Sutton with 2,000 and Merton with 1,958. This may reflect difficulties in recruiting GPs to certain areas. In 2016/17, 11.4% of practices were reporting vacancies in London, 19.4% in South Central and 25.0% in the South East²⁴.

1.3.2.2 Community

In Surrey Downs, adult community services from October 2018 will be provided by the Integrated Dorking, Epsom and East Elmbridge Alliance (IDEEA) – a partnership of local organisations, led by ESTH, and including Central Surrey Health (CSH) Surrey and the three GP federations (GP Health Partners in the Epsom, Leatherhead and Ewell area, Dorking Healthcare for Dorking practices and Surrey Medical Network for practices in the East Elmbridge area). The partnership will deliver a range of services, including community nursing; rapid response and intermediate care services; discharge to assess service; community rehabilitation (therapies); domiciliary physiotherapy; community neuro-rehabilitation service; dietetic service; podiatry and orthotic service; speech and language therapy; specialist respiratory service; pulmonary rehabilitation service; home oxygen assessment and review; specialist heart failure and specialist lymphoedema services; specialist continence service; community diabetes services; multiple sclerosis, motor neurone and Parkinson’s disease specialist service; specialist community falls service; community Hub Model and community hospital inpatient services.

Children’s community health services in Surrey Downs are provided by Children and Family Health Surrey, through the Surrey Healthy Children and Families Limited Liability Partnership (an alliance between CSH Surrey, First Community Health and Surrey & Borders Partnership NHS Foundation Trust). Services focus on the prevention of ill health, promoting and supporting child development and providing targeted and specialist medical, nursing or therapy services when needed.

In Sutton, the majority of community services are provided by the Royal Marsden NHS Foundation Trust via Sutton Community Health Services. This includes adult community nursing and specialist therapies; long-term conditions; end-of-life care; services for people aged 65 and over; adult musculoskeletal and neurotherapy services; children’s therapies; and a range of other children’s services such as health visiting, school nursing, weight management, immunisations, safeguarding and children’s respite services.

From April 2019, adult community services in Sutton will be provided by Sutton Health and Care, hosted by ESTH. We are still deciding who we think the best provider of children’s community services in Sutton is for our populations in Sutton, from April 2019.

In Merton, community services are provided by Central London Community Healthcare NHS Trust (CLCH), which provides a broad range of services across twelve locations. Its main services include adult community nursing services; children and family services; rehabilitation and therapies; end of life care; long-term condition management; specialist services; and walk-in and urgent care centres.

²³ NHS Digital

²⁴ *General and Personal Medical Services, England* (March 2017) <https://digital.nhs.uk/catalogue/PUB30044>

1.3.2.3 Mental health

In Surrey Downs, most services are provided by Surrey and Borders NHS Partnership Trust which provides an extensive range of services, including eight locations which serve mental health and learning disability needs (including four hospital sites with acute wards); a range of community sites which offer community mental health and learning disability services; and a specialist hospital drug and alcohol service.

In SWL the majority of our mental health services are provided by South West London and St George's Mental Health NHS Trust, which runs services from Springfield University Hospital as well as around 10 other locations across Richmond, Wandsworth, Kingston, Merton and Sutton – around 400 inpatient beds are located on three of its sites. The Trust provides a comprehensive range of mental health services for adults and children, as well as specialist services for people who are deaf, services for people who have obsessive compulsive disorders as well as forensic and eating disorder services.

1.3.2.4 Social care

Adult social care plays an important role in the care system, supporting people to keep well and independent in their own homes and communities. It offers help and care to people with a wide range of needs arising from age, disability, illness or other life situations helping them to keep well and live independently, protect them from harm and provide essential help at times of crisis.

Adult social care focuses on the whole person and their overall life, and enables their family support and community networks. It supports carers in their very important role so they can live their own lives, remain well and avoid stress and crisis. It works closely with the community and voluntary sector to support people to live in their own homes and be active in their own communities. It is critical in supporting the whole system to deliver more joined up care.

The majority of our social care services are either provided (or funded and then delivered by social enterprises, charities or private providers) by our local authorities (Surrey County Council, Sutton Council and Merton Council), and people in Surrey Downs, Sutton and Merton also access social care services such as private care homes directly. It is also important that children's needs are addressed in developing the local health and care plans.

1.3.2.5 Acute

The Surrey Heartlands and SWL STPs contain multiple acute hospitals. Most acute services (e.g., A&E, paediatrics, obstetric-led births) are provided by most hospitals, while more specialised acute services (e.g., major trauma, stroke and tertiary care) are centralised in specialised centres.

Table 2: NHS acute trusts in Surrey Heartlands and South West London²⁵

NHS Trust	Hospital site(s)
Surrey Heartlands STP	
Epsom and St Helier University Hospitals NHS Trust	• Epsom Hospital, Epsom
Ashford and St Peter's Hospitals NHS Foundation Trust	• Ashford Hospital, Ashford (planned) St Peter's Hospital, Chertsey
Royal Surrey County Hospital NHS Foundation Trust	• Royal Surrey County Hospital, Guildford
South West London STP	
Croydon Health Services NHS Trust	• Croydon University Hospital, Croydon
Epsom and St Helier University Hospitals NHS Trust	• St Helier Hospital and Queen Mary's Hospital for Children, Carshalton • Sutton Hospital, Sutton • Epsom Hospital, Epsom (geographically in Surrey)
Kingston Hospital NHS Foundation Trust	• Kingston Hospital, Kingston upon Thames
St George's University Hospital NHS Foundation Trust	• St George's Hospital, Tooting

The only acute provider that is wholly within our combined geographies is ESTH. ESTH currently provides services from all three of its sites (Epsom, St Helier and Sutton).

- **Epsom Hospital and St Helier Hospital** are district general hospitals, each providing a 24/7 consultant-led accident and emergency (A&E), acute and general medicine, maternity, children's services and outpatients. In addition, Epsom Hospital hosts the South West London Elective Orthopaedic Centre (SWLEOC) and St Helier Hospital provides renal services and emergency surgery.
- **Sutton Hospital** – adjacent to The Royal Marsden NHS Foundation Trust's Sutton site – is mainly vacant and only provides a few services for outpatients.

1.3.2.6 Provision of acute care across ESTH sites has changed in recent years

ESTH has consolidated certain services to improve quality.

To improve care across its two sites, and manage with the resources available, ESTH has consolidated certain services. This includes:

- **Planned orthopaedic surgery:** Since 2004, planned orthopaedic surgery has been consolidated at SWLEOC, a centre of excellence for orthopaedic surgery. SWLEOC is the largest hip and knee replacement centre in the UK, providing elective orthopaedic surgery services for 1.5m people across South West London (c. 5,200 procedures a year).²⁶ The facility is located on the Epsom Hospital site but is self-contained with 71 beds and a high dependency unit.²⁷ In 2016, the Care Quality Commission rated the service as outstanding – its highest rating – with patient outcomes and patient satisfaction consistently exceeding national averages.²⁸

²⁵ Improving Healthcare Together 2020-2030 analysis

²⁶ *South West London Elective Orthopaedic Centre: A centre of excellence in patient-focused elective orthopaedic care* <http://nhsproviders.org/media/1823/swleoc-final-m.pdf>; *Epsom and St Helier University Hospitals NHS Trust: Quality report (2016)* https://www.cqc.org.uk/sites/default/files/new_reports/AAAE5976.pdf

²⁷ South West London Elective Orthopaedic Centre <http://www.eoc.nhs.uk/>

²⁸ The CQC regularly inspects healthcare providers to assess the quality of their care across five domains: safe, effective, caring, responsive and well-led. Trust can be rated outstanding, good, requires improvement or inadequate. *Epsom and St Helier University Hospitals NHS Trust: Quality report (2016)* https://www.cqc.org.uk/sites/default/files/new_reports/AAAE5976.pdf

- **Emergency surgery:** Since October 2006, emergency surgery and some critical care has been consolidated at St Helier Hospital. This includes intensive care (ITU) but high dependency care is still provided at Epsom Hospital. Prior to this change, ESTH had a Hospital Standardised Mortality Rate (HSMR) for non-elective activity of 105.8 (average Q2 2002 – Q2 2006), above the expected rate. Following the change, the HSMR fell to 90.2 (average Q3 2006 – Q1 2013), consistently below the rate expected. (A HSMR of 100 would reflect the expected rate.)²⁹
- **Fractured neck of femur:** Emergency care for patients with fractured neck of femur has been consolidated at St Helier Hospital. In 2017, the Royal College of Physicians found the hip fracture service had a crude mortality rate of 4.3% (casemix adjusted 2.5%) compared to an average of 6.7% across all hip fracture services (this is the fourth lowest mortality rate in the country)³⁰.

1.3.3 National strategic context to the case for change

Nationally, there is a drive towards more preventative, integrated care.

In 2014, the FYFV defined the priorities for the NHS in England for the next five years.³¹ This included identifying three gaps that the NHS must focus on:

- **Health and wellbeing:** improving healthy life expectancy by preventing ill-health and deterioration in health, while tackling health inequalities.
- **Care and quality:** making better use of technology to improve health outcomes while minimising the risk of harm and inconsistency through services.
- **Finance and efficiency:** making sure resources are used effectively to provide the services needed by the population, while freeing up capacity to deliver new treatments.

To address these, the FYFV articulated a need for care to be delivered in different ways, including the need for care models that are better integrated and offer more holistic, population-based healthcare approaches. Aligned forward views have also been developed for the areas of general practice and mental health, both of which are national priorities for improvement.³²

In support of this, some STP areas are developing further into integrated care systems (ICSs). In an ICS, NHS organisations, in partnership with local authorities and others, take collective responsibility for managing resources, delivering standards and improving the health of the population they serve.³³ They will have greater responsibility for local healthcare but also greater autonomy to deliver that care differently.

²⁹ *Dr Foster Intelligence: Quality Investigator (2014)*

³⁰ *National Hip Fracture Database Annual Report 2017 (2017)* <https://www.nhfd.co.uk/files/2017ReportFiles/NHFD-AnnualReport2017.pdf>; National Hip Fracture Database <https://www.nhfd.co.uk/>

³¹ *Five Year Forward View (2014)* <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>; *Next Steps on the Five Year Forward View (2017)* <https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/>

³² *General Practice Forward View (2016)* <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>; *The Five Year Forward View for Mental Health (2016)* <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>; *The Five Year Forward View for Mental Health: One Year On (2017)* <https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf>

³³ *Integrated care systems* <https://www.england.nhs.uk/systemchange/integrated-care-systems/>; *Next Steps on the Five Year Forward View (2017)* <https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/>

1.4 Our aims

We are aiming to prevent as much ill health as possible and ensure services are appropriate, joined up and high-quality when healthcare is needed.

Taking local context, national context and the healthcare needs of our populations into account, we have identified aims for the future of healthcare locally. These aims, and associated plans, are being articulated through our emerging local health and care plans.

Overall, our aims are:

- Delivering care close to patients' homes.
- Ensuring high standards of healthcare across all our providers.
- Maintaining the provision of acute services within our combined geographies.
- Improving the health of our populations.

This will be achieved through:

- Greater prevention of disease.
- Improved integration of care.
- Enhanced standards for the delivery of major acute services.

This is aligned to the three gaps defined by the FYFV and to the priorities established by our STPs.

1.4.1 Prevention

We need to avoid people becoming ill wherever possible, either by preventing diseases in the first place or preventing existing conditions deteriorating.

As demand for healthcare is expected to increase it is critical that we prevent ill health at all stages – from supporting the health of the population to preventing deterioration in long-term conditions.

We therefore all have plans to enhance prevention in our geographies.

- **In Surrey Downs**, this includes a combination of social prescribing, care navigation, risk stratification and patient activation. Alongside this, we are improving population health management and commissioning a range of local services, supported by technology (including new apps). The prevention strategy is underpinned by a system-wide Making Every Contact Count (MECC) approach, which encourages health and social care staff to have brief conversations, during routine interactions, on how people might make positive changes, such as stopping smoking, eating more healthily (including children), exercising more, and reducing alcohol consumption. This is expected to result in reductions in the incidence of key long-term conditions and improvements in patients' abilities to manage existing long-term conditions without the need for urgent treatment for exacerbations.
- **In Sutton**, this includes enhanced patient education, social prescribing, enhanced screening and early intervention, enhanced health visiting, immunisation and vaccination programmes and an enhanced role for the voluntary sector.
- **In Merton**, this includes the full implementation of social prescribing, expanding expert patient models, and the integration of health and wellbeing services, particularly around the Wilson Hospital site in East Merton.

1.4.2 Integration

Integration is the key way we will ensure continuity of care and deliver care closer to patients' homes.

In each of our CCGs, we have clear plans to improve the integration of care and deliver more care closer to patients' homes through various forms of ICS.

In Surrey Downs, as part of devolution to the STP and development of a Surrey Heartlands ICS (see Section 1.4.2.1), this includes:

- **Primary care:** Development of federations of practices, Primary Care Home, community service mobilisation, extended access and new types of care delivery (including social prescribing and use of clinical pharmacists).
- **Proactive care:** Developing community hubs, utilising risk stratification to identify high-risk patients, and delivering new types of care (including social prescribing and enhanced planned care pathways). Supporting this, we will make greater use of the voluntary sector, 111 and out of hours services, and care homes.
- **Reactive care:** Deploying a range of reactive interventions – including 111, primary care streaming, urgent treatment centres and ambulatory care, paediatric clinics, and increased primary care capacity (including GPs in care homes) – to meet urgent needs. In parallel, we are enhancing discharge to assess to maintain hospital flows.

In Sutton, this includes:

- **Primary care at scale:** Greater use of networks, shared workforce (including clinical pharmacists), shared back office and shared clinical services to enhance the scale and scope of primary care (including enhanced clinical triage).
- **Proactive care:** Multi-disciplinary locality teams using risk stratification to deliver targeted case management, enhanced care navigation, development of locality hubs, and increased role for the voluntary sector and social care.
- **Reactive care at home:** Multi-disciplinary working to support admissions avoidance and complex discharge both in hospital (working with ESTH) and in the community, enhanced roles for GP clinical co-ordinators, development of a step closer to home ward at ESTH, and enhanced older adult mental health services.

In Merton, this includes:

- **Integrated locality teams:** Delivering proactive care for people with complex comorbidity and frailty and reactive care for vulnerable patients encompassing rapid response and supporting discharge. Includes the Care Homes Improvement Programme, which builds on evidence from the Sutton care homes vanguard.
- **Primary care at scale:** Development of practices into locality teams to improve resilience, offer greater access (meeting access standards) and deliver new types of care, such as social prescribing and wellbeing services.
- **Integrated urgent care:** Enhancing streaming in emergency departments at St George's Hospital and subsequently ESTH, direct booking for 111 and ambulatory care for adults and children at St George's Hospital.
- **Planned care:** Redesign of key pathways, including changes to outpatients, community and intermediate support and primary care.

This is expected to result in a system where patients are treated holistically, reducing the need for hospital stays.

1.4.2.1 Devolution in Surrey Heartlands

Surrey Heartlands is at the forefront of the integration of care nationally.

Surrey Heartlands is one of ten first wave ICSs and one of two devolved health and care systems (the other being Greater Manchester) in England.³⁴

³⁴ *Integrated care systems* <https://www.england.nhs.uk/systemchange/integrated-care-systems/>;

Signed by NHS England (NHSE), NHS Improvement (NHSI), Guildford and Waverley CCG, North West Surrey CCG, Surrey Downs CCG and Surrey County Council, the devolution deal commits the partners to working together to improve the health outcomes of the 850,000 people living in Surrey Heartlands.³⁵

The system is bringing health and social care more closely into partnership by implementing primary care networks, with strong clinical leadership from the GP community, and strengthening out-of-hospital services by coordinating approaches to A&E in the hospitals across the system.

In the long-term, the partnership aims to:

- Accelerate the integration of health and social care through much closer working between partners.
- Increase public engagement and the involvement of the people of Surrey Heartlands around the transformation of health and social care.
- Increase local decision-making and flexibilities to achieve the best possible outcomes for the local population.

Surrey Downs CCG is an integral part of this system, which will transform the way care is delivered to patients in this part of the geography.

1.4.2.2 Progress with the integration of care

We are already making progress with integrating care.

Across the health economy care is being provided in an increasingly integrated way.

In Surrey Downs, this includes:

- **Epsom Health and Care:** The service provides extra support and care within a patient's home to support those who have two or more long term conditions to live as independently as they can and to prevent them from needing a hospital admission (see Box 2 for further detail on Epsom Health and Care).
- **Epsom Community Contract:** ESTH is providing community services for the Surrey Downs population in partnership with CSH Surrey.
- **IDEEA:** IDEEA is developing integrated care across Surrey Downs (see Section 1.3.2.2).
- **Surrey Downs Community Hub Programme:** On 1 July 2015 the CCG launched three new Community Hubs, with one operating in each of the three localities (Dorking, Epsom and East Elmbridge). The hubs are a new locality-based GP service put in place to better manage frail elderly patients in the community. The teams are locality-specific and include GPs, nursing services, physiotherapy, occupational therapy, social work and domiciliary care.
- **Surrey Downs planned care service redesign:** The CCG has work underway to look at the commissioned pathway for planned services. One of the key objectives of this work is to ensure that as much of a patient's care is as close to home and based in local communities as possible.

In Sutton, this includes:

- **Sutton Health and Care** delivers integrated care in two ways:
 - Preventative and proactive care: Providing a spectrum of services from social prescribing to locality teams.
 - Reactive care: Admission avoidance and accelerated discharge for the frail, older population.
- **Sutton Health and Care 'At Home'** went live in April 2018 with a single team and service for avoiding admission to, and accelerating discharge from, St Helier Hospital (see Box 1 for further detail on Sutton Health and Care)

³⁵ *Devolution Pledge* <http://surreyheartlands.uk/devolution/surrey-health-care-organisations-sign-devolution-pledge/>

- **Sutton CCG's commissioning for integrated community care** will require our providers to continue to work to deliver a new model of care for Sutton residents that builds on the principles of the integrated care system, including:
 - Ensuring an integrated approach to admission avoidance and discharge
 - Embedding the learning from the Sutton Vanguard scheme into other pathways of patient cohorts
 - Looking at enablers to integration such as changes in workforce and use of technology.

In Merton, this includes:

- **The Merton out of hospital strategy** focuses on integrating locality teams to provide proactive care, develop primary care at scale and integrate urgent care. For example, the East Merton model of care development pilot is currently exploring social prescribing and wellbeing models. Merton CCG is also intending to focus on further integrating community care by extending the number of people with complex needs managed by multi-disciplinary locality teams, providing proactive ongoing care and effective step up and step down support.
- **To improve the integration of mental health services, Merton CCG** intends to integrate commissioning for children and young people with multiple needs. For example, this would occur through integration of community mental health services with primary care, through extending the Primary Care Plus model.

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Box 1: Sutton Health and Care

Building upon the success of the Quality Care Homes Vanguard, partners in Sutton formally came together in April 2018 to provide one integrated approach to reactive services across the borough through the Sutton Health and Care (SHC) at Home Service.

SHC partners are now actively working together, with commissioners and with local people to design and implement the wider preventive and proactive ways of working in a 'one service', integrated way. During this period, Sutton CCG has made the decision to enter into a transitional contract with Sutton Health and Care for the provision of community services from April 2019.

Box 2: Epsom Health and Care

There is a strong track record of integrated working across Surrey Downs. Epsom Health and Care (EHC) has been established for three years as a legal joint venture between the acute provider, community provider, GP Federation and Surrey County Council. Working together as one entity EHC @home service provides rapid response and enhanced discharge services for local people over the age of 65 years together with ongoing care coordination for up to 12 weeks when required. EHC uses the GP Clinical System as the one record for all patients meaning that the care plan agreed with the patient is immediately visible to the GP and the full GP record is visible to the team.

The @home service has proved to be very successful with excellent feedback from patients and carers and a reduction in 2017/18 of overnight admissions to EGH of 6% compared to 2016/17.

Building on this success, EHC partners have started providing an integrated stroke service at EGH, working as one team from time of admission to ongoing community support and life after stroke. In addition, EHC now runs a newly-established post-acute unit on the EGH site, providing care for people whose acute medical needs have resolved but who need ongoing health and care to support their return home.

This integrated delivery model has recently been strengthened through the NHS providers of EHC, together with the two other GP Federations covering the Surrey Downs area, winning the contract to provide adult community services to the local population. Structured around localities or "Primary Care Homes" of GP practices working together covering populations of around 50,000 this place-based approach to care will work closely with local populations ensuring appropriate support, care coordination and care planning through multi-disciplinary teams involving GPs, community, acute, social care and mental health professionals.

1.4.3 Standards for major acute services

We have set clear standards for the quality of major acute healthcare that we expect acute trusts to meet.

Nationally, the standards expected of healthcare are increasing. In particular, there is a growing recognition of the importance of consistent, consultant-delivered acute care as a vital component of clinical quality. In 2015, this has led NHSE to establish national standards for the delivery of seven-day acute hospital services.³⁶

Nationally, the Royal College of Emergency Medicine (RCEM) has recommended minimum staffing levels for emergency departments.³⁷ The RCEM recommends a minimum of 10 consultants per emergency department to provide cover 14/7 and 12–16 consultants to provide cover 16/7. Additional consultants are recommended for larger units and major trauma centres.

In September 2017, the SWL STP – working with Surrey Downs – defined clinical standards for six acute services for acute services provided in South West London or operated by a South West London trust.³⁸ The acute trusts covered were:

- St George's University Hospitals NHS Foundation Trust
- Kingston Hospital NHS Foundation Trust
- Croydon Health Services NHS Trust
- ESTH (including Epsom Hospital, which is in Surrey)

The services in scope were:

- Emergency department
- Acute medicine
- Paediatrics
- Emergency general surgery
- Obstetrics
- Intensive care

The standards were developed by the medical directors of the four acute trusts in SWL and were approved by the SWL Clinical Senate on 28th September 2017 (see Figure 3).

³⁶ *Seven Day Services Clinical Standards* (2017) <https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

³⁷ *Emergency Medicine Consultants: Workforce Recommendations* (2010) <https://www.rcem.ac.uk/docs/Workforce/CEM5324-Emergency-Medicine-Consultants--CEM-Workforce-Recommendations-Apr-2010.pdf>; "Rules of Thumb" for Medical and Practitioner Staffing in Emergency Departments (2015) <https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf>

³⁸ *Clinical quality standards for acute services provided in South West London or operated by a South West London Trust* (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>. These standards were agreed with the SWL Clinical Senate but have not been clinically signed off in Surrey Heartlands.

Figure 3: Selected requirements of standards for major acute services³⁹

1	2	3	4	5	6
Emergency Department	Acute medicine	Paediatrics	Emergency general surgery	Obstetrics	Intensive care
<ul style="list-style-type: none"> 16/7 consultant staffing (24/7 major trauma) 'Good' in CQC 5 domains 7 day access to diagnostics 4 hour waiting time Emergency mental health in 60 mins Core24 mental health teams 	<ul style="list-style-type: none"> 14/7 consultant staffing 'Good' in CQC 5 domains 7 day access to diagnostics Continually assessed with MEWS score AMUs supported by 24/7 GI bleed rota AAU tertiary advice 24/7 	<ul style="list-style-type: none"> 14/7 consultant staffing 'Good' in CQC 5 domains 7 day access to diagnostics CAHMS assessment within 1 hour for emergency care and 14 hours for urgent care 	<ul style="list-style-type: none"> 14/7 consultant staffing 'Good' in CQC 5 domains 7 day access to diagnostics Continually assessed with MEWS score SAU/HDU twice daily consultant assessment 	<ul style="list-style-type: none"> 14/7 consultant staffing 'Good' in CQC 5 domains Meet RCOG standards on midwifery numbers BAPM guidance on medical/ nursing numbers 	<ul style="list-style-type: none"> 12/7 consultant staffing 'Good' in CQC 5 domains 7 day access to diagnostics Consultant assessment within 14 hours of admission

Based on these, minimum staffing levels have been defined for each service delivered at an acute site. These are defined in Table 3; some vary by size and specialisation of the unit.

Table 3: Consultant hours of cover and headcount to meet standards⁴⁰

Service	Hours of cover	Heads (per site)
Emergency department⁴¹		
Minimum requirement to meet the standards	16/7	12
Requirement to meet the standards and provide sustainable working patterns if activity is high (>100,000 attendances p.a.)	16/7	12–16
Requirement for a major trauma centre	24/7	24
Obstetrics		
RCOG category A (<3,000 births p.a.)	14/7	10
RCOG category B (3,000–4,000 births p.a.)	14/7	12
RCOG category C1 (4,000–5,000 births p.a.)	14/7	14
RCOG category C2 (>5,000 births p.a.)	14/7	16
Specialist Centre	14/7	21
Emergency general surgery		
Requirement to meet the standards	14/7	10
Paediatrics⁴²		
Minimum requirement to meet the standards at a non-tertiary centre	14/7	12
Requirement to meet the standards and manage large volumes at a non-tertiary centre (>2.5k emergency admissions p.a.)	14/7	16
Requirement for a specialist centre (to cover acute general paediatrics only)	14/7	10 ⁴³

³⁹ Clinical quality standards for acute services provided in South West London or operated by a South West London Trust (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>, summary by Improving Healthcare Together 2020-2030

⁴⁰ Clinical quality standards for acute services provided in South West London or operated by a South West London Trust (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>, Summary by Improving Healthcare Together 2020-2030.

⁴¹ Emergency department requirement expressed in WTE.

⁴² Minimum hours also require on call.

⁴³ Separate specialist paediatrics rota.

Acute medicine ⁴⁴		
Requirement to meet the standards	14/7	12
Intensive care ⁴⁵		
Requirement to meet the standards	12/7	9

There are a range of benefits to meeting standards and increasing the hours of consultant cover, including:

- Faster triaging of patients and improved decision making;
- More consistent care, seven days a week; and
- Ensuring that patients are seen in the right care setting at the right time, and by the most appropriate clinician.

⁴⁴ Minimum hours also require on call.

⁴⁵ Minimum hours also require on call.

1.5 Our challenges and opportunities

1.5.1 Summary of challenges and opportunities facing the combined geographies

As commissioners, we face challenges in achieving our aims; in particular, we face clinical quality, estates and financial sustainability challenges.

In achieving our aims, we have identified five issues, principally:

- Preventing ill health.
- Growing demand for healthcare as the population ages and healthcare becomes more complex.
- Delivering clinical quality, including challenges with recruiting and retaining sufficient staff.
- Delivering care in fit-for-purpose buildings.
- Growing financial pressures as the costs of healthcare increase.

Prevention and growing demand will be addressed through our existing plans (see Section 1.4). However, addressing the issues of clinical quality, estates and finance will be more significant – in these areas, there is a clear case for major service change.

1.5.2 Delivering clinical quality

1.5.2.1 Quality of care across acute trusts

The CQC found variation in the quality of care delivered by acute trusts (see Table 4); for one trust, this has resulted in regulatory intervention.

The most recent inspections of our closest trusts in Surrey and SWL found:

- Consistently good quality at Royal Surrey and Surrey and Sussex.
- Areas for improvement across Ashford and St. Peter's (identified in one area, although overall rating is good), Croydon, ESTH, and Kingston. ESTH required improvement across a number of domains, with the CQC highlighting significant shortfalls in staffing in critical care, medicine, surgery, and maternity services.⁴⁶
- Significant issues (including safety and leadership) at St George's, leading to the Trust being placed into special measures.

The latest CQC report on ESTH in 2018 highlighted a number of issues at St Helier in particular:

- “There were significant staffing issues in some areas. In surgery, ward staff were expected to provide care for too many patients and did not always have enough time to provide the level of care they felt appropriate. Staffing on the neonatal unit (NNU) and on the children's ward were also a challenge.”
- “The ED was not meeting the Royal College of Emergency Medicine (RCEM) recommendations that consultants should provide 16 hours of emergency cover seven days per week. This was also the case at the last inspection in 2015. However, the trust was actively trying to recruit additional consultants.”
- “The physical environment of the ED did not enhance patient safety; the layout of the department was 'cramped'”
- “[Critical care] did not meet the minimum environment standards.”
- “The hospital had one lift to serve all floors [in paediatrics]. The lift was taken out of service when routine maintenance was required. However, a business plan was in place to build a new external lift.”

To improve, the CQC stated that St Helier should:

⁴⁶ Epsom and St Helier University Hospitals NHS Trust: Quality report (2018): http://www.cqc.org.uk/sites/default/files/new_reports/AAAH0093.pdf

- “Ensure that there is adequate staffing on all wards to provide the safe delivery of care to patients”; and
- “Ensure that ED meets the Royal College of Emergency Medicine recommendations that consultants should provide 16 hours of emergency cover seven days per week.”

Table 4: CQC inspection results

Trust	Date	Domain					Overall
		Safe	Effective	Caring	Respon- sive	Well-led	
Ashford and St. Peter's Hospitals NHS Foundation Trust⁴⁷	2017	Requires improvement	Good	Good	Good	Good	Good
Croydon Health Services NHS Trust⁴⁸	2018	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Epsom and St Helier University Hospitals NHS Trust⁴⁹	2018	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Kingston Hospital NHS Foundation Trust⁵⁰	2016	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Royal Surrey County Hospital NHS Foundation Trust⁵¹	2013	Good	Good	Good	Good	Good	Good
St George's University Hospitals NHS Foundation Trust⁵²	2017	In-adequate	Requires improvement	Good	Requires improvement	In-adequate	In-adequate
Surrey and Sussex Healthcare NHS Trust⁵³	2014	Good	Good	Good	Good	Good	Good

⁴⁷ Ashford and St. Peter's Hospitals NHS Foundation Trust (2017) <http://www.cqc.org.uk/provider/RTK>

⁴⁸ Croydon Health Services NHS Trust (2018) <http://www.cqc.org.uk/provider/RJ6>

⁴⁹ Epsom and St Helier University Hospitals NHS Trust (2018) <http://www.cqc.org.uk/provider/RVR>

⁵⁰ Kingston Hospital NHS Foundation Trust (2016) <http://www.cqc.org.uk/provider/RAX>

⁵¹ Royal Surrey County Hospital NHS Foundation Trust (2013) <http://www.cqc.org.uk/provider/RA2>

⁵² St George's University Hospitals NHS Foundation Trust (2017) <http://www.cqc.org.uk/provider/RJ7>

⁵³ Surrey and Sussex Healthcare NHS Trust (2014) <http://www.cqc.org.uk/provider/RTP>

1.5.2.2 Performance against standards

When assessed against our standards, there are significant gaps in consultant workforce; in particular, ESTH has major gaps in emergency department and acute medicine that mean it is not clinically sustainable.

In 2017, all SWL acute trusts undertook a self-assessment to identify their performance against clinical standards and their ability to meet the required levels of consultant cover (Surrey trusts were not included but Epsom Hospital was included as part of a SWL Trust).⁵⁴ Consultant staffing was forecast to 2021 based on expected retirement rates and HEE recruitment estimates.

This self-assessment identified gaps in all specialties across SWL acute trusts, with the most significant in emergency department and acute medicine consultant staffing (see Table 5).

This gap is based on the standards set by SWL STP. The gap identified in the emergency department also aligns with national expectations. The most recent Care Quality Commission inspection of ESTH identified a need for consultant staffing to meet Royal College of Emergency Medicine (RCEM) guidance for consultant cover 16/7. RCEM recommends 12–16 consultants to provide cover 16/7⁵⁵. The SWL standards described here require a minimum of 12 to provide cover 16/7.

Based on this, the SWL STP concluded that three of the four acute trusts are clinically sustainable, but there is a specific need to address issues at ESTH; in particular its significant gaps meeting standards across two sites for acute medicine and emergency department.⁵⁶

This gap in consultant workforce remains even after new consultants qualify as per current plans.

A comparable gap analysis of future consultant workforce has not been undertaken for CCGs outside SWL. In the absence of additional information, it is unlikely their position will be materially different to the rest of the country.

Addressing the issues at ESTH is therefore the focus of our work.

⁵⁴ *Clinical quality standards for acute services provided in South West London or operated by a South West London Trust: Current position and gap analysis* (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>

⁵⁵ *Emergency Medicine Consultants: Workforce Recommendations* (2010) <https://www.rcem.ac.uk/docs/Workforce/CEM5324-Emergency-Medicine-Consultants---CEM-Workforce-Recommendations-Apr-2010.pdf>; "Rules of Thumb" for Medical and Practitioner Staffing in Emergency Departments (2015) <https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf>

⁵⁶ *South West London Five Year Forward Plan* (October 2016) <https://www.swlondon.nhs.uk/wp-content/uploads/2016/11/SWL-Five-Year-Forward-Plan-21-October-2016.pdf>.

Table 5: Consultant staffing against clinical standards, SWL trusts⁵⁷

<i>Consultants</i>	<i>Acute trust</i>	<i>Emergency department</i>	<i>Obstetrics</i>	<i>Emergency general surgery</i>	<i>Paediatrics</i>	<i>Acute medicine⁵⁸</i>	<i>Intensive care</i>
Current staffing	St George's	27	19	9	9	9	24
	Kingston	10	16	9	14	9	8
	Croydon	10	12	10	12	8	8
	ESTH	14	26	10	26	11	7
	SWL	61	73	38	61	37	47
Requirement to meet standards	St George's	24	21	10	10	12	27
	Kingston	12–16	16	10	16	12	9
	Croydon	12–16	12	10	12–16	12	9
	ESTH ⁵⁹	24	22	10	24	24	9
	SWL	72–80	71	40	62–66	60	54
Current gap (2017)⁶⁰	St George's	<i>No gap</i>	2	1	1	3	3
	Kingston	2–6	<i>No gap</i>	1	2	3	1
	Croydon	2–6	<i>No gap</i>	<i>No gap</i>	0–4	4	1
	ESTH	10	<i>No gap</i>	<i>No gap</i>	<i>No gap</i>	13	2
	SWL	14–22	2	2	3–7	23	7
Projected SWL gap (2021)		21–29	11	7	12–16	29	13
Total availability of new consultants in SWL to cover all new posts (2021)		18–21	41–44	15–16	30–31 ⁶¹	9	9

⁵⁷ Clinical quality standards for acute services provided in South West London or operated by a South West London Trust: Current position and gap analysis (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>

⁵⁸ Dedicated acute care physicians only.

⁵⁹ ESTH requirement for two sites.

⁶⁰ Gaps calculated on a site-by-site basis.

⁶¹ General paediatric consultants only.

1.5.2.3 The workforce challenge

In addition to gaps against standards, we face challenges ensuring there are sufficient consultant staff to run our emergency departments; this is a challenge that is expected to grow.

Across England, acute hospital staffing is challenging, especially in the areas of emergency departments and acute medicine where we have the greatest issue.

1.5.2.4 Local challenges

In our combined geographies, workforce shortages mean we are not clinically sustainable. Issues include:

- **Meeting standards for acute care:** Our major acute trust, ESTH, cannot meet the consultant workforce standards we have set for major acute services across two sites and has a shortage of 25 consultants in emergency department, acute medicine and intensive care (see Section 1.5.2). This aligns with national standards for the emergency department. For emergency departments, RCEM recommends 12-16 consultants to provide cover 16/7⁶². SWL standards described here require a minimum of 12 to provide cover 16/7.
- **Recruitment and retention:** ESTH has made significant efforts to enhance recruitment and retention of consultant workforce but despite this, there are still vacancies and rota gaps – for example, it spent £3.9m on medical agency and £9.6m on medical bank and locums in 2017/18. This reduces the quality and continuity of care and creates a financial pressure.⁶³
- **Junior doctors and middle grades:** Junior doctors training posts are allocated by HEE on a trust basis, whereas ESTH must staff its rotas across two sites; this leads to a structural shortage of trainees. These must be filled by a combination of agency, fixed-term and non-training posts – and it still operates with vacancies in junior and middle grade rotas. This is expected to worsen as acute training posts are shifted to primary and community care.
- **Specialties:** The increasing specialisation of medicine creates additional staffing pressures across two sites. Due to a lack of consultants, ESTH cannot operate seven-day consultant-led rotas in:
 - GI bleed (ESTH relies on a networked solution);
 - Cardiology (ESTH relies on general physicians); and
 - Respiratory (including ventilation).

Most significantly for our aims for clinical quality, ESTH is unable to meet our standards for acute medicine and emergency department. As it is unlikely significant additional staff will be recruited or trained to meet requirements this has led us, and ESTH, to conclude that it is not clinically sustainable in its current configuration. Addressing these issues is therefore the focus of our work.

1.5.2.5 National perspective

These challenges are mirrored nationally: regulators and workforce planning bodies have identified significant workforce gaps in emergency department consultant staffing.

⁶² *Emergency Medicine Consultants: Workforce Recommendations* (2010) <https://www.rcem.ac.uk/docs/Workforce/CEM5324-Emergency-Medicine-Consultants--CEM-Workforce-Recommendations-Apr-2010.pdf>; "Rules of Thumb" for Medical and Practitioner Staffing in Emergency Departments (2015) <https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf>

⁶³ *Strategic outline case for investment in our hospitals 2020-2030* (2017) <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93ijim4n8158.pdf&ver=19818>

In 2016, providers identified a national need for an additional 300 WTE consultants (a 15% increase).⁶⁴

In 2017, Health Education England (HEE), NHSE, NHSI and RCEM collectively identified that a combination of demand pressures and increasing standards have created significant pressures on emergency department staffing. This leads to high locum spend, attrition rates and early retirement. The four bodies therefore identified that “we need more clinical staff” across all grades and have established a priority plan to help close this gap, primarily through new roles and multidisciplinary teams, reduced attrition and improved retention.⁶⁵

Subsequently in 2017, the draft HEE ten-year workforce strategy identified emergency department and acute medicine as two priority staffing areas. In March 2016, emergency department and acute medicine have the highest vacancy rates of all specialties (15.6% and 13.9% respectively compared to an average of 9.6%) and were identified as priority improvements areas in the FYFV in 2014. To help meet demand in both areas, HEE proposed to recruit 300 medical and 100 emergency trainees a year to help fill junior doctor and middle grade gaps and support alternative roles.⁶⁶

1.5.3 Providing healthcare from modern buildings

We need to ensure our buildings are safe, fit for purpose and can support the delivery of 21st century care.

The STPs set out an ambition to deliver a future model of care from facilities that are accessible, safe, fit for purpose and cost effective. Well-designed physical settings of hospital care play an important role in patient health outcomes, experience of care, as well as making it a better place for staff to work. The design of estates also has implications in terms of the effectiveness of the models of care they enable, as well as the ongoing running costs of maintenance. Poor quality estates can increase the cost of care delivery and disrupt services while being more expensive to maintain.

In common with much of the NHS estate nationally, hospital sites across South West London and Surrey Heartlands are in varying condition. Many require investment to make sure they are fit for purpose into the future. A number of hospitals are in conditions that must be urgently addressed.

1.5.3.1 Challenges with ESTH

There are particular challenges with ESTH and especially at the St Helier Hospital site, where over 90% of the buildings are older than the NHS.

Our local hospital buildings are old: 57% of ESTH estate, and 93% of the St Helier Hospital site, was built before 1948, meaning most of the hospital is older than the NHS. This means significant ongoing maintenance is required and the buildings are not configured in a way that supports modern healthcare. Partly due to this, 52% of the hospital space occupied by patients is not functionally suitable.⁶⁷

In 2016, the CQC assessed St Helier as having the 16th highest critical backlog maintenance requirement nationally (and the 3rd highest in its peer group in London) – this includes important

⁶⁴ *Securing the future workforce for emergency departments in England* (2017)

https://improvement.nhs.uk/documents/1826/Emergency_department_workforce_plan_-_111017_Final.3.pdf

⁶⁵ *Securing the future workforce for emergency departments in England* (2017)

https://improvement.nhs.uk/documents/1826/Emergency_department_workforce_plan_-_111017_Final.3.pdf

⁶⁶ *Facing the Facts, Shaping the Future* (2017)

<https://hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%2C%20Shaping%20the%20Future%20%E2%80%93%20a%20draft%20health%20and%20care%20workforce%20strategy%20for%20England%20to%202027.pdf>

⁶⁷ *Estates Return Information Collection* (2016/17) <http://hefs.hscic.gov.uk/ERIC.asp>

building repairs, refurbishment and other vital maintenance work to make sure buildings are safe.⁶⁸ In its latest report in 2018, the CQC noted: “...in many areas of the trust, the environment was not always appropriate for the services being delivered, due to the age and structure of the estate.”⁶⁹

This issue has been recognised by our STPs as a priority. Surrey Heartlands STP sets out that an early decision to address the challenges we have with the hospital’s buildings is important and the South West London STP recognises the specific challenges around St Helier Hospital.

ESTH has started to explore how it could improve its buildings. Its SOC for future investment in its hospitals identifies that investment in the estate would help to address a number of issues, help meet standards, and support clinical changes.⁷⁰

1.5.3.2 Investment is needed to address these challenges

Significant investment is needed to ensure that our buildings are safe.

Significant investment is required to meet safety standards, including new boilers and plant for the heating and hot water systems; and investment to ensure compliance with asbestos, fire and water regulations.

Investment is also needed to make sure that the buildings can deliver care to the modern standards that our populations expect.

As well as the investment needed to make basic safety repairs, buildings must be fit-for-purpose. This means:

- Wards and beds are laid out in the right way so that patients have a better experience of our services, including ensuring staff can access and oversee patients effectively.
- The chances of acquiring an infection whilst in hospital are low as there is sufficient space between beds, there are areas for patients to be isolated and the hospitals is designed to be easy to clear.
- Staff can provide services to the modern standards that patients expect, including ensuring departments are close to the supporting services they need.

Delivering this will require further changes, and additional investment, in how ESTH configures its buildings – its current estate is not fit-for-purpose.

In its SOC published in 2017, ESTH estimated that £398m of capital investment would be needed between 2017/18 and 2025/26, to address its estates issues and to allow it to continue to deliver the services which it currently provides from its sites. In its SOC, ESTH estimated that of the £398m, £142m would be funded through existing ESTH cash which has been set aside; an additional £48m would be funded through external sources, such as borrowing from the government; and the remaining £208m is currently unfunded. Further work is needed to understand the investment required.

1.5.4 Achieving financial sustainability

We currently spend more than we receive in funding, and expect this to continue unless we change the way we deliver care.

⁶⁸ Epsom and St Helier University Hospitals NHS Trust: Quality report (2016) https://www.cqc.org.uk/sites/default/files/new_reports/AAAE5976.pdf

⁶⁹ Epsom and St Helier University Hospitals NHS Trust: Quality report (2018): http://www.cqc.org.uk/sites/default/files/new_reports/AAAH0093.pdf

⁷⁰ Strategic outline case for investment in our hospitals 2020-2030 (2017) <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93ijim4n8158.pdf&ver=19818>

It is important that any plans for future services can support the NHS to become financially sustainable. The NHS as a whole has identified a need to achieve £22bn of efficiencies between 2016/17 and 2020/21, which is around 20% of current NHS funding.

Additional funding has been made available to support the system through a ‘sustainability and transformation fund’, to help local health economies to transform and for hospitals to return to financial balance. The total value of this fund was £1.8bn in 2015/16 for 2016/17 and has been increased to £2.45bn (and renamed the ‘provider sustainability fund’) for 2018/19 and money has also been set aside for capital investment projects for STPs.⁷¹

The 2017 Autumn Budget announced £6.3bn of new funding for the NHS in England, including £2.8bn over the next three years for day to day services and £3.5bn of capital investment by 2022/23.⁷²

1.5.4.1 The financial gap

Similar to many parts of the NHS, we are currently spending more money than we are receiving, and expect this to continue unless we make changes.

As a system, we currently spend more than we receive in funding. In 2016, the Surrey Heartlands STP estimated a ‘pre transformation’ recurrent financial gap of c. £102m by 20/21, which reflects around 10% of the total £1bn funding received. In November 2017, the South West London STP estimated that NHS providers and commissioners have identified an underlying deficit of £166m (excluding sustainability and transformation funding), this reflects around 6% of the total £2.7bn funding received.⁷³

A key feature of these challenges is the financial deficit at ESTH (c. £23m outturn in 2017/18, including c. £14m of provider sustainability funding); this is expected to worsen if current trends continue. In particular, to meet expected increases in demand from the ageing population and other increases in our costs, by 2025/26 ESTH may need an estimated c. £33m (including c. £14m of provider sustainability funding) of additional annual funding above that which is likely to be available, based on current services. This is around 8% of ESTH’s current income.

This is because average increases in funding are outstripped by demand growth, cost inflation, the cost of meeting clinical standards, and the high cost of maintaining the existing estate. This deficit also includes significant efficiency programmes (such as reducing our reliance on agency workforce) and demand management plans agreed across the system (such as reducing average length of stay safely and avoiding unnecessary admissions). These schemes reflect ‘business as usual’ improvements which can be delivered without changing services significantly; without these the deficit would be much greater.

Despite all these efforts, ESTH will still face a deficit, largely driven by working across two sites and therefore duplicating rotas and support services. The scale of this deficit means our local healthcare system will not achieve financial sustainability unless we can address the challenges at ESTH.

We are unsure how much money will be provided to the NHS between 2021 and 2026, so we have assumed that current trends are likely continue. This means that our financial forecasts could change if the government makes significant changes to the way that the NHS is funded in the future.

1.5.5 The growing need for change

We have been exploring for some time ways to address long-term issues of sustainability in the combined geography, but there is now a growing need for change, driven by the three main issues:

- **Clinical quality:** Clinical standards are increasing locally and nationally, and in 2017 we defined clear clinical standards for six acute services (discussed in section 1.4.3). Standards provide clear

⁷¹ <https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf>

⁷² <https://www.gov.uk/government/publications/nhs-spending-autumn-budget-2017-brief>

⁷³ <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>

guidance around the quality of care expected; meeting these needs changes locally. There is a shortage of consultants in emergency department, acute medicine and intensive care against the standards agreed in SWL. The gap identified in the emergency department also aligns with national expectations as per the Royal College of Emergency Medicine guidance for consultant cover, as recently identified by the Care Quality Commission. Additionally there is a shortage in middle grade doctors and nursing staff.

- **Providing healthcare from modern buildings:** ESTH's buildings in particular, are ageing and are not designed for modern healthcare – an issue repeatedly highlighted by the CQC, including in its latest report (May 2018). The deterioration of the estate has started to impact the day to day running of clinical services and patients' experience.
- **Achieving financial sustainability:** ESTH in particular, has a progressively deteriorating underlying financial position. Its deficit has worsened from c. £7m in 2013/14 to c. £37m in 2017/18 (excluding sustainability and transformation funding). This trend is driven by unavoidable increases in costs for clinical workforce; increasing costs for estates maintenance; and decreasing opportunities for efficiencies within the existing operating and clinical models. The financial position will continue to worsen unless changes are made.⁷⁴

⁷⁴ By 2025/26, ESTH may need c. £33m of additional annual funding above that which is likely to be available, based on current services, however this includes c. £14m of provider sustainability funding – without this extra funding the underlying deficit would worsen to c. £47m by 2025/26.

1.6 The need for change

The current situation cannot continue if we want to deliver quality healthcare and change is needed – specifically, we need to enhance prevention in our geographies, integrate more change our major acute services and invest in our estate.

As a healthcare system, we are facing many related issues that challenge the delivery of the care we expect for our populations. These include an increasing need to prevent ill health through enhanced prevention, growing demand, delivering quality healthcare with the available workforce, poor quality estate and growing financial pressures.

Most critical of these are the challenges of clinical quality, estates and financial sustainability – including delivering more care closer to home for most patients while also ensuring major acute hospital services are sufficiently staffed with experienced consultants to deliver care to the most critically ill.

To address these issues, changes are needed:

- **We need to continue to integrate care and enhance prevention** – including ensuring our healthcare providers (primary, community, mental health and acute) work better together and ensuring care is co-ordinated across health and social care across all the services that are provided in our combined geographies.
- **We need to change the way major acute services are delivered to meet the standards we expect and maintain services** that would otherwise be under threat – but this is only needed in the six major acute specialties we have focused on (emergency department, acute medicine, paediatrics, emergency general surgery, obstetrics and intensive care) and services that are reliant upon them.
- **We need to invest to ensure care is delivered from buildings that are fit for purpose** – and this investment must support our wider aims for the future of healthcare and meet expected future demand.

These changes will also aim to improve the system's future financial position. As this work is developed further we will undertake the analysis required to estimate the potential impact of any changes on the financial position of the system.

These challenges – in particular the challenge of staffing major acute services sufficiently – are so significant that large changes may be needed in how healthcare is organised and delivered in our combined geographies.

We believe this change only needs to consider ESTH hospitals, as the rest of the local health and care system can be improved by existing plans. And we believe this change is only needed to those major acute services where there is a clear case for change – all other services should continue to develop in line with existing plans.

This is the focus of our work. However, as commissioners, we are committed to maintaining services within our combined geographies and this will be a priority for any further analysis.

2 CLINICAL MODEL

2.1 Process

To address the challenges outlined in the case for change, the CCGs of Surrey Downs, Sutton and Merton established a Clinical Advisory Group (CAG) in January 2018. The group membership includes clinical leaders from across the Surrey Downs, Sutton and Merton area. We have asked it to develop a clinical model to meet local needs for our combined geographies based on clinical standards and evidence based best practice, focusing on the areas where we have sustainability challenges.

As part of the development of the emerging clinical model, where appropriate, the group has built upon existing sustainability work undertaken locally.

The CAG formed working groups of clinicians and other stakeholders from across primary and secondary care to further develop the clinical model. These considered specific pathways with input from relevant specialists.

Two clinical workshops allowed input from a wider audience of stakeholders based within the local health economy.

Based on this, the CAG has recommended this emerging clinical model.

2.1.1 Development

The emerging clinical model has been refined through subgroups, clinical workshops and the Programme Board. It will subsequently be tested with the public and with clinical senates

As part of the development of the **emerging** clinical model, the CAG additionally set up four subgroups to consider from a patient's perspective, the 'as-is' and 'to-be' pathways as well other critical questions across the following four areas:

1. Urgent and Emergency Care
2. Maternity
3. Paediatrics
4. Planned Care

Through a series of meetings, these subgroups refined and identified other areas for discussion. Further questions were discussed when all the subgroups were brought together with other key stakeholders at two clinical workshops, held on the 11th and 25th April 2018.

This work has been informed by clinical standards, national and regional guidance and best clinical practice.

The CAG has reviewed the emerging clinical model and has recommended an overall clinical model to our Programme Board.

2.1.2 Further testing

This model will be further tested with the public through an engagement process. This will involve the publication of an issues paper asking for the public's input on our emerging clinical model and initial thoughts on a range of potential solutions.

It will also be tested with clinical senates in two ways:

- Ongoing informal testing via the South West London Clinical Senate and the Surrey Heartlands Academy.
- Formal joint testing by the London and South East clinical senates.

It will additionally be tested with the relevant Royal colleges and other professional bodies

As a result of this testing, the model will be refined further.

2.1.3 Benefits of change

We have used a consistent benefits framework to identify intended impacts of changes from the emerging clinical model. This is an initial review of benefits, which we will consider further as we explore how this clinical model can be delivered.

This has been used to understand the impact of changes to be understood for each of the four pathways: urgent and emergency care, maternity, paediatrics, and planned care. The framework considers the inputs, outputs and outcomes of the emerging clinical model:

- **Inputs:** The elements of change within the new clinical model. This includes, for example, pathway redesign, changes to opening hours or new models of working.
- **Outputs:** What the changes achieve. This includes, for example, changes to service provision, a reduction in transfers or changes to the type of professional that a patient interacts with.
- **Outcomes:** The results and benefits that demonstrate whether changes have been successful. This includes, for example, reduced avoidable deaths, morbidity, improved satisfaction and team work.

We have considered the benefits against this framework for each pathway throughout this document:

- The overall summary benefits of the model in Section 2.2.3.
- Urgent and emergency care benefits are captured in Section 2.3.6.
- Paediatrics benefits are captured in Section 2.4.4.
- Maternity benefits are captured in Section 2.5.5.
- Planned care benefits are captured in Section 2.6.4.

2.2 Clinical model

Our emerging clinical model, as recommended by our CAG, focuses on two types of services: major acute and district services based on their reliance of critical care.

Major acute services are defined as those services that are reliant on the presence of critical care and/or services that critical care is dependent on. These are services that the only the highest risk and sickest patients require from a healthcare service.

Major acute services include emergency department, acute medicine, critical care, emergency surgery, obstetrician led births, paediatrics emergency department and paediatric inpatients.

District hospital services are services that do not require critical care and/or services that critical care is dependent on. These are services that patients are likely to require more frequently, and often should be strongly integrated with community health and care settings. For these services, where there is not a clear case for change, they would continue to develop in line with current plans.

District hospital services include urgent treatment centres, outpatients, daycase surgery, low risk antenatal and postnatal care, imaging and diagnostics, and district hospital beds.

Critical care services are specialist hospital services that provide monitoring and/or treatment for the sickest or highest risk patients and include intensive care units (ICU), high dependency units (HDU) and post-anaesthesia care units (PACU).

- ICU patients often have multiple organ failure and require one-to-one nursing care.⁷⁵
- HDUs are for patients who require single organ support or monitoring such as renal hemofiltration or cardiac monitoring.
- PACUs care for patients recovering from anaesthetics until they regain full control of their airway reflexes.⁷⁶

2.2.1 Major acute services

Major acute services include the highest acuity services offered in our combined geographies. These services are subject to specific clinical standards. These have been developed nationally and in South West London and define expectations of major acute services.

Figure 4: An overview of some of the clinical standards set out in the South West London Clinical Quality Standards for Acute Services⁷⁷

1	2	3	4	5	6
Emergency Department	Acute medicine	Paediatrics	Emergency general surgery	Obstetrics	Intensive care
<ul style="list-style-type: none"> • 16/7 consultant staffing (24/7 major trauma) • 'Good' in CQC 5 domains • 7 day access to diagnostics • 4 hour waiting time • Emergency mental health in 60 mins • Core24 mental health teams 	<ul style="list-style-type: none"> • 14/7 consultant staffing • 'Good' in CQC 5 domains • 7 day access to diagnostics • Continually assessed with MEWS score • AMUs supported by 24/7 GI bleed rota • AAU tertiary advice 24/7 	<ul style="list-style-type: none"> • 14/7 consultant staffing • 'Good' in CQC 5 domains • 7 day access to diagnostics • CAHMS assessment within 1 hour for emergency care and 14 hours for urgent care 	<ul style="list-style-type: none"> • 14/7 consultant staffing • 'Good' in CQC 5 domains • 7 day access to diagnostics • Continually assessed with MEWS score • SAU/HDU twice daily consultant assessment 	<ul style="list-style-type: none"> • 14/7 consultant staffing • 'Good' in CQC 5 domains • Meet RCOG standards on midwifery numbers • BAPM guidance on medical/ nursing numbers 	<ul style="list-style-type: none"> • 12/7 consultant staffing • 'Good' in CQC 5 domains • 7 day access to diagnostics • Consultant assessment within 14 hours of admission

⁷⁵ ESTH (2018) Available at: <https://www.epson-sthelier.nhs.uk/critical-care>

⁷⁶ Preston et al. (2012). Available at: [https://www.anaesthesiajournal.co.uk/article/S1472-0299\(12\)00234-2/abstract](https://www.anaesthesiajournal.co.uk/article/S1472-0299(12)00234-2/abstract)

⁷⁷ *Clinical quality standards for acute services provided in South West London or operated by a South West London Trust* (2017). Available at: <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>. NHS Services, Seven Days a Week (2017), <https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf> *Emergency Medicine Consultants: Workforce Recommendations* (2010) <https://www.rcem.ac.uk/docs/Workforce/CEM5324-Emergency-Medicine-Consultants--CEM->

2.2.1.1 Co-dependencies

Across each of the four workstreams (urgent and emergency care, maternity, paediatrics and planned care) we have identified that there are numerous services where the presence of critical care is either **essential or highly desirable** and therefore these services should be co-located with critical care.

This has been informed by relevant national and regional guidance, best clinical practice and previous co-dependency mappings.⁷⁸ An overview of some of these services can be found in Figure 5 and details of the co-dependencies in Figure 6.

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[Workforce-Recommendations-Apr-2010.pdf](https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf); "Rules of Thumb" for Medical and Practitioner Staffing in Emergency Departments (2015) <https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf>

⁷⁸ *Insights from the clinical assurance of service reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed-methods study* (2015) <https://www.ncbi.nlm.nih.gov/books/NBK280129/>; *South West London Discussion Document: One Year On* (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>; *The Clinical Co-Dependencies 2 of Acute Hospital Services: A Clinical Senate Review* (2014) http://www.secsenate.nhs.uk/files/4015/0029/9866/The_ClinicalCo-dependencies_of_Acute_Hospital_Services_SEC_Clinical_Senate_Dec_2014_errata_grids_B_and_C_corrected.pdf

Figure 5: Services determined to be ‘major acute’ - either due to a co-dependency with critical care or a strong association with another major acute service.

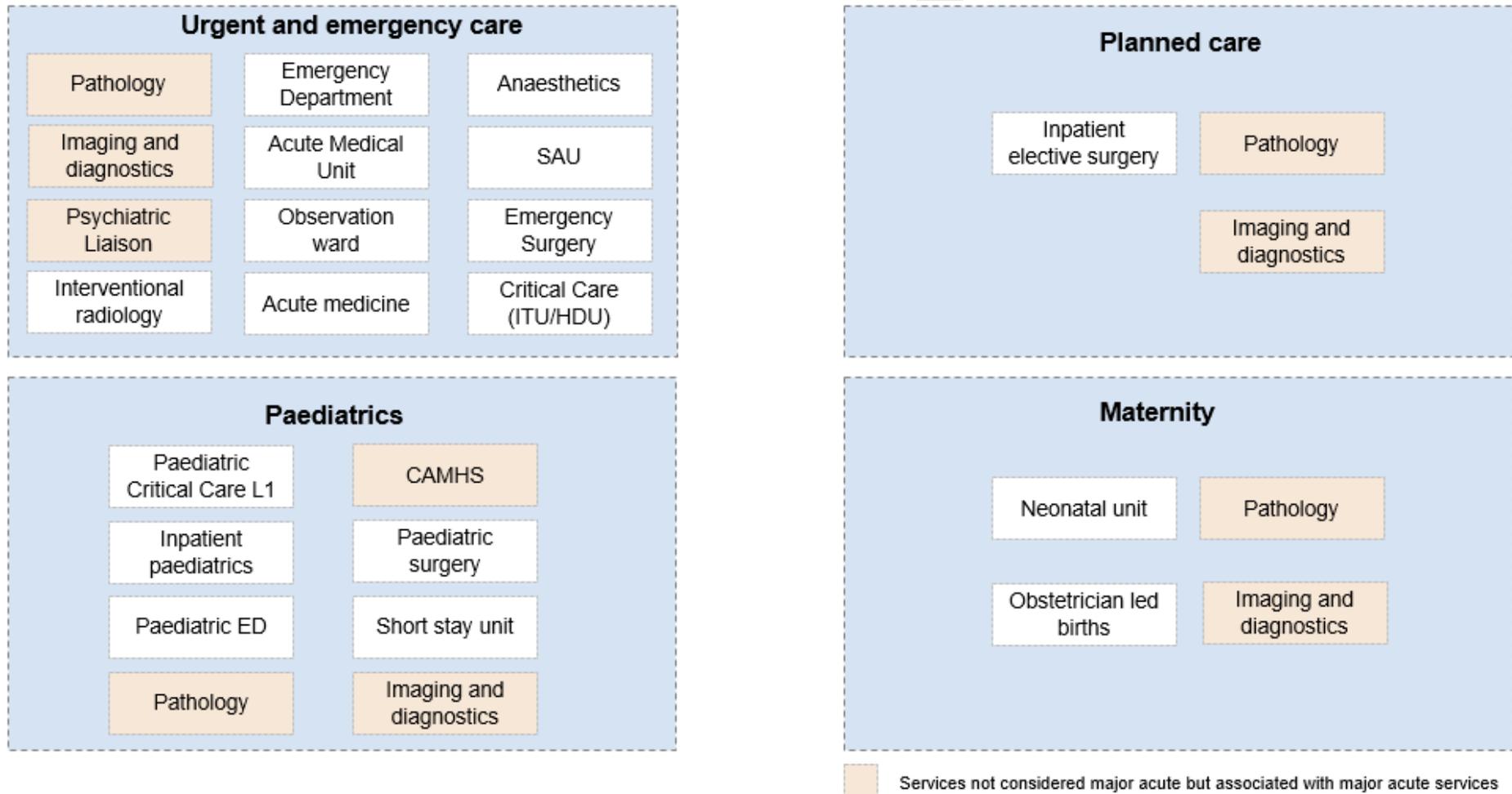
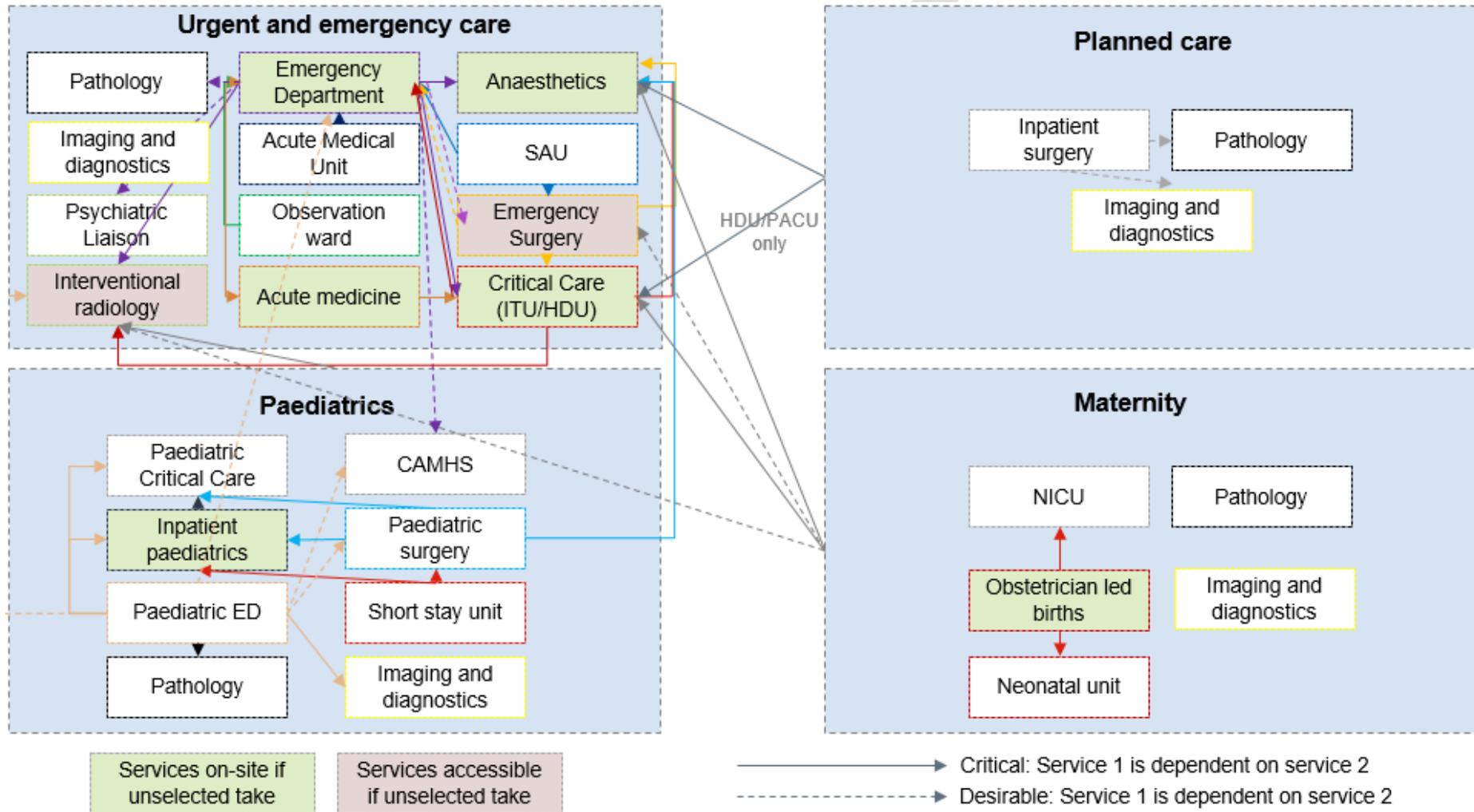


Figure 6: The critical and highly desirable co-dependencies between secondary care services.



In summary, some of the key dependencies include:

- **The emergency department** relies on the presence of critical care, anaesthesia, emergency surgery, interventional radiology, liaison psychiatry and acute medicine. These services must be co-located to offer a viable major emergency department.
- **Acute medicine** relies on critical care and anaesthesia, and requires an emergency department for its take.
- **Emergency surgery** relies on the presence of critical care and anaesthesia, and requires an emergency department for its take.
- **Critical care** is also dependent on some services including interventional radiology and anaesthesia.
- **Obstetrician-led births** rely on critical care, emergency surgery for women, interventional radiology, anaesthesia and neonatal services (midwife-led births are discussed in Section 2.5.3).
- **Emergency and inpatient paediatrics** rely on anaesthetics and interventional radiology.

2.2.1.2 Clusters of major acute services

These major acute services can be organised in multiple ways. Within our clinical model, we have considered two clusters of services:

- **Major emergency department (adults):** Emergency department, acute medicine, emergency surgery and critical care.
- **Women’s and children’s services:** Obstetrician-led births, emergency paediatrics and inpatient paediatrics.

Women’s and children’s major acute services (obstetrician-led births, emergency paediatrics and inpatient paediatrics) have been clustered together as they are typically closely linked and clinical rotas are often shared. For obstetrics and gynaecology at St Helier there is joint consultant out of hours cover for neonatology and paediatrics; at Epsom, there is currently one rota covering neonates, general paediatrics and the paediatric emergency department.⁷⁹

Where these services are considered separately, units are of a significantly different scale than those required to meet the needs of our local populations. For example, Liverpool Women’s Hospital sees c. 8,600 births a year⁸⁰ – the largest unit in the country – compared to the c. 5,000 hospital deliveries in our combined geographies⁸¹; similarly, dedicated standalone children’s hospitals (e.g., Great Ormond Street Hospital and Alder Hey Children’s Hospital) focus on specialised paediatrics for large regional populations rather than the generalist paediatric services we require in our geographies.

2.2.1.3 Co-locating major acute services

Based on the co-dependencies and clusters described above, there are two ways major acute services can be co-located:

1. **Major emergency department (adults):** These services must be co-located to offer a viable major emergency department (emergency surgery can, in some circumstances, be closely networked but this could add additional risk to the pathway and is not desirable).⁸²

⁷⁹ ESTH

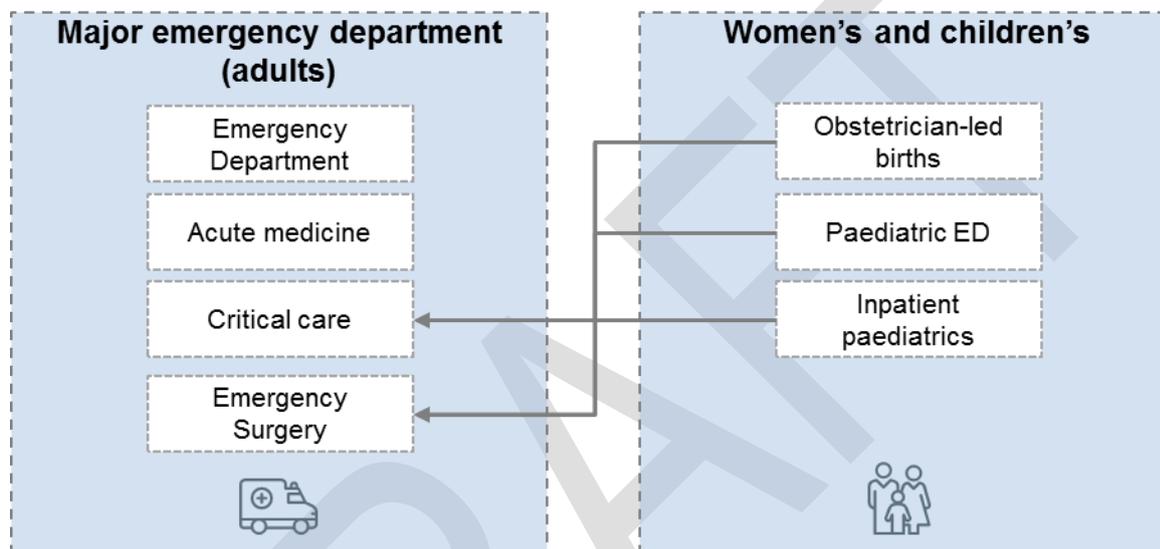
⁸⁰ Liverpool Women’s Hospital: <https://www.liverpoolwomens.nhs.uk/>

⁸¹ ESTH

⁸² Currently ESTH only provides emergency surgery at St Helier Hospital. Epsom Hospital is closely networked and patients requiring emergency surgery are transferred. This aligns with SWL clinical standards, which require that emergency surgery must be accessible for an emergency department. The relevant Royal colleges identify that this is a possible configuration of services, but highlight issues: the RCEM recommends “robust and safe” policies are in place with access to senior opinion and transfer; the RCS highlights sustainability challenges and recommends

2. **Women’s and children’s services alongside a major emergency department:** Obstetrician-led births and paediatrics must be co-located with critical care and emergency surgery. This means any service with obstetrician-led births and/or paediatrics requires a major emergency department.

Figure 7: The two clusters of services and the dependences linking the clusters



Our case for change has identified there are issues with the current provision of major acute services. Therefore, how these services are delivered in the future will need to be considered as part of the identification of potential solutions. This is discussed in Section 3.

2.2.2 District hospital services

District hospital services do **not** require critical care and/or services that critical care is dependent on. These are services that patients may require more frequently and should be accessible closer to patients' homes through close links with community health and care settings.

Across the local health economy, care is already being provided in an increasingly integrated manner to reduce fragmentation between care settings.

This is in alignment with the FYFV, the priorities established by our STPs (Surrey Heartlands and SWL), and our individual CCGs own strategies.⁸³

networked access to surgical opinion; the RCoA highlights that without emergency surgery, intensive care units are difficult to staff. The desirability of co-location is reinforced by the South East Coast Clinical Senate mapping of dependencies, which identifies that emergency departments are dependent on emergency surgery and this should be provided on the same site.'

Clinical quality standards for acute services provided in South West London or operated by a South West London Trust (2017)

<https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>; Imison et al *Insights from the clinical assurance of service reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed-methods study*. Health Services and Delivery Research, No. 3.9 ; SEC Clinical Senate (2014) <http://www.secsenate.nhs.uk/clinical-senate-advice/published-advice-and-recommendations/clinical-co-dependencies-acute-hospital-services-clinical-senate-review/>

⁸³ This includes: NHS Five Year Forward View (2014) <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>; South West London Five Year Forward Plan (October 2016) <https://www.swlondon.nhs.uk/wp-content/uploads/2016/11/SWL-Five-Year-Forward-Plan-21-October-2016.pdf>; South West London Health and Care Partnership: One Year On (November 2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>; Surrey Heartlands Sustainability and Transformation Plan (June 2016); Surrey Heartlands Sustainability and Transformation Plan (October 2016) <http://www.surreyheartlands.uk/wp-content/uploads/2017/04/surrey-heartlands-stp-october-2016.pdf>

2.2.2.1 Our local strategies and plans

Each of our CCGs has strategies to improve health and care for the local health economy.

These are summarised in Figure 8.

Figure 8: An overview of our (Surrey Downs, Sutton and Merton) strategies⁸⁴

Merton	<ul style="list-style-type: none"> • Integrated locality teams including Care Homes Improvement Programme • Primary care at scale including locality teams 	<ul style="list-style-type: none"> • Integrated urgent care including enhanced streaming • Redesign of key planned care pathways
Sutton	<ul style="list-style-type: none"> • Enhanced prevention • Primary care at scale including greater use of networks 	<ul style="list-style-type: none"> • Proactive care including multidisciplinary locality teams • Reactive care including admissions avoidance and discharge support
Surrey Downs	<ul style="list-style-type: none"> • Enhanced prevention with a focus on risk stratification • Enhanced primary care including federations of practices 	<ul style="list-style-type: none"> • Proactive care including community hubs • Reactive care to meet urgent needs

Bringing together our CCG strategies, objectives for the local health economy include:

- Delivering care closer to patients' homes.
- Ensuring high standards of healthcare across all providers.
- Maintaining the provision of acute services within CCG's combined geographies.
- Greater prevention of disease.
- Improved integration of care.
- Enhanced standards for the delivery of major acute services.

2.2.2.2 Integrating care

Reflected in our CCG strategies and the objectives for the local health economy, there is a local drive for care to be provided in a more integrated and joined up manner. This is to reduce the level of fragmentation between services and facilitate patients to access the support they need in a timely manner.

Our existing work and strategies for integrated care include:

In Surrey Downs, this includes:

- **Epsom Health and Care Alliance:** This partnership between Surrey County Council, ESTH, the local GP Federation and Central Surrey Health aims to provide extra support and care within a patient's home to support those who have two or more long term conditions to live as independently as they can and to prevent them from needing a hospital admission.⁸⁵
- **Integrated Dorking, Epsom, and East Elmbridge Alliance (IDEEA):** Through this alliance, ESTH is providing community services for the Surrey Downs population in partnership with CSH Surrey.⁸⁶
- **Surrey Downs Community Hub Programme:** On 1 July 2015 the CCG launched three new Community Hubs, with one operating in each of the three localities (Dorking, Epsom and East Elmbridge). The hubs are a new locality-based GP service put in place to better manage frail

⁸⁴ CCGs of Surrey Downs, Sutton and Merton

⁸⁵ CSH Surrey: <https://www.cshsurrey.co.uk/our-services/service-adults/epsom-health-and-care-home> and ESTH: <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93jjm4n6587.pdf&ver=14955>

⁸⁶ Surrey Downs CCG: <http://www.surreydownscg.nhs.uk/get-informed/news/2018/february/more-integrated-care-for-patients-as-new-adult-community-services-contract-awarded/>

elderly patients in the community. The teams are locality-specific and include GPs, nursing services, physiotherapy, occupational therapy, social work and domiciliary care.

- **Surrey Downs planned care service redesign:** The CCG has work underway to look at the commissioned pathway for planned services. One of the key objectives of this work is to ensure that as much of a patient's care is as close to home and based in local communities as possible.

In Sutton, this includes:

- **Sutton Health and Care⁸⁷:** delivers integrated care along two workstreams:
 - Preventative and proactive care: Spectrum of services from social prescribing to Locality Teams
 - Reactive care: Admission avoidance and accelerated discharge for the frail, older population
- **Sutton CCG's commissioning for integrated community care** will require our providers to continue to work to deliver a new model of care for Sutton residents that builds on the principles of the integrated care system, including:
 - Ensuring an integrated approach to admission avoidance and discharge
 - Embedding the learning from the Sutton Vanguard scheme into other pathways of patient cohorts
 - Looking at enablers to integration such as changes in workforce and use of technology.

In Merton, this includes:

- **The Merton integrated primary and community services strategy** focuses on integrating locality teams to provide proactive care, develop primary care at scale and integrate urgent care⁸⁸. Merton CCG is also intending to focus on further integrating community care by extending the number of people with complex needs managed by multi-disciplinary locality teams, providing proactive ongoing care and effective step up and step down support.
- **To improve the integration of mental health services Merton CCG** intends to integrate commissioning for children and young people with multiple needs. For example, this would occur through integration of community mental health services with primary care, through extending the Primary Care Plus model.

2.2.2.3 Further development of district services

Given there is no case for major service change in district hospital services, the numerous existing district hospital services that are a key part of local strategies and objectives will continue to be developed without need for major changes to be considered.

The diagram below shows broadly the district services that will continue to be offered within the local health economy. This model will develop further as we realise our integrated primary and community services plans.

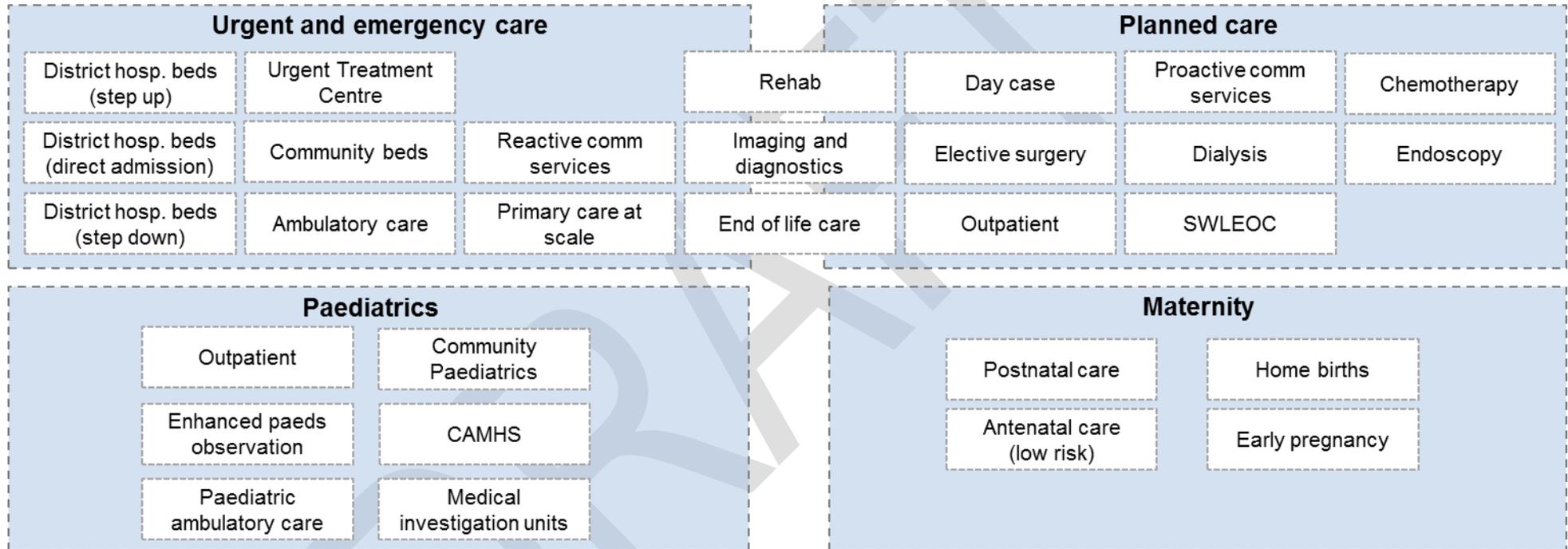
The implications of the clinical model has been considered at pathway level in Sections 2.3, 2.4, 2.5 and 2.6. Specific considerations include urgent treatment centres (Section 2.3.3) and district hospital beds (Section 2.3.4).

Additionally, other services need to be considered that have elements of both major acute and district hospital services. This includes midwife-led units and elective surgery.

⁸⁷ Sutton CCG

⁸⁸ Merton CCG

Figure 9: Existing district hospital services that will continue to be offered within our combined geographies.



2.2.3 Overall benefits of the clinical model

The proposed changes within the emerging clinical model are expected to have a positive impact on the care offered to patients. The overall benefits of the clinical model are outlined in the figure below.

Figure 10: Applying the benefits framework to the overall clinical model



2.3 Urgent and emergency care

2.3.1 The 'as is' pathway

The urgent and emergency care 'as is' pathway has been mapped based on extensive discussions with representatives from ESTH, primary care and other community health and care stakeholders through the CAG, subgroup meetings and clinical workshops. The pathway is not intended to show every service that is currently offered, but those pertinent to the changes recommended in the emerging clinical model.

2.3.2 The 'to be' pathway

The key changes to the clinical model aim to meet the latest clinical standards and evidence based best practice⁸⁹. This includes the co-location of major acute services (including the emergency department, emergency surgery, acute medical services and critical care) and developments and considerations for district hospital services, particularly around urgent treatment centres (UTCs) and district hospital beds. Additionally, Core24 liaison psychiatry is being introduced consistently as a major acute service.

The co-location of major acute services is required in order to maintain a viable emergency department.

For district hospital services, UTCs will be developed to maintain access for patients requiring urgent medical attention with access for walk-in, triaged ambulances and NHS 111 bookings. As stipulated in national guidance, UTCs are mandated to be open for a minimum of 12 hours a day, 7 days a week. Our urgent treatment centres, as defined by this emerging clinical model, will meet all national standards, including these standards for access. We will continue to review the appropriate opening hours of our UTCs. UTCs will also be supported by district ambulatory care services (further work is required to define the specification of district ambulatory care services).

Section 2.3.4 contains further detail on district hospital beds. While we have ambitious plans to treat more patients in their own homes and/or in the community, some patients will still require a hospital bed in the future. However, these patients may not require a service that is dependent on the presence of critical care. Our emerging thinking is that these patients can be better cared for in district hospital beds, accepting referrals via three pathways: admission from an urgent treatment centre, a 'step down' for patients who no longer require major acute services and being 'stepped up' from the community base care.

⁸⁹ NHS Services, Seven Days a Week (2017), <https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>; Urgent Emergency Care Facilities and System Specifications (2017), <https://www.healthylondon.org/wp-content/uploads/2015/11/London-UJEC-facilities-and-system-specifications-November-2017.pdf>; NHS Urgent Treatment Centre Guidance (2017), <https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf>; Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report (2013), <https://www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf>; London quality standards (2015); Royal College of Surgeons: Emergency Surgery Standards for unscheduled care, <https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/emergency-surgery-standards-for-unscheduled-care/>; NHS London: Adult emergency services: Acute medicine and emergency general surgery commissioning standards (2011), <http://www.londonhp.nhs.uk/wp-content/uploads/2011/09/AES-Commissioning-standards.pdf>

Figure 11: The ‘as is’ pathway for urgent and emergency care

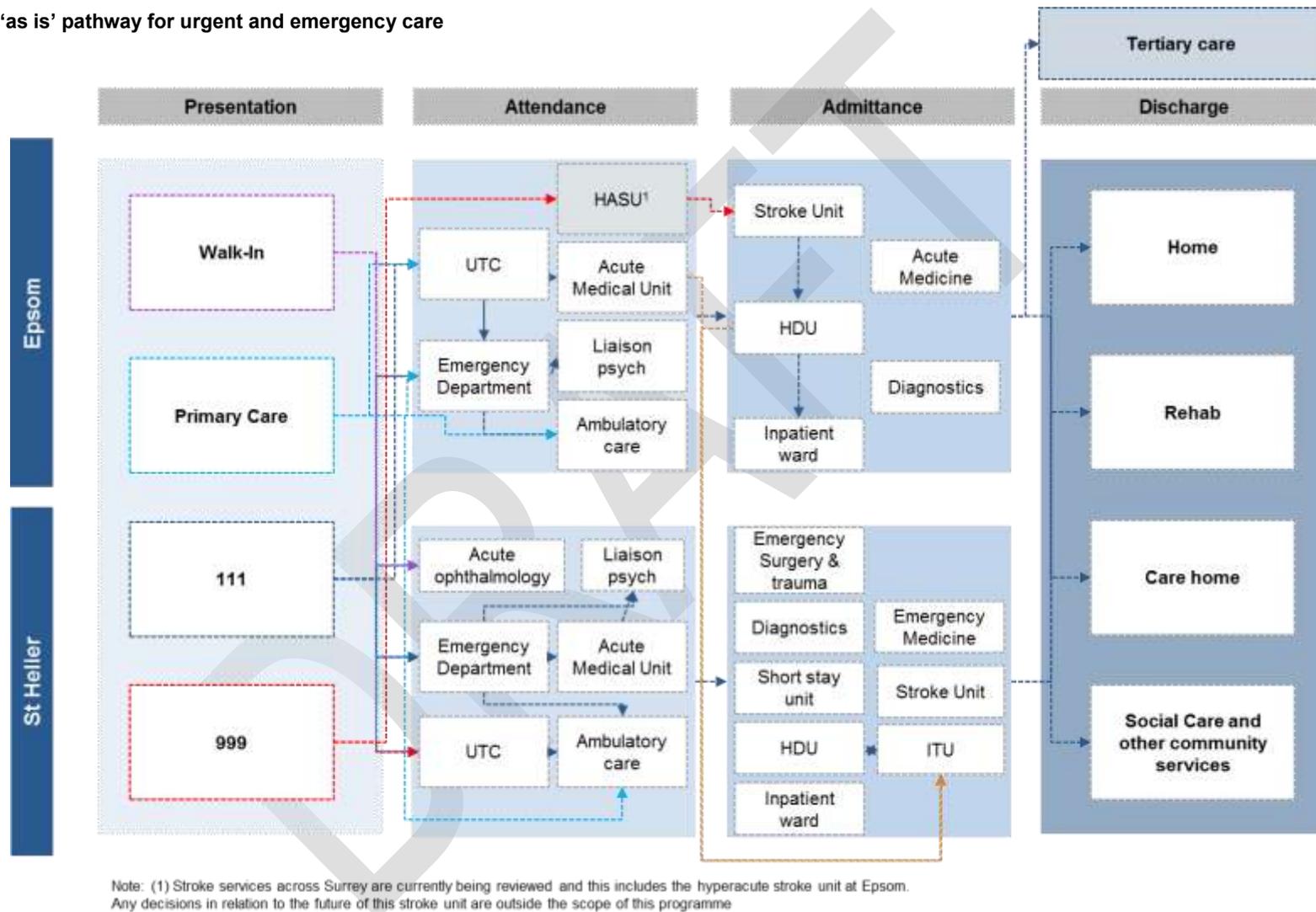
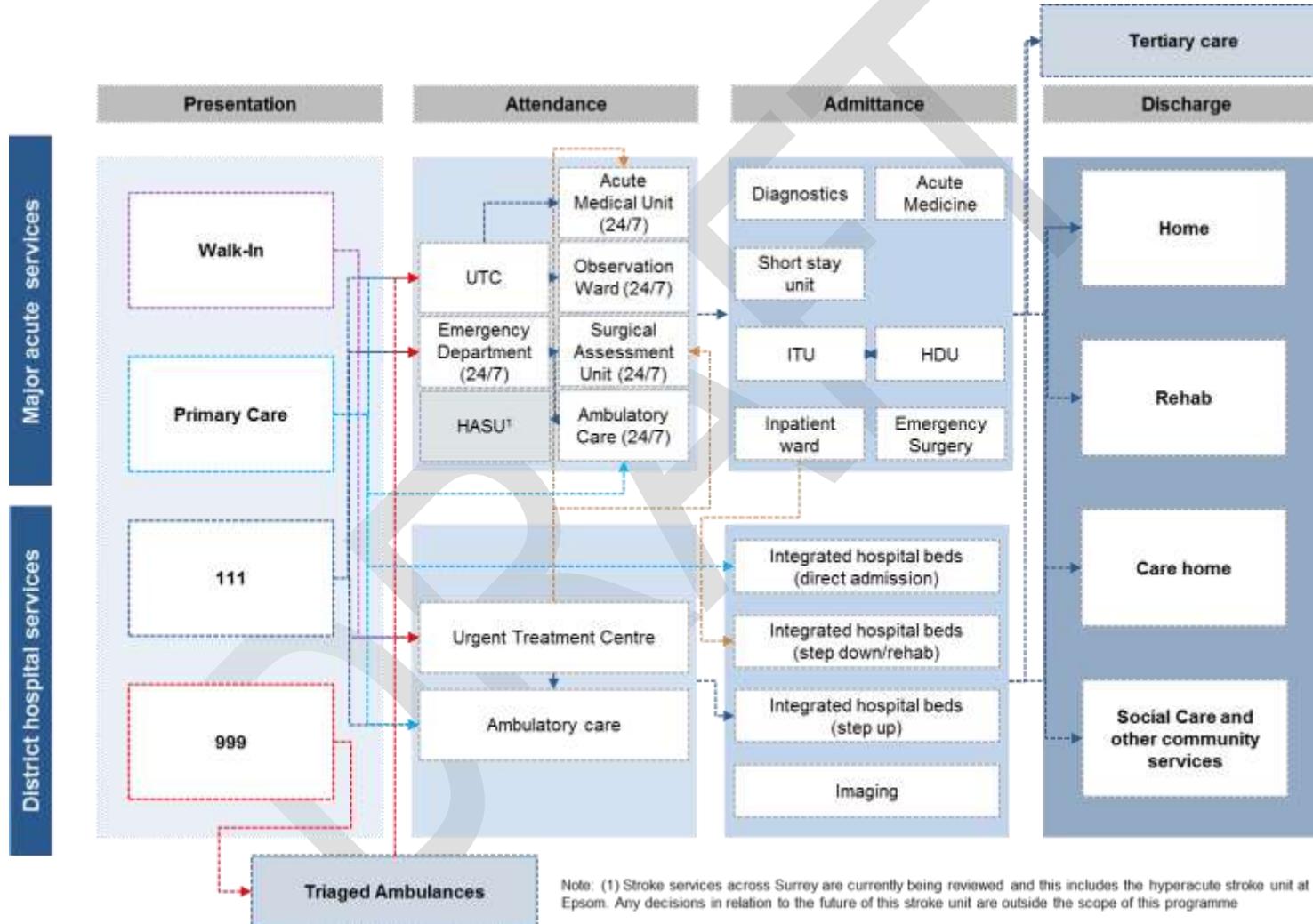


Figure 12: The ‘to be’ pathway for urgent and emergency care in the emerging clinical model.



2.3.3 Urgent Treatment Centres

Nationally, there is a drive to provide patients with the most appropriate care, in the right place, at the right time. In order to achieve this aim and to simplify and standardise the diverse range of ‘non-emergency’ accident and emergency (A&E) alternatives there is a national requirement to enhance existing walk in centres, urgent care centres, minor injury units and other urgent care services into UTCs.⁹⁰

UTCs are considered to be district services within the emerging clinical model and would ensure that patient’s urgent care needs are met within a local setting.

National guidance also specifies the minimum standards (coming into effect December 2019) required at a UTC including standards around access, diagnostics, staffing and transfer protocols. We have considered these standards and believe services should be developed in some specific areas.

2.3.3.1 Access

As stipulated in national guidance, UTCs are mandated to be open for a minimum of 12 hours a day, 7 days a week. Our UTCs, as defined by this emerging clinical model, will meet all national standards, including these standards for access. We will continue to review the appropriate opening hours of our UTCs.

The centres would be accessible to walk-ins, triaged ambulances, referrals from primary care and direct bookings through NHS 111.

2.3.3.2 Staffing and diagnostics

A multi-disciplinary team, led by GPs, would staff the UTCs (consisting of general practitioners/generalists, advanced nurse practitioners and nurses, physicians associates, independent prescribers including clinical pharmacist(s), physiotherapist(s), occupational therapist(s) and paramedic(s)).

This team would be operating at the ‘top end of their license’ and have access to specialists as required (either on-site or remotely), including mental health practitioners.

All existing diagnostics, including CT, X-ray, MRI and pathology would be available to patients attending a UTC.

As per national guidance, if UTCs are co-located with an emergency department shared leadership with an ED consultant would be considered.⁹¹

2.3.3.3 Transfers

To ensure a safe service, robust transfer protocols will need to be established in order to safely manage patients who require major acute services. This could occur in the following circumstances:

- If a critically ill walk-in arrives at UTC they will need to be stabilised and transferred to more major acute services.
- Paediatric patients who require inpatient treatment.
- Patients in the UTC who unexpectedly deteriorate and require a more acute service.

Transfers may rely on support from the ambulance service for transport to the correct facility if required and will form part of the approach recommended by national guidance to ‘design for the usual, and plan for the unusual’.

⁹⁰ Urgent Treatment Centres – Principles and Standards (2017), <https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf>

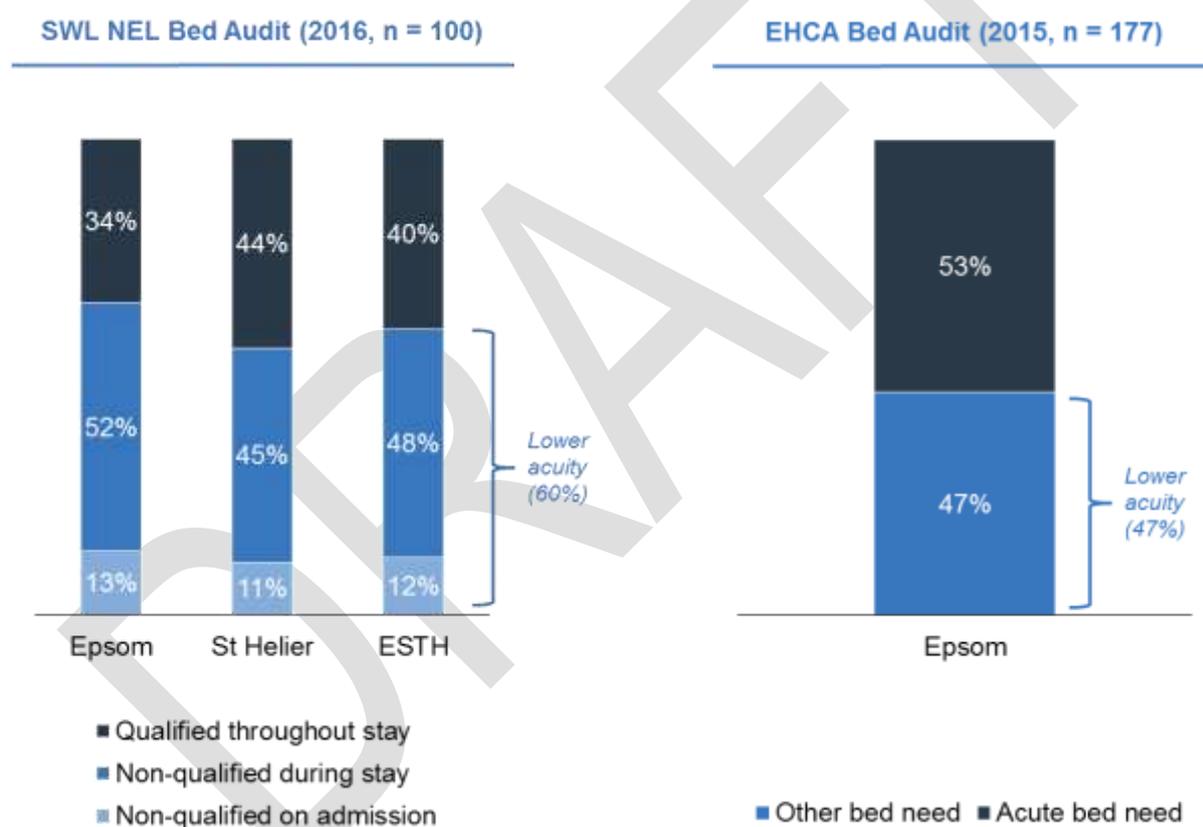
⁹¹ Urgent Treatment Centres – Principles and Standards (2017), <https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf>

2.3.4 District hospital beds

We have ambitious district primary and community services strategies to try to prevent hospital admissions, enabling more patients to be cared for both in their own homes and other community settings. However, for some patients there is no other suitable alternative to a hospital bed. We recognise that not all of these patients have the same care needs and have therefore explored different models of care for our hospitals to provide the best care for our patients.

Multiple bed audits have demonstrated that there is a cohort of patients who do not require major acute support. The SWL non-elective bed audit and the Epsom Health and Care Alliance both concluded that there was a group of patients whose needs could be better met outside of a major acute hospital bed.⁹² These ‘snapshot’ audits, looking at a total of 277 patients, found that a large proportion of patients could be better treated for in alternative, lower-acuity settings with the right support.

Figure 13: Results from the South West London non-elective bed audit and the Epsom Health and Care Alliance showing the level of patients who could be treated in a lower acuity setting.



This suggests there is a patient cohort that needs inpatient care but does not need major acute services. Our emerging clinical model proposes that this is a cohort of patients whose care requirements could be met via a district hospital bed, supported by a new model of care.

2.3.4.1 Patient cohort

While further work is required to define the specific types of patient within this cohort, the needs of these patients could include:

- Active and short term rehabilitation requirements;

⁹² SWL NEL Bed Audit (2016), <https://www.swlondon.nhs.uk/wp-content/uploads/2017/03/160309-SWL-NEL-Bed-Audit-Results-All-SWL-Trusts-v1-1.pdf>; EHCA (2015)

- Patients who have complex psychosocial needs who require short-term input into long term conditions;
- Need for ongoing therapy assessment and equipment installation;
- Awaiting further assessment (e.g., activity charts);
- Clear end point in sight (e.g., discharge <1 week) with discharge destination identified; and
- IV therapy with clear timeline for recovery

We will continue to refine the cohort of patients for these district hospital beds as our clinical model is further developed.

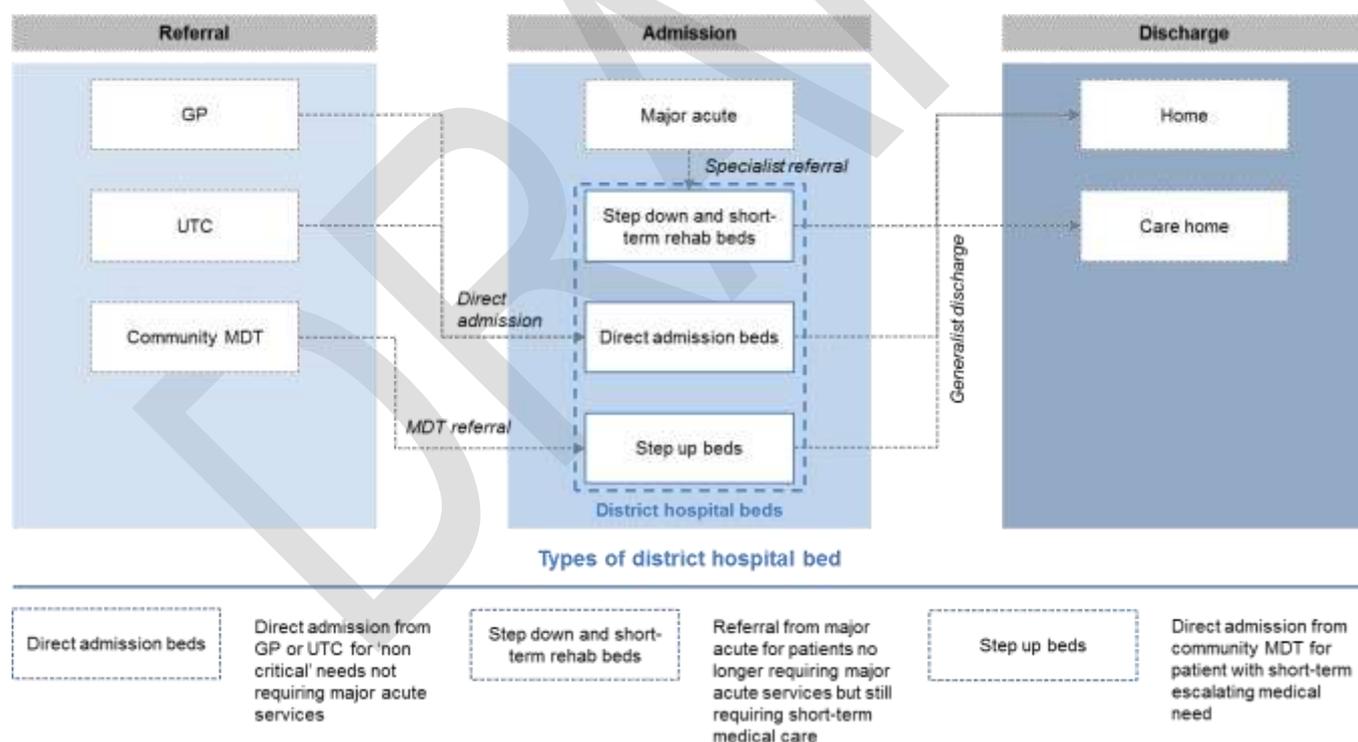
2.3.4.2 Referral pathways

Based on this developing patient cohort, there are three potential routes for patients to be admitted to these district hospital beds.

These are:

- **Direct admission beds:** Direct admission from GP or UTC for patients who do not requiring major acute services.
- **Step down and short-term rehab beds:** Referral from major acute for patients no longer requiring the high intensity of major acute services but still requiring short-term medical care.
- **Step up beds:** Direct admission from community multidisciplinary team (MDT) for patients with short-term escalating medical need.

Figure 14: The different referral pathways into district hospital beds within the emerging clinical model



2.3.4.3 Staffing

While further work is required to determine the staffing of the district hospital beds, based on the defined patient cohort, it is expected that wards would be generalist-led with input from a range of health and care professionals. This generalist role could be a GP or another responsible clinician with appropriate seniority and skillset. A full list of the potential staffing of the district hospital beds can be found in Figure 15.

Figure 15: The proposed ward cover for the district hospital beds

Role	Care professional	Description
Clinical leadership	Generalists ¹	<ul style="list-style-type: none"> Wards would be generalist-led; generalist has ultimate responsibility for patients 12/7 generalist presence (2 per unit and ANP and/or PA support (ratio-based)) Daily generalist ward rounds ANP overnight presence (1 per unit) with PA support (ratio-based)
Support	Specialists	<ul style="list-style-type: none"> Specialist in-reach consultations where requested by generalists Specialists on site delivering out-patient clinics Rounds after initial consultation as deemed required by specialist Specialist availability on call 24/7 with networked imaging
	Nursing	<ul style="list-style-type: none"> 40:60 RN:HCA ratio Specialist nursing for wound care available Other in-reach for specialised nursing needs e.g. respiratory, palliative, cardiac Access to community nursing team
	AHPs	<ul style="list-style-type: none"> Physiotherapists Occupational therapists Speech and language therapists Dietician Clinical pharmacists Specialist neuro-rehabilitation therapists Psychiatry
	Social care	<ul style="list-style-type: none"> Social care team on-site seven days a week, including: <ul style="list-style-type: none"> Case management/ care co-ordinator Social care assessor

Note: (1) Generalists are assumed to be undertaking a 'GP' type role

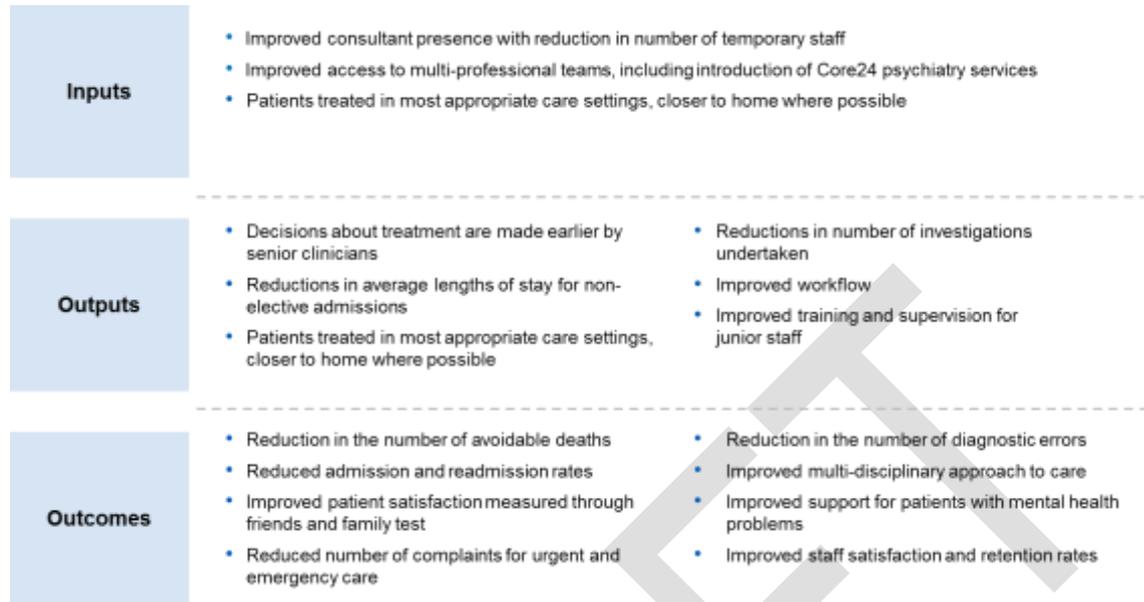
2.3.5 Potential impact on patients

The proposed changes within the provisional clinical model are expected to have a positive impact on the care offered to patients. This includes:

- Patients presenting at the emergency department requiring emergency surgery and/or ITU would not require a transfer due to the co-location of services.
- The urgent care needs of patients are met locally through UTCs with a specification that goes beyond national standards.
- Improved consistency, continuity and efficiency of district services.
- Multi-disciplinary teams in the community and primary care have access to district hospital beds for lower acuity patients.
- Core24 psychiatry introduced as a major acute service with liaison psychiatry (in reach) as a district service better integrates mental health services.

2.3.6 Benefits framework

Figure 16: The completed benefits framework for the Urgent and Emergency Care pathway



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2.4 Paediatrics

2.4.1 The 'as is' pathway

The paediatrics 'as is' pathway has been mapped based on extensive discussions with representatives from ESTH, primary care and other community health and care stakeholders through the CAG, subgroup meetings and clinical workshops. The pathway is not intended to show every service that is currently offered, but those pertinent to the changes recommended in the emerging clinical model.

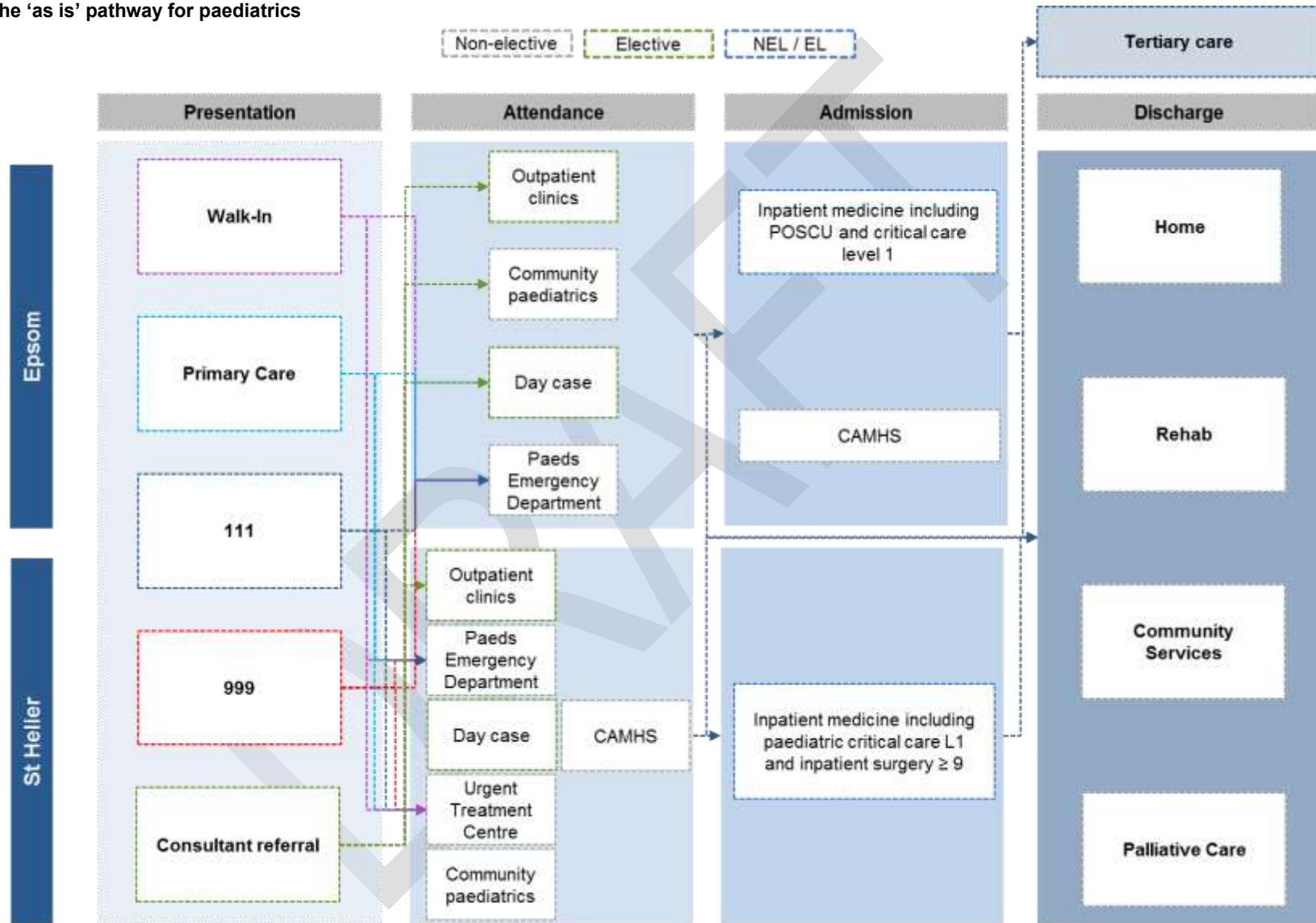
2.4.2 The 'to be' pathway

There are a number of key developments of the paediatric 'to be' pathway within the emerging clinical model. These aim to meet the latest clinical standards and evidence based best practice for paediatric care⁹³. This includes the co-location of key paediatric services with other major acute services. For example, this includes the paediatric emergency department, paediatric critical care (Level 2), inpatient paediatrics (including medicine and surgery (≥ 9 years old), daycase surgery and paediatric oncology shared care unit). Additional developments include:

- Upgrading paediatric critical care from Level 1 to Level 2.
- UTCs offer immediate paediatric assessment and treatment with access to paediatric specialists (on-site or remote). UTCs will transfer patients when necessary.
- Child and adolescent mental health services (CAMHS) to be provided more consistently as a district service.
- Support for community paediatrics as a district service.
- Outpatient clinics to be provided as district hospital services with potential for virtual/telephone consultations and outreach clinics.
- Medical investigation units to be offered as district hospital services.

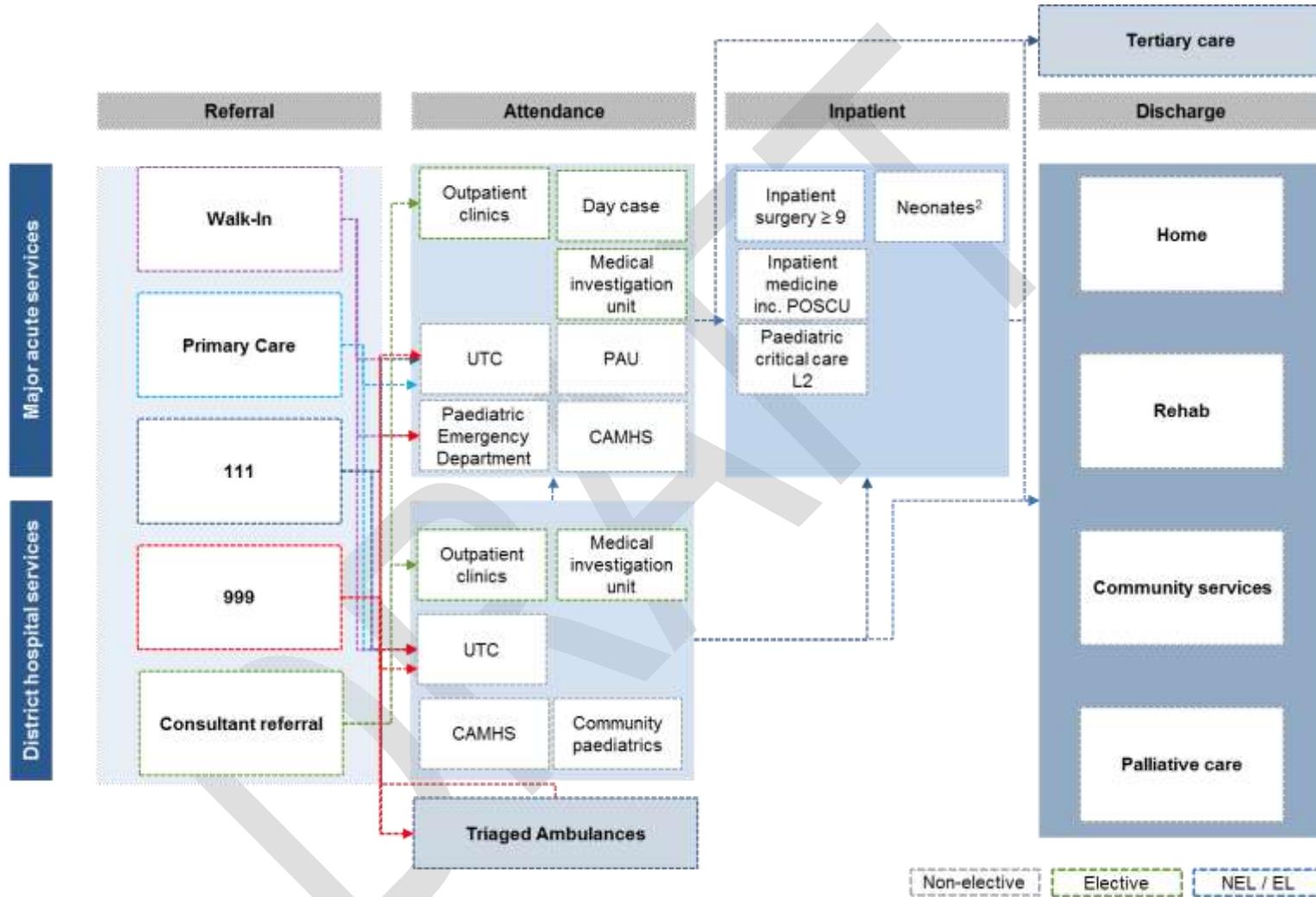
⁹³ Clinical quality standards for acute services provided in South West London or operated by a South West London Trust (2017), <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>, British Association of Perinatal Medicine (2017), Healthy London Partnership Standards: London Acute Standards for Children and Young People (2016), <https://www.myhealth.london.nhs.uk/system/files/Healthy%20London%20Partnership%20-%20Paediatric%20Critical%20Care%20Level%201%20and%202%20Standards.pdf>, Neonatal Service Quality Indicators, <https://www.bapm.org/NSQI/>, RCPCH (2015) Facing the Future: Standards for Acute General Paediatric Services, https://www.rcpch.ac.uk/sites/default/files/2018-03/facing_the_future_standards_for_acute_general_paediatric_services.pdf; Royal College of Paediatrics and Child Health (2012) Standards for Children and Young People in Emergency Care Settings, https://www.rcpch.ac.uk/sites/default/files/Standards_for_children_and_young_people_in_emergency_care_settings_2012.pdf; London Quality Standards (2013), Quality and Safety Programme Acute Emergency and Maternity Services, <https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf>; Department of Health: Our Children deserve better (2013) ; Paediatric Critical Care Standards for London, Level 1 & 2 (2016), https://www.myhealth.london.nhs.uk/sites/default/files/Healthy%20London%20Partnership%20-%20Paediatric%20Critical%20Care%20Level%201%20and%202%20Standards_0.pdf

Figure 17: The ‘as is’ pathway for paediatrics



Note: (1) Most paediatric surgery is ≥ 9 , except urology (≥ 5) and orthopaedics (not specified)

Figure 18: The 'to be' pathway for paediatrics in the emerging clinical model



Note: (1) POSCU and CAMHS both have direct referral to admission. (2) Neonatal pathway defined by maternity subgroup.

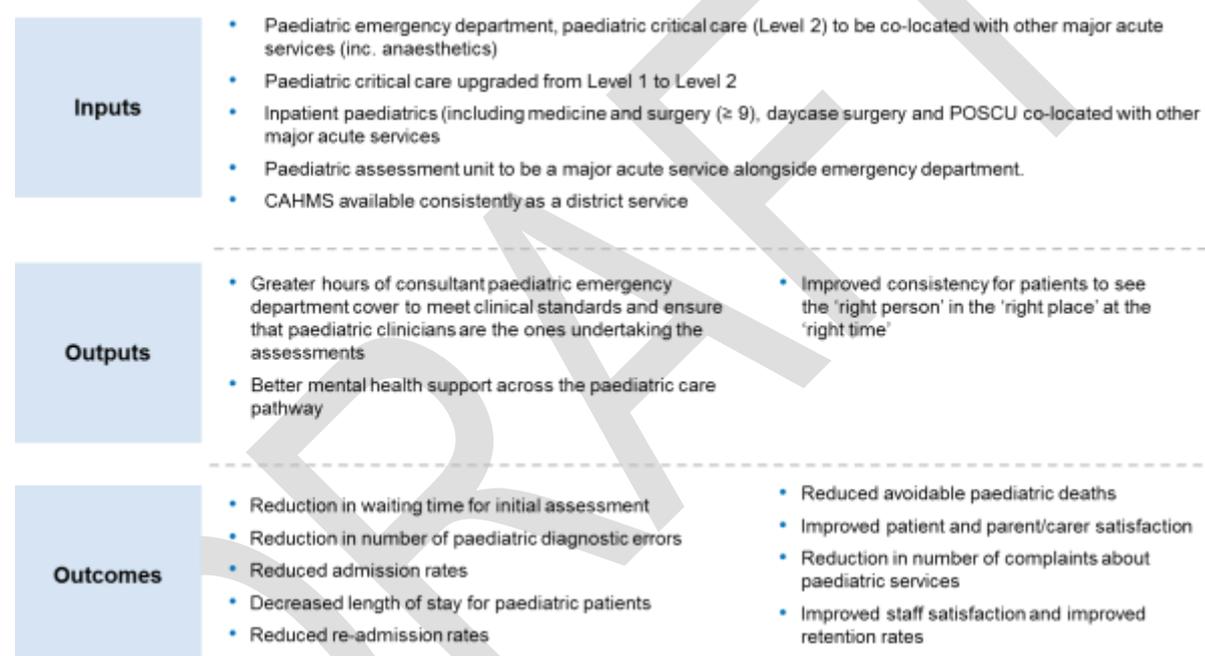
2.4.3 Potential impact on patients

The proposed changes within the emerging clinical model are expected to have a positive impact on the care offered to patients. This includes:

- More hours of consultant paediatric emergency department cover to meet clinical standards and ensure that paediatric clinicians undertake assessments
- By upgrading paediatric critical care from Level 1 to Level 2, this is expected to maintain the high skill level within the workforce
- Paediatric observation and ambulatory treatment at UTCs will allow patients to be appropriately assessed and treated closer to home and transferred if necessary.
- Novel models of outpatient consultations including one-stop shops and virtual clinics increases patient choice and allows deployment of more flexible workforce models

2.4.4 Benefits framework

Figure 19: The completed benefits framework for the Paediatrics pathway



2.5 Maternity

2.5.1 The 'as is' pathway

The maternity 'as is' pathway has been mapped based on extensive discussions with representatives from ESTH, primary care and other community health and care stakeholders through the CAG, subgroup meetings and clinical workshops. The pathway is not intended to show every service that is currently offered, but those pertinent to the changes recommended in the emerging clinical model.

2.5.2 The 'to be' pathway

There are a number of key developments of the maternity 'to be' pathway within the provisional clinical model, aiming to meet the latest clinical standards and evidence based best practice for maternity care.⁹⁴ This includes:

- Low risk antenatal and postnatal clinics are offered as district services with improved consistency of carer, personalised care and multi-professional working across boundaries.
- Mental health access is featured across the entire care pathway.
- Obstetrician led births, high risk antenatal services and alongside midwife led birthing unit co-located with other major acute services.
- Neonatal care to be closely aligned with paediatric pathway.
- Drive to work towards comprehensive, patient records integrated across all relevant care settings.

⁹⁴ Clinical Quality Standards for acute services provided in South West London or operated by a South West London Trust (2017), <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>; National Maternity Review: "Better Births, Improving outcomes of maternity services in England" (2016), <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>; Royal College of Obstetricians and Gynaecologists: Reconfiguration of women's services in the UK (2013), <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-15/>; National Institute of Clinical Excellence: Antenatal Care (2016), <https://www.nice.org.uk/guidance/CG62>; National Institute of Clinical Excellence: Intrapartum Care for healthy women and babies (2017), <https://www.nice.org.uk/guidance/cg190>; National Institute of Clinical Excellence: Postnatal Care (2015), <https://www.nice.org.uk/guidance/qs37>; Royal College of Obstetricians and Gynaecologists Standards for maternity care: report of a working party (2008), <https://www.rcog.org.uk/globalassets/documents/guidelines/wprmaternitystandards2008.pdf>; Department of Health: Midwifery 2020 Delivering expectations (2010), <https://www.gov.uk/government/publications/midwifery-2020-delivering-expectations>; British Association of Perinatal Medicine: Standards for providing neonatal care (2010), <https://www.bapm.org/resources/service-standards-hospitals-providing-neonatal-care-3rd-edition-2010>

Figure 20: The 'as is' pathway for maternity

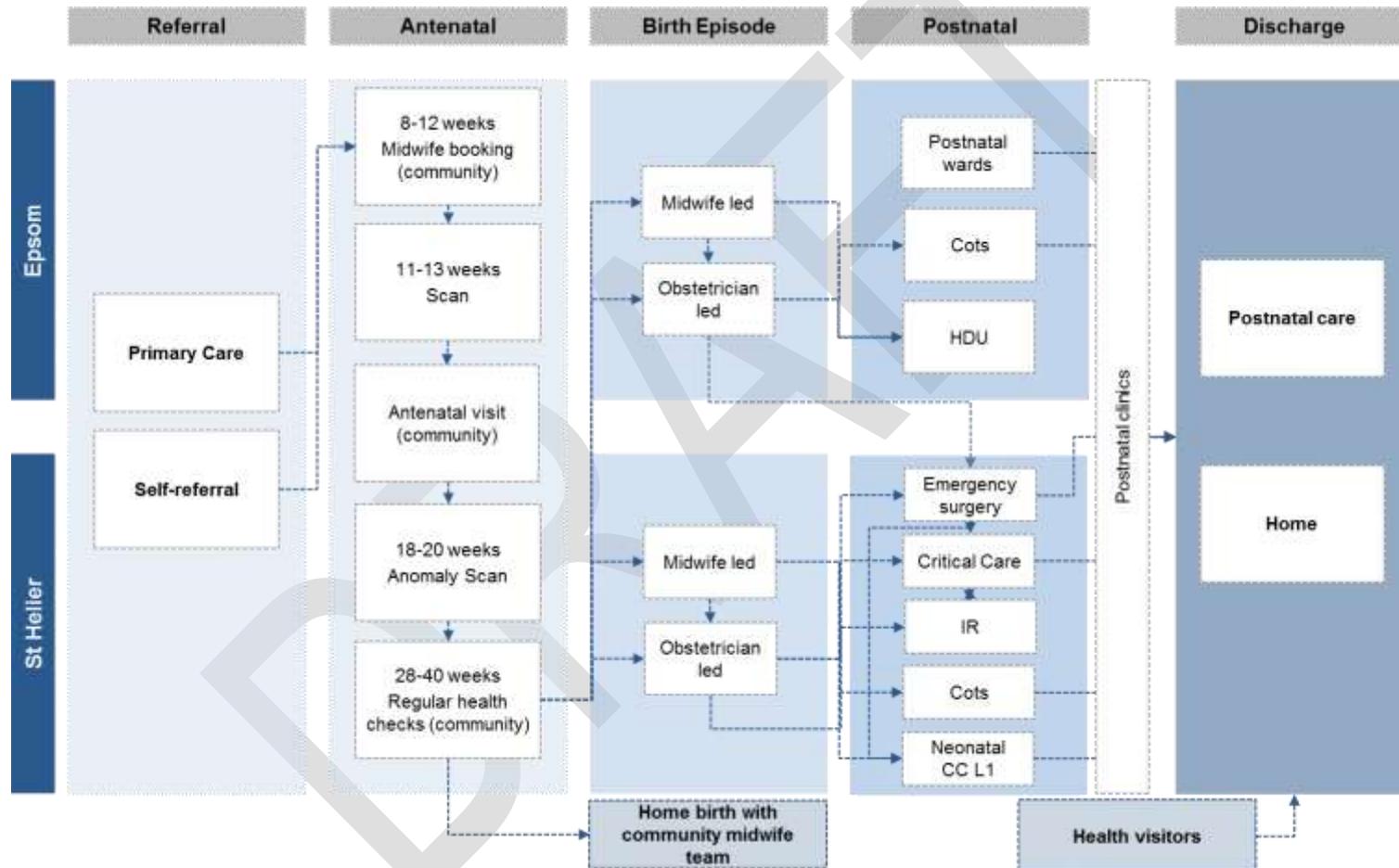
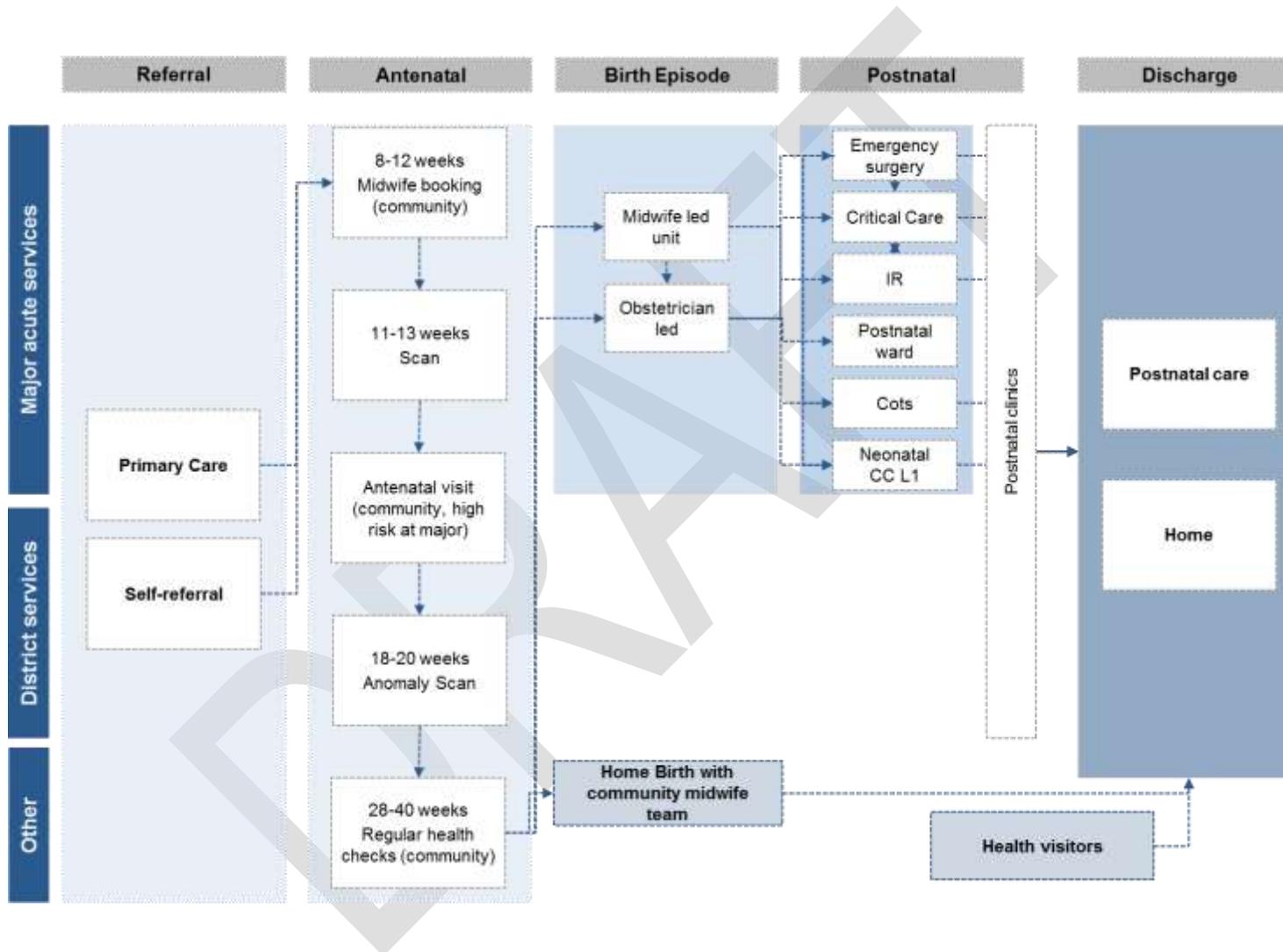


Figure 21: The ‘to be’ pathway for maternity in the emerging clinical model



2.5.3 Births

For women planning to give birth there are three options available for their delivery:

- Women can give birth **at home** with support from a midwife.
- **Midwife-led deliveries** can be provided from two types of unit: freestanding units and alongside units. Alongside midwife led units are co-located on the same site as an obstetric unit (see below) whereas freestanding units are not.
- **Obstetric units** have obstetricians delivering babies. This is a major acute service and so should be co-located with other services including emergency surgery for women, critical care and interventional radiology (see Section 2.1).

The National Maternity Review⁹⁵ stressed the importance of women being able to make an informed choice about where they would prefer to give birth. The review states that women need to be supported to make decisions on whether they would like to give birth at **home**, in a **midwife unit** or in an **obstetric unit** after a full discussion of the benefits and risks of each setting.

The national maternity review does not specify the type of midwifery unit that must be available to women in order to fulfil the standard of improved choice.

For **home births**, we recognise that more needs to be done within our combined geographies to enable women to give birth at home if this is their preferred option. There is an established a home birth team, with a view to increasing the uptake of home births from current levels. This will involve having open discussions with women about their options for birth and providing educational material on the maternity journey so that they are able to make an informed decision.

For midwife-led deliveries, we have considered whether this service needs to co-located with obstetric units or whether the service should be freestanding.

2.5.3.1 Delivery units and different types of midwife-led unit

For low-risk⁹⁶ women, national evidence has captured the outcomes for women giving birth in different types of unit. These are described in Figure 22 and Figure 23 below for women giving birth to their first child and for those giving birth to a subsequent child.

⁹⁵ National Maternity Review, *Better Births* (2016), <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

⁹⁶ Factors that can increase the risk of complications during birth include being over 35, being overweight or obese, bleeding after 24 weeks of gestation, and having a high blood pressure. National Institute of Clinical Excellence (2014) <https://www.nice.org.uk/news/article/midwife-led-units-safest-for-straightforward-births>

Figure 22: Low-risk nulliparous (first child) women (c. 45%)⁹⁷

Rate/1,000 births	Home birth	Stand-alone MLU	Along-side MLU	Obs-led unit
Spontaneous vaginal birth	794	813	765	688
Interventions ²¹	80–165	69–165	76–216	121–242
Transfer to obs-led unit	450	363	402	10
Babies without serious medical problems	991	995	995	995

Figure 23: Low-risk multiparous (second or subsequent child) women (c. 55%)⁹⁸

Rate/1,000 births	Home birth	Stand-alone MLU	Along-side MLU	Obs-led unit
Spontaneous vaginal birth	984	980	967	927
Interventions ⁹⁹	7–15	8–23	10–35	35–56
Transfer to obs-led unit	115	94	125	10
Babies without serious medical problems	997	997	998	997

The National Institute of Clinical Excellence (NICE) recommends that for the 45% of women who have a low risk of developing complications during their pregnancy, midwife-led care is the appropriate choice.¹⁰⁰

The data above suggest that there is little difference in outcomes for babies between the two types of maternity unit, however both types of unit have a relatively high transfer rate to obstetrician led units (transfers undertaken when unexpected complications encountered).

⁹⁷ Birthplace Cohort Study (2011), <https://www.npeu.ox.ac.uk/birthplace> ; Blix et al. (2012):

<https://www.sciencedirect.com/science/article/pii/S1877575612000481>

⁹⁸ Birthplace Cohort Study (2011), <https://www.npeu.ox.ac.uk/birthplace> ; Blix et al. (2012):

<https://www.sciencedirect.com/science/article/pii/S1877575612000481>

⁹⁹ Interventions include instrumental vaginal birth, caesarean section and/or episiotomy. NICE (2014),

<https://www.nice.org.uk/news/article/midwife-led-units-safest-for-straightforward-births>; Birthplace (2011), Birthplace Cohort Study (2011),

<https://www.npeu.ox.ac.uk/birthplace>

¹⁰⁰ NICE Guidance CG190: Intrapartum care for healthy women and babies (2014) <https://www.nice.org.uk/guidance/cg190>

For alongside midwife led units, these transfers are typically smooth, based on the proximity of alongside units to the obstetric units. However for freestanding units, ambulance-based transfers may be required and this can be a distressing experience for patients.

Additionally, at freestanding midwife led units, there is not the ability to administer epidural pain relief should women choose that this is something they would like during labour.¹⁰¹

2.5.3.2 Volume and staffing for midwife-led units

Currently, approximately 15–20% of births at ESTH are midwife led.¹⁰² While this volume is relatively low, in an alongside midwife led unit, the staffing rota is shared between the midwife led unit and the obstetric unit which are co-located on the same site. However, for freestanding units dedicated midwives are required for the effective staffing of the unit.

2.5.3.3 Midwife-led deliveries in emerging clinical model

We have considered the type of midwife led unit to be included in the provisional clinical model through our CAG, maternity subgroup and amongst the wider clinical community through our clinical workshops. We have considered a number of factors, including:

- Transfer rates from midwife-led births can be c. 21%¹⁰³ due to complications with the mother and/or the baby. These mothers and/or babies would then require an obstetrician, a neonatal doctor and/or other major acute services (e.g., emergency surgery, emergency gynaecology). Co-locating midwife-led units with obstetrician-led units ensure that these services are on the same site and long inter-hospital transfers are avoided.
- Currently, midwife-led births comprise c. 15–20%¹⁰⁴ of all hospital births and are delivered via alongside midwife-led units. Having units co-located with obstetrician-led units enables effective use of midwives, who can operate across both units; separating these births is unlikely to offer a viable scale.
- In the local area, we have a significant number of midwife-led units available, including at Kingston, St Peter's, St George's, Croydon, West Middlesex, Royal Surrey County, and Chelsea and Westminster hospitals.

Based on these considerations, our emerging thinking is that it is more appropriate in our local area to maintain midwife-led units alongside obstetrician-led units.

2.5.4 Potential impact on patients

The proposed changes within the emerging clinical model are expected to have a positive impact on the care offered to patients:

- Obstetric led births is co-located with emergency surgery and critical care for all births in case these services are required.
- High risk antenatal care is co-located with other major acute support services.
- Low risk antenatal care is offered as a district hospital service and offered close to home.
- Postnatal care delivered as a district hospital service and offered closer to home.
- Enhanced personalisation and integration improves the quality and of care across the pathway.
- Classifying mental health services as district hospital services allows enhanced access and improves quality for mothers with mental health needs.
- Support for and alignment with local plans to improve maternity services across the area.
- Continued provision of a separate neonatal rota, ensuring dedicated staff are available.

¹⁰¹ NHS Choices (2018), www.nhs.uk/conditions/pregnancy-and-baby/where-can-i-give-birth

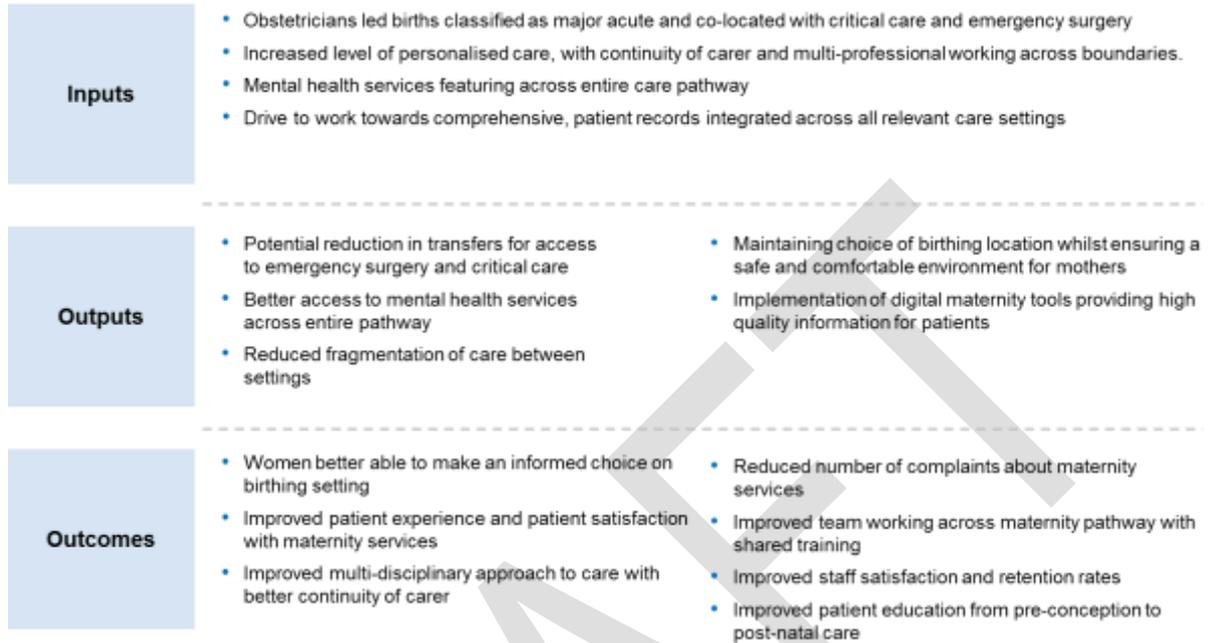
¹⁰² ESTH

¹⁰³ Birthplace Cohort Study (2011) <https://www.npeu.ox.ac.uk/birthplace>

¹⁰⁴ ESTH

2.5.5 Benefits framework

Figure 24: The completed benefits framework for the maternity pathway



2.6 Planned care

2.6.1 The ‘as is’ pathway

The planned care ‘as is’ pathway has been mapped based on extensive discussions with representatives from ESTH, primary care and other community health and care stakeholders through the CAG, subgroup meetings and clinical workshops. The pathway is not intended to show every service that is currently offered, but those pertinent to the changes recommended in the emerging clinical model.

2.6.2 The ‘to be’ pathway

There are a number of key developments of the planned care ‘to be’ pathway within the provisional clinical model. These aim to meet the latest clinical standards and evidence based best practice for planned care.¹⁰⁵ The developments include:

- Outpatients would continue to be developed with a desire to provide one-stop clinics (where all the necessary investigations and consultations can be completed in one location) and offering virtual/tele triage and follow-ups for all appropriate patients.
- Renal dialysis, endoscopy and chemotherapy would be provided as district hospital services and offered as close to home as possible
- The majority of elective surgery (i.e, daycase surgery) would be provided as a district hospital service.
- Elective inpatient surgery would require co-location with a PACU or HDU.

¹⁰⁵ Includes: Royal College of Anaesthetists (2018) Guidance on the provision of obstetric anaesthesia services, <https://www.rcoa.ac.uk/node/20150> ; Royal College of Obstetricians and Gynaecologists (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, <https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf>; RCD standards for children’s surgery; Recovery, Rehabilitation and Reablement programme for early supported discharge and rehabilitation in the community; Department of Health (2013) Integrated care and support: our shared commitment, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf; RCOS (2006); The Royal College of Surgeons of England, Separating emergency and elective surgical care: Recommendations for practice, <https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/emergency--elective.pdf>; The Association of Anaesthetists in GB & Ireland and The British Association of Daycase surgery (2011): Daycase and Short stay surgery, <https://www.aagbi.org/sites/default/files/Day%20Case%20for%20web.pdf>; Department of Health (2000): The NHS Plan. A plan for investment. A plan for reform, http://webarchive.nationalarchives.gov.uk+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960

Figure 25: The 'as is' pathway for planned care

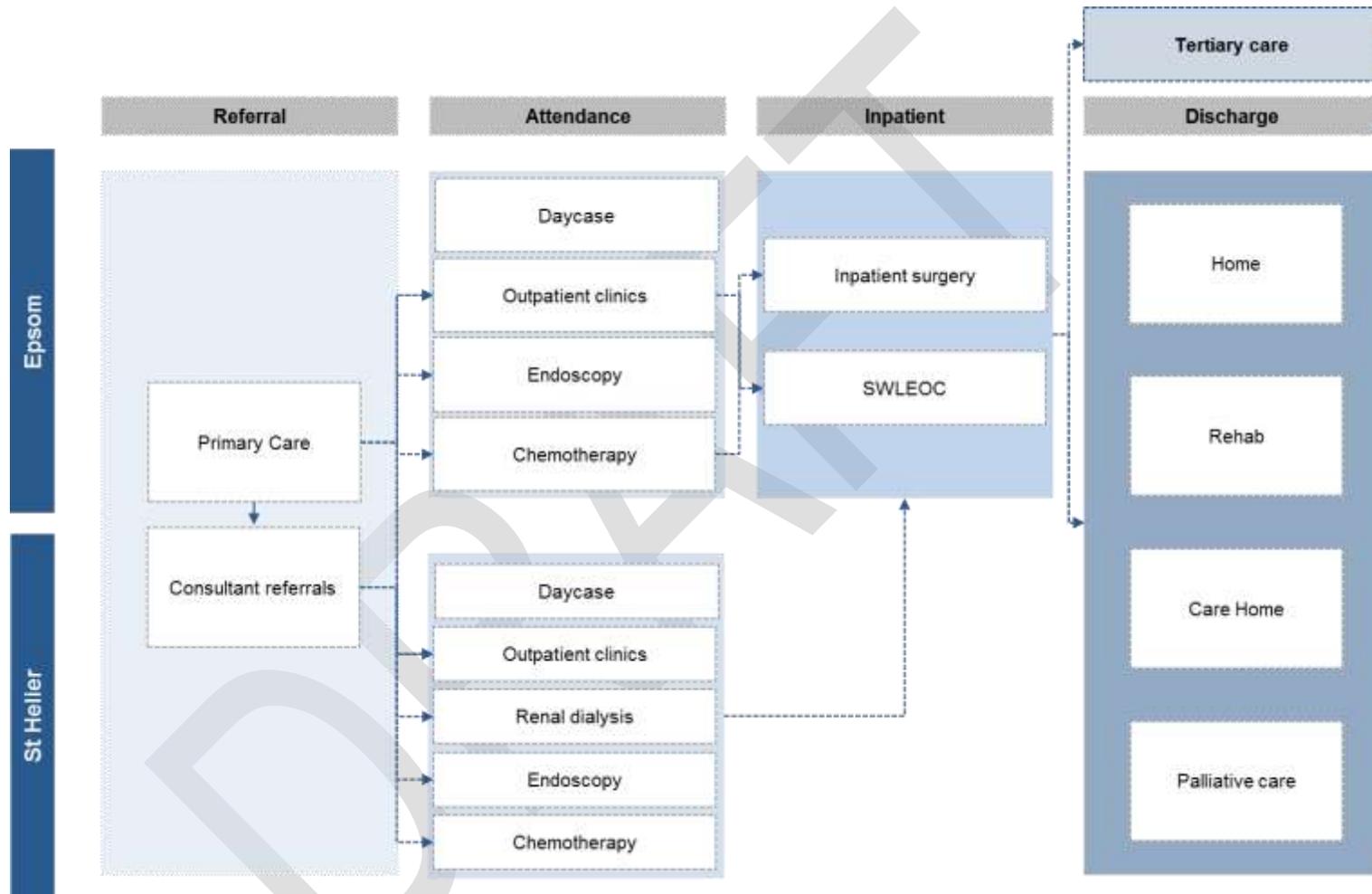
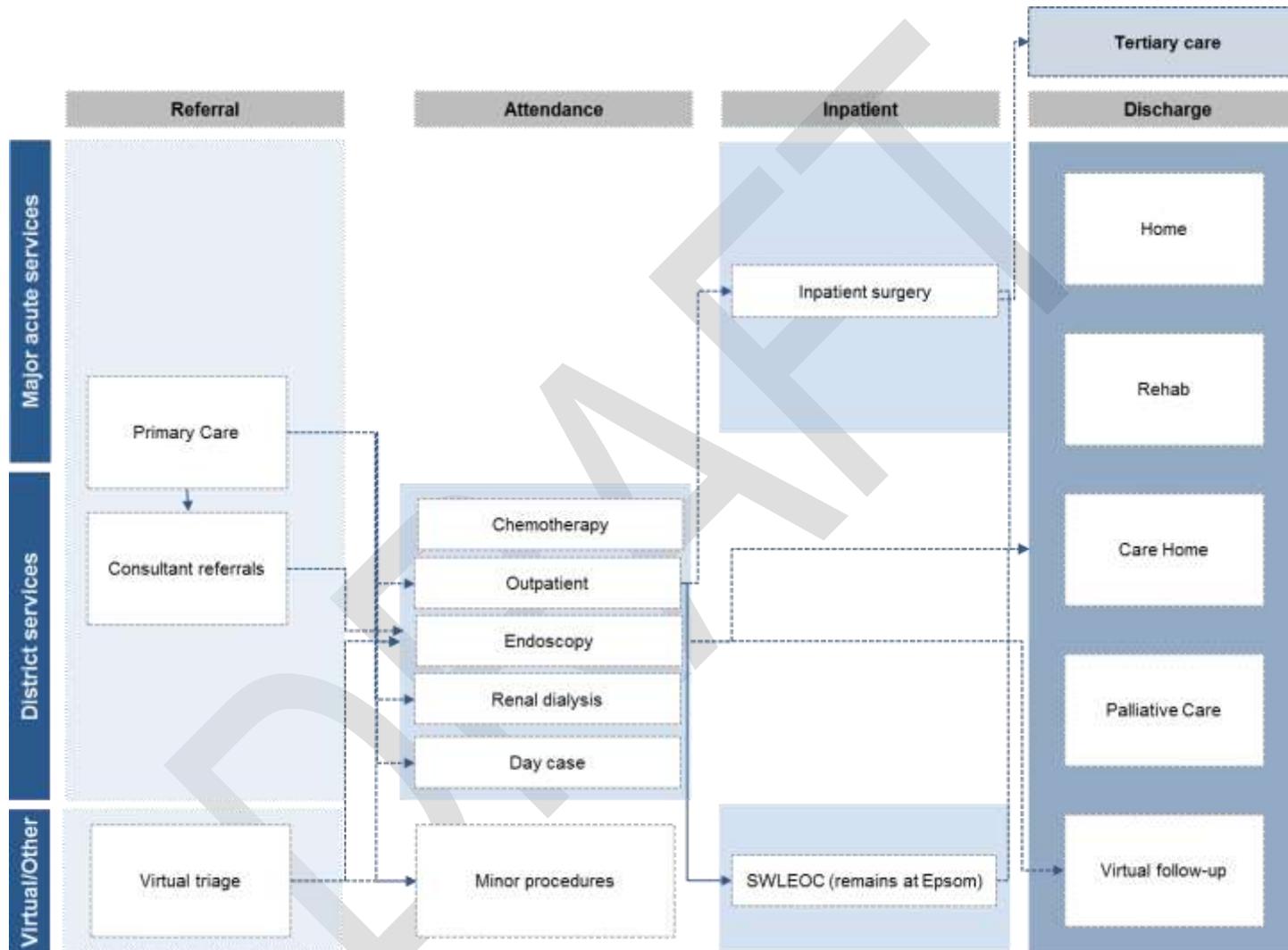


Figure 26: The 'to be' pathway for planned care within the emerging clinical model



2.6.2.1 Elective surgery

Most elective surgery at ESTH is performed as a daycase (in 2017 66% of all elective surgery was daycase).¹⁰⁶ This type of surgery does not require the support of higher intensity care units and therefore can be delivered as a district hospital service, closer to patients' homes where possible.

However, the more complex elective surgery (surgery that requires an inpatient bed) has a co-dependency with a PACU or HDU. Of the 12,328 inpatient elective surgical cases performed in our combined geographies in 2017, 584 (4.7%) required a high dependency unit during their stay.¹⁰⁷ As a result, this type of surgery is being classified as a major acute service.

Inpatient elective surgery therefore will need to be co-located with an existing post-anaesthesia care or high dependency unit (e.g., a major acute critical care unit or an existing dedicated post-anaesthesia care or high dependency unit).

Any changes to SWLEOC are out of scope as this is a standalone unit that will continue to deliver elective orthopaedic surgery.

2.6.3 Potential impact on patients

The proposed changes within the provisional clinical model are expected to have a positive impact on the care offered to patients, including:

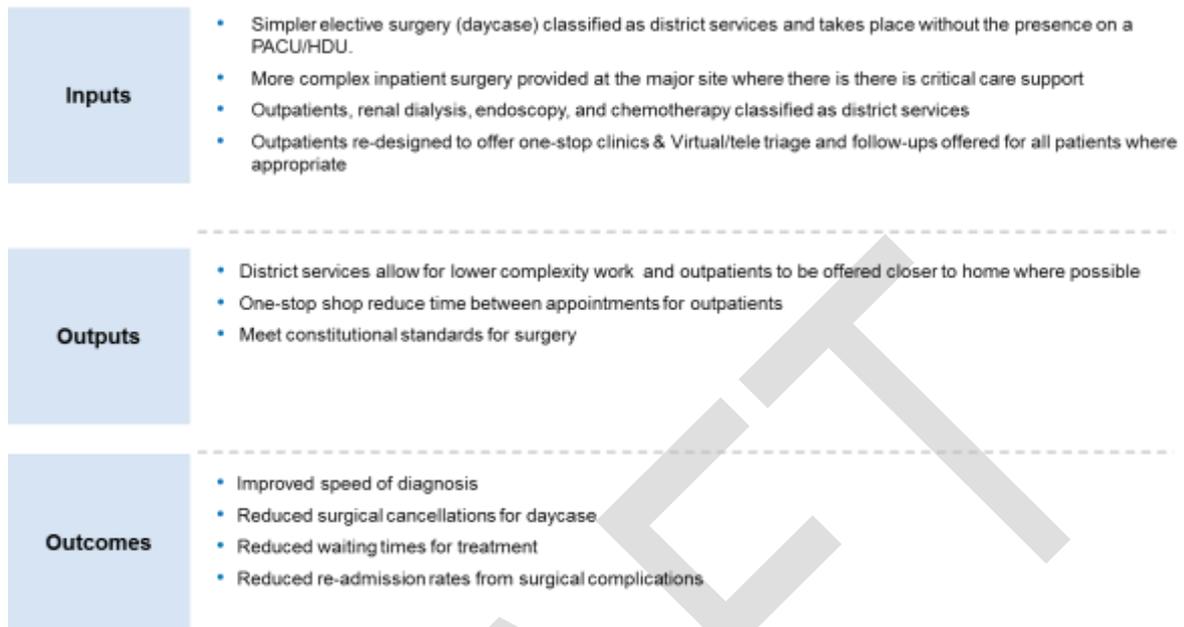
- Maintaining co-dependencies to ensure a safe service.
- Offering dedicated district services for planned care, maintaining access and offering care close to home.
- Novel models of outpatient consultations including one-stop shops and virtual clinics increases patient choice and allows deployment of more flexible workforce models.
- In addition, outpatient one-stop shops reduce the need for patients to travel multiple times, improve utilisation of resources, increase throughput and reduce cancellations, and can improve speed of diagnosis.
- Maintaining the highly effective SWLEOC model.

¹⁰⁶ ESTH

¹⁰⁷ ESTH

2.6.4 Benefits framework

Figure 27: The completed benefits framework for the planned care pathway



2.7 Conclusion

An emerging clinical model has been developed following input from a Clinical Advisory Group, subgroups, and from a wider group of local clinicians and stakeholders at two workshops. This clinical model has been designed to align with our local plans and objectives, particularly around integrated care, however has a specific focus on hospital services – an area where we currently have challenges.

As a result, the emerging clinical model has categorised services into major acute services (services for the highest risk and sickest patients who rely on the presence of critical care and/or services that critical care relies on) and district services (services that do not rely on the presence of critical care and that should be strongly integrated with community health and care).

Within major acute services, we have created two clusters of services based on the interdependencies between amongst services: **major emergency department (adults)** and **women and children’s services**. Major emergency department (adults) services must be co-located to maintain a viable major emergency department; women’s and children’s services are closely linked and have been considered together here.

We have concluded that due to the close links between the two categories of services that these services should be co-located within our emerging clinical model.

The emerging clinical model additionally outlines our plans to develop our district hospital services. The model describes our current position on a number of important areas including **urgent treatment centres, district hospital beds, midwife led units** and **elective surgery**. This includes the development of urgent treatment centres to meet national guidance and the needs of the local population; district hospital beds to provide more appropriate care closer to home for patients who don’t require major acute services; continuing offer a choice of birth settings and maintaining midwife-led delivery units alongside obstetric-led units; and delivering elective surgery that does not require post-anaesthetic care or a high dependency unit as a district service. Other services – including district services, which comprise the majority of healthcare – would continue to develop as per current plans.

We believe that this emerging clinical model could benefit the quality of our services and the experience offered to patients.

We have developed a benefits framework to assess the potential impact of any changes and our emerging thinking is that these developments will ensure a high quality and safe service for our populations.

This clinical model will now form the basis of our planning of potential solutions for our combined geographies. **The public will be asked to give their input on the emerging clinical model** and it will be further refined by the subgroups. It will additionally be tested more widely both formally with the London and South East Clinical Senates and informally with Royal colleges, regulators, the SWL Clinical Senate and the Surrey Clinical Academy.

3 DEVELOPMENT OF POTENTIAL SOLUTIONS

3.1 Our approach

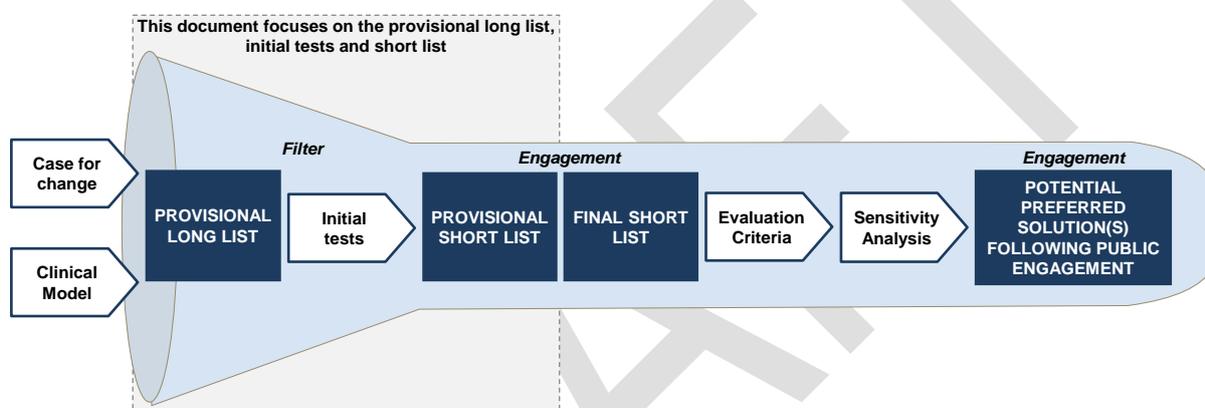
3.1.1 Approach to solutions development

We have adopted a standard approach to identifying a long list of potential solutions and refining this through a small set of initial tests.

To understand how we can address the issues identified in our case for change and deliver our clinical model, we are undertaking a process of considering a wide range of potential solutions and then refining them in a structured and consistent way. This is summarised in Figure 28.

Throughout, this process is tested with the public through engagement and consultation.

Figure 28: Approach to solutions development and refinement



The approach has seven main stages:

- Based on our case for change and clinical model, a provisional long list is generated of all potential solutions.
- This is refined through a small set of initial tests to reach a provisional short list of potentially feasible solutions.
- This process is tested with the public before a final short list is agreed.
- This short list is then analysed in detail and evaluated against set criteria. The sensitivity of this analysis is also tested to ensure conclusions are robust.
- Again, this process is tested with the public.
- Following this evaluation, a potential preferred solution can be identified.
- This recommendation, and supporting evidence, is then published as part of a pre-consultation business case.

3.1.2 Process to reach a provisional short list

We are at the beginning of this process.

We have developed a case for change and a clinical model. This document seeks to define the long list of potential solutions and apply a series of initial tests to reach a provisional short list.

We have discussed this process with the public and will continue this conversation through our planned engagement process.

Wherever possible, we have been informed by engagement with the public about potential solutions. This includes learning from the broad engagement exercise undertaken by ESTH in July to October

2017. It was clear from this feedback that maintaining services locally where possible is important but there is also an understanding that some services may need to change to address challenges we are facing. Feedback from the public also indicated there are different views about what these changes need to be, which led us to explore the widest range of potential solutions as part of our long list.¹⁰⁸

Our process has been further shaped and refined by broad discussions with local stakeholders, including our governing bodies and local clinicians. This has included:

- Discussions with our Clinical Advisory Group about the ways in which we can address our case for change and deliver our clinical model, including the long list, initial tests and provisional shortlist.
- Discussions with our local partners (including ESTH and regulators) through our Programme Board about the process we have undertaken and the long list, initial tests and provisional shortlist.
- Discussions with other local providers about the potential solutions we should consider within our long list.
- Discussions with each of our governing bodies about the process we have undertaken and the long list, initial tests and provisional shortlist.

These discussions will continue through our planned engagement with the public before a short list is considered further.

¹⁰⁸ *Epsom and St Helier 2020 - 2030 Your views* (2017) <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93ijim4n8161.pdf&ver=19815>

3.2 Our requirements

Any potential solutions must align with both the case for change and the clinical model.

We are focused on addressing specific issues and opportunities within our combined geographies. This includes addressing our case for change and delivering our clinical model.

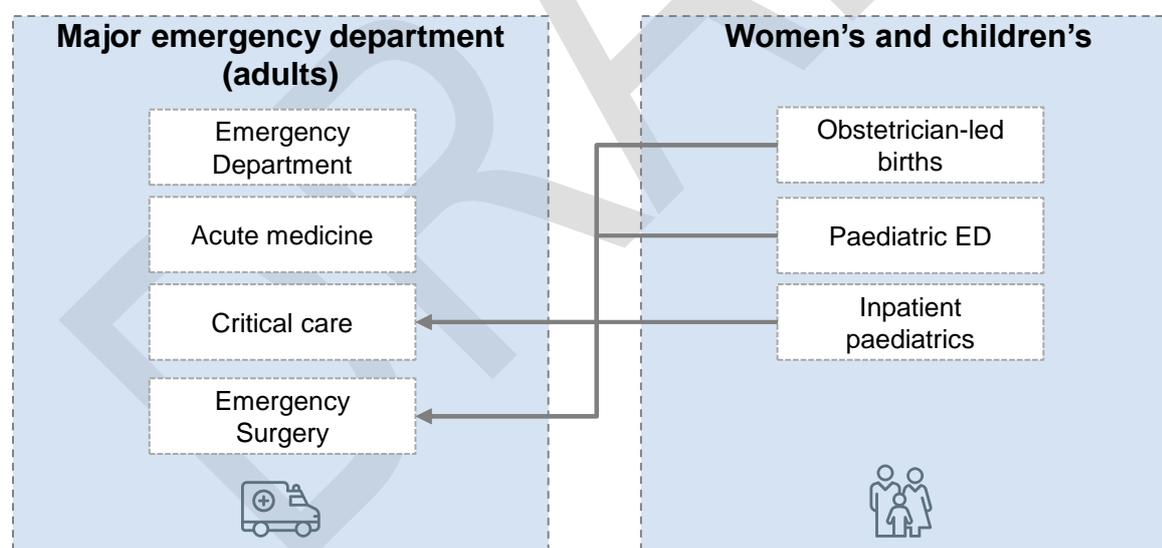
Our clinical model (see Section 2) identifies that there is a difference between district hospital services and major acute hospital services.

- Within the clinical model, **the provision of district hospital services on existing sites will continue**. These services comprise the majority of healthcare provided on our hospital sites and they will continue to be provided at their current location(s) in the future. Our potential solutions development does not consider changing the location of district hospital services.
- Major acute services are services for the sickest patients or those at greatest risk of becoming sick. They include the most critical emergency care, planned care, paediatrics and maternity services.

As described in the clinical model, major acute services are linked by critical co-dependencies, which are defined in our clinical model. As a result, services can be categorised into two linked clusters of:

- **Major emergency department (adults):** These services must be co-located to offer a major emergency department.
- **Women’s and children’s services:** These two services are linked by neonatology and shared rotas. Moreover, obstetrician-led births and paediatrics must be co-located with critical care and emergency surgery. This means any service with obstetrician-led births and/or paediatrics requires a major emergency department.

Figure 29: Selected major acute hospital service dependencies



3.2.1 Focus of potential solutions development

Our potential solutions development focuses on ways this clinical model can be delivered.

Our case for change (see Section 1) is clear that clinically, our issue is with supporting emergency department and acute medicine services. Due to the co-dependencies described above, this means all major acute services need consideration.

However, there is no need to consider major service changes to district hospital services, which do not have co-dependencies with emergency department, acute medicine and/or associated services. We may need to consider investments in estates to support ongoing delivery of these services, but

this does not require major service change. Therefore, potential solutions development does not consider changing the location of district hospital services.

Therefore, to develop our potential solutions, two assumptions have been made:

- **Service co-dependencies must be maintained.** This therefore leads to the two key categories of services that could be considered around major acute hospital services, as described above.
- **Potential solutions focus on major acute services where there is a case for change.** District services will continue to be provided to our populations in an increasingly integrated way from our hospital sites. These services comprise the majority of healthcare provided in our hospitals.

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3.3 Identifying potential solutions

3.3.1 Identifying potential solutions

To identify the different potential solutions that could address our case for change and deliver our clinical model, we have considered four ways that services can be organised. This is intended to capture as many potential solutions as possible to create a long list that can be considered further.

We have considered:

- The **number of major acute hospitals** in our combined geographies.
- The **services offered** by these major acute hospitals.
- Ways that **additional workforce** from outside the area can support services.
- The sites that can be used to deliver major acute services.

At this stage, we are focused on the widest range of potential solutions. The feasibility and appropriateness of these potential solutions is considered at later stages, through both our initial tests (see Section 3.4.2) and subsequent analysis of a shorter list of potential solutions.

3.3.2 Number of major acute hospitals

Potential solutions could include up to two major acute hospitals.

To deliver major acute hospitals, potential solutions could:

- Have no major acute hospitals in the combined geographies and use nearby providers to deliver major acute services. Though this is not our intention (see Section 3.4), we have included this in our long list for completeness.
- Have a single major acute hospital in the combined geographies delivering major acute services.
- Have two major acute hospitals in the combined geographies, both delivering major acute services.

We have limited our consideration to up to two major acute hospitals as increasing the total number of acute sites in our combined geographies is highly unlikely to be deliverable given the current challenges of two major acute hospitals.

3.3.3 Services offered by major acute hospitals

These major acute hospitals could provide adult emergency department services only or adult emergency department services and women's and children's services.

The co-dependencies defined in our clinical model (see Section 2.2.1.1) suggest models of major acute service configuration:

- Adult emergency department services only, as there is no dependency on other major acute services for this group.
- Adult emergency department and women's and children's services together, as women's and children's services require emergency surgery, critical care and anaesthesia.

Either of these service options is available for each major acute hospital defined in Section 3.3.2. If any services are not provided within the combined geographies they would be provided by nearby providers. That is, if site(s) offered only adult emergency department services, women's and children's services would need to be provided out of area; if no sites offer major acute services, all major acute services would be provided out of area.

3.3.4 Use of additional workforce

Potential solutions could seek to utilise additional workforce from outside the combined geographies.

In securing the consultants needed for acute rotas – and in particular consultants in emergency department and acute medicine, where our case for change identified issues – we have identified two options:

- Consultants employed within the combined geographies only are used, meaning we rely on the expected workforce within the combined geographies. This can include the existing acute workforce, newly trained staff and new recruits.
- Consultants from outside the combined geographies are used by networking acute rotas with nearby providers to ensure sufficient cover. This would mean consultants from outside the area working at major acute hospitals within our combined geographies.

3.3.5 Major acute hospital sites

Existing or new sites could be used to provide major acute hospitals.

There are current three sites in our combined geographies that host acute hospital services: Epsom, St Helier and Sutton Hospital.

Epsom Hospital and St Helier Hospital are general hospitals, each providing a 24/7 consultant-led emergency departments, acute and general medicine, maternity, children's services and outpatients. In addition, Epsom Hospital hosts SWLEOC and St Helier Hospital provides renal services and emergency surgery.

Sutton Hospital – adjacent to The Royal Marsden NHS Foundation Trust's (RMH) Sutton site – is mainly vacant and only provides a few services for outpatients. ESTH has sold most of its land at the site to Sutton Council, as it was not being used for clinical services.

Sutton Council and the Institute of Cancer Research plan to use the Sutton site for the London Cancer Hub, which would be a major centre for cancer research and biotechnology that could generate c. 13,000 jobs. This plan is supported by ESTH, RMH and the Greater London Authority.¹⁰⁹ One of the planning scenarios for the London Cancer Hub includes space for a major hospital at Sutton. This potential hospital site is described as 'Sutton Hospital' in this document.

Therefore, to deliver any configuration of major acute hospital services, we have four options for sites:

- Utilise the existing Epsom Hospital site.
- Utilise the existing St Helier Hospital site.
- Utilise the existing Sutton Hospital site.
- Purchase a new site within the combined geographies.

Any potential solution that has more than one major acute hospital within our combined geographies would need more than one site. Any potential solution that does not have a major acute hospital within our combined geographies would not need a site (these are described in Section 3.3.2.).

3.3.6 Potential solutions

The four ways that services can be organised (dimensions) are summarised in Figure 30.

¹⁰⁹ *London Cancer Hub* <https://www.londoncancerhub.org/>; *The London Cancer Hub* <https://www.opportunitysutton.org/sutton-for-investment/the-london-cancer-hub/>

Figure 30: Solution dimensions

	Question	Elements of potential solutions
Number of major acute hospitals in the geographies	How many major acute hospitals are provided in the combined geographies?	<ul style="list-style-type: none"> • 0 • 1 • 2
Services offered by major acute hospitals	Which major acute service clusters do these hospitals provide?	<ul style="list-style-type: none"> • Major adult emergency department • Major adult emergency department + women's and children's
Using additional workforce	Is workforce from outside the area used to supplement rotas?	<ul style="list-style-type: none"> • No • Yes
Site(s) used	Which sites could be used to deliver major acute services?	<ul style="list-style-type: none"> • St Helier • Epsom • Sutton • Another site in the combined geographies

The possible combinations of these four dimensions results in a long list of 73 potential solutions; this long list is detailed in the Appendix (Section 5.1.1).

These dimensions can be combined in any way. This generates our long list, which is every combination of the different responses to each dimension.

This creates 73 potential solutions. As this includes any combination of the dimensions, it is a comprehensive list based on the aspects we have considered.

As we cannot analyse in detail this long list of 73 potential solutions, and many of these potential solutions will not be feasible, we need to apply our initial tests to identify potential solutions that merit further detailed consideration.

3.4 Initial tests for potential solutions

To refine our potential solutions, we need to apply initial tests to reach a manageable list.

From our long list, we need to identify the potential solutions that merit further consideration. Some will be clearly unfeasible on the basis of an initial analysis – ruling these out allows us to focus on potential solutions that are more likely to be feasible.

For this reason, we have developed three initial tests for the long list.

3.4.1 Principles for initial tests

Initial tests should provide a consistent framework through which potential solutions are refined.

To ensure that initial tests support our aims for health and care locally and effectively reduce the potential solutions to an appropriate short list, we have based them on five principles.

Initial tests must:

- Align to the case for change.
- Reduce the potential solutions to a manageable number.
- Have a clear pass/fail answer.
- Be evidence-based.
- Be clear and understandable.

This ensures we have an effective set of tests that support our local aims and meaningfully help us focus on the potential solutions that are most likely to be viable. More detailed analysis can then be completed on the potential solutions that pass our tests.

Any test that does not meet these principles has not been included.

3.4.2 Three initial tests

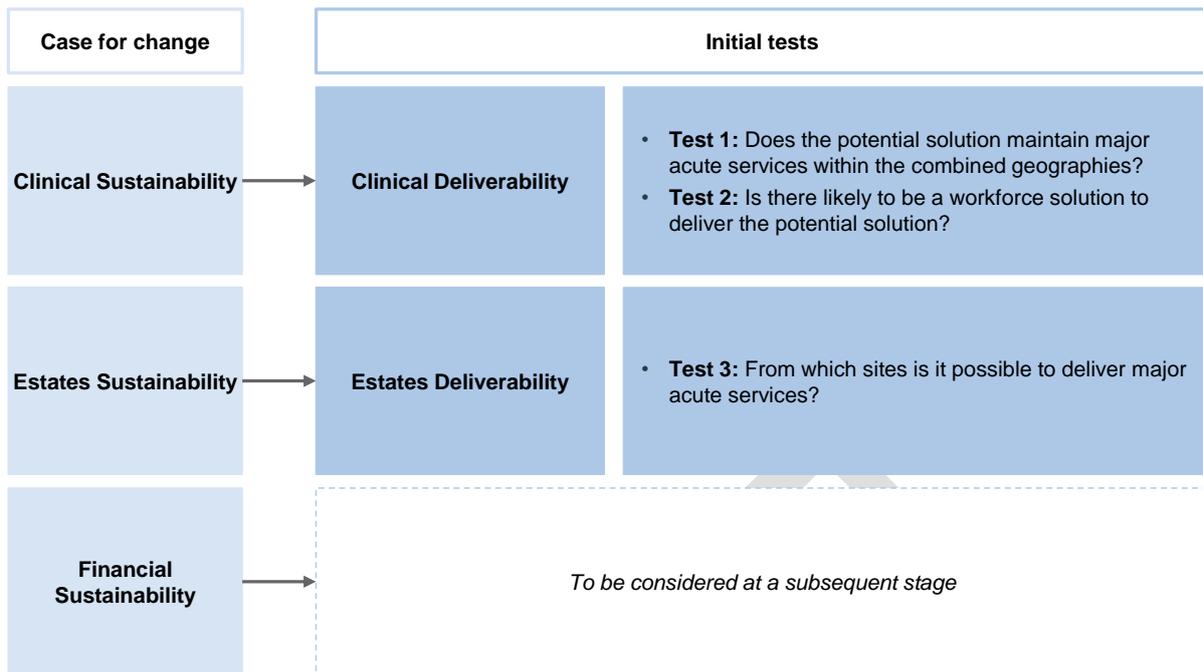
We have identified three initial tests that align to the case for change and focus on ensuring potential solutions are feasible.

Based on clinical and estates deliverability, we have identified three initial tests:

1. Does the potential solution maintain major acute services within the combined geographies?
2. Is there likely to be a workforce solution to deliver the potential solution?
3. From which sites is it possible to deliver major acute services?

Alignment with the case for change is described in Figure 31. We have not at this stage included any initial tests of financial sustainability (including affordability and impact on the overall system financial position). This would be considered at a subsequent stage of the analysis.

Figure 31: Initial tests

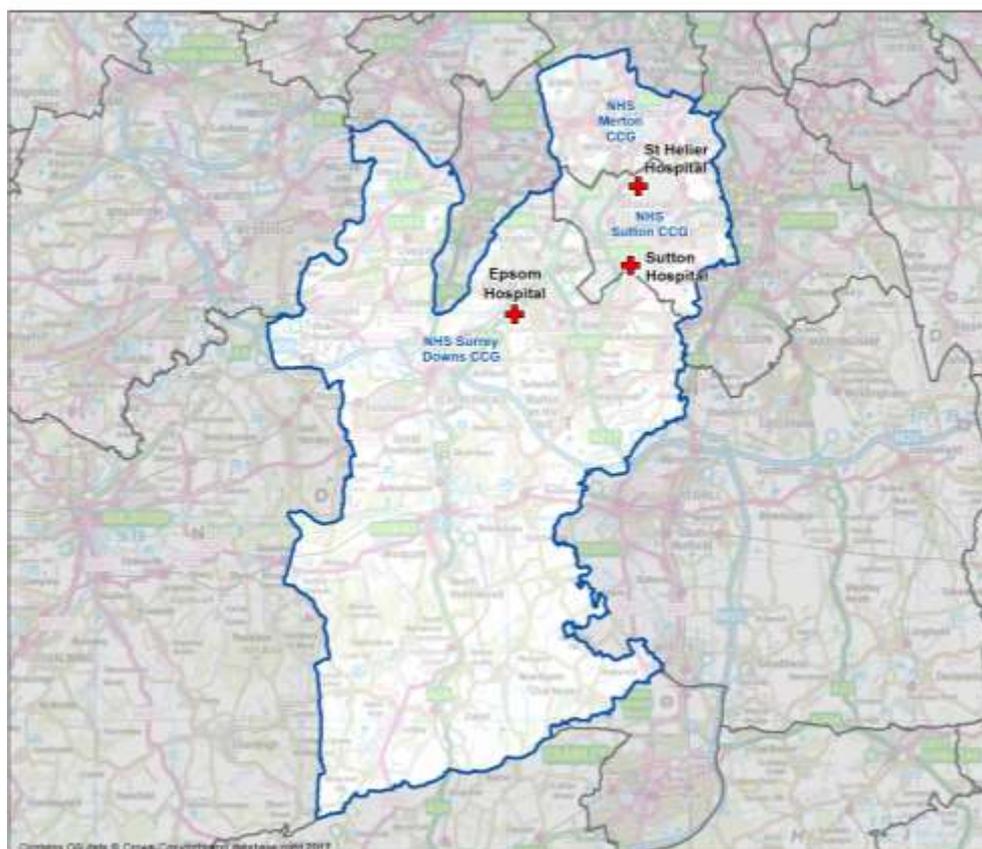


These initial tests may be revisited if no shortlisted potential solutions are viable.

3.4.2.1 Test 1: Does the potential solution maintain major acute services within the combined geographies?

We have committed to maintain major acute services in the combined geographies. This is based on our understanding of local needs.

We have each, as commissioners of services for our local populations, publicly committed to continuing to deliver major acute services from within our combined geographies (see Figure 32). This commitment is reiterated in our case for change, where we commit to maintaining the provision of acute services within our combined geographies.

Figure 32: Combined geographies of Surrey Downs, Sutton and Merton ¹¹⁰

We understand that maintaining services in our local areas is important. This has highlighted through previous engagement with the public, including the work ESTH completed exploring scenarios for its future development. This engagement suggested that the population expect local services as long as standards are met.¹¹¹

Any shortlisted potential solution must therefore deliver all major acute services within our combined geographies. These could be configured in any way, but the services must be provided within the combined boundaries of Surrey Downs, Sutton and Merton.

As with all our initial tests, this may be revisited if there is no viable potential solution within our combined geographies.

3.4.2.2 Test 2: Is there likely to be a workforce solution to deliver the potential solution?

We must have sufficient workforce to deliver any potential solution.

Any potential solution must have a safe level of staffing and be able to meet the standards we have set for relevant services. This is important to ensure our local people have consistent access to high quality care with sufficient hours of consultant presence.

We know there are critical shortages in workforce across our combined geographies. This was articulated in the case for change; in particular, ESTH has a shortage of 25 consultants against the standards we have set in emergency department, acute medicine and intensive care. Additionally there are shortages in middle grade doctors and nursing staff.

¹¹⁰ Improving Healthcare Together 2020-2030 analysis.

¹¹¹ Epsom and St Helier 2020 - 2030 Your views (2017) <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93ijim4n8161.pdf&ver=19815>

This gap in consultant staffing is based on the standards set by SWL STP.¹¹² However, the gap identified in the emergency department aligns with national expectations. The most recent Care Quality Commission inspection of ESTH identified a need for consultant staffing to meet RCEM guidance for consultant cover 16/7.¹¹³ RCEM recommends 12–16 consultants to provide cover 16/7.¹¹⁴ The SWL standards described here require a minimum of 12 to provide cover 16/7.

There must therefore be sufficient workforce for any shortlisted potential solution. This will be focused on areas where we have clear expectations of the number of staff required – in particular, the number of consultants required to meet our clinical standards (see Table 3).¹¹⁵ This is central to our expectations for major acute services due to the clear benefits of consultant-delivered care; for this reason, we have kept this expectation consistent and would not consider in detail potential solutions that do not meet our standards.

This analysis is preliminary. Full workforce modelling would follow as potential solutions are analysed in more detail.

¹¹² *Clinical quality standards for acute services provided in South West London or operated by a South West London Trust* (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>. Summary by Improving Healthcare Together 2020-2030.

¹¹³ *Epsom and St Helier University Hospitals NHS Trust: Quality report* (2018) http://www.cqc.org.uk/sites/default/files/new_reports/AAAH0093.pdf

¹¹⁴ *Emergency Medicine Consultants: Workforce Recommendations* (2010) <https://www.rcem.ac.uk/docs/Workforce/CEM5324-Emergency-Medicine-Consultants---CEM-Workforce-Recommendations-Apr-2010.pdf>; "Rules of Thumb" for Medical and Practitioner Staffing in Emergency Departments (2015) <https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf>

¹¹⁵ *Clinical quality standards for acute services provided in South West London or operated by a South West London Trust* (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>

Table 6: Consultant hours of cover and headcount to meet standards¹¹⁶

Service	Hours of cover	Heads (per site)
Emergency department¹¹⁷		
Minimum requirement to meet the standards	16/7	12
Requirement to meet the standards and provide sustainable working patterns if activity is high (>100,000 attendances p.a.)	16/7	12–16
Requirement for a major trauma centre	24/7	24
Obstetrics		
RCOG category A (<3,000 births p.a.)	14/7	10
RCOG category B (3,000–4,000 births p.a.)	14/7	12
RCOG category C1 (4,000–5,000 births p.a.)	14/7	14
RCOG category C2 (>5,000 births p.a.)	14/7	16
Specialist Centre	14/7	21
Emergency general surgery		
Requirement to meet the standards	14/7	10
Paediatrics¹¹⁸		
Minimum requirement to meet the standards at a non-tertiary centre	14/7	12
Requirement to meet the standards and manage large volumes at a non-tertiary centre (>2.5k emergency admissions p.a.)	14/7	16
Requirement for a specialist centre (to cover acute general paediatrics only)	14/7	10 ¹¹⁹
Acute medicine¹²⁰		
Requirement to meet the standards	14/7	12
Intensive care¹²¹		
Requirement to meet the standards	12/7	9

3.4.2.3 Test 3: From which sites is it possible to deliver major acute services?

The site(s) for any potential solution must be feasible for the delivery of relevant services.

Any potential solution will require a site of sufficient size to accommodate the relevant services and this site must be available for healthcare purposes.

At this stage, this will be a preliminary assessment. Detailed space and site planning would follow as potential solutions are analysed in more detail.

The site(s) must therefore be available and feasible for the delivery of major acute hospital(s).

¹¹⁶ *Clinical quality standards for acute services provided in South West London or operated by a South West London Trust* (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>. Summary by Improving Healthcare Together 2020-2030.

¹¹⁷ Emergency department requirement expressed in WTE.

¹¹⁸ Minimum hours also require on call.

¹¹⁹ Separate specialist paediatrics rota.

¹²⁰ Minimum hours also require on call.

¹²¹ Minimum hours also require on call.

3.5 Applying initial tests

To reach a provisional shortlist, we have applied our three tests.

The tests have been applied sequentially – that is, potential solutions that fail a previous test are ruled out of consideration for subsequent tests.

3.5.1 Test 1: Does the potential solution maintain major acute services within the combined geographies?

A number of potential solutions include delivering some or all services outside the combined geographies.

Potential solutions that would move services out of the combined geographies include those that:

- Have no major acute sites within the combined geographies: Potential solutions that have no major acute sites in the combined geographies and do not provide adult emergency department, women's and children's services in the combined geographies.
- Have no women's and children's services at major acute sites within the combined geographies: Potential solutions that provide adult emergency department services only from major acute site(s) and have no women's and children's services in the combined geographies .

In these potential solutions, services would move to other providers nearby, which could include:

- Ashford and St. Peter's Hospitals NHS Foundation Trust
- Croydon Health Services NHS Trust
- Kingston Hospital NHS Foundation Trust
- Royal Surrey County Hospital NHS Foundation Trust
- St George's University Hospitals NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust

None of these providers are within our combined geographies.

As these potential solutions move services outside the combined geographies, they fail our first test.

Each of these potential solutions means that some or all major acute services (i.e., adult emergency department and/or women's and children's services) are not provided within our combined geographies. This does not meet our requirement of this first test; these potential solutions are therefore ruled out.

This reduces our list to 50 potential solutions (described in Appendix Section 5.1.2).

3.5.2 Test 2: Is there likely to be a workforce solution to deliver the potential solution?

We need to consider whether there are ways different potential solutions could be delivered with the workforce available or that is expected to be available.

As described in the case for change, there are not currently enough consultants within our combined geographies to meet standards for emergency department, acute medicine and intensive care at both Epsom Hospital and St Helier Hospital.

This is based on our standards. However, the expectation of c. 12 emergency department consultants per unit also aligns with national guidance from the RCEM.¹²²

¹²² RCEM recommends a minimum of 10 consultants per emergency department to provide cover 14/7 and 12–16 consultants to provide cover 16/7. Additional consultants are recommended for larger units and major trauma centres. *Emergency Medicine Consultants: Workforce Recommendations* (2010) <https://www.rcem.ac.uk/docs/Workforce/CEM5324-Emergency-Medicine-Consultants---CEM-Workforce-Recommendations-Apr-2010.pdf>; "Rules of Thumb" for Medical and Practitioner Staffing in Emergency Departments (2015)

In addition, we have shortages of acute middle grade doctors, junior doctors and nurses across our combined geographies.

Table 7: ESTH consultant headcount against standards¹²³

Service	Total requirement (two sites)	Current consultant staffing	Gap (two sites)
Emergency department ¹²⁴	24	14	10
Obstetrics	22	26	-
Emergency general surgery	10	10	-
Paediatrics	24	26	-
Acute medicine	24	11	13
Intensive care	9	7	2

The feasibility of certain potential solutions (particularly those with multiple emergency department rotas and acute medicine rotas) relies on whether additional workforce is available to supplement the workforce available.

There are three ways this could be achieved:

- Training new consultants.
- Recruiting additional consultants from out of the local area.
- Utilising consultants from other nearby trusts by networking services across the providers, allowing rotas to be shared.

3.5.2.1 Training new consultants

It does not appear that sufficient new consultants will be trained to address the gaps in workforce.

As described in the case for change, we previously in SWL considered the likely availability of new consultants to 2021 for the specialties covered by standards, based on estimates from Health Education England. This was compared with the forecast gap in each specialty to 2021.¹²⁵

Expected availability of new consultants is to cover all new posts; some will need to cover retirements and consultants moving away.

This is summarised in Table 8. It suggests that there will not be sufficient consultants trained by 2021 to close the gaps within SWL. We will still have shortages in emergency department and acute medicine to address.

Therefore, we do not expect significant numbers of newly trained consultants to be available to support the local workforce.

<https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf>

¹²³ *Clinical quality standards for acute services provided in South West London or operated by a South West London Trust. Current position and gap analysis (2017)* <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>. Summary by Improving Healthcare Together 2020-2030.

¹²⁴ Emergency department requirement expressed in WTE.

¹²⁵ *Case for Change: Merton, Sutton and Surrey Downs CCGs 2018; Clinical quality standards for acute services provided in South West London or operated by a South West London Trust. Current position and gap analysis (2017)* <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>

Table 8: SWL projected gaps to standards and expected availability of new consultants¹²⁶

Service	Projected SWL gap	Total availability of new consultants in SWL to cover all new posts
Emergency department ¹²⁷	21–29	18–21
Obstetrics	2	11
Emergency general surgery	2	7
Paediatrics	3–7	12–16
Acute medicine	23	29
Intensive care	7	13

3.5.2.2 Recruiting additional consultants from out of the local area

An alternative source of additional consultants would be recruiting from out of the area. However, local, regional and national evidence suggests this will be challenging.

There are national shortages in emergency department and acute medicine.

As described in the case for change, nationally, regulators and workforce planning bodies have identified significant workforce gaps in emergency department consultant staffing.

In 2016, providers identified a national need for an additional 300 WTE consultants (a 15% increase).¹²⁸

In 2017, Health Education England (HEE), NHSE, NHSI and RCEM collectively identified that a combination of demand pressures and increasing standards have created significant pressures on emergency department staffing. This leads to high locum spend, attrition rates and early retirement. The four bodies therefore identified that “we need more clinical staff” across all grades and have established a priority plan to help close this gap, primarily through new roles and multidisciplinary teams, reduced attrition and improved retention.¹²⁹

Subsequently in 2017, the draft HEE ten-year workforce strategy identified emergency department and acute medicine as two priority staffing areas. In March 2016, emergency department and acute medicine have the highest vacancy rates of all specialties (15.6% and 13.9% respectively compared to an average of 9.6%) and were identified as priority improvements areas in the Five Year Forward View in 2014. To help meet demand in both areas, HEE proposed to recruit 300 medical and 100 emergency trainees a year to help fill junior doctor and middle grade gaps and support alternative roles.¹³⁰

¹²⁶ *Clinical quality standards for acute services provided in South West London or operated by a South West London Trust: Current position and gap analysis* (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>. Summary by Improving Healthcare Together 2020-2030.

¹²⁷ Emergency department requirement expressed in WTE.

¹²⁸ *Securing the future workforce for emergency departments in England* (2017) https://improvement.nhs.uk/documents/1826/Emergency_department_workforce_plan_-_111017_Final.3.pdf

¹²⁹ *Securing the future workforce for emergency departments in England* (2017) https://improvement.nhs.uk/documents/1826/Emergency_department_workforce_plan_-_111017_Final.3.pdf

¹³⁰ *Facing the Facts, Shaping the Future* (2017) <https://hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%2C%20Shaping%20the%20Future%20%E2%80%93%20a%20draft%20health%20and%20care%20workforce%20strategy%20for%20England%20to%202027.pdf>

Regionally, Health Education England have identified significant vacancies in emergency departments, suggesting challenges recruiting to posts.

The NHS collects data on some vacancies across multiple specialties. While this does not specify consultant vacancies, it suggests that the regional labour market is similar to the national and that there are challenges recruiting to posts in emergency departments. Between October 2016 and September 2017, there were 535 medical and dental vacancies in emergency departments across South London, Kent, Surrey and Sussex (9.4% of all vacancies in the regions) – an average of over 10 a week.¹³¹

Table 9: Medical and dental vacancies (medical and dental pay scales only), WTE, selected specialties, October 2016–September 2017¹³²

Specialty	Kent, Surrey and Sussex	South London	TOTAL
Emergency department	341	194	535
Acute internal medicine	18	34	52
Acute medicine	80	55	135
Obstetrics and gynaecology	109	104	213
General surgery	167	56	223
Paediatrics ¹³³	146	152	299
Intensive care	33	31	64
Critical care	23	16	39
Other specialties (not listed)	2,104	2,020	4,123
TOTAL (all specialties)	3,021	2,662	5,682

This suggests that recruiting to existing posts is challenging; recruiting to additional posts is therefore unlikely to be feasible.

ESTH has undertaken significant recruitment efforts to address its shortages.

In recent years, ESTH has been attempting to close its gaps in consultant staffing through focused recruitment efforts and attempts to change the roles and skill mix needed, drawing on local best practice. Vacancies are reviewed in each division, with individual plans in place to address vacancies and regular reviews of temporary and agency spend. Departments review all vacancies on a weekly basis.

Specific efforts have included:

- **National media campaign:** In 2017/18, ESTH ran a national media campaign for consultant vacancies across the medicine specialties and emergency department. This was timed to coincide with key exam dates to allow access to the widest pool of candidates.
- **Rolling advertisements and recruitment agencies:** Rolling advertisements are in place for key vacancies across medicine and surgery and for difficult to fill roles, ESTH engaged executive search agencies and permanent recruitment agencies.

¹³¹ NHS Vacancy Statistics England, February 2015 - September 2017 <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/nhs-vacancy-statistics-england-february-2015-september-2017-provisional-experimental-statistics>

¹³² NHS Vacancy Statistics England, February 2015 - September 2017 <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/nhs-vacancy-statistics-england-february-2015-september-2017-provisional-experimental-statistics>

¹³³ Excluding –ologies and surgery.

- **Maximising trainees:** ESTH are working with the Royal colleges to maximise opportunities to utilise the medical training initiative trainee posts in all divisions and is expanding on the number of clinical observers taken on as a possible route to increasing its junior doctor fill.
- **Exploring overseas partnerships:** ESTH is establishing formal relationships with overseas organisations to introduce rotational posts.
- **Improving the attractiveness of roles:** The composition of roles has been reviewed to improve their attraction, for example by offering acute medicine posts with a special interest in another medicine specialty.
- **Using new roles:** ESTH is exploring using physician associate and advance nurse practitioner roles to substitute hard to fill CT1/ST1 roles.

Despite this, ESTH still faces consultant shortages in key areas.

In combination, local efforts, regional vacancies and national shortages all suggest that recruiting to the posts is unlikely to offer a significant increase in consultant numbers. Additionally, there are shortages in middle grade doctors and nursing staff.

3.5.2.3 Utilising consultants from other nearby trusts by networking services

Available evidence suggests that other providers do not have consultants available who could contribute to rotas.

Utilising consultants from other nearby trusts by networking services requires that rotas (e.g., emergency department or acute medicine) are shared across multiple sites and another provider either contributes to local rotas (which are still operated by a local provider) or runs the rotas across multiple sites.

In either scenario, the trust contributing consultants needs to be able to release consultants from its existing rotas while continuing to deliver a safe service that meets standards.

For the specialties where we lack consultants locally, existing analysis of consultant staffing in SWL suggests that all providers have either sufficient consultants for their rotas or have shortages they also need to fill (see Table 5):

- All other SWL providers have small gaps in acute medicine; none has a surplus of consultants.
- Only St George's Hospital has more consultants than are required in the emergency department, but this is a slight difference of c. 3 WTE. All other SWL providers have small gaps.

A comparable gap analysis of future consultant workforce has not been undertaken for CCGs outside SWL. In the absence of additional information, it is unlikely their position will be materially different to the rest of the country.

Based on this available evidence, and the scale of the gap we need to close within our combined geographies, other providers are not likely to have excess workforce to supplement local rotas.

3.5.2.4 Workforce for potential solutions

Based on the available evidence, any potential solution relying on workforce from outside the combined geographies is not feasible and fails our second test.

On this basis, it does not appear that additional consultants are available at other nearby providers to supplement local rotas. Therefore, we can only consider potential solutions that utilise existing local workforce

Based on the available evidence, any potential solution with more than one major acute hospital site is not feasible due to the availability of workforce and fails our second test.

As additional consultants are not available, any potential solution will need to meet our standards with 14 emergency department consultants and 11 acute medicine consultants.

Based on our standards, and relevant RCEM guidance, this would support only a single rota in each specialty; more than this would require more consultants than are available, particularly for the emergency department.

One rota in these specialties means we can only support a single adult emergency department (based on critical co-dependencies).

To maintain services in the combined geographies (as per Test 1), and to maintain critical co-dependencies, women's and children's services would also need to be provided on the same site.

This reduces our list to four potential solutions (described in Appendix Section 5.1.3).

Table 10: Consultant workforce requirement for two sites and one site

Service	Current consultant staffing	Total requirement (two sites)	Total requirement (one site)[*]	Gap (one site)
Emergency department^[1]	14	24	12-16	None
Obstetrics	26	22	12-16	None
Emergency general surgery	10	10	10	None
Paediatrics	26	24	12-16	None
Acute medicine	11	24	12	1
Intensive care	7	9	9	2

[*] emergency department, obstetrics and paediatrics volume dependent

^[1] Emergency department requirement expressed in WTE.

Table 11: Consultant staffing against clinical standards, SWL trusts¹³⁴

Consultants	Acute trust	Emergency department	Obstetrics	Emergency general surgery	Paediatrics	Acute medicine ¹³⁵	Intensive care
Current staffing	St George's	27	19	9	9	9	24
	Kingston	10	16	9	14	9	8
	Croydon	10	12	10	12	8	8
	ESTH	14	26	10	26	11	7
	SWL	61	73	38	61	37	47
Requirement to meet standards	St George's	24	21	10	10	12	27
	Kingston	12–16	16	10	16	12	9
	Croydon	12–16	12	10	12–16	12	9
	ESTH ¹³⁶	24	22	10	24	24	9
	SWL	72–80	71	40	62–66	60	54
Current gap (2017)¹³⁷	St George's	<i>No gap</i>	2	1	1	3	3
	Kingston	2–6	<i>No gap</i>	1	2	3	1
	Croydon	2–6	<i>No gap</i>	<i>No gap</i>	0–4	4	1
	ESTH	10	<i>No gap</i>	<i>No gap</i>	<i>No gap</i>	13	2
	SWL	14–22	2	2	3–7	23	7
Projected SWL gap (2021)		21–29	11	7	12–16	29	13
Total availability of new consultants in SWL to cover all new posts (2021)		18–21	41–44	15–16	30–31 ¹³⁸	9	9

¹³⁴ Clinical quality standards for acute services provided in South West London or operated by a South West London Trust: Current position and gap analysis (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>

¹³⁵ Dedicated acute care physicians only.

¹³⁶ ESTH requirement for two sites.

¹³⁷ Gaps calculated on a site-by-site basis.

¹³⁸ General paediatric consultants only.

3.5.3 Test 3: From which sites is it possible to deliver major acute services?

It is unlikely there is another site within the combined geographies.

Locating the major acute hospital on another site (i.e., not one of the three existing sites described in Section 3.3.5) in the combined geographies would require locating a suitable site and building of a new hospital.

We have completed an initial search of potential sites in the area, which has indicated that there is no viable new site within the area of our combined geographies that would meet our requirements.

In addition, buying new land when existing sites are available does not support the strategic intent of the Naylor Review, which requires NHS land is used as effectively as possible.¹³⁹

This suggests existing sites would need to be used for any potential solution.

This reduces our list to three potential solutions (described in Appendix Section 5.1.4).

3.5.4 Provisional short list

We have a provisional short list of four potential solutions.

Following application of the three tests, three potential solutions appear to pass all the tests and may be feasible. These are potential solutions delivering all major acute services from a single site, which can be one of Epsom, St Helier or Sutton (district hospital services will continue to be delivered from St Helier and Epsom Hospitals).

In addition, HM Treasury guidance requires that any provisional list must include a ‘do minimum’ counterfactual as an additional potential solution for comparative purposes.¹⁴⁰ Therefore, we have included this as a fourth potential solution.

As a result, our provisional short list is:

- **The ‘do minimum’:** Continuing to provide current acute services at Epsom Hospital and St Helier Hospital.
- **A single major acute site at Epsom Hospital,** providing all major acute services (adult emergency department and women’s and children’s services) with continued provision of district hospital services at Epsom and St Helier Hospitals.
- **A single major acute site at St Helier Hospital,** providing all major acute services (adult emergency department and women’s and children’s services) with continued provision of district hospital services at Epsom and St Helier Hospitals.
- **A single major acute site at Sutton Hospital,** providing all major acute services (adult emergency department and women’s and children’s services) with continued provision of district hospital services at Epsom and St Helier Hospitals.

This list is provisional and may be revised if additional evidence changes either the long list or the initial assessment against the three tests.

As described in Section 2, district services would continue to be provided from their current locations.

¹³⁹ *NHS property and estates: Naylor review* (2017) <https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review>

¹⁴⁰ *The Green Book: Central government guidance on appraisal and evaluation* (2018)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/685903/The_Green_Book.pdf

4 NEXT STEPS

The case for change makes clear that we need to consider our plans for the future and explore the ways that the issues we face can be addressed. We are clear that any potential solutions must address the three main issues of clinical quality, estates and financial sustainability, while supporting our broader plans for the system. This should only consider those areas where there is a clear case for change: that is, major acute services at ESTH hospitals.

To do this we will continue to explore:

- How the clinical model can change to address our challenge of clinical quality and ensure that care is integrated and standards for major acute services are met.
 - Further refinement of the clinical model will be undertaken by the subgroups, as well as some informal testing with the Royal colleges, regulators, SWL Clinical Senate and Surrey Clinical Academy.
 - The clinical model will be more formally tested through a joint review by the London and South East Clinical Senates.
- The potential solutions that deliver this clinical model to our populations while addressing our challenges of workforce, estates and financial sustainability.
 - The implications of these potential solutions on patients, the public and the health and social care system (including commissioners and providers).
 - Testing whether the process we have undertaken is appropriate, including the initial tests we have applied.
 - Requesting additional evidence to support our development of a long list or the application of our three tests.

This will include understanding the number of beds in our combined geographies currently and how many might be needed in the future to meet our aims. Based on our initial work in developing the provisional clinical model and potential solutions, we do not expect the total number of beds in our combined geographies to change significantly. More work is needed to explore this further.

The public will be involved throughout the process. As a first step, we are publishing an *Issues Paper as a starting point for engagement and discussion with the public*. It summarises the key challenges faced by the local health community – and in particular by ESTH – and explains why change is necessary. Specifically, it summarises the case for change, the provisional clinical model and the process of engagement.¹⁴¹

Following engagement, we will then be able to commence further analysis of the provisional shortlist of potential solutions as part of a PCBC, considering the full implications of any changes, including clinical benefits, travel times and access, patient volume and flows, workforce impacts, impacts on other providers and financial impacts (including revenue and capital). Alongside this, we will complete specific analyses of deprivation and the impact of any changes on equalities.

The PCBC will be considered by the three CCGs who will ultimately make any decisions, in line with the regulatory framework. No decisions have been made at this point, and before we make any decisions, there will be full public consultation and the decisions will take account of the feedback received from the public.

¹⁴¹ *Issues Paper: Merton, Sutton and Surrey Downs CCGs (2018)*

5 APPENDIX

5.1 Lists of potential solutions

The following tables show the potential solutions at each stage of our provisional short listing.

- Table 13 shows the long list of potential solutions resulting from our dimensions (see Section 3.3).
- Table 14, Table 15, and Table 16 show the impact of the application of our initial tests, as described in Section 3.4.

For all tables, the same referencing numbers are used – ineligible potential solutions are shown with a strike out. Struck-out potential solutions with a grey background have been eliminated by previous initial tests; those with a white background have been eliminated by the relevant test.

For multi-site potential solutions, services can either be the same on each site or different, depending on the service configuration(s) applied. If different, sites are demarcated by (A) and (B).

Throughout, the ‘do minimum’ counterfactual – which we must consider – is not explicitly included here but is added to any resulting short list.

As described in Section 3.2, district hospital services would continue to be provided from their current locations.

Table 12: Example potential solutions list

#	Number of sites	Service(s)	...
1	#	EXAMPLE	<i>Potential solution still in consideration</i>
2	#	EXAMPLE	<i>Potential solution eliminated by current initial test</i>
3	#	EXAMPLE	<i>Potential solution eliminated by previous initial test</i>

5.1.1 Long list of potential solutions

Table 13: Long list of potential solutions

#	Number of sites	Service(s)	Workforce sharing	Site(s)
1	0	N/A	N/A	N/A
2	1	ED	Yes	St Helier
3	1	ED	Yes	Epsom
4	1	ED	Yes	Sutton
5	1	ED	Yes	Other site
6	1	ED + women's and children's	Yes	St Helier
7	1	ED + women's and children's	Yes	Epsom
8	1	ED + women's and children's	Yes	Sutton
9	1	ED + women's and children's	Yes	Other site
10	1	ED	No	St Helier
11	1	ED	No	Epsom
12	1	ED	No	Sutton
13	1	ED	No	Other site
14	1	ED + women's and children's	No	St Helier
15	1	ED + women's and children's	No	Epsom
16	1	ED + women's and children's	No	Sutton
17	1	ED + women's and children's	No	Other site
18	2	ED	Yes	St Helier & Epsom
19	2	ED	Yes	St Helier & Sutton
20	2	ED	Yes	St Helier & Other site
21	2	ED	Yes	Epsom & Sutton
22	2	ED	Yes	Epsom & Other site
23	2	ED	Yes	Sutton & Other site
24	2	ED	Yes	Other site & Other site
25	2	ED + women's and children's (both)	Yes	St Helier & Epsom
26	2	ED + women's and children's (both)	Yes	St Helier & Sutton
27	2	ED + women's and children's (both)	Yes	St Helier & Other site
28	2	ED + women's and children's (both)	Yes	Epsom & Sutton
29	2	ED + women's and children's (both)	Yes	Epsom & Other site
30	2	ED + women's and children's (both)	Yes	Sutton & Other site

#	Number of sites	Service(s)	Workforce sharing	Site(s)
31	2	ED + women's and children's (both)	Yes	Other site & Other site
32	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Epsom
33	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Sutton
34	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Other site
35	2	(A) ED and (B) ED + women's and children's	Yes	(A) Epsom & (B) Sutton
36	2	(A) ED and (B) ED + women's and children's	Yes	(A) Epsom & (B) Other site
37	2	(A) ED and (B) ED + women's and children's	Yes	(A) Sutton & (B) Other site
38	2	(A) ED and (B) ED + women's and children's	Yes	(A) Other site & (B) Other site
39	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Epsom
40	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Sutton
41	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Other site
42	2	(A) ED + women's and children's and (B) ED	Yes	(A) Epsom & (B) Sutton
43	2	(A) ED + women's and children's and (B) ED	Yes	(A) Epsom & (B) Other site
44	2	(A) ED + women's and children's and (B) ED	Yes	(A) Sutton & (B) Other site
45	2	(A) ED + women's and children's and (B) ED	Yes	(A) Other site & (B) Other site
46	2	ED	No	St Helier & Epsom
47	2	ED	No	St Helier & Sutton
48	2	ED	No	St Helier & Other site
49	2	ED	No	Epsom & Sutton
50	2	ED	No	Epsom & Other site
51	2	ED	No	Sutton & Other site
52	2	ED	No	Other site & Other site
53	2	ED + women's and children's (both)	No	St Helier & Epsom
54	2	ED + women's and children's (both)	No	St Helier & Sutton
55	2	ED + women's and children's (both)	No	St Helier & Other site
56	2	ED + women's and children's (both)	No	Epsom & Sutton
57	2	ED + women's and children's (both)	No	Epsom & Other site
58	2	ED + women's and children's (both)	No	Sutton & Other site
59	2	ED + women's and children's (both)	No	Other site & Other site
60	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Epsom
61	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Sutton
62	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Other site

#	Number of sites	Service(s)	Workforce sharing	Site(s)
63	2	(A) ED and (B) ED + women's and children's	No	(A) Epsom & (B) Sutton
64	2	(A) ED and (B) ED + women's and children's	No	(A) Epsom & (B) Other site
65	2	(A) ED and (B) ED + women's and children's	No	(A) Sutton & (B) Other site
66	2	(A) ED and (B) ED + women's and children's	No	(A) Other site & (B) Other site
67	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Epsom
68	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Sutton
69	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Other site
70	2	(A) ED + women's and children's and (B) ED	No	(A) Epsom & (B) Sutton
71	2	(A) ED + women's and children's and (B) ED	No	(A) Epsom & (B) Other site
72	2	(A) ED + women's and children's and (B) ED	No	(A) Sutton & (B) Other site
73	2	(A) ED + women's and children's and (B) ED	No	(A) Other site & (B) Other site

5.1.2 Test 1: Does the potential solution maintain major acute services within the combined geographies?

Table 14: Application of initial test 1 to long list

#	Number of sites	Service(s)	Workforce sharing	Site(s)
1	0	N/A	N/A	N/A
2	4	ED	Yes	St Helier
3	4	ED	Yes	Epsom
4	4	ED	Yes	Sutton
5	4	ED	Yes	Other site
6	1	ED + women's and children's	Yes	St Helier
7	1	ED + women's and children's	Yes	Epsom
8	1	ED + women's and children's	Yes	Sutton
9	1	ED + women's and children's	Yes	Other site
10	4	ED	No	St Helier
11	4	ED	No	Epsom
12	4	ED	No	Sutton
13	4	ED	No	Other site
14	1	ED + women's and children's	No	St Helier
15	1	ED + women's and children's	No	Epsom
16	1	ED + women's and children's	No	Sutton
17	1	ED + women's and children's	No	Other site
18	2	ED	Yes	St Helier & Epsom
19	2	ED	Yes	St Helier & Sutton
20	2	ED	Yes	St Helier & Other site
21	2	ED	Yes	Epsom & Sutton
22	2	ED	Yes	Epsom & Other site
23	2	ED	Yes	Sutton & Other site
24	2	ED	Yes	Other site & Other site
25	2	ED + women's and children's (both)	Yes	St Helier & Epsom
26	2	ED + women's and children's (both)	Yes	St Helier & Sutton
27	2	ED + women's and children's (both)	Yes	St Helier & Other site
28	2	ED + women's and children's (both)	Yes	Epsom & Sutton
29	2	ED + women's and children's (both)	Yes	Epsom & Other site
30	2	ED + women's and children's (both)	Yes	Sutton & Other site

#	Number of sites	Service(s)	Workforce sharing	Site(s)
31	2	ED + women's and children's (both)	Yes	Other site & Other site
32	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Epsom
33	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Sutton
34	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Other site
35	2	(A) ED and (B) ED + women's and children's	Yes	(A) Epsom & (B) Sutton
36	2	(A) ED and (B) ED + women's and children's	Yes	(A) Epsom & (B) Other site
37	2	(A) ED and (B) ED + women's and children's	Yes	(A) Sutton & (B) Other site
38	2	(A) ED and (B) ED + women's and children's	Yes	(A) Other site & (B) Other site
39	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Epsom
40	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Sutton
41	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Other site
42	2	(A) ED + women's and children's and (B) ED	Yes	(A) Epsom & (B) Sutton
43	2	(A) ED + women's and children's and (B) ED	Yes	(A) Epsom & (B) Other site
44	2	(A) ED + women's and children's and (B) ED	Yes	(A) Sutton & (B) Other site
45	2	(A) ED + women's and children's and (B) ED	Yes	(A) Other site & (B) Other site
46	2	ED	No	St Helier & Epsom
47	2	ED	No	St Helier & Sutton
48	2	ED	No	St Helier & Other site
49	2	ED	No	Epsom & Sutton
50	2	ED	No	Epsom & Other site
51	2	ED	No	Sutton & Other site
52	2	ED	No	Other site & Other site
53	2	ED + women's and children's (both)	No	St Helier & Epsom
54	2	ED + women's and children's (both)	No	St Helier & Sutton
55	2	ED + women's and children's (both)	No	St Helier & Other site
56	2	ED + women's and children's (both)	No	Epsom & Sutton
57	2	ED + women's and children's (both)	No	Epsom & Other site
58	2	ED + women's and children's (both)	No	Sutton & Other site
59	2	ED + women's and children's (both)	No	Other site & Other site
60	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Epsom
61	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Sutton
62	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Other site

#	Number of sites	Service(s)	Workforce sharing	Site(s)
63	2	(A) ED and (B) ED + women's and children's	No	(A) Epsom & (B) Sutton
64	2	(A) ED and (B) ED + women's and children's	No	(A) Epsom & (B) Other site
65	2	(A) ED and (B) ED + women's and children's	No	(A) Sutton & (B) Other site
66	2	(A) ED and (B) ED + women's and children's	No	(A) Other site & (B) Other site
67	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Epsom
68	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Sutton
69	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Other site
70	2	(A) ED + women's and children's and (B) ED	No	(A) Epsom & (B) Sutton
71	2	(A) ED + women's and children's and (B) ED	No	(A) Epsom & (B) Other site
72	2	(A) ED + women's and children's and (B) ED	No	(A) Sutton & (B) Other site
73	2	(A) ED + women's and children's and (B) ED	No	(A) Other site & (B) Other site

5.1.3 Test 2: Is there likely to be a workforce solution to deliver the potential solution?

Table 15: Application of initial test 2 to long list

#	Number of sites	Service(s)	Workforce sharing	Site(s)
1	0	N/A	N/A	N/A
2	1	ED	Yes	St Helier
3	1	ED	Yes	Epsom
4	1	ED	Yes	Sutton
5	1	ED	Yes	Other site
6	1	ED + women's and children's	Yes	St Helier
7	1	ED + women's and children's	Yes	Epsom
8	1	ED + women's and children's	Yes	Sutton
9	1	ED + women's and children's	Yes	Other site
10	1	ED	No	St Helier
11	1	ED	No	Epsom
12	1	ED	No	Sutton
13	1	ED	No	Other site
14	1	ED + women's and children's	No	St Helier
15	1	ED + women's and children's	No	Epsom
16	1	ED + women's and children's	No	Sutton
17	1	ED + women's and children's	No	Other site
18	2	ED	Yes	St Helier & Epsom
19	2	ED	Yes	St Helier & Sutton
20	2	ED	Yes	St Helier & Other site
21	2	ED	Yes	Epsom & Sutton
22	2	ED	Yes	Epsom & Other site
23	2	ED	Yes	Sutton & Other site
24	2	ED	Yes	Other site & Other site
25	2	ED + women's and children's (both)	Yes	St Helier & Epsom
26	2	ED + women's and children's (both)	Yes	St Helier & Sutton
27	2	ED + women's and children's (both)	Yes	St Helier & Other site
28	2	ED + women's and children's (both)	Yes	Epsom & Sutton
29	2	ED + women's and children's (both)	Yes	Epsom & Other site
30	2	ED + women's and children's (both)	Yes	Sutton & Other site

#	Number of sites	Service(s)	Workforce sharing	Site(s)
31	2	ED + women's and children's (both)	Yes	Other site & Other site
32	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Epsom
33	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Sutton
34	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Other site
35	2	(A) ED and (B) ED + women's and children's	Yes	(A) Epsom & (B) Sutton
36	2	(A) ED and (B) ED + women's and children's	Yes	(A) Epsom & (B) Other site
37	2	(A) ED and (B) ED + women's and children's	Yes	(A) Sutton & (B) Other site
38	2	(A) ED and (B) ED + women's and children's	Yes	(A) Other site & (B) Other site
39	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Epsom
40	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Sutton
41	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Other site
42	2	(A) ED + women's and children's and (B) ED	Yes	(A) Epsom & (B) Sutton
43	2	(A) ED + women's and children's and (B) ED	Yes	(A) Epsom & (B) Other site
44	2	(A) ED + women's and children's and (B) ED	Yes	(A) Sutton & (B) Other site
45	2	(A) ED + women's and children's and (B) ED	Yes	(A) Other site & (B) Other site
46	2	ED	No	St Helier & Epsom
47	2	ED	No	St Helier & Sutton
48	2	ED	No	St Helier & Other site
49	2	ED	No	Epsom & Sutton
50	2	ED	No	Epsom & Other site
51	2	ED	No	Sutton & Other site
52	2	ED	No	Other site & Other site
53	2	ED + women's and children's (both)	No	St Helier & Epsom
54	2	ED + women's and children's (both)	No	St Helier & Sutton
55	2	ED + women's and children's (both)	No	St Helier & Other site
56	2	ED + women's and children's (both)	No	Epsom & Sutton
57	2	ED + women's and children's (both)	No	Epsom & Other site
58	2	ED + women's and children's (both)	No	Sutton & Other site
59	2	ED + women's and children's (both)	No	Other site & Other site
60	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Epsom
61	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Sutton
62	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Other site

#	Number of sites	Service(s)	Workforce sharing	Site(s)
63	2	(A) ED and (B) ED + women's and children's	No	(A) Epsom & (B) Sutton
64	2	(A) ED and (B) ED + women's and children's	No	(A) Epsom & (B) Other site
65	2	(A) ED and (B) ED + women's and children's	No	(A) Sutton & (B) Other site
66	2	(A) ED and (B) ED + women's and children's	No	(A) Other site & (B) Other site
67	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Epsom
68	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Sutton
69	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Other site
70	2	(A) ED + women's and children's and (B) ED	No	(A) Epsom & (B) Sutton
71	2	(A) ED + women's and children's and (B) ED	No	(A) Epsom & (B) Other site
72	2	(A) ED + women's and children's and (B) ED	No	(A) Sutton & (B) Other site
73	2	(A) ED + women's and children's and (B) ED	No	(A) Other site & (B) Other site

5.1.4 Test 3: From which sites is it possible to deliver major acute services?

Table 16: Application of initial test 3 to long list

#	Number of sites	Service(s)	Workforce sharing	Site(s)
1	0	N/A	N/A	N/A
2	1	ED	Yes	St Helier
3	1	ED	Yes	Epsom
4	1	ED	Yes	Sutton
5	1	ED	Yes	Other site
6	1	ED + women's and children's	Yes	St Helier
7	1	ED + women's and children's	Yes	Epsom
8	1	ED + women's and children's	Yes	Sutton
9	1	ED + women's and children's	Yes	Other site
10	1	ED	No	St Helier
11	1	ED	No	Epsom
12	1	ED	No	Sutton
13	1	ED	No	Other site
14	1	ED + women's and children's	No	St Helier
15	1	ED + women's and children's	No	Epsom
16	1	ED + women's and children's	No	Sutton
17	1	ED + women's and children's	No	Other site
18	2	ED	Yes	St Helier & Epsom
19	2	ED	Yes	St Helier & Sutton
20	2	ED	Yes	St Helier & Other site
21	2	ED	Yes	Epsom & Sutton
22	2	ED	Yes	Epsom & Other site
23	2	ED	Yes	Sutton & Other site
24	2	ED	Yes	Other site & Other site
25	2	ED + women's and children's (both)	Yes	St Helier & Epsom
26	2	ED + women's and children's (both)	Yes	St Helier & Sutton
27	2	ED + women's and children's (both)	Yes	St Helier & Other site
28	2	ED + women's and children's (both)	Yes	Epsom & Sutton
29	2	ED + women's and children's (both)	Yes	Epsom & Other site
30	2	ED + women's and children's (both)	Yes	Sutton & Other site

#	Number of sites	Service(s)	Workforce sharing	Site(s)
31	2	ED + women's and children's (both)	Yes	Other site & Other site
32	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Epsom
33	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Sutton
34	2	(A) ED and (B) ED + women's and children's	Yes	(A) St Helier & (B) Other site
35	2	(A) ED and (B) ED + women's and children's	Yes	(A) Epsom & (B) Sutton
36	2	(A) ED and (B) ED + women's and children's	Yes	(A) Epsom & (B) Other site
37	2	(A) ED and (B) ED + women's and children's	Yes	(A) Sutton & (B) Other site
38	2	(A) ED and (B) ED + women's and children's	Yes	(A) Other site & (B) Other site
39	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Epsom
40	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Sutton
41	2	(A) ED + women's and children's and (B) ED	Yes	(A) St Helier & (B) Other site
42	2	(A) ED + women's and children's and (B) ED	Yes	(A) Epsom & (B) Sutton
43	2	(A) ED + women's and children's and (B) ED	Yes	(A) Epsom & (B) Other site
44	2	(A) ED + women's and children's and (B) ED	Yes	(A) Sutton & (B) Other site
45	2	(A) ED + women's and children's and (B) ED	Yes	(A) Other site & (B) Other site
46	2	ED	No	St Helier & Epsom
47	2	ED	No	St Helier & Sutton
48	2	ED	No	St Helier & Other site
49	2	ED	No	Epsom & Sutton
50	2	ED	No	Epsom & Other site
51	2	ED	No	Sutton & Other site
52	2	ED	No	Other site & Other site
53	2	ED + women's and children's (both)	No	St Helier & Epsom
54	2	ED + women's and children's (both)	No	St Helier & Sutton
55	2	ED + women's and children's (both)	No	St Helier & Other site
56	2	ED + women's and children's (both)	No	Epsom & Sutton
57	2	ED + women's and children's (both)	No	Epsom & Other site
58	2	ED + women's and children's (both)	No	Sutton & Other site
59	2	ED + women's and children's (both)	No	Other site & Other site
60	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Epsom
61	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Sutton
62	2	(A) ED and (B) ED + women's and children's	No	(A) St Helier & (B) Other site

#	Number of sites	Service(s)	Workforce sharing	Site(s)
63	2	(A) ED and (B) ED + women's and children's	No	(A) Epsom & (B) Sutton
64	2	(A) ED and (B) ED + women's and children's	No	(A) Epsom & (B) Other site
65	2	(A) ED and (B) ED + women's and children's	No	(A) Sutton & (B) Other site
66	2	(A) ED and (B) ED + women's and children's	No	(A) Other site & (B) Other site
67	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Epsom
68	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Sutton
69	2	(A) ED + women's and children's and (B) ED	No	(A) St Helier & (B) Other site
70	2	(A) ED + women's and children's and (B) ED	No	(A) Epsom & (B) Sutton
71	2	(A) ED + women's and children's and (B) ED	No	(A) Epsom & (B) Other site
72	2	(A) ED + women's and children's and (B) ED	No	(A) Sutton & (B) Other site
73	2	(A) ED + women's and children's and (B) ED	No	(A) Other site & (B) Other site

Report Cover Sheet Committees in Common Improving Healthcare Together: 2020-2030

Date of Meeting: 21st June 2018

Agenda No: 4

ENCLOSURE: 4

Title of Document: Improving Healthcare Together 2020-2030: early engagement plan	Purpose of Report: For approval
Report Authors: Programme Team	Lead Director: Andrew Demetriades, Joint Acute Sustainability Programme Director
Executive Summary: This outline plan sets out the aims, objectives and methods of engagement we will include to deliver a best practice, transparent approach that engages and involves local people and communities as the programme develops. A detailed engagement work plan will be published following approval of the early engagement plan by the Committees in Common.	
Key issues to note are: <ul style="list-style-type: none"> • All documentation is draft subject to approval by Committees in Common. • All documentation has been written at a point in time, reflecting information (including sources and references accessed) as of the date of publication. • All documentation may change based on new or additional information which is made available to the programme. 	
Recommendation: The Committees in Common is asked to: <ul style="list-style-type: none"> • Approve the early engagement plan 	
Committees which have previously discussed/agreed the report: The communications and engagement sub-group has reviewed early drafts of this paper.	
Financial Implications: The financial implications of any potential solutions will be conducted in due course as part of the Programme.	
Equality Impact Assessment: An Equality Impact Assessment (Phase 1) has been commissioned for the Improving Healthcare Together: 2020-2030 programme.	
Information Privacy Issues: None	
Communication Plan: The Improving Healthcare Together 2020-2030: early engagement plan has been developed and will be approved by the Committees in Common.	

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EARLY ENGAGEMENT PLAN

Surrey Downs, Sutton and Merton CCGs

June 2018

CONTENTS

1	INTRODUCTION	3
1.1	Purpose of this document	3
1.2	Background	3
1.3	Phasing of engagement	3
2	AIMS AND OBJECTIVES	4
2.1	Aims and objectives	4
2.2	Principles	4
3	APPROACH TO ENGAGEMENT	6
3.1	Approach	6
3.2	Equalities	7
3.3	Evaluation and assessment	7
3.4	Next steps	7

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1 INTRODUCTION

1.1 Purpose of this document

We (NHS Surrey Downs Clinical Commissioning Group, NHS Sutton Clinical Commissioning Group and NHS Merton Clinical Commissioning Group) have been exploring how to meet the healthcare needs of our populations in a sustainable way.

The *Issues Paper* set out our considerations to date as a starting point for engagement and discussion with the public.

This *Outline Engagement Plan* sets out the aims and objectives of early engagement, and the approach to ensuring we will continue to involve the public across all areas of the programme.

1.2 Background

In 2017, Epsom and St Helier University Hospitals NHS Trust developed a Strategic Outline Case (SOC) for investment in its hospitals. Within it they established that some services are not sustainable in their current form. As part of this, the Trust carried out a public and stakeholder engagement programme on the future of its services.

Following the publication of the SOC, Surrey Downs CCG, Sutton CCG and Merton CCG set up the Improving Healthcare Together: 2020-2030 programme, as the main commissioners of services at the Trust.

The programme has published a case for change, emerging clinical model and a framework for the development of provisional solutions. These set out the issues affecting the provision of healthcare in the area, describe the services that could be provided to meet local needs and the potential ways in which the clinical model can be delivered.

Public engagement will take place throughout the development of Improving Healthcare Together: 2020-2030 that builds on the engagement work undertaken by the Trust and through the programme mobilisation phase.

Through ongoing engagement with stakeholders over the coming months, we will seek to receive feedback on the case for change, clinical model and development of potential solutions as summarised in the *Issues Paper*. At every stage of the process we will consider the views of patients, the public and wider stakeholders.

No decisions have been made at this point, and before we make any decisions, there will be full public consultation. Any future decisions will take account of the feedback received from the public.

1.3 Phasing of engagement

This plan sets out the approach the programme will take to communications and engagement in the initial phases of the programme.

Engagement will occur in a number of phases:

- Early engagement
- Immediate pre-consultation
- Consultation
- Post consultation

This paper focuses on early engagement. More detailed plans for pre-consultation and consultation will be co-produced and developed when required.

2 AIMS AND OBJECTIVES

2.1 Aims and objectives

As a first step, this outline engagement plan will aim to ensure that engagement will:

- Effectively explain work undertaken around the case for change, clinical model and any potential solutions to patients and the public;
- Ensure that all feedback from the public is collected and considered over the course of the programme; and
- Ensure there is a joined-up approach to engagement by the three CCGs, the Trust, the two STPs and NHS regulators.

The objectives of this outline engagement plan are that:

- A best practice approach to public and stakeholder engagement is taken, so that local people and communities are able to communicate their views on the work carried out by the programme;
- The right activities, mechanisms and enablers are in place to ensure that key stakeholders are briefed and involved at every step of the programme; and
- Impacts on groups protected under the Equality Act are fully taken into account.

2.2 Principles

The commitment is to deliver to a best practice, transparent approach that engages and involves local people and communities at every step of the programme. NHS England recommends an approach based on co-production with patients and the public. As such we will ensure that:

- Key stakeholders such as local authority leaders and senior officers, OSCs, Health and Wellbeing Boards, MPs, GPs and hospital staff are briefed and involved at each key milestone of the programme.
- We will work with local authorities to establish a Joint Health and Overview Scrutiny Committee.
- Patients and the public will be involved at every stage of the programme, including development and appraisal of the clinical model, potential solutions development and appraisal, using existing CCG and STP routes to engage local groups and stakeholders.
- Co-production will involve the community at each stage in the process, testing our assumptions and emerging thinking.
- We will specifically engage with seldom heard groups to ensure that activities and events are inclusive. This will include working with voluntary organisations to engage through their networks and create events designed for a specific audience.
- Specific consideration is given to the impact of any potential changes on groups protected under the Equality Act 2010 and consideration given to any potential negative impacts.
- An assessment of the impact on carers and those living in social deprivation is also carried out as part of equalities analysis, and any necessary mitigations are to be considered.

Engagement will follow these six principles:

1. Transparency: information about the programme, including the case for change, clinical model and initial solutions framework will be made available online in order to comply with Freedom of Information legislation.

2. Inclusivity: it will seek to involve local people and stakeholders at every stage, including those who have expressed an interest and people that the NHS does not always successfully engage, such as groups protected under the Equality Act.
3. Listening: all feedback will be conscientiously taken into account and all evidence will be given careful consideration. Feedback will be published and commissioners will respond to it.
4. Partnership: all partners in the programme will work to an agreed communications and engagement protocol. A dedicated Communications and Engagement Working Group will oversee the approach to communications and engagement.
5. Meeting best practice: it will follow a best practice approach to public engagement and, if needed, public consultation. Our engagement approach will be independently assessed by experts from The Consultation Institute.

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3 APPROACH TO ENGAGEMENT

3.1 Approach

We will establish a programme of engagement to enable a discussion of the work the programme has carried out to date, and to incorporate public, patient and stakeholder feedback into any consideration of future work. This will include:

- **The publication of an *Issues Paper and Technical Annex***, with which we will launch our programme of early engagement.
- **A dedicated website**: this will be a central forum where the public and patients can access information about the programme.
- **Social media** channels will be used to communicate information to different audiences.
- **A short film** will summarise the challenges and opportunities, for use at public events.
- **Independently-facilitated public events** will be held during the early engagement phase including specific focus group conversations on aspects of the emerging clinical model.

All feedback from public events will be collected and considered, with the publication of a report summarising the findings of the engagement programme.

An overview of the methods of engagement are outlined below.

Table 1: Methods of engagement

Format	Purpose
Public discussion events	Discussion events are to be held in the early engagement phase, to enable patients and the public to shape the programme and address the key questions set out in the issues paper. A minimum of two public events in each CCG locality are to be scheduled at this stage.
Public activities	Public activities are to be held in open spaces such as supermarkets and shopping centres during the early engagement phase to publicise Improving Healthcare Together: 2020-2030 and address the key questions set out in the issues paper.
Focus groups	Using the findings from the equalities analysis, focus groups will be held with protected characteristic groups to listen to and fully understand their concerns and needs.
Animation film	The animation will provide background information on the programme and contain key messages including: the programme's vision for healthcare and the key challenges needing to be addressed. It will also detail how local people can get involved during the engagement phase.
Stakeholder Reference Group (SRG)	The SRG has been set up to support the programme by providing a local voice and sounding board reflecting local opinion, concerns and questions. The SRG will be involved in the development and testing of aspects of the emerging clinical model and any potential solutions. The group comprises: Healthwatch, local authorities, voluntary and community sector representatives (including those representing protected characteristic groups) and members of the public.
Mobile engagement	Mobile engagement will visit a variety of areas, such as shopping centres, schools and universities to encourage local communities to engage and share their views.
Primary care engagement	Each CCG is to put in place a specific programme of GP/primary care engagement, with programme support. GPs and primary care staff are important stakeholders who need to be kept fully informed and engaged.

Updates on previous engagement	Those groups previously engaged by the Trust are to be contacted to test feedback from engagement to date and build on it by seeking their views on the proposed clinical model and potential solutions.
Healthwatch	The three local Healthwatch organisations will independently support the delivery of the engagement plan, gathering views and input from the public and ensuring that all feedback is recorded and responded to.
Social media	The programme will be promoted and explained on social media, particularly Twitter and Facebook, and will consider activities such as ‘chats’ to enable full public debate. Other social media such as sli.do and Coosto, which monitors online dialogues, will also be explored.
Local and national media	A proactive approach is will be taken with local and national media, including BBC London, BBC Surrey, the Evening Standard as well as the local press. This will include specific briefings for key journalists.
Programme website	Key programme materials are made available online in order to ensure public engagement on a dedicated programme website.

3.2 Equalities

Following best practice, the Improving Healthcare Together: 2020-2030 programme has commissioned two pieces of work. An

- Equality Impact Assessment (Phase 1), and a
- Impact on deprived communities study

This work will focus on the needs of the eleven ‘protected characteristic’ groups as defined by the Equality Act 2010. The Equality Impact Assessment will identify existing health inequalities and equality issues to be considered by the programme as the emerging clinical model and potential solutions develop. The impact on deprived communities will assess and evidence the potential impact of any proposed service changes on local populations, in particular those living in deprived communities

The engagement programme will draw on key findings and recommendations from this work to target its engagement activity on the key protected groups and locations in which they live.

Should consultation be required, further phases of equalities analysis would follow.

3.3 Evaluation and assessment

An engagement sub group which includes Healthwatch will oversee the delivery of this plan and all engagement activity on behalf of the Programme Board.

The Consultation Institute, who are experts in best practice public engagement and consultation will assure the delivery of the engagement programme against best practice.

The Programme Board will receive regular updates on communications and engagement progress and issues.

3.4 Next steps

A detailed engagement work plan will be published following approval of the engagement approach by the Committees in Common.