



IMPROVING HEALTHCARE TOGETHER 2020-2030 PRE-CONSULTATION BUSINESS CASE

**FOR REVIEW AND APPROVAL – SUBJECT TO
COMMITTEES IN COMMON (CIC) APPROVAL**

Surrey Downs, Sutton and Merton Clinical Commissioning Groups

EXECUTIVE SUMMARY

We (NHS Surrey Downs Clinical Commissioning Group (CCG), 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. For this purpose, we established the Improving Healthcare Together 2020 – 2030 programme.

The purpose of this pre-consultation business case is to:

- 1. Describe the health needs of our combined geographies and 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.
- 2. Describe the process we have followed:** This describes the governance of the Improving Healthcare Together programme, and the process we have followed to ensure any decision-making is supported by underlying evidence and local stakeholders.
- 3. Describe how key stakeholders and the public have been engaged and involved in our process:** Our early engagement has been extensive and captured a wide range of views. We also set out how we will plan to consult if a decision is made to proceed.
- 4. Describe the clinical model and potential benefits thereof:** The clinical model has been developed to meet local needs for our combined geographies based on clinical standards and evidence based best practice.
- 5. Set out our options consideration process:** We have followed a standard approach to understand the possible options to address the challenges set out in our case for change and deliver our clinical model. This document describes a long list, initial tests to reach a short list, and the evaluation of the short list through defined criteria.
- 6. Carry out an analysis of financial impact and affordability:** We have used a range of financial metrics to assess the financial impact of the shortlisted options, and to test the affordability of each.
- 7. Set out how we will assure and potentially implement our plans if a decision is made to move forward:** This describes the role of assurance bodies and governance around decision-making. An initial view of how any plans may be implemented is also provided.

The programme has worked within the context of other local, regional and national initiatives and will consider any further initiatives as they arise. We have also assessed the impact of changes on the acute providers outside our combined geographies.

Surrey Downs, Sutton and Merton CCGs are continuing to work with health and care services across our combined geography to address the challenges set out in our case for change

Surrey Downs, Sutton and Merton CCGs are located across the Sustainability and Transformation Partnerships of Surrey Heartlands and South West London, and commission services for a combined population of 720,000.

We are continuing to work with all local health and care organisations to improve healthcare for our populations. This includes but is not limited to primary care, community care, mental health, social care and acute care.

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 core 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 delivery. Over 90% of St Helier Hospital is older than the NHS; 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. £23m 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.

We have followed a defined process to address our case for change, develop options to solve our challenges and carry out any decision-making

To develop this pre-consultation business case, Improving Healthcare Together has developed principles, processes and governance that supported decision-making. The programme is clinically led, informed by engagement with key stakeholders and the public and works with partners across our combined geographies.

Governance groups were established to make recommendations that would be considered by the Committees in Common as part of any decision-making process. These groups were supported by workstreams to carry out key elements of work.

Four key processes supported the development of this pre-consultation business case:

- **The development of the clinical model**, overseen by the Clinical Advisory Group, which included initially defining an emerging clinical model for public engagement, and a further phase where areas of work were identified following a review by the Joint Clinical Senate for London and the South East.
- **The development of the finance and activity model**, overseen by the Finance, Activity and Estates Group, which modelled the short list of options to determine their impacts.
- **The options consideration process**, which established the approach to developing a long list, short list and any evaluation thereof and involved the public in the consideration of a short list of options.
- **Public and stakeholder engagement**, which tested proposals and the options consideration process with the public.

The programme engaged the public and wider stakeholders, capturing a wide range of views and informing our proposed consultation process

We undertook a significant amount of patient and public engagement during our programme of early engagement. This ensured patients, carers and residents were fully involved in the development of the case for change, clinical model and potential solutions.

Our overarching aims in undertaking this engagement activity were to seek feedback on:

- the emerging **clinical model**;
- the **case for change** – our vision and challenges;
- the **potential solutions** developed by the programme; and
- how the **short list of potential solutions** may affect different groups

Our early engagement was undertaken as part of a four stage process which includes pre-consultation, consultation and post consultation. During the pre-consultation stage, we engaged with a wide and diverse range of interest groups.

Through this engagement 1,500 people and staff across our geography were informed and asked to give their views on the work of the programme. There was a particular focus on those groups most impacted by the potential changes to major acute services, such as users of paediatric, maternity and emergency services.

During engagement, we heard that:

- there was support for the main areas of the clinical vision;
- there was a widespread recognition of a **need for change**;
- there was not a clear consensus over what that change should be;
- no new alternative proposals were identified;
- there was an underlying concern about **potential loss of services**; and
- people tended to advocate for the **services that they are familiar with** and hospitals that are closer to them;
- there was particular concern about **transport and accessibility** and the impact on proposals to those who are perceived to be most in need; in particular older and less mobile people and those in areas of higher deprivation.

Feedback gathered from pre-consultation engagement with local residents, patients, carers and equality groups informed each stage of the development of proposals. Local priorities and needs for healthcare services were gathered and fed directly into the options consideration process. This feedback included the views of equality groups potentially impacted by the proposals and their specific needs.

We will continue our programme of engagement through our proposed consultation process. We will aim to obtain a broad range of views from a wide variety of communities, services users and their representatives on our proposals.

The consultation will seek to:

- Ensure the population of our combined geographies are **aware of and understand the case for change and the proposed options for change**, by providing information in clear and simple language and in a variety of formats.
- Hear people's views on the proposed changes to major acute services.
- Ensure the CCGs as decision-makers are made aware of **any information which may help to inform the proposals** and the decision-making process.

We will commission an independent company to formally analyse the consultation responses and outputs from all engagement methods. On conclusion of the analysis the independent company will

produce a final written report which will be publicly available. The report will be used to inform the Decision-Making Business Case, on which the Committee in Common of the three local Clinical Commissioning Groups final decision will be based.

We are clear that the results of consultation are an important factor in health service decision making, and are one of a number of factors that need to be taken into account.

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

We have set out a 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. This model was 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 model was 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. A review by the Joint Clinical Senate for London and the South East as part of the assurance process supported the aims and direction of our clinical model.

As our challenges are local, this emerging clinical model focused 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 were considered as part of detailed analysis.

Our clinical model aims to ensure the very best quality of care is available to our populations and sets the direction for care in our combined geographies.

It describes how we will deliver **district hospital services** and **major acute services** to provide excellent care in the future, integrated with and supported by **out of hospital services**.

- The aim of our **community-facing, proactive health, wellness and rehabilitation district hospital model** is to support people who do not require high acuity services but who still need some medical input. This includes district beds for patients 'stepping down' from a major acute facility, 'stepping up' from the community and directly admitted via an urgent treatment centre(s). For the district hospital model, access is therefore important due to the frequency of contact. Our clinical model keeps district services as local as possible and these services will continue to be delivered from both Epsom and St Helier Hospitals, whilst being further integrated with other services people use.
- **Major acute services are for the treatment of patients who are acutely unwell or are at risk of becoming unwell**, such as those treated within the emergency department. These are services that require 24/7 delivery and include the highest acuity services. We have considered the co-dependencies between these services, to define the minimum set of services that need to be co-located. For major acute services clinical standards of care and co-location are central to clinical outcomes due to the importance of consultant input and critical nature of the care – and the aim is to ensure these services are co-located appropriately.

We believe that this clinical model – where local access to district services is maintained and major acute services are co-located – will benefit the quality of our services and the experience offered to patients.

We are already providing the district hospital model locally.

We have very deliberately called our community-facing, proactive health, wellness and rehabilitation model the district hospital model. This future model builds on existing work and practice that is already happening across our combined geographies and is in line with the direction of travel for healthcare across the country.

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

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.

These audits suggest there is a patient cohort that needs inpatient care but within a lower acuity setting. Our 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.

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

Our clinical model will allow us to deliver major acute standards and evidence based best practice through co-location of major acute services.

Major acute services include the highest acuity services offered in our combined geographies and are subject to specific clinical standards. Major acute services include:

- Major emergency department (ED)
- Acute medicine
- Critical care
- Emergency surgery
- Inpatient paediatrics
- Obstetrician-led births

The changes to the clinical model aim to meet the latest clinical standards and evidence based best practice for major acute services. 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.

Our case for change identified that there are issues with the current provision of major acute services. Therefore, how these services are delivered in the future needed to be considered as part of the options consideration process.

The clinical model is expected to bring a wide range of positive impacts, including clinical benefits, workforce benefits, technology benefits and estates benefits.

Overall the clinical model is expected to translate into improved clinical outcomes for patients, an improved way of working for staff, opportunities for the implementation of new technology, fewer patient falls and transfers, fewer adverse drug events and infections, an improved patient experience and shorter stays in hospital.

The clinical model formed the basis of our planning for potential solutions for our combined geographies. It was tested with the public and clinical senates and may be further refined if additional evidence emerges as part of the consultation process.

We followed a defined options consideration process to address our challenges and deliver our vision

This process was informed by previous engagement with the public on the potential solutions to the issues we face and extensive discussion within the local area, including amongst clinicians, commissioners, providers and regulators. This included 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*.

In order to determine the potential solutions to address our case for change and deliver the clinical model, we continued to follow a standard approach for options consideration. This involved:

1. Developing an **initial long list of options** to address our case for change and deliver the clinical model.
2. Developing and applying **initial tests to reduce the long list** to reach a manageable short list. This allowed us to focus on evaluating the short list to ensure they are feasible.
3. Developing and **evaluating the short list of options** through non-financial evaluation criteria in line with guidance from The Consultation Institute.
4. Carrying out a **financial analysis** and reporting a series of financial metrics for each short listed option.

We developed an initial long list of options to address our case for change and deliver the clinical model.

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

- **First, we focused on major acute services only**, as there is a need for significant changes in these services. District hospital services will continue to be developed as described in our existing plans.
- Second, we have focused only on changes within our combined geographies.

Based on this, we then considered how potential solutions might vary to develop a long list of potential solutions. This intended to capture a wide range of potential solutions – consideration of their viability is a subsequent step. We 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 not providing major acute hospital site(s) would not align with our commitment to maintaining major acute services within our combined geographies, it was 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) with supporting major acute services only or provide major adult emergency department(s) with supporting major acute services 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 led to 73 potential solutions. This formed our long list.

Our long list was refined by testing the viability of potential solutions against three initial tests

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

The initial tests we applied were:

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 reduced the long list:

- After the first test, **any potential solution that did not offer all major acute services within the combined geographies was eliminated** (e.g. no major acute hospitals or only providing major adult emergency department services within the combined geographies). This resulted in 50 potential solutions.
- After the second test, workforce limitations and co-dependencies meant that any potential solution with more than one major acute site and any potential solution relying on external workforce was eliminated. This resulted 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 resulted in three potential solutions.

In addition, our provisional short list includes a ‘no service change’ counterfactual – continuing with existing service provision at both Epsom Hospital and St Helier Hospital.

There are therefore four potential solutions in our provisional short list, which includes:

- **The ‘no service change’:** 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 was tested with the public before further analysis was completed.

We developed and evaluated the short list of options through non-financial evaluation criteria in line with guidance from The Consultation Institute

The short list of options was considered through non-financial criteria and financial metrics, including metrics defined by our regulators.

We have undertaken a standard process for the development of the non-financial criteria and scoring of options against these criteria. This was based on the recommendation of The Consultation Institute, which offered expert advice and guidance of public consultation and engagement, based on relevant legislation and case law, and informed by previous experience of this process from across the UK.

There were three steps to this process:

1. Pre-consultation engagement captured public priorities and feedback.
2. Three different groups of balanced representative people were identified, drawn from across the three CCGs (including the public, clinicians and professionals), where:
 - the first facilitated group agreed non-financial criteria;
 - the second facilitated group agreed what weighting each non-financial criterion should carry; and

- the third facilitated group scored the shortlisted options against the non-financial criteria, without sight of the weightings.

3. Application of the weightings to the scores and reporting to Programme Board and the Joint Governing Body of the outcome of the non-financial scoring process.

The outputs of the non-financial consideration (including overall weighted scores) were reported to Programme Board and the Governing Bodies.

Following the first two workshops, 16 weighted non-financial criteria were established.

For the scoring of the short list against the non-financial evaluation criteria, the participants of the third and final workshop were provided with the best available evidence for each shortlisted option and the no service change comparator. Each participant then individually scored each option.

The scoring workshop resulted in a mean average score for options against the criteria, against which the weightings were applied. A table is shown below with the mean average scores for each criterion and the applied weightings. The total row at the bottom shows the score for each of the options once the weightings were applied. The scores are out of 10, where 10 is high.

Based on the workshop participants:

- Sutton** scored most highly for **11 criteria**: availability of beds, delivering urgent and emergency care, workforce safety, recruitment and retention, alignment with wider health plans, integration of care, complexity of build, impact on other providers, time to build, deprivation, health inequalities and safety.
- Epsom** scored most highly for **1 criterion**: older people.
- St Helier** scored most highly for **3 criteria**: staff availability, clinical quality and patient experience.
- No service change** scored most highly for **1 criterion**: access.

The table below shows the average scores once weightings were applied, and the total scores for each of the options.

Table 1: Average scores of scoring workshop with weightings applied to show total average score

Domain	Criteria	Weighting	No service change	Epsom	St Helier	Sutton
Access	Accessibility	8.4%	0.56	0.45	0.44	0.52
Clinical sustainability	Availability of beds	5.0%	0.28	0.33	0.37	0.37
	Delivering urgent and emergency care	8.6%	0.55	0.50	0.54	0.60
	Staff availability	7.1%	0.23	0.53	0.56	0.55
	Workforce safety, recruitment and retention	6.9%	0.28	0.45	0.47	0.48
Contribution to wider healthcare aims	Alignment with wider health plans	3.9%	0.11	0.27	0.26	0.28
	Integration of care	6.8%	0.36	0.42	0.42	0.46
Deliverability	Complexity of build	5.0%	0.23	0.30	0.25	0.40
	Impact on other providers	5.3%	0.29	0.19	0.34	0.35
	Time to build	3.0%	0.15	0.17	0.14	0.23
	Deprivation	6.3%	0.31	0.26	0.33	0.35

Domain	Criteria	Weighting	No service change	Epsom	St Helier	Sutton
Meeting population health needs	Health inequalities	6.0%	0.21	0.22	0.23	0.25
	Older people	6.0%	0.33	0.38	0.33	0.36
Quality of care	Clinical quality	7.8%	0.29	0.50	0.54	0.49
	Patient experience	6.6%	0.29	0.40	0.44	0.42
	Safety	7.3%	0.34	0.51	0.54	0.54
Total		100%	4.79	5.89	6.21	6.65

Overall, all the options scored more highly than no service change (4.79). The Sutton option (6.65) scores more highly than Epsom (5.89) or St Helier (6.21) options.

Following these workshops in October and November 2018, as a result of further evidence development and assurance by NHS England, NHS Improvement and the Joint Clinical Senate, further work was undertaken in areas relevant to the scoring workshop. This is focused across three main areas:

1. Clinical Senate review of the clinical model
2. Interim integrated impact assessment development
3. Other local provider impacts

The further evidence was assessed by the Clinical Advisory Group and Programme Board to establish whether there would be any impact on the scores for the options in the relevant criteria as part of the decision-making process. Table 2 demonstrates how this further evidence development supports the option ranking as established through the options development process.

Table 2: Further evidence development impact by relevant domain

Domain	Changes to evidence
Accessibility	Small changes to travel times as a result of the updated analysis, which does not result in a change in the direction of potential rankings.
Availability of beds	Small changes to bed numbers as a result of the updated analysis, with all options providing the same number of beds.
Impact on other providers	The provider impacts are consistent with the initial analysis. With the right mitigations, all providers have indicated that the options would be deliverable.
Deprivation	The IIA has indicated that the Epsom option may have a greater impact on deprived groups due to the increased length of journey, and increased complexity and costs of the journey for deprived areas which are predominately located in Sutton and Merton.
Health inequalities	The IIA reconfirms the evidence base for the importance of district services in impacting positively on reducing health inequalities.
Older people	The IIA has indicated that the St Helier option may have a greater impact on older people due to the increased length of journey, and increased complexity and costs of the journey for older communities which are predominately located in Surrey Downs.

These non-financial scores are one of the sources of evidence that will support the CCGs' decision-making process. The non-financial scores and further evidence development suggested the ranking of options as shown in Table 3.

Table 3: Non-financial relative option ranking

Category	No service change	Epsom	St Helier	Sutton
Non-financial scores	4.79	5.89	6.21	6.65
Non-financial ranking	-	3	2	1

The non-financial ranking is summarised below.

Figure 1: Summarised option rankings

Criteria	Sutton	St Helier	Epsom
 Quality of care Would it improve safety and quality of clinical care, improve patient experience, deliver the required beds and resolve the workforce, recruitment and retention issues?	The proposed changes would deliver improved quality of care in all options. In all options how care is delivered would be the same, there would be the same number of beds (a slight increase on what is available now) and the workforce issues would be resolved.		
 Long term clinical sustainability Does it improve access to urgent and emergency care and are there other clinical benefits for patients?	Three urgent treatment centres that would be open 24 hours a day, every day of the year. Located with Royal Marsden it would improve care for Epsom and St Helier cancer patients	Two urgent treatment centres that would be open 24 hours a day, every day of the year	Two urgent treatment centres that would be open 24 hours a day, every day of the year
 Meeting the health needs of local people What would the impact be on older people and people from deprived communities?	Least overall impact on travel for older people and people from deprived communities	Greatest impact on travel for older people and least impact on travel for people from deprived communities	Least impact on travel for older people and greatest impact on travel for people from deprived communities
 Fit with NHS Long Term Plan Would it fit with the NHS Long Term Plan and support bringing health and care services together?	All options would deliver a similar fit with how the NHS Long Term Plan sees healthcare delivered in the future		
 Access including travel What would the impact be on travel and accessibility?	Smallest increase in average travel time. Fewer local people would have to travel further as Sutton is the most central to where people live in the areas of Surrey Downs, Sutton and Merton	Second greatest increase in average travel time. More local people would have to travel further with more complicated journeys	Greatest increase in average travel times. A larger number of local people would have to travel further with more complicated journeys
 How easy it is to deliver? Complexity and length of time to build and impact on neighbouring hospitals	Easiest to build. Would take four years to build. Least impact on neighbouring hospitals – 50 beds move to other local providers	More complicated to build. Would take seven years to build. Bigger impact on neighbouring hospitals – 81 beds move to other local providers	More complicated to build. Would take six years to build. Greatest impact on neighbouring hospitals – 205 beds move to other local providers

The programme used a range of financial metrics to assess the financial impact of the short listed options, and to test the affordability of each

To determine the financial impact of the shortlisted options, a range of financial metrics were reported by the Finance, Activity and Estates workstream.

These metrics were produced to determine the affordability and feasibility of delivering the options.

The clinical model and consolidation of key services is expected to result in a range of financial benefits by 25/26. This includes cost reductions and a number of income improvements. Through delivering the benefits of the clinical model, the options are expected to deliver financial benefits of c. £33 - 49m per annum by 25/26.

Table 4: Financial benefits of options

Category	Epsom	St Helier	Sutton
Financial benefits (£m)	32.9	39.1	49.1

In order to deliver the significant benefits expected, a large capital investment in the hospital sites is required across all options. In particular, capital investment of between £292m and £472m is required (including at other hospitals) after accounting for financing already secured.

Capital requirements under each option have been calculated by expert estates advisors based on best practice and relevant standards and guidance, including DHSC Health Premises Cost Guides (HPCG). The estimates include the costs required for new buildings and any refurbishment needed, across all relevant sites.

This included:

- Estimating the space required for the activity required on each site under each option and, of this, the refurbishment or new build space required; and
- Estimating the capital requirement for this new build and refurbished space for each site under each option, including completion of OB1 cost forms.

Table 5: Capital requirement of options

Category	No service change	Epsom	St Helier	Sutton
ESTH net capital investment (£m)	(225)	(292)	(386)	(472)

To understand how this capital requirement may be financed, we also undertook an initial appraisal of potential financing sources, and considered their advantages and disadvantages as well as tested the affordability of a short list of potential financing scenarios.

The main financing scenario we explored was drawing on public dividend capital (PDC) to secure the financing as our preferred financing route. This was based on a number of advantages:

- **Simplicity** – there is only one transaction – between the Department of Health and Social Care and Epsom and St Helier – compared to other financing arrangements which often involve complex contracting arrangements between multiple parties;
- **Affordability** – the financing costs are lower than most other forms of financing; and
- **Availability** – public dividend capital was appropriate for funding large capital schemes such as this. This is compared to many other financing routes which are restricted to specific purposes such as energy efficiency financing.

As an alternative, should public financing routes be unavailable, we also considered a mixed financing approach – drawing on a number of sources, including leveraging local authority (LA) financing.

Initial analysis suggests that all financing scenarios can help to drive a positive income and expenditure for the options.

Table 6: Income and expenditure of options under emerging financial proposition

Category	Epsom	St Helier	Sutton
ESTH 25/26 in year I&E, with PDC financing (preferred route) (£m)	11.1	12.2	16.3
ESTH 25/26 in year I&E, with alternative mixed financing (£m)	6.5	5.2	12.7

The system net present value (NPV) of the options considered the total benefits for each option. NPV is used as best practice within The Green Book¹ as an objective measure for comparing total benefits for different options over an extended period of time. Therefore using this as the core metric, the system NPV of the options suggested a ranking of the options.

¹ The Green Book, Central government guidance on appraisal and evaluation, HM Treasury, 2018

Table 7: System NPV

Category	No service change	Epsom	St Helier	Sutton
System NPV (50 years) (£m)	50	354	487	584
Option financial ranking	-	3	2	1

Table 8 below shows a summary of the key financial metrics for each of the options.

Table 8: Summary of key financial metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
ESTH key financial metrics	ESTH net capital investment (£m)	(225)	(292)	(386)	(472)
	Capital investment other providers (£m)		(174)	(44)	(39)
	ESTH return on investment 25/26 (%)		11.5%	8.8%	8.4%
	ESTH 25/26 in year I&E, with PDC financing (preferred route) (£m)		11.1	12.2	16.3
System key financial metrics	System return on investment 25/26 (£m)		5.3%	7.4%	7.3%
	System net present value (50 years) (£m)	50	354	487	584

The system is clear that without changes there will continue to be an overspend of over c. £20m per annum. This will require central revenue support, such as through financial recovery and provider sustainability funds.

Programme Board and the Committees in Common considered the evidence to determine whether the options were viable, and whether there was a preferred option

Programme Board reached a shared position on the meaning of the current evidence base for the relative merits of the different options. The evidence to date has been summarised below for each of the options.

Major acute services at Epsom Hospital

- **Non-financial:** All the options deliver the clinical model and associated benefits. The non-financial analysis suggests Epsom is the least favourable of the short list of options (excluding the no service comparator). In addition, there is a risk that the level of births expected for the Epsom option may impact on the viability of a level 2 neonatal unit.
- **Financial:** The Epsom option has the lowest system NPV and the second highest capital requirement.
- **Local provider impact:** The Epsom option has the highest impact on local providers outside of the combined geography, with the highest outflow of beds and highest capital requirement.
- **Interim integrated impact assessment:** The change in median travel time is highest for the Epsom option. While the Epsom option has a lower impact than other options on older people, it has the greatest impact on deprived communities.

Major acute services at St Helier Hospital

- **Non-financial:** All the options deliver the clinical model and associated benefits. The non-financial analysis suggests St Helier is mid-ranked of the short list of options (excluding the no service change comparator). Building this option is the most complex of the three options, due to the difficulties redeveloping the St Helier site.
- **Financial:** The St Helier option has the lowest capital requirement of the options, but does not deliver the highest NPV of the options, with the Sutton option having a higher NPV.
- **Local provider impact:** There is a lower impact on other providers for the St Helier option than the Epsom option, although there is a higher capital requirement than the Sutton option.
- **Interim integrated impact assessment:** St Helier has the lowest impact on deprived communities, however it also has the highest impact on older people of the options.

Major acute services at Sutton

- **Non-financial:** All the options deliver the clinical model and associated benefits, with the addition of a third UTC on the Sutton site. The Sutton option ranks most highly against non-financial criteria. As a new build on an unused site, it is the simplest option to build. In addition, co-locating with the Royal Marsden Hospital offers further opportunities for joint working.
- **Financial:** The Sutton option has the highest capital requirement of the short list of options, however it also delivers the highest NPV of the options.
- **Local provider impact:** The Sutton option, located between Epsom and St Helier, has the lowest impact on other providers. It requires the least incremental capital and has the lowest net impact in terms of numbers of beds.
- **Interim integrated impact assessment:** The median increase in travel time is lowest for the Sutton option. It has a lower impact on deprived communities compared to the Epsom option, and a lower impact on older people compared to the St Helier option.

Subject to approval by the Committees in Common of this business case, based on this work, we have considered all the evidence and established and a preferred option.

Figure 2: Summary of non-financial evidence, financial evidence and overall preferred option

		Preferred option		
	Criteria	Sutton	St Helier	Epsom
	Quality of care Would it improve safety and quality of clinical care, improve patient experience, deliver the required beds and resolve the workforce, recruitment and retention issues?	The proposed changes would deliver improved quality of care in all options. In all options how care is delivered would be the same, there would be the same number of beds (a slight increase on what is available now) and the workforce issues would be resolved.		
	Long term clinical sustainability Does it improve access to urgent and emergency care and are there other clinical benefits for patients?	Three urgent treatment centres that would be open 24 hours a day, every day of the year Located with Royal Marsden it would improve care for Epsom and St Helier cancer patients	Two urgent treatment centres that would be open 24 hours a day, every day of the year	Two urgent treatment centres that would be open 24 hours a day, every day of the year
	Meeting the health needs of local people What would the impact be on older people and people from deprived communities?	Least overall impact on travel for older people and people from deprived communities	Greatest impact on travel for older people and least impact on travel for people from deprived communities	Least impact on travel for older people and greatest impact on travel for people from deprived communities
	Fit with NHS Long Term Plan Would it fit with the NHS Long Term Plan and support bringing health and care services together?	All options would deliver a similar fit with how the NHS Long Term Plan sees healthcare delivered in the future		
	Access including travel What would the impact be on travel and accessibility?	Smallest increase in average travel time. Fewer local people would have to travel further as Sutton is the most central to where people live in the areas of Surrey Downs, Sutton and Merton	Second greatest increase in average travel time. More local people would have to travel further with more complicated journeys	Greatest increase in average travel times. A larger number of local people would have to travel further with more complicated journeys
	How easy it is to deliver? Complexity and length of time to build and impact on neighbouring hospitals	Easiest to build Would take four years to build Least impact on neighbouring hospitals - 50 beds move to other local providers	More complicated to build Would take seven years to build Bigger impact on neighbouring hospitals - 81 beds move to other local providers	More complicated to build Would take six years to build Greatest impact on neighbouring hospitals - 205 beds move to other local providers
	Finance What is the capital cost to build and long term financial benefit to the NHS over 50 years, which is the planned lifetime of hospital buildings?	Most cost to build: \$511 million. It has the most new buildings but because it keeps the most patients in the area and there are extra benefits of being located with the Royal Marsden it is the best value for the tax payer	Least cost to build: \$430 million as it has the most amount of refurbished buildings and keeps the majority of patients in the area making it medium value for the tax payer	Medium cost to build: \$466 million as the build size is smaller as it keeps the least number of patients in the area. It also has the largest investment needed at other providers and therefore it is the least value for the tax payer

The Programme Board considered all the evidence set out within this pre-consultation business case and concluded that:

- The three options are viable and should be included in any public consultation.
- The options continue to be ranked as:
 - Sutton as the top ranked, and on this basis, subject to CiC review and approval, the preferred option.
 - St Helier as the second ranked option and,
 - Epsom as the lowest ranked option

No decision will be made until after consultation.

The work set out within this pre-consultation business case was assured by a range of organisations prior to any decision-making

This pre-consultation business case and the work set out within it was assured by a range of organisations. This includes:

- NHS England and Improvement: Any proposal for service change must satisfy the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks and be affordable in capital and revenue terms. This also includes ensuring each option submitted for public consultation is sustainable in service and revenue and capital affordability terms.

- The Joint Clinical Senate for London and the South East: This organisation scrutinised the clinical model and provided recommendations to address, which have been incorporated within this PCBC.
- The joint health authority oversight and scrutiny committee reviews the PCBC as it relates to the planning, provision and operation of health services in their local area.

A further assessment of the possible impact of the options and any changes were captured as part of the detailed interim integrated impact assessment. This identified positive and negative impacts of any proposals and recommend mitigations.

We submitted the draft PCBC to NHS England and NHS Improvement for assurance and decision in principle on availability of capital. Any final decision-making by the Committees in Common will be informed by this assurance and the reviews that have already taken place, including:

- the outputs of **early engagement**;
- the options consideration process;
- the outputs of the detailed provider impact analysis;
- assurance by **NHS England and NHS Improvement** of this pre-consultation business case;
- assurance by the **Clinical Senate** of the clinical model;
- outputs of the integrated impact assessment; and
- any public consultation (subject to CiC approval of this document).

The implementation plan describes, subject to assurance, public consultation and decision-making by the Committees in Common of CCGs, the provisional high-level steps to implement the preferred solution. Following assurance and consultation, a decision-making business case (DMBC) will be developed to review the outcomes and set out any decisions for the Committees in Common to consider.

This PCBC summarises the work we have carried out to date.

An overall summary of the options is shown below. We will consider any additional material evidence in relation to all options throughout the process. No decision on options will be made until after consultation.

Table 9: Overall summary of options

Category	No service change	Sutton	St Helier	Epsom
Non-financial rank		1	2	3
Financial rank		1	2	3
Advantages		<ul style="list-style-type: none"> • Delivers the clinical model and associated benefits • Joint working with RMH • Delivers an additional UTC • Lowest increase in median travel time • Lower impact on older people (vs. St Helier) and deprived communities (vs. Epsom) • Some impact on providers • Least complex build – new build • Shortest build time • Highest NPV of the options 	<ul style="list-style-type: none"> • Delivers the clinical model and associated benefits • Some impact on other providers • Lower impact on deprived communities (vs. Epsom) • Lowest total capital requirement for the options 	<ul style="list-style-type: none"> • Delivers the clinical model and associated benefits • Lower impact on older people (vs. St Helier)
Disadvantages	Undeliverable – for comparative purposes only	<ul style="list-style-type: none"> • Highest total capital requirement of the options 	<ul style="list-style-type: none"> • Second greatest increase in median travel time • Greatest impact on older people • Most complex build – extensive refurbishment with multiple decants/phases • Longest time to build • Second highest NPV 	<ul style="list-style-type: none"> • Greatest increase in median travel time • High impact on providers • Greatest impact on deprived communities • Medium complex build – extensive refurbishment • Second shortest time to build • Lowest NPV of the options • Second highest total capital requirement
Risks		<ul style="list-style-type: none"> • Potential further benefits from London Cancer Hub – including potential shared surgical centre • Risk of additional provider impacts from further development • Greater number of intersite transfers required 	<ul style="list-style-type: none"> • Intersite transfers required 	<ul style="list-style-type: none"> • Staffing and maintaining a L2 neonatal unit • Significant capacity required from other providers • Intersite transfers required

PURPOSE OF THIS DOCUMENT

This pre-consultation business case details the key challenges faced by our healthcare system and describes why change is necessary. It details a sustainable clinical model for our combined geographies based on clinical standards and evidence based best practice, and sets out an approach for options consideration to address our case for change and deliver the clinical model, resulting in a non-financial and financial appraisal of a short list of options.

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.

This pre-consultation business case outlines:

The case for change, which 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 other acute services in Surrey Heartlands or South West London.

The process we have been through to support decision-making in terms of principles, governance and engagement. It describes:

- The governance groups established to make recommendations to the Committees in Common as part of any decision-making process.
- The development of the clinical model and finance and activity model through workstreams reporting to key governance groups.
- The options consideration process and public and stakeholder engagement.

The public and stakeholder engagement that has been carried out by the programme.

- Our engagement sought feedback on the emerging clinical model, case for change and potential solutions set out within the *Issues Paper*.
- Feedback gathered from local residents, patients, carers and equality groups informed each stage of the development of proposals.
- Specific engagement as undertaken to gather feedback from patient groups most impacted by potential changes to major acute services as well as equality groups.

The clinical model, which describes district services, major acute services and the potential benefits for patients and staff.

- It was developed locally by our Clinical Advisory Group and its working groups, with inputs from a number of other stakeholders.

- It describes how we will deliver district hospital services and major acute services to ensure the very best quality of care is available to our local population. It describes the services that will be provided to meet local needs and the co-dependencies between them.
- It is expected to result in improved outcomes for patients and an improved staff experience, with a wide range of potential impacts including clinical, workforce, technology and estates benefits.

The standard approach to understand and evaluate the possible options to deliver the clinical model. This document describes a long list, initial tests to reach a short list, and the evaluation of the short list through defined 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.
- Set out a detailed non-financial and financial options consideration process for the short list, with an estimation of the costs and benefits of different options.

The analysis of financial impact and affordability of the short list of options for consideration by the Committees in Common.

- This describes a range of financial metrics to assess the financial impact of the short listed options, where system net present value was used as the key indicator.
- It sets out an affordability analysis for each of the short listed options based on a range of financing options.

A plan to assure and potentially implement our plans if a decision is made to move forward.

- This sets out the assurance process that has been undertaken for this pre-consultation business case, including the NHS England process and the integrated impact assessment.
- Should a decision be made to proceed to consultation, our consultation plan sets out the aims of our consultation to ensure a broad range of views are heard and decision-making appropriately informed.
- The implementation plan describes, subject to assurance, public consultation and decision-making by the Committees in Common, the provisional high-level steps to implement any preferred option.

SCOPE OF THIS DOCUMENT

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. 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 as well as our Long Term Plans, are expected to deliver the wider changes needed in the system.

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 Long Term Plans and are described further in this document.²

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. 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.³ 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 further acute services reconfiguration across the region.⁴

We are therefore focused on addressing issues that affect our combined geographies of Surrey Downs, Sutton and Merton CCGs, while aiming to retain major acute services in that geography and secure investment for the area. Wider changes or other acute services across South West London, Surrey Heartlands or individual clinical commissioning groups are out of scope of the programme.

The programme will continue to work within the context of the other emerging initiatives and will consider any further initiatives as they arise. As part of this pre-consultation business case, we have also assessed the impact of potential changes on the local acute providers outside our combined geographies.

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 will ensure we take all feedback from any consultation into consideration, and understand the views of those within our geography and those living in other areas separately.

² 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>

³ *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>.

⁴ *Surrey Heartlands Sustainability and Transformation Plan* (October 2016) <http://www.surreyheartlands.uk/wp-content/uploads/2017/04/surrey-heartlands-stp-october-2016.pdf>

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1 INTRODUCTION AND BACKGROUND

The Improving Healthcare Together 2020-2030 programme was established by Surrey Downs CCG, Sutton CCG and Merton CCG to address long-standing issues within our combined geographies.

Surrey Downs, Sutton and Merton CCG are located across the Sustainability and Transformation Partnerships of Surrey Heartlands and South West London, and commission services for a combined population of 720,000.

There are health inequalities and areas of deprivation across our geography, which means that there are varying health needs. Future health and care services need to be designed to ensure we meet the needs of our whole population. Our local health and care strategies aim to prevent as much ill health as possible and ensure services are high quality. We are also progressing our work to integrate care to deliver care closer to patients' homes.

We are continuing to work with all local health and care organisations to improve healthcare for our populations. This includes but is not limited to primary care, community care, mental health, social care and acute care.

To address the issues within our combined geographies, we have now developed this pre-consultation business case which explores the options to deliver our vision for future healthcare and address our challenges in detail.

1.1 Aims of the pre-consultation business case

This programme seeks to address long-standing issues in our combined geographies.

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

This 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.⁵

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).

Previously we published the *Issues Paper*, which described these challenges and launched a programme of public engagement on the case for change, clinical model and development of potential solutions.

Following our engagement programme, to address the issues within our combined geographies, we have now developed this pre-consultation business case which explores the options to address these challenges in detail.

⁵ 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>

1.1.1 Building on previous work

We have developed this programme to identify potential solutions and ensure consensus is maintained across the system.

The issues at ESTH (explored further in Section 2) are longstanding and there have been numerous attempts to resolve them. These did not address a number of critical issues and did not have full commissioner support, and therefore were not successful. However, these issues remained and have worsened, creating a need for change at ESTH.

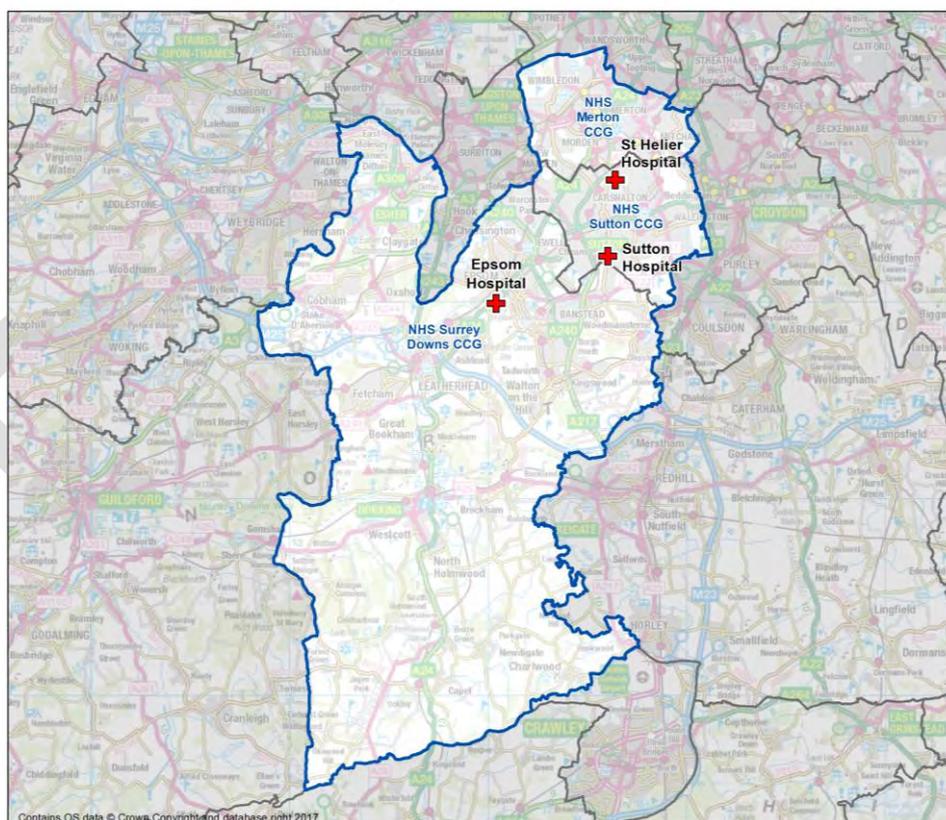
In 2017 ESTH published a strategic outline case (SOC) for investment in its hospitals.⁶ This document described ESTH's view of its challenges. As commissioners, we accepted that there were issues to address and agreed to commence further work to explore the future for healthcare locally.

To address the issues the Trust faces, we need to firstly determine that there is a clear case for change and consensus among commissioners and providers that something must change. We then need to agree the right options to address these issues and identify the best option for our populations.

1.2 Geography and demographics of the region

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 3).

Figure 3: Combined geographies of Surrey Downs, Sutton and Merton⁷



⁶ Strategic outline case for investment in our hospitals 2020-2030 (2017) <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93jijm4n8158.pdf>

⁷ Improving Healthcare Together 2020-2030 analysis

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 ICS 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).

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.

Figure 4: Catchment of ESTH shown by A&E attendances for the combined geographies

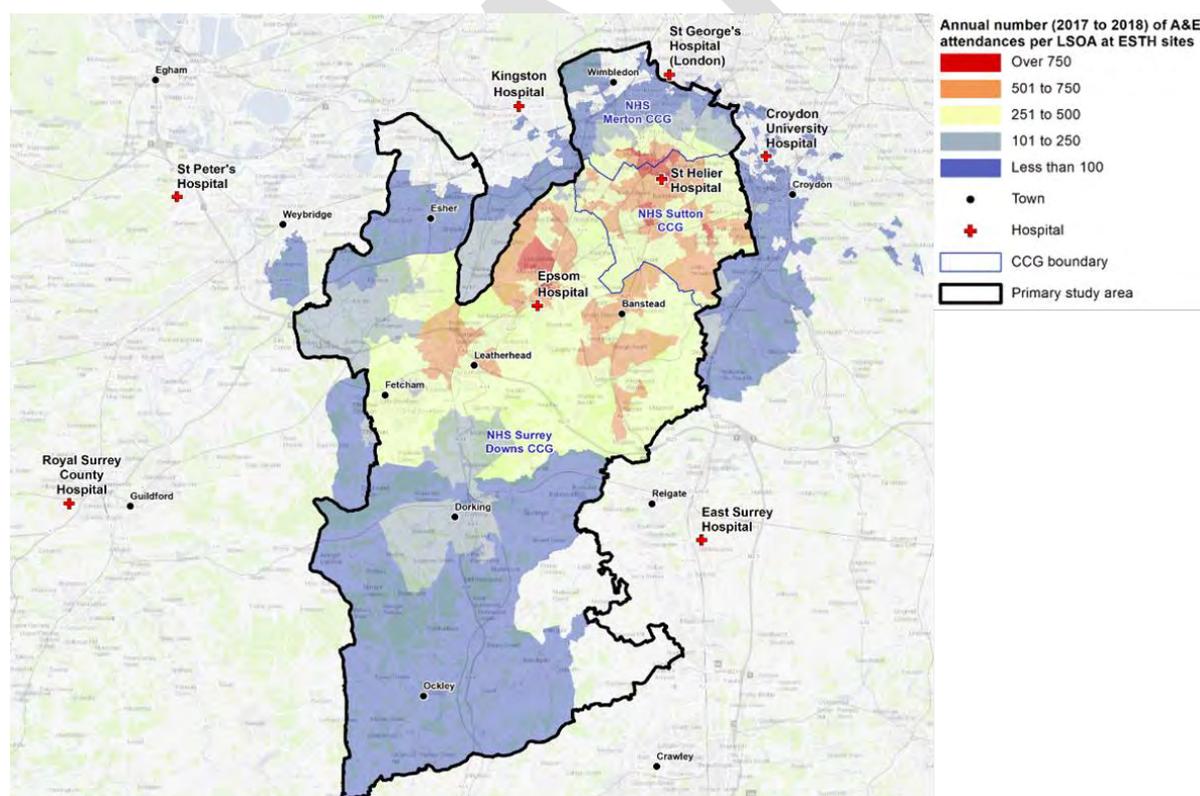


Figure 4 shows the catchment of ESTH by total number of A&E attendances at ESTH sites (Epsom and St Helier) for 17/18, commissioned by all SWL CCGs and Surrey Downs CCG. The map shows there are a high number of A&E attendances in areas which are close to the Epsom and St Helier sites. As the distance from Epsom and St Helier sites increases, there are fewer A&E attendances at these sites, reflecting the different local acute hospitals for these patients. ESTH therefore does not serve the whole geography of Surrey Downs, Sutton and Merton CCG, with some patients flowing to other providers.

The population of Surrey Downs, Sutton and Merton is growing and getting older. For example, since 2014, the population has grown by 4% in Surrey and 5% in Sutton and Merton. This is expected to continue to grow 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 health and care system can be designed and targeted in the right way to meet the needs of our growing and ageing populations.

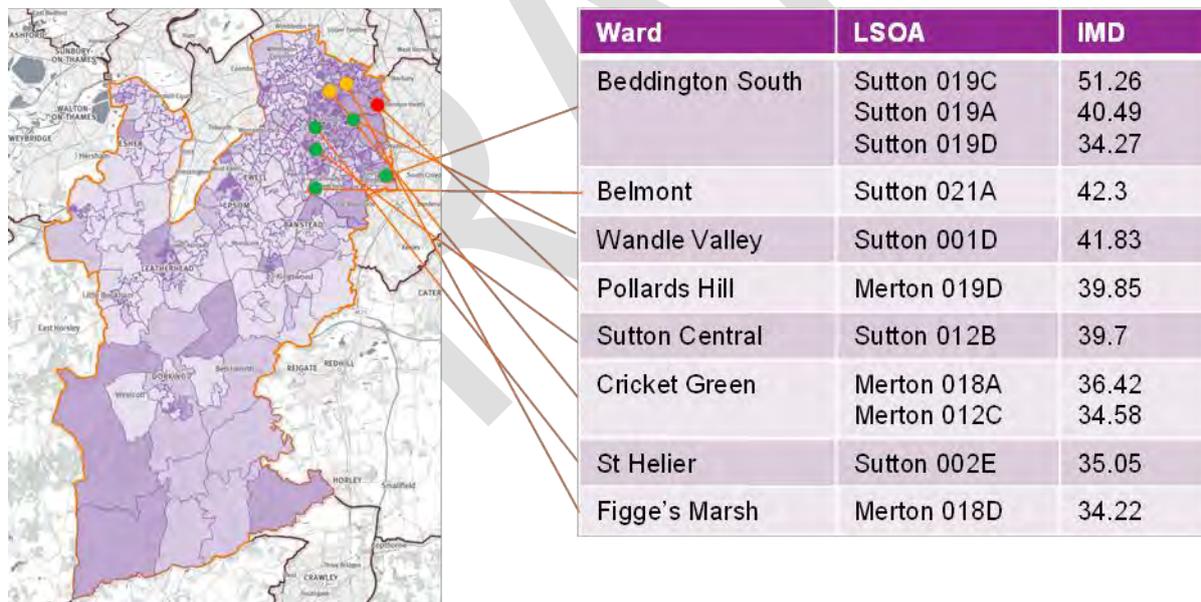
1.2.1 Deprivation

While much of the area is among the most affluent in England, 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.

Ranked nationally, Merton ranks 153 out of 191 CCGs in the overall Index of Multiple Deprivation (“IMD”), Sutton ranks 161 and Surrey Downs ranks 188 where 1 is the most deprived and 191 is the least deprived⁸. 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.⁹

Analysis has shown that while those from areas of high deprivation do not necessarily have a disproportionate need for acute services they do tend to have a higher usage compared to other groups which is linked to poor health behaviours¹⁰.

Figure 5: LSOAs in most deprived quintile in the combined geographies and the Trust’s catchment area ¹¹



Future health and social care services need to be designed to ensure that the needs of the most deprived communities are met. The analysis undertaken by the local authorities covering the

⁸ Deprivation study

⁹ 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 (2019)* <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>

¹⁰ Equalities scoping report

¹¹ *English indices of deprivation (2015)* <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

combined geography, in line with the deprivation impact assessment, have identified that those residing in the highest quintiles of deprivation (largely to the East of Merton and the north of Sutton with some areas of high deprivation also in Belmont and Beddington South) typically have poorer health outcomes particularly when reviewed against indicators such as premature mortality and years of potential life lost.

To understand this further, we commissioned an independent report to explore the healthcare issues associated with deprivation. This concluded:

1. There is a wealth of evidence that health outcomes decline with increasing deprivation;
2. However, there is less evidence linking deprivation with the need/usage of the specific major acute services;
3. In addition, within the combined geographies, overall deprivation is comparatively limited when compared nationally. There are, however, individual LSOA areas within the most deprived quintile nationally which is a helpful indicator of the areas of greatest need;
4. These pockets of the most deprived LSOAs are dispersed in several locations, in Sutton and Merton;
5. The geographical area of Sutton and Merton, which contains the pockets of deprivation, is fairly concentrated resulting in a relative ease of access to major acute services. Changes to locations of major acute services within the short list are likely to have relatively marginal impact on access.
6. Addressing health inequality is an important goal for those accountable for population health, but decisions about the major acute service locations within the combined geographies are likely to only have marginal impacts on this. A greater impact on health outcomes for deprived communities within the combined geographies would be more likely to come from concerted effort earlier in the health and care service pathways prior to need for major acute services. It is also likely to require involvement of wider partners on the wider social determinants of health.

In addition, the report recommended that the individual responsible CCGs as part of their wider responsibilities for population health management may consider, for people living in the LSOAs in the most deprived quintile:

- Further research into what works in relation to the needs of these people in relation to managing demand and improving health outcomes;
- Creating an evidence-based plan targeting the specific needs of these people; and
- Formative evaluation to understand and monitor health outcomes.

This has been further assessed through a detailed interim integrated impact assessment, which is described further in Section 10.6.

Local CCG strategies provide the opportunity for a locality to design and target these local services to those population groups who may currently face inequalities in access or in outcome. These local strategic priorities have clear alignment in seeking to reduce health inequalities through increased access to local primary or community care, a focus on prevention, as well as targeted initiatives to manage patients with risk factors around diabetes or high blood pressure and supporting behaviour change.

1.2.2 Health inequalities

Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by one's economic and social status. They are however largely preventable.

The Joint Health and Wellbeing Strategies and Joint Strategic Needs Assessments for Surrey Downs, Sutton and Merton describe the health needs of the population of our combined geography. These assessments have a particular focus on health outcomes, disease prevalence and health inequalities.

Sir Michael Marmot's 2010 report 'Fairer society, healthy lives' found that people living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods. People living in poorer areas not only die sooner, but spend more of their lives with disability - an average total difference of 17 years.

In Surrey Downs¹²:

- Only 8.8% of children in Surrey are from low income families, with Surrey being within the top 10 least deprived counties in England. Although on the whole Surrey is widely perceived as a 'healthy and wealthy' county, it is not without its share of challenges. It is estimated that 10,600 5 to 15 year-olds in Surrey have a mental health disorder. Similarly, there is considerable variation in deprivation, with over 23,000 children in Surrey living in poverty, which is linked to poor health and wellbeing outcomes for them and their parents.
- However, in Surrey there are also pockets of inequality, which have a significant impact on those children's outcomes - both health related and more widely. The Income Deprivation Affecting Children Index indicates that whilst overall 10% of Surrey's children are impacted by income deprivation, in the worst affected areas over 40% are affected. Where poverty exists, it is also frequently accompanied by higher incidence of poorer average health, obesity, isolation and difficulty accessing local support services.

In Sutton:

- The JSNA shows that Sutton ranks as one of the healthier boroughs in England, with mortality rates lower than the averages for England and for London¹³¹⁴.
- However beneath this overall profile there are variations within the borough. The more disadvantaged electoral wards tend to have higher mortality rates. Mortality ranged from 28% lower in Nonsuch to 19% higher in Sutton South than the national rate. Two Sutton wards, Wandle Valley and Sutton South, had a significantly higher mortality rate than the average for England, whilst eight had a significantly lower rate (Beddington North, Belmont, Carshalton South, Worcester Park, Carshalton Central, Nonsuch, Sutton North and Carshalton South and Clockhouse).

In Merton:

- The Joint Strategic Needs Assessment shows that Merton is a safe and healthy place and compares favourably with other London boroughs¹⁵. Merton is more affluent than average for England, with few people affected by severe economic deprivation. Life expectancy is higher than average and health is generally good. However, Merton is far from homogenous.
- The eastern half has a younger, poorer and more ethnically mixed population. The western half is whiter, older and richer. Largely as a result, people in East Merton have worse health and shorter lives.
- Most of the excess deaths in East Merton are because of cardiovascular disease and cancer, with larger differences seen in younger people. These large differences in mortality from cardiovascular disease and cancer are not reflected in admission rates, suggesting that the high need for services for the treatment of these two diseases in East Merton, especially below age 75 years, is not matched by the uptake of inpatient hospital services.

The report for East Merton highlights two main opportunities¹⁶:

- Improving the quality of chronic disease management in primary care is of the greatest importance. Much of this will be achieved by primary health care teams themselves,

¹² Surrey Downs Health and Wellbeing Strategy

¹³ <http://data.sutton.gov.uk/wp-content/uploads/2017/08/MORTALITY-Fact-Sheet.pdf>

¹⁴ Sutton Health and Wellbeing Strategy 2016-2021

¹⁵ Merton Health and Wellbeing Strategy 2019-24

¹⁶ https://www2.merton.gov.uk/merton_the_health_needs_of_east_merton.pdf

supported by the CCG, the public health team and others, and should be pursued regardless of changes in the healthcare infrastructure in the locality.

- Transforming how health care is delivered, with less reliance on hospital services and more imaginative and effective use of community-based approaches. This provides people with more accessible care and strengthens collective health resources.

1.2.3 Older people

The independent deprivation study¹⁷ concludes that age is the largest contributor to acute health need. Our equalities impact scoping report¹⁸ concludes that older people tend to have a higher need for/use of emergency acute services such as the emergency department, acute medicine and emergency general surgery. The integrated impact assessment further details the needs of older people for health and care services.

Currently the 90+ age group makes up 0.6%, 0.4% and 0.3% of the population of Surrey Downs, Sutton and Merton CCG respectively. By 2041, the number of people aged 90 and over is expected to grow by an average of 127% across the CCGs, compared to a growth in the general population of 14%¹⁹.

It is clear that there is variation across our combined area in level of deprivation and health inequalities. This is shown by local needs assessments and our local areas are looking to address these needs through various local strategies, as set out in the following Section.

1.3 Our priorities for healthcare

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

This is based on our understanding of local health needs and areas where we understand improvement is needed.

1.3.1 Local priorities

Local priorities include specific improvements in key disease pathways.

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

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

¹⁷ Deprivation impact analysis, independent report prepared by Cobic/Nuffield Trust/PPL

¹⁸ Improving Healthcare Together 2020-2030 Initial equalities analysis of major acute services

¹⁹ Office of national statistics, population projections by single year of age – clinical commissioning groups: SNPP Z2, 2018 based

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>

- 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.

Surrey County Council and Surrey Heartlands have developed a 10 year strategic plan, which aims to align key stakeholders to a common set of system-wide priorities with agreed targeted outcomes. These priorities are those which will have the biggest impact on population health overall in Surrey. This includes:

- **Helping people in Surrey to lead healthy lives:** Empowering the population to lead healthier lives. This includes individual lifestyle factors, but also considers built environments and how that impacts on health. This priority area is entirely focused on prevention, and about creating healthy and proactive people who take ownership of their health.
- **Supporting the mental health and emotional wellbeing of people in Surrey:** Enabling the emotional wellbeing of the population by focusing on preventing poor mental health and supporting those with mental health needs. Empowering people to seek out support where required to prevent further escalation of need, but this priority is also about creating communities and environments that support good mental health.
- **Supporting people in Surrey to fulfil their potential:** Enabling the population to generate aspirations and fulfil their potential by helping them to develop the necessary skills needed to succeed in life. This is not only related to academic success, but also to wider skills and involvement in communities. Healthy lifestyles and emotional wellbeing are fundamental to fulfilling potential - this priority builds on this by empowering citizens locally.²²

1.3.2 National priorities

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.²³

This was followed by the publication of the NHS long term plan in 2019, which describes how the challenges in the NHS may be addressed by:

- **Doing things differently:** the LTP aims to give people more control over their own health and the care they receive. It encourages more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly. It further increases the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.
- **Preventing illness and tackling health inequalities:** the LTP describes how the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2

²² Health and wellbeing strategy, Healthy Surrey, <https://www.healthysurrey.org.uk/about/strategy>

²³ *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/>

diabetes, with a particular focus on the communities and groups of people most affected by these problems.

- **Backing our workforce:** The LTP has a particular focus on workforce given current challenges. It aims to increase the NHS workforce through training and recruiting more professionals – including more clinical placements for undergraduate nurses and medical school places, and more routes into the NHS such as apprenticeships. It also aims to make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.
- **Making better use of data and digital technology:** The LTP describes a more convenient access to services and health information for patients, with the new NHS App as a digital ‘front door’, better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.
- **Getting the most out of taxpayers’ investment in the NHS:** The NHS will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS’ combined buying power to get commonly used products for cheaper, and reduce spend on administration.

In support of the FYFV and LTP, 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.²⁴ They will have greater responsibility for local healthcare but also greater autonomy to deliver that care differently.

Across our geography, we are aligned to these priorities and are developing health and care strategies to deliver these priorities. This is described below.

1.4 Health and care strategies

1.4.1 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:

- Improving the health of our populations.
- 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.

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, NHS LTP and to the priorities established by our STPs.

²⁴ 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/>

1.4.2 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. As reported by the British Medical Association, preventable ill-health accounts for an estimated 50% of all GP appointments, 64% of outpatient appointments and 70% of all inpatient bed days. It is estimated that 40% of the uptake of health services in England may be preventable through action on smoking, drinking alcohol, physical inactivity and poor diet. The impact of these factors is also having a detrimental impact on life expectancy.²⁵

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.

The importance of prevention is emphasised in our most recent Long Term Plans. In Surrey, this includes²⁶:

- Expanding social prescription services that help point people to community based support
- Embedding a population health management approach within the social prescription service and any community development initiatives
- Exploring behavioural insights into community participation, co-designing the language to describe strong communities and community participation and communicating effectively
- Supporting development of infrastructure that allows residents to take part in their communities, especially for those cohorts who may have previously experienced exclusion from community life
- Working alongside a small number of communities to understand and then model how community-statutory partner collaborations could be most effective.
- Maximising corporate social value for the benefit of local communities.

Across South West London, interventions include:

- Making sure that everyone who has to stay overnight in hospital is given the chance and provided with help to stop smoking.

²⁵ South West London Long Term Plan

²⁶ Surrey Heartlands Long Term Plan

- Rolling-out the concepts of the National Diabetes Prevention Programme, including a digital option, to other long term conditions, such as cardiovascular disease, across South West London.
- Implementing Community Health Checks targeted at hard to reach populations.
- Developing Wellbeing Hubs in our boroughs which will help our local residents access health and care support more easily, in one place.
- Providing digital tools such as smartphone apps to enable more people to access online NHS services and support self management.
- Supporting more people to attend weight management services, especially those who are obese and have another condition such as high blood pressure.

1.4.2.1 Public health measures and the role of local authorities

Socioeconomic factors (education, employment and housing) are major drivers of population health, and preventable deaths. Lifestyle factors are a further major driver, including smoking, alcohol and obesity, as well as emotional well-being.

Some of these factors are preventable. Excess weight, lack of exercise, smoking and excess alcohol consumption account for 40% of ill health and are one of the largest pressures on health and care resources²⁷.

Some of the greatest improvements in health outcomes have resulted from addressing the causes of diseases rather than just treating their consequences. Focusing on prevention has the potential to yield significant savings over the medium and longer-term. In 2014, the FYFV set out the vision for the NHS as a 'social movement', arguing that the NHS would not be sustainable without support for communities to take greater control over their health²⁸.

Surrey Heartlands ICS places preventing ill health and disability at the heart of the health system, through the delivery of interventions to improve and maintain people's physical and mental health. The delivery of this vision will improve experience and outcomes for citizens of all ages and abilities and reduce variation and health inequalities and deliver and scale at pace. Objectives include preventing the development of long term conditions by focusing on the major causes of ill health, and empowering citizens to remain independent in their own homes by supporting carers, strengthening social networks and the generation of social capital.

South West London aims to strengthen the focus on prevention and reducing health inequalities, and keeping people healthy at home by treating them earlier. Given that nationally we know that 50% of mental health conditions develop before the age of 14, and 75% by 24, South West London is prioritising children and young peoples' mental health and well-being. Merton has the second highest rate of child mental health admissions compared to comparative boroughs (122.7 per 100,000, equivalent to 56 admissions, 2014/15). This is the higher than the average for England (87.4 per 100,000) and London (94.2 per 100,000)²⁹.

Sutton has a larger than average number of children who self-harm compared to other London boroughs. The rate of admission for self-harm in Sutton has been increasing year on year and at a faster rate than most adjacent boroughs³⁰.

The South West London Health and Care Partnership has made a commitment to champion children and young people's mental health and well-being as a shared health promotion and prevention

²⁷ Public Health England, Burden of Disease Study for England, 2013

²⁸ NHS Five Year Forward View (2014)

²⁹ SWL STP

³⁰ SWL STP

activity. The reduction of self-harm in children and young people is the first focus for this programme³¹.

1.4.3 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 integrating care. All of the CCGs are considering the provision of care and how this can be integrated, involving the redesign of key pathways, including changes to outpatients, community and intermediate support and primary care.

In Surrey Downs, as part of devolution to the STP and development of integrated care in Surrey Heartlands (see Section 1.4.3.1), 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.

As part of the SW London Health and Care Partnership each borough is developing a Health and Care Plan. 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 (this includes Sutton Health and Care, as described in Section 5.4.1.2), 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.

³¹ SWL Health and Care Partnership: Children and young people's mental wellbeing, May 2018

- **Merton health and care together:** This new partnership aims to establish a shared vision to improve the integration and delivery of the health and care that the people of Merton receive³².

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

1.4.3.1 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.³³

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.³⁴

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.

1.4.3.2 London Health and Care Devolution

Since 2015, health and care partners across London and nationally have worked to develop London's health and care devolution deal.

In December 2015, London Partners committed to work more closely together to support those who live and work in London to lead healthier independent lives, prevent ill-health, and to make the best use of health and care assets. The London Health Devolution Agreement sets out the transfer of decision-making closer to local populations to accelerate transformation plans and respond to the needs of Londoners more quickly.

The London Health and Care Devolution Programme is underpinned by three key principles:

- Devolution proposals must be co-developed locally by pilots;
- Grounded in the needs of our local populations; and
- Shaped through collaboration with national and London partners.

³² <http://www.mertonccg.nhs.uk/about-us/Our-Governing-Body/Merton%20Board%20Papers/9GB%20JUN18%20PT1%20MHCP.pdf>

³³ *Integrated care systems* <https://www.england.nhs.uk/systemchange/integrated-care-systems/>;

³⁴ *Devolution Pledge* <http://surreyheartlands.uk/devolution/surrey-health-care-organisations-sign-devolution-pledge/>

The approach of the programme has been to explore how devolution could work through five pilots. These pilots have focused on three priorities that emerged from Better Health for London - prevention, health and care integration and making best use of NHS buildings and land³⁵.

1.4.3.3 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:

- **Surrey Downs 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 Section 5.4.1 for further detail on Surrey Downs Health and Care). ESTH is providing community services for the Surrey Downs population in partnership with Central Surrey Health and the three GP federations that cover Surrey Heartlands ICS. This incorporated Surrey Downs Health and Care from April 2019.
- **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:

- From April 2019, adult and children's community services in Sutton has been provided by Sutton Health and Care, hosted by ESTH and the London Borough of Sutton respectively.
- **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 Section 5.4.1.2 for further detail on Sutton Health and Care).
- **The Sutton Health and Care Plan has been developed to deliver against the NHS LTP**, including how an Integrated Care Place is established in the area through partners in Sutton working together to define and drive the strategy and transformation plans that will ensure that the right care is delivered in the right place for local residents.
- **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 patient cohorts

³⁵ Health and Care Devolution, November 2017

https://www.london.gov.uk/sites/default/files/what_health_devolution_means_for_london_2017.pdf

- 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.

1.5 Current service provision in the local area

1.5.1 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 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.³⁶

There are 78 practices across Surrey Downs, Sutton and Merton CCGs, covering a population of 732,000.

Table 10: Practices across Surrey Downs, Sutton and Merton³⁷

	Number of practices	Number of patients
Merton	23	221,990
Sutton	25	202,418
Surrey Downs	30	307,896

Surrey Downs has a ratio of patients to GPs at 1,452 patients per GP, with Sutton at 1,510 and Merton at 1,479³⁸. 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 East³⁹.

Primary care networks and primary care at scale is in development across Surrey Downs, Sutton and Merton. This includes the development of federations of practices, Primary Care Homes, extended access and new types of care delivery, with a greater use of networks, shared workforce, shared back office and shared clinical services to enhance the scale and scope of primary care.

1.5.2 Community

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

³⁶ *General Practice Forward View* (2016) <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

³⁷ Patients Registered at a GP Practice - November 2018, NHS Digital

³⁸ General and Personal Medical Services, England, Detailed Tables March 2018, NHS digital

³⁹ *General and Personal Medical Services, England* (March 2017) <https://digital.nhs.uk/catalogue/PUB30044>

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. CSH Surrey has been providing therapy and community nursing services to the Surrey Downs CCG population since 2006 and is the main provider of community services. Adult community services are provided by Epsom Health and Care.

Since April 2019, adult and children's community services in Sutton has been provided by Sutton Health and Care, hosted by ESTH and the London Borough of Sutton respectively.

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.

1.5.3 Mental health

There are variations in mental health needs across the combined geographies and service provision varies according to differing commissioning intentions, clinical views and historical service infrastructure.

In Surrey Heartlands, people who use services, carers and professionals report gaps in the current provision of mental health. This includes ineffective working to deliver services across the system, barriers to change and a lack of integration of mental and physical healthcare. There is a defined need within the STP to improve access to early intervention services and ensure that people complete treatment to prevent escalation of need.⁴⁰

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 a significant investment in mental health services is ongoing. 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.

In SWL, the aim is to make sure that people who are being treated in an inpatient service are as close to their home as possible and to provide better care for both young people and adults experiencing a mental health crisis. Hospitals will have 24 hour psychiatric liaison services in place to ensure that patients with a mental health crisis are seen by the appropriate experts.⁴¹

Currently ESTH provides a 24/7 psychiatric liaison service at St Helier, and a 8am to 12am service at Epsom which has now received funding to increase its provision to 24/7.

1.5.4 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.

⁴⁰ Surrey Heartlands ICS

⁴¹ SWL discussion document

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.

There is a national workforce challenge within social care, which is reflected within Surrey Downs, Sutton and Merton. In South West London there are 686 organisations related to social care, with a workforce of approximately 34,000 WTE. The estimated turnover rate in South West London is 30.7% with a vacancy rate of 9.9%. 30% of staff in South West London are over 55 and therefore more than 7,000 staff will be retiring within the next 5 to 10 years. If the workforce grows proportionally to the projected number of people aged 65 and over, then the number of adult social care jobs needed in the London region will increase by 38% by 2035 (16,000-19,000 jobs in South West London)⁴². New staffing models are considering how social care services may be incorporated into MDTs at the primary care network level in localities across South West London, which would look to support out of hospital interventions and provide care closer to home for patients who otherwise may have been admitted to hospital.

There is a similar picture in Surrey, which has developed several initiatives to address workforce challenges such as the Surrey Training Hub (also known as Surrey CEPN). The Training Hub aims to attract, develop, support and retain health and social care professionals working across primary and community settings (for example GP surgeries, community clinics, care homes) throughout Surrey to ensure the provision of high quality care and services to patients⁴³.

1.5.5 Acute care

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. ESTH is unusual as it crosses both STPs and is the only acute Trust in England to be situated within two different NHS planning regions.

⁴² South West London Long Term Plan

⁴³ Surrey Heartlands Long Term Plan

Table 11: NHS acute trusts in Surrey Heartlands and South West London⁴⁴

NHS Trust	Hospital site(s)
Surrey Heartlands ICS	
Epsom and St Helier University Hospitals Trust	<ul style="list-style-type: none"> • St Helier Hospital and Queen Mary's Hospital for Children, Carshalton (geographically in London) • Sutton Hospital, Sutton (geographically in London) • Epsom Hospital, Epsom
Ashford and St Peter's Hospitals Foundation Trust	<ul style="list-style-type: none"> • Ashford Hospital, Ashford (planned) • St Peter's Hospital, Chertsey
Royal Surrey County Hospital Foundation Trust	<ul style="list-style-type: none"> • Royal Surrey County Hospital, Guildford
South West London STP	
Croydon Health Services Trust	<ul style="list-style-type: none"> • Croydon University Hospital, Croydon
Epsom and St Helier University Hospitals Trust	<ul style="list-style-type: none"> • St Helier Hospital and Queen Mary's Hospital for Children, Carshalton • Sutton Hospital, Sutton • Epsom Hospital, Epsom (geographically in Surrey)
Kingston Hospital Foundation Trust	<ul style="list-style-type: none"> • Kingston Hospital, Kingston upon Thames
St George's University Hospital Foundation Trust	<ul style="list-style-type: none"> • St George's Hospital, Tooting

Surrey and Sussex Healthcare Trust is a further provider located close to our combined geography within Sussex and East Surrey STP.

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).

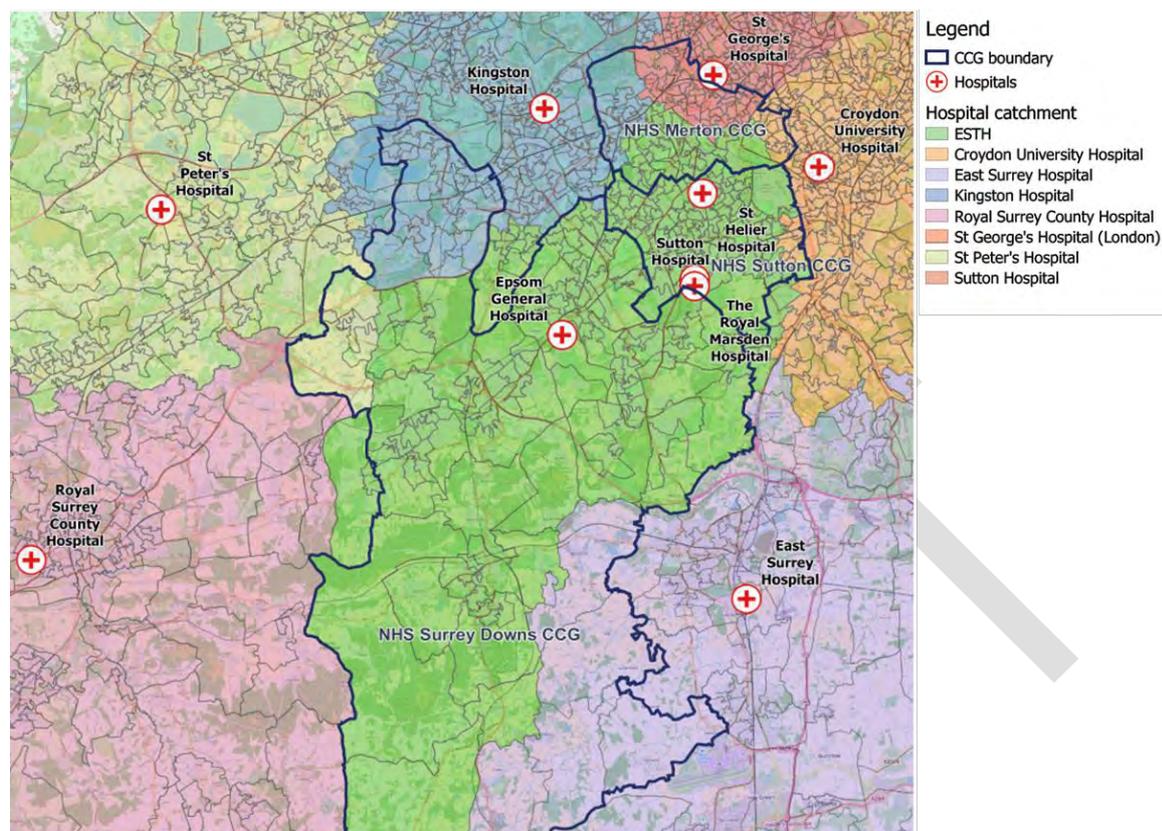
- **Epsom Hospital and St Helier Hospital** are district general hospitals, each providing a 24/7 consultant-led accident and emergency (A&E), acute and general medicine, maternity, children's services and outpatients. In addition, Epsom Hospital hosts the South West London Elective Orthopaedic Centre (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.

The map below shows the locations of acute hospitals across the combined geographies and the wider area, and includes the catchment areas of the Trust⁴⁵.

⁴⁴ Improving Healthcare Together 2020-2030 analysis

⁴⁵ These catchment areas are based on the closest hospital by travel time and may not reflect actual patient flows.

Figure 6: Map of ESTH catchment and Surrey Downs, Sutton and Merton CCGs



1.5.6 ESTH provision of care

Epsom and St Helier University Hospitals Trust offers an extensive range of services, including cancer, pathology, surgery, and gynaecology. St Helier Hospital is home to the South West Thames Renal and Transplantation Unit and Queen Mary's Hospital for Children, while Epsom Hospital is home to the South West London Elective Orthopaedic Centre (SWLEOC). Both Epsom and St Helier hospitals have emergency departments and maternity services. There is a workforce of almost 5,000 staff and 500 volunteers, with nearly 900,000 people coming to these hospitals for care and treatment every year.

The Trust offers a full range of diagnostic facilities, including endoscopy, pathology and radiology (MRI, nuclear medicine, spiral CT scanning, multi-slice CT scanning, ultrasound and vascular diagnostic services).

1.5.6.1 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 a partnership between ESTH, St George's, Croydon and Kingston Trusts and 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).⁴⁶ The facility is located

⁴⁶ 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

on the Epsom Hospital site but is self-contained with 71 beds and a high dependency unit.⁴⁷ In 2016, the Care Quality Commission rated the service as outstanding – its highest rating – with patient outcomes and patient satisfaction consistently exceeding national averages.⁴⁸

- **Emergency surgery:** Since October 2006, emergency surgery has been consolidated at St Helier 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.)⁴⁹
- **Critical care:** A Level 3 ITU has been consolidated at St Helier Hospital. High dependency care is still provided at Epsom Hospital.
- **Elective surgery:** Most services have now been centralised at Epsom Hospital (day case surgery and inpatients).
- **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)⁵⁰.

⁴⁷ South West London Elective Orthopaedic Centre <http://www.eoc.nhs.uk/>

⁴⁸ 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

⁴⁹ *Dr Foster Intelligence: Quality Investigator (2014)*

⁵⁰ *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/>

2 CASE FOR CHANGE

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.

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:

- **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.
- **Providing healthcare from modern buildings**: Our acute hospital buildings are ageing and are not designed for modern healthcare.
- **Achieving financial sustainability**: The cost of maintaining acute services across two hospital sites is a major driver of the system's deficit. This is a major challenge to the sustainability of the local health economy.

2.1 Addressing health economy challenges

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 which are aligned to our priorities for healthcare, 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 and future plans (see Section 1.4.1). 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.

2.1.1 Population health needs

People in Surrey Downs, Sutton and Merton are generally more affluent and have better outcomes than the rest of England⁵¹, although there is significant variation.

⁵¹ 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)*

The populations across Surrey Downs, Sutton and Merton vary significantly, although outcomes across all three areas are generally better than the average for England.⁵²

- Surrey Downs has a comparatively older and less ethnically diverse population, living in more rural areas, and is more affluent than the England average.⁵³ While outcomes are better than the England average, there is some variation, including cancer survival rates.
- 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.⁵⁴

2.1.2 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 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.⁵⁵ 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.⁵⁶ 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

<https://www.ons.gov.uk/economy/regionalaccounts/grossdisposablehouseholdincome/datasets/regionalgrossdisposablehouseholdincomegdhbylocalauthorityintheuk>

⁵² 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

⁵³ For example: 56% of the population is of persons aged between 20–64 years and 20% are aged 65 years and over.

⁵⁴ *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>

⁵⁵ *UK health and social care spending* <https://www.ifs.org.uk/uploads/publications/budgets/gb2017/gb2017ch5.pdf>

⁵⁶ *Population estimates* <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates>

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 40.⁵⁷ 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 condition⁵⁸, and across Surrey Downs, Sutton and Merton, a number of these conditions are particularly prevalent, including⁵⁹:

- 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 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.⁶⁰

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.⁶¹ People with a serious mental illness are more likely to die at an earlier age.

⁵⁷ *Long Term Conditions Compendium of Information: Third Edition* (2012) <https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition>

⁵⁸ *Long Term Conditions Compendium of Information: Third Edition* (2012) <https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition>

⁵⁹ *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>

⁶⁰ *Surrey Heartlands Sustainability and Transformation Plan* (October 2016) <http://www.surreyheartlands.uk/wp-content/uploads/2017/04/surrey-heartlands-stp-october-2016.pdf>

⁶¹ *Depression Reported Prevalence: Disease Register, Estimated Population 18yrs +, Quality and Outcomes Framework (QOF)* (2015/16)

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.

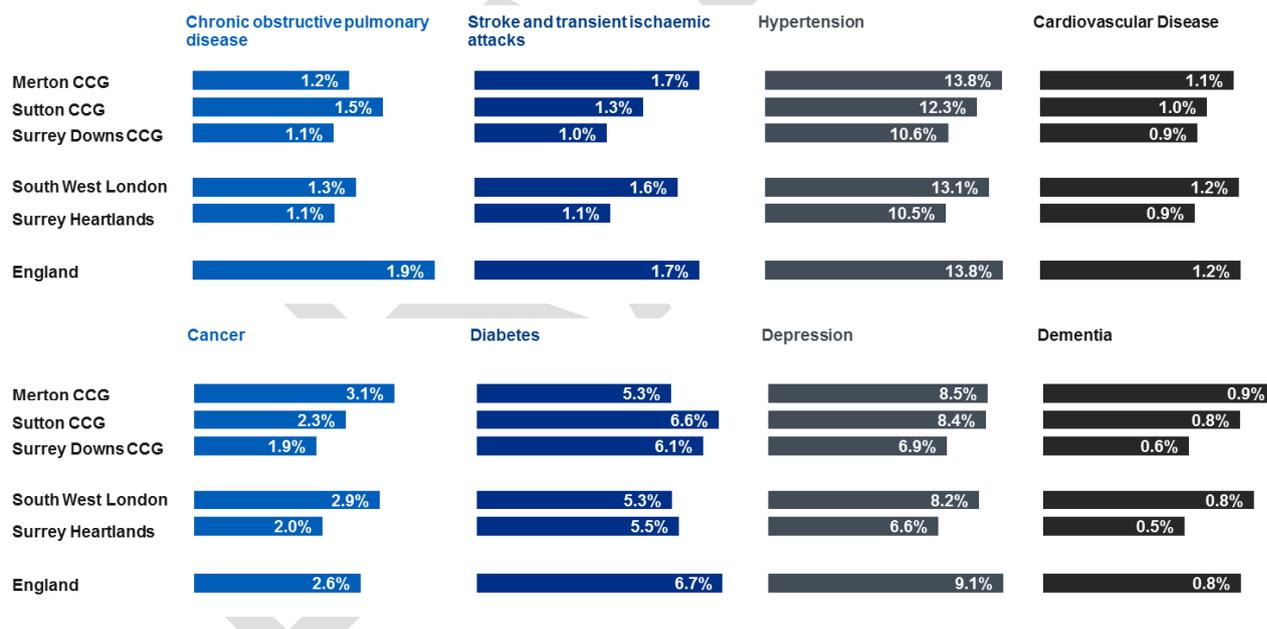
More than one person in three will develop cancer at some time in their lives, and one in four will die of the condition. Cancer can develop at any age, but it is most common in older people. Cancer is prevalent in around 2% of the population in Merton and Sutton and around 3% of the population in Surrey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

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

2.1.3 Areas of unwarranted variation

Around one in four people have two or more long-term conditions or ‘multimorbidity’. This rises to two thirds of people aged 65 years or over⁶². Multimorbidity is associated with higher mortality, adverse drug events and greater use of unplanned care⁶³.

Figure 7: Prevalence of long term conditions, QOF data, 2016/17



As shown by the chart above, Surrey Downs, Sutton and Merton CCGs generally have a lower rate of prevalence for long term conditions compared to national rates. However, there is variation in their care outcomes compared to the national average.

- For Surrey Downs, Merton and Sutton the average percentage of patients with a LTC who are achieving reliable recovery is lower than the national average.

⁶² [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(12\)60240-2.p](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)60240-2.p)

⁶³ *http://www.bmj.com/lookup/ijlink?linkType=FULL&journalCode=bmj&resid=354/sep21_16/i4843&atom=%2Fbmj%2F354%2Fbmj.i5195.atom

- Surrey Downs, Merton and Sutton CCGs have a higher percentage of residents with dementia who had an emergency admission in the last year of their life than the England average, and a higher average annual number of ordinary hospital admissions.
- For cancer, the average annual number of days spent in emergency hospital admissions during the last year of life of CCG residents was higher for Surrey Downs, Merton and Sutton. The percentage of deaths in usual place of residence for people with cancer was also below average. In addition, the average annual number of days spent in ordinary hospital admissions during the last year of life was also higher than the national average for Surrey Downs.
- Under 75 mortality for serious mental illness is high for Merton, and for Sutton in particular.
- There is a high proportion of people aged over 65 in hospital for ten days or more for Surrey Downs, Sutton and Merton.
- For Sutton and Merton, there is a higher than average rate of emergency admissions aged 75+ with a stay of under 24 hours per 100,000 population.
- In Surrey Downs, there is a lower percentage than average for people aged 65 and over who received reablement/rehabilitation services after discharge from hospital, as well as those who were still at home 91 days after discharge from hospital into reablement/rehabilitation services⁶⁴.

2.1.4 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 becoming increasingly rigorous. 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.⁶⁵

Nationally, the Royal College of Emergency Medicine (RCEM) has recommended minimum staffing levels for emergency departments.⁶⁶ 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 provided in South West London or operated by a South West London trust.⁶⁷ 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:

⁶⁴ NHS RightCare, Long term condition focus packs, 2016.

⁶⁵ *Seven Day Services Clinical Standards* (2017) <https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

⁶⁶ *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>

⁶⁷ *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.

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

The standards were based on national standards and developed by the medical directors of the four acute trusts in SWL. They were approved by the SWL Clinical Senate on 28th September 2017 (see Figure 8).

Figure 8: Selected requirements of standards for major acute services⁶⁸

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 12; some vary by size and specialisation of the unit.

Table 12: Consultant hours of cover and headcount to meet standards⁶⁹

Service	Hours of cover	Min number of consultants on rota (per site)
Emergency department⁷⁰		
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

⁶⁸ *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

⁶⁹ *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.

⁷⁰ Emergency department requirement expressed in WTE.

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
Paediatrics⁷¹		
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 ⁷²
Acute medicine⁷³		
Requirement to meet the standards	14/7	12
Intensive care⁷⁴		
Requirement to meet the standards	12/7	9

An effective consultant-led model of care has been shown to be more efficient in delivering care, with decreased length of stay, more efficient use of beds, decreased rates of readmission and decreased need for patient follow-up. Consultants are central to educating new doctors and developing research and innovation.⁷⁵ 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.

These benefits will enable patients to be seen more quickly, by specialists 7 days a week. This will improve patient access to services, outcomes and experience of services.

Evidence is well established around the correlation of improved patient outcomes as a result of consultant delivered care in emergency medicine, with many studies providing evidence that patients experience increased morbidity and mortality when there is a delay in involvement of a consultant in their care. Consultants improve safety, quality and efficiency of clinical care through:

- Enhanced clinical decision making, especially by leading the resuscitation of critically ill and injured patients in the EDs.
- Improved supervision of junior members of the medical workforce by either direct review of cases or discussions on areas of concern. This ensures that patients are provided with the most efficient, and effective diagnostic and therapeutic pathways if they need to be admitted.
- Reducing numbers of serious incidents and complaints through robust quality improvement cycles.

⁷¹ Minimum hours also require on call.

⁷² Separate specialist paediatrics rota.

⁷³ Minimum hours also require on call.

⁷⁴ Minimum hours also require on call.

⁷⁵ Leading for Quality the foundation for healthcare over the next decade, Royal College of Physicians, 2010

2.2 The clinical challenge

2.2.1 Quality of care across acute trusts

The CQC found variation in the quality of care delivered by acute trusts (see Table 13); 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, Kingston and Surrey and Sussex.
- Areas for improvement across Ashford and St. Peter's (identified in one area, although overall rating is good), Croydon, St George's and ESTH.
- In a report in May 2019, ESTH was rated Good across most domains, other than safety which required improvement. The Trust was rated Good overall across most services, other than Urgent and Emergency Care which required improvement. The CQC highlighted staffing issues in critical care, medicine, surgery, and maternity services.⁷⁶

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:

- “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.”

This was further built upon in the latest CQC 2019 inspection report, which noted that:

- “We noted that 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”
- “The department was not achieving 16 hours a day consultant cover as requirement by the Royal College of Emergency Medicine (RCEM).”

⁷⁶ *Epsom and St Helier University Hospitals NHS Trust: Quality report (2019):*
https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ3131.pdf

Table 13: CQC inspection results

Trust	Date	Domain					Overall
		Safe	Effective	Caring	Respon- sive	Well-led	
Ashford and St. Peter's Hospitals FT ⁷⁷	2018	Requires improvement	Good	Good	Good	Good	Good
Croydon Health Services Trust ⁷⁸	2019	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Epsom and St Helier Trust ⁷⁹	2019	Requires improvement	Good	Good	Good	Good	Good
Kingston FT ⁸⁰	2018	Good	Good	Outstanding	Good	Outstanding	Outstanding
Royal Surrey County Hospital FT ⁸¹	2018	Good	Good	Good	Outstanding	Good	Good
St George's University Hospitals FT ⁸²	2018	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surrey and Sussex Healthcare Trust ⁸³	2019	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding

Though mortality rates are better than expected in most areas, there is variation in mortality rates across our acute trusts.

The standardised hospital mortality indicator (SHMI) is a measure of whether the number of deaths linked to a particular hospital is more or less than expected, and whether that difference is statistically significant. SHMI includes deaths within hospital, and deaths that occur within 30 days of being discharged. A similar metric is the hospital standardised mortality ratio (HSMR). This metric adds to the SHMI, by focussing on deaths that occur within hospital and adjusting for factors such as social deprivation. The figures for the Trusts across the area are shown below. For SHMI and HSMR, a score of below 1 and below 100 respectively indicates a better performance than expected.

⁷⁷ Ashford and St. Peter's Hospitals NHS Foundation Trust (2017) <http://www.cqc.org.uk/provider/RTK>

⁷⁸ Croydon Health Services NHS Trust (2018) <http://www.cqc.org.uk/provider/RJ6>

⁷⁹ Epsom and St Helier University Hospitals NHS Trust (2018) <http://www.cqc.org.uk/provider/RVR>

⁸⁰ Kingston Hospital NHS Foundation Trust (2018) <http://www.cqc.org.uk/provider/RAX>

⁸¹ Royal Surrey County Hospital NHS Foundation Trust (2013) <http://www.cqc.org.uk/provider/RA2>

⁸² St George's University Hospitals NHS Foundation Trust (2017) <http://www.cqc.org.uk/provider/RJ7>

⁸³ Surrey and Sussex Healthcare NHS Trust (2014) <http://www.cqc.org.uk/provider/RTP>

Table 14: Variation in mortality outcomes by Trust

Trust	SHMI (1 = expected, <1 = better than expected) ⁸⁴	HSMR – general surgery (100 = expected, <100 = better than expected) ⁸⁵	HSMR – general medicine (100 = expected, <100 = better than expected)
Ashford and St. Peter's Hospitals NHS Foundation Trust	0.98	50.42	72.60
Croydon Health Services NHS Trust	0.88	67.44	102.59
Epsom and St Helier University Hospitals NHS Trust	0.96	83.96	104.92
Kingston Hospital NHS Foundation Trust	0.82	87.16	83.71
Royal Surrey County Hospital NHS Foundation Trust	0.83	62.43	No data
St George's University Hospitals NHS Foundation Trust	0.83	105.58	72.25
Surrey and Sussex Healthcare NHS Trust	0.95	75.90	89.51

ESTH's performance against these indicators is varied, with general medicine mortality higher than expected and higher than any other Trust across the area.

2.2.2 Providing access to care

Access to emergency care across SWL and Surrey varies as acute trusts manage demand challenges.

⁸⁴ NHS Digital, October 2016 – September 2017

⁸⁵ Dr Foster: This information is published with kind permission of Dr Foster Intelligence. The information was generated by [Product name] tool, which is a proprietary software product of Dr Foster Intelligence, and Dr Foster Intelligence reserves all rights to [Product name]. No further copying or reproduction of this information is permitted without consent from Dr Foster Intelligence.

Table 15: Urgent and emergency care targets⁸⁶

Trust	% in four hours	Total attendances	Total emergency admissions	Number of patients spending >4 hours from decision to admit to admission
Ashford And St. Peter's Hospitals NHS Foundation Trust	76%	9,457	2,404	535
Croydon Health Services NHS Trust	85%	20,132	2,087	674
Epsom And St Helier University Hospitals NHS Trust	87%	15,595	3,941	355
Kingston Hospital NHS Foundation Trust	89%	11,560	2,915	340
Royal Surrey County Hospital NHS Foundation Trust	89%	6,537	2,953	13
St George's University Hospitals NHS Foundation Trust	87%	15,434	5,234	201
Surrey and Sussex Healthcare NHS Trust	95%	9,501	3,380	196

While ESTH is performing well against the four hour target, the strain on resources is showing in other metrics, such as ambulance handover times when they arrive at the emergency department, where there are significant delays.

Table 16: Ambulance handover times over winter, 2017/18⁸⁷

Trust	Arriving by ambulance	Delay 30-60 mins	Delay >60 mins
England	1,411,768	10.2%	3.0%
Croydon Health Services NHS Trust	10,077	6.6%	0.3%
Epsom And St Helier University Hospitals NHS Trust	9,995	8.9%	2.5%
Kingston Hospital NHS Foundation Trust	7,899	2.3%	0.2%
St George's University Hospitals NHS Foundation Trust	11,488	7.4%	0.1%
Ashford And St Peter's Hospitals NHS Foundation Trust	8,878	13.8%	1.8%
Royal Surrey County Hospital NHS Foundation Trust	5,019	16.6%	1.2%

⁸⁶ A&E Attendances & Emergency Admission monthly statistics, NHS and independent sector organisations in England, May 2019

⁸⁷ Ambulance performance indicators, NHS England, 2017/18

Surrey and Sussex Healthcare NHS Trust	9,969	14.5%	4.7%
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There is variation in waiting times for planned care across the region.

While ESTH is performing well across many areas when providing access to care, there are examples of where it is performing less well. One of the key performance indicators around providing access to care is referral to treatment time. This indicator shows how quickly patients are seen by a consultant after they are referred by their GP.

Table 17: Variation in access to care

Trust	% seen within 18 weeks ⁸⁸	General surgery median waiting time (weeks)	General medicine median waiting time (weeks)	Two week waits ⁸⁹
Ashford and St. Peter's Hospitals NHS Foundation Trust	91%	7.56	5.60	91%
Croydon Health Services NHS Trust	93%	7.71	9.75	98%
Epsom and St Helier University Hospitals NHS Trust	88%	7.82	6.18	98%
Kingston Hospital NHS Foundation Trust	94%	6.41	7.17	99%
Royal Surrey County Hospital NHS Foundation Trust	91%	6.89	7.21	92%
St George's University Hospitals NHS Foundation Trust	No data	No data	No data	93%
Surrey and Sussex Healthcare NHS Trust	91%	5.73	8.31	94%

2.2.3 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).⁹⁰ 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 18).

⁸⁸ NHS England, Referral to treatment data, May 2018

⁸⁹ NHS England, Two week waits, July 2018

⁹⁰ *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>

This gap is based on the standards set by SWL providers and the STP on recommendations of the clinical senate and medical directors. 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 16/7⁹¹. The SWL standards described here require a minimum of 12 to provide cover 16/7.

Based on a self-assessment against these standards, providers advised the SWL health and care partnership 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.⁹²

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.

⁹¹ *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>

⁹² *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 18: Consultant staffing against clinical standards, SWL trusts⁹³

<i>Consultants</i>	<i>Acute trust</i>	<i>Emergency department</i>	<i>Obstetrics</i>	<i>Emergency general surgery</i>	<i>Paediatrics</i>	<i>Acute medicine⁹⁴</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 ⁹⁵	24	22	10	24	24	9
	SWL	72–80	71	40	62–66	60	54
Current gap (2017)⁹⁶	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 ⁹⁷	9	9

⁹³ 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>

⁹⁴ Dedicated acute care physicians only.

⁹⁵ ESTH requirement for two sites.

⁹⁶ Gaps calculated on a site-by-site basis.

⁹⁷ General paediatric consultants only.

2.3 Staffing acute services

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.

2.3.1 Our acute workforce challenges

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

In particular, at ESTH 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. This aligns with national standards for the emergency department. For emergency departments, RCEM recommends 12-16 consultants to provide cover 16/7⁹⁸. 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.⁹⁹
- **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.
- **Nursing and midwifery posts:** ESTH currently has a vacancy rate of 29% for nursing, midwifery and health visiting staff¹⁰⁰. There is currently a 12% vacancy rate in midwifery posts specifically¹⁰¹.
- **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. While ESTH is one of the best performing trusts regarding the 95% target for treating patients within 4 hours, the Trust is not achieving all of the quality standards

⁹⁸ *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>

⁹⁹ *Strategic outline case for investment in our hospitals 2020-2030* (2017) <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93ijim4n8158.pdf&ver=19818>

¹⁰⁰ ESTH workforce data

¹⁰¹ ESTH workforce data

relating to the emergency department (see Section 2.2). This includes the time to assessment, triage, consultant sign off, ambulance handover times (as shown in Section 2.2.2) and college audits¹⁰².

Consultants are working additional hours to provide further support and cover rotas, however this is not sustainable in the future. Based on local, regional and national growth projections, 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.

2.3.2 National workforce challenges

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

Ensuring there is sufficient supply of doctors across all grades and specialties is essential to deliver excellent and safe care. In 2016, providers identified a national need for an additional 300 WTE consultants in the emergency department (a 15% increase).¹⁰³

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.¹⁰⁴

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.¹⁰⁵

A report by the Nuffield Trust found that there was variation in the level and configuration of acute medical staffing. Acute medical physicians make up 3% of the total general medical workforce. Consultant cover for acute medical services is provided by a rota of on-call consultants from the medical specialties. But the number of consultants supporting the medical on-call rota varies significantly. A number of specialties have started to withdraw from the on-call rota, including gastroenterology, which was not contributing in 35% of surveyed sites, cardiology in 60%, rheumatology in 67%, and stroke in 83%. Specialists’ progressive withdrawal from the acute medical ‘take’ leaves acute physicians and a reducing pool of other medical staff to manage the acute medical workload, while it grows in complexity and size. This is leading to increasing pressures on a reducing pool of staff¹⁰⁶.

¹⁰³ *Securing the future workforce for emergency departments in England* (2017)

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

¹⁰⁴ *Securing the future workforce for emergency departments in England* (2017)

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

¹⁰⁵ *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>

¹⁰⁶ *Acute medical care in England, findings from a survey of smaller acute hospitals*. Imison and Vaughan, 2018

In addition, emergency medicine consultants, CT3 trainees and ST4 to ST7 trainees as well as non-consultant, non-training emergency medical staff posts are on the national shortage occupation list¹⁰⁷.

2.3.3 Expected availability of consultants

We do not expect workforce growth to enable us to close the critical gaps we have in the consultant workforce.

Given the major gap in standards, the forecast supply of future consultants by specialty and growth rates locally, regionally and nationally have been considered. While the number of consultants has been increasing in these specialties, it is unlikely that the improvements will fill the gap against standards at ESTH. Since 2012, consultant numbers have increased by c. 3.4% p.a. nationally across key specialties. By 2025/26, looking at the local, regional and national growth rates in consultants, the gap in intensive care consultants may be closed at ESTH. However the gap in ED and acute medicine consultants may not be closed when applying any of the growth rates (ESTH: 5.0%, South London and Kent, Surrey and Sussex 4.4%, national: 3.4%). This means that availability of new consultants of itself may not close key gaps.

Possible mitigations for this include considering new ways of working and using our workforce more effectively. However this will not address the fundamental issue that clinical standards are not being met with current consultant numbers.

It has been raised across the service that postgraduate training is producing too many specialists and not enough generalists. Therefore HEE is supporting the development of general skills in formal training. HEE is working with the General Medical Council (GMC) and colleges to define generalist training and transferable competencies.

Multi-disciplinary teams (MDTs) improve safety, patient experience, productivity and the working lives of clinicians. Further opportunities are being sought for local education and training that benefit doctors not in formal training and staff stepping up into advanced clinical practice roles. Blurring of professional boundaries through education and training across the clinical workforce can reduce the impact of individual rota gaps. This improves the working lives of doctors and enables employers to improve access to education and training. This will aid retention and job satisfaction.

Looking further into the future, and building on new care models which focus more on integration, there is a national drive consider how both consultants and GPs can work across traditional organisational boundaries. More flexible employment models may be part of the answer for these groups, as they will be for other staff¹⁰⁸.

2.3.4 Managing the workforce challenges

Though ESTH is managing its workforce, this is not sustainable and does not meet the standards for quality we expect.

These issues are beginning to translate into significant issues in key clinical metrics such as meeting the target within the emergency department to see and treat patients within four hours (see Section 2.2). ESTH is managing through a number of mitigations, however, these are creating significant pressures on the ESTH workforce, many of whom are working significant out-of-hours shifts and providing additional cover out of goodwill. This is not a safe and sustainable workforce model.

Moreover, this does not address the critical shortages in workforce against our standards – therefore, these must be addressed to ensure acute services are of the quality we expect. Other providers

¹⁰⁷ Immigration Rules Appendix K: shortage occupation list, <https://www.gov.uk/guidance/immigration-rules/immigration-rules-appendix-k-shortage-occupation-list#table-1---united-kingdom-shortage-occupation-list>

¹⁰⁸ *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%20draft%20health%20and%20care%20workforce%20strategy%20for%20England%20to%202027.pdf>

across the area have furthermore advised that there are no other options to support these workforce challenges.

2.4 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.

2.4.1 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 (91% of the St Helier Hospital site and 14% of the Epsom 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.¹⁰⁹

Table 19: Age profile of St Helier and Epsom Hospital¹¹⁰

	Age profile - 1985 -2024 (%)	Age profile - 1948 to 1985 (%)	Pre-1948
St Helier	5.3	3.6	91.1
Epsom	34	52	14

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 building repairs, refurbishment and other vital maintenance work to make sure buildings are safe.¹¹¹ 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.”¹¹²

¹⁰⁹ Estates Return Information Collection (2016/17) <http://hefs.hscic.gov.uk/ERIC.asp>

¹¹⁰ Estates Return Information Collection (2016/17) <http://hefs.hscic.gov.uk/ERIC.asp>

¹¹¹ Epsom and St Helier University Hospitals NHS Trust: Quality report (2016) https://www.cqc.org.uk/sites/default/files/new_reports/AAAE5976.pdf

¹¹² Epsom and St Helier University Hospitals NHS Trust: Quality report (2018): http://www.cqc.org.uk/sites/default/files/new_reports/AAAH0093.pdf

This issue has been recognised by our STPs as a priority. Surrey Heartlands ICS 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.¹¹³

However currently ESTH has the third largest maintenance backlog in the country.

Table 20: Trusts with highest estates maintenance backlog

Organisation	Backlog £ million	Backlog per m ²
Imperial College Healthcare NHST	669.6	£2,360
The Hillingdon Hospitals NHSFT	98.9	£1,172
Epsom And St Helier University Hospitals NHST	93.1	£817

2.4.2 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.

2.5 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.

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.

¹¹³ *Strategic outline case for investment in our hospitals 2020-2030* (2017) <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93jijm4n8158.pdf&ver=19818>

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 was 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.¹¹⁴

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 2022/23.¹¹⁵

In 2018, the government made a commitment to grow NHS funding by 3.4% per annum in real terms from 2019/20 to 2023/24¹¹⁶. Indicative CCG allocations have since been identified in line with this.

2.5.1 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 its Long Term Plan, Surrey Heartlands ICS committed to improving the underlying position and addressing some of the embedded structural financial issues through the transformation of services outlined in the 5 year plan and the 10 year strategy. The modelling outlines a reduction from the deficit in 2020/21 to 2023/24. This reflects a significant reduction in costs across the 4 years. These plans assume that Surrey Heartlands ICs will receive the £25m of local devolution transformation funding in 2020/21.

Similarly in South West London, despite its allocation increasing by an additional £325 million by 2023/24, they are still facing a system challenge by 23/24. This is a result of various factors, including increased activity from local people needing health services and an increase in the size of our overall population.¹¹⁷

2.5.1.1 Current and future financial position at ESTH

A key feature of these challenges is the financial deficit at ESTH (c. £22m forecast outturn in 2018/2019, including c. £15m of provider sustainability funding as at April 2019). 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. £23m (including c. £8m of provider sustainability funding which is assumed to be recurrent for the system) of additional annual funding above that which is likely to be available, based on current services. This is around 6% of ESTH’s current income. ESTH has agreed an underlying deficit of £38m going into 2019/20 with NHS Improvement.

Figure 9 shows detailed income and expenditure for the ESTH baseline to 25/26.

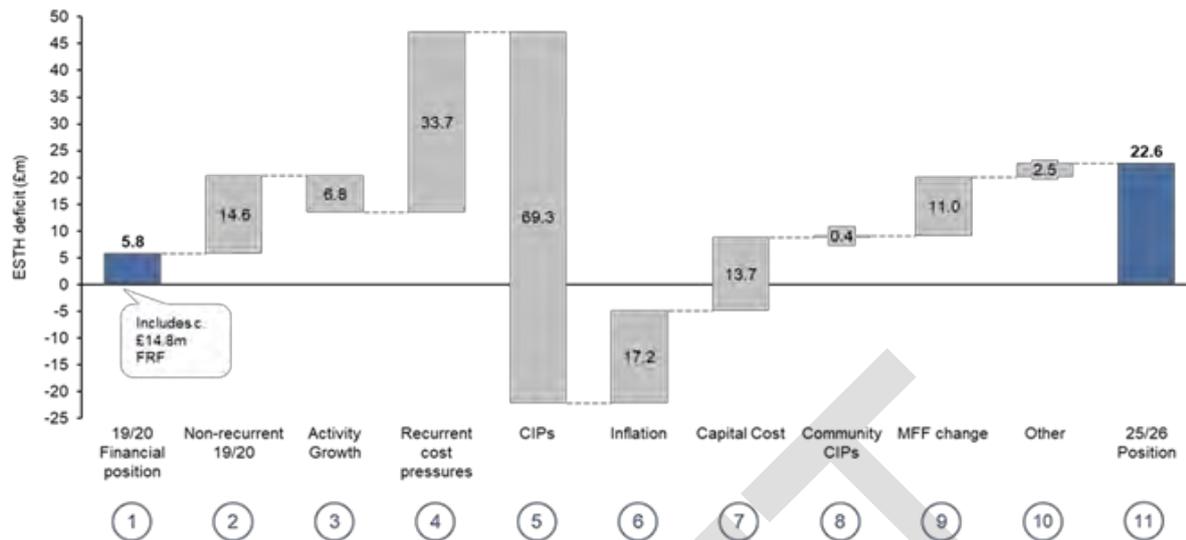
¹¹⁴ [Surrey Heartlands and South West London LTP](#)

¹¹⁵ <https://www.gov.uk/government/publications/nhs-spending-autumn-budget-2017-brief>

¹¹⁶ <https://www.gov.uk/government/speeches/pm-speech-on-the-nhs-18-june-2018>

¹¹⁷ <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>

Figure 9: Income and expenditure for ESTH



The categories in Figure 9 are described as follows:

1. 2019/20 financial position: ESTH's LTFM planned position in 19/20 (includes PSF and FRF). This is consistent to ESTH's agreed control total, less a few minor adjustments.
2. Non-recurrent 2019/20: non-recurrent items, included in 19/20 starting position, to remove from underlying position. This includes c £15m of financial recovery fund (FRF) which is assumed to be non-recurrent.
3. Activity growth: additional income (net of costs) from activity growth (net of QIPP) of c. -0.9% to 3.1% per year, depending on services. Individual CCGs have provided activity forecast assumptions including demand management plans to feed in to this work.
4. Recurrent cost pressures: unplanned cost pressures faced by the Trust – for example short term and unexpected requirements to use agency workforce - (c.1% of opex per annum), based on historic local costs pressures experienced and expected future pressures.
5. CIPs: reduction in Trust expenditure from the Trust 's cost improvement plans (CIPs), based on reference costs benchmarking to upper quartile for up to 20/21 (c. 8% cost reduction), and 1.35% frontier shift for remaining years.
6. Inflation: Net impact of inflation based on cost increases reflecting inflation in different areas (drugs, pay, non-pay, capex) and annual funding increases to ESTH (1.7% tariff deflator) in line with the 19/20 national tariff.¹¹⁸
7. Capital costs: this comprises depreciation and interest paid on capital loans, including the annual cost of the capital investment needed to keep both existing sites safe.
8. Community contract CIPs: Contract contribution / additional CIP from taking on community services from FY 2019; and additionally the incremental cost of converting the two A&E units in to UTCs as well as 24/7 A&Es
9. MFF change: The reduction to ESTH income from the recently updated MFF indices – a nationally determined update.
10. Other: driven by changes in PDC dividends and interim revenue loans.
11. 25/26 position: draft forecast position for ESTH based on latest assumptions and 19/20 plan data.

¹¹⁸ <https://improvement.nhs.uk/resources/national-tariff/>

2.5.1.2 Addressing the financial gap

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.

The increasing demand on the system cannot always be met by moving care out of the hospital and into the community. Therefore it is essential that a solution is found that addresses the financial deficit at ESTH, while working with the wider system to further support the strain on resources¹¹⁹.

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.

While there have been recent announcements regarding providing further capital funding to the NHS, we are unsure how much recurrent money will be provided to the NHS between 2021 and 2026, so we have assumed that current trends are likely to 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.

2.6 Turning the case for change into action

2.6.1 Focus on Epsom and St Helier

We are focused here on specific issues within our combined geographies and specifically on ESTH.

Previous documentation, including the SW London Health and Care Partnership refresh, Surrey Heartlands ICS and the ESTH SOC established there were challenges to achieving sustainability within the health economy of Epsom and St Helier. Specifically, within the SWL STP refresh, clinical standards at Epsom and St Helier are addressed:

"In October 2017, the South West London Clinical Senate agreed a set of clinical standards for six clinical services in hospitals: emergency department; acute medicine; paediatrics; emergency general surgery; obstetrics; and intensive care. Hospitals in South West London were asked to self-assess their services against the agreed clinical standards and to feed this work into their local transformation boards as they progress their local health and care plans. This is the first stage of wider evaluation work into sustainability in each of our local transformation board areas across South West London. This assessment provides a clear position for these specific clinical services for each of the South West London hospital sites.

With the exception of Epsom and St Helier, hospital trusts believe that taking this self-assessment into account, with their knowledge of their individual staffing, estates and operational issues and plans that they can be clinically sustainable in these six clinical services.

However, Epsom and St Helier have indicated that they are unable to sustainably deliver all of these services to meet the quality standards without a level of change to their clinical model.

As other Trusts within the STP have assessed themselves as being clinically sustainable, the immediate priority is identifying a solution for clinical sustainability for Epsom and St Helier. Wider changes in configuration would only be considered if this was not achievable. No decision has been made on the future of the Trust, and the clinical commissioning groups are now developing a formal process to consider the future of Epsom and St Helier and how they will be able to deliver sustainable

¹¹⁹ Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), *Shifting the balance of care: great expectations*. Research report. Nuffield Trust.

services for the local population: “This could mean changes to services locally to improve care for local people: we may need to change how some services are delivered, and we will of course be open and transparent about this and involve local people. We will continue to need all our hospitals though we do not think every hospital has to provide every service”.

2.6.2 The growing need for change

We need to address these critical challenges of delivering clinical quality with the available workforce, providing healthcare from modern buildings and achieving financial sustainability.

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:

- **Delivering clinical quality with the available workforce:** Clinical standards are becoming more rigorous locally and nationally, and in 2017 we defined clear clinical standards for six acute services (discussed in section 2.1.4). Standards provide clear 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. We do not expect the training and recruitment of new consultants to close this gap. 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 2019). 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.

2.6.3 The need for change

To address these challenges, significant changes are needed that solve the clinical, estates and financial challenges.

The current situation cannot continue if we want to continue to deliver quality healthcare in the future. Change is needed – specifically, we need to enhance prevention in our geographies, integrate more, address 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 with the appropriate number of beds across services 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 these services** – 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 critical 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. We will continue to estimate the potential impact of any changes on the financial position of the system as our work progresses.

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.

This case for change does not – and is not intended to – provide a solution for all providers within the STP boundaries. Surrey Heartland and SWL are continuing work to develop plans to deliver sustainability, however changes at ESTH are needed to support retention of services in the combined geographies. 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 is a priority for our consideration of any options.

Figure 10: What we learned from our engagement with local people on the case for change¹²⁰

What we learned from our engagement with local people

Within our *Issues Paper*, published in June 2018 for public engagement, the key question for consideration was:

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

Key themes arising in response to this include:

- Universal recognition that the buildings needed to be improved not least because of the impact on patient experience;
- Recognition of the workforce challenges that existed and needed to be overcome to ensure high quality care could continue to be provided; and
- The need for more transparency and information about the current situation and assumptions underpinning the case for change – especially those relating to finances – in order for patients and public to make informed comments about potential solutions.

What we have changed

We have reviewed the case for change since the publication of the *Issues Paper*:

- We have carried out a review of our estates to assess the investment required to address the challenges set out in the case for change;
- We have reviewed workforce requirements and staff availability, and developed a workforce model which assesses the impact on staff numbers required; and
- We have carried out further analysis of the challenges set out within the case for change, including finances which are published in this pre-consultation business case. The public have been involved in the evaluation of the analysis set out within this pre-consultation business case.

¹²⁰ Improving Healthcare Together 2020 – 2030, Independent analysis of feedback from public engagement, The Campaign Company, 2018

3 PROCESS

To develop this pre-consultation business case, Improving Healthcare Together has developed principles, processes and governance that will support any decision-making. The programme has been clinically led, informed by engagement with key stakeholders and the public and worked with partners across our combined geographies.

Governance groups were established to make recommendations that were considered by the Committees in Common as part of any decision-making process. These groups were supported by workstreams to carry out key elements of work.

Four key processes supported the development of this pre-consultation business case:

- The development of the clinical model, overseen by the Clinical Advisory Group, which included initially defining an emerging clinical model for public engagement, and a second phase where further areas of work were identified, followed by further work responding to the recommendations of the Joint Clinical Senate for London and the South East.
- The development of the finance and activity model, overseen by the Finance, Activity and Estates Group, which modelled the short list of options to determine their impacts.
- The options consideration process, which established the approach to developing a long list, short list and any evaluation thereof.
- Public and stakeholder engagement, which tested proposals and the options consideration process with the public.

3.1 Developing the pre-consultation business case

In June 2018 we published the *Issues Paper* and supporting *Technical Annex*, which described our challenges and launched a programme of public engagement on the case for change, emerging clinical model and development of potential solutions.

Following our engagement programme, to address the issues within our combined geographies, we developed this pre-consultation business case which explores the options to address these challenges in detail.

To enable commissioners to identify the potential solutions for the combined geography and develop the PCBC, we took an approach based upon core principles:

- **Clinically led (as described in Section 3.2) and supported by commissioners** – Clinical leadership engaged local clinicians at each stage of PCBC development to understand the clinical impact of any proposals, ensuring that our guiding principle was improving the quality and safety of care and patient experience.
- **Informed by engagement with the public, patients and local authorities** – we actively engage with local stakeholders at each stage of development to inform the development of proposals and explore the potential impact of any proposals, including direct involvement of an external Stakeholder Reference Group as described in Section 3.6.4.1. This included specific work to understand the implication of proposals on different equalities groups, in particular traditionally under-represented groups such as people with learning impairments and the LGBT+ community.
- **Robust and transparent process underpinned by a sound clinical evidence base** – our case for change is based on local and national clinical evidence. We have developed a robust, evidence-based process for developing and appraising options for change, working with stakeholders, senior local clinicians and patients and the public.

- **The programme was designed as a partnership approach**, involving the public, clinical stakeholders and organisations across our combined geographies.

3.1.1 Programme Governance: Improving Healthcare Together

From its outset, the programme established governance groups to ensure all decision-making processes were underpinned by recommendations set out by workstreams (see below), and supported by key stakeholders across our combined geographies.

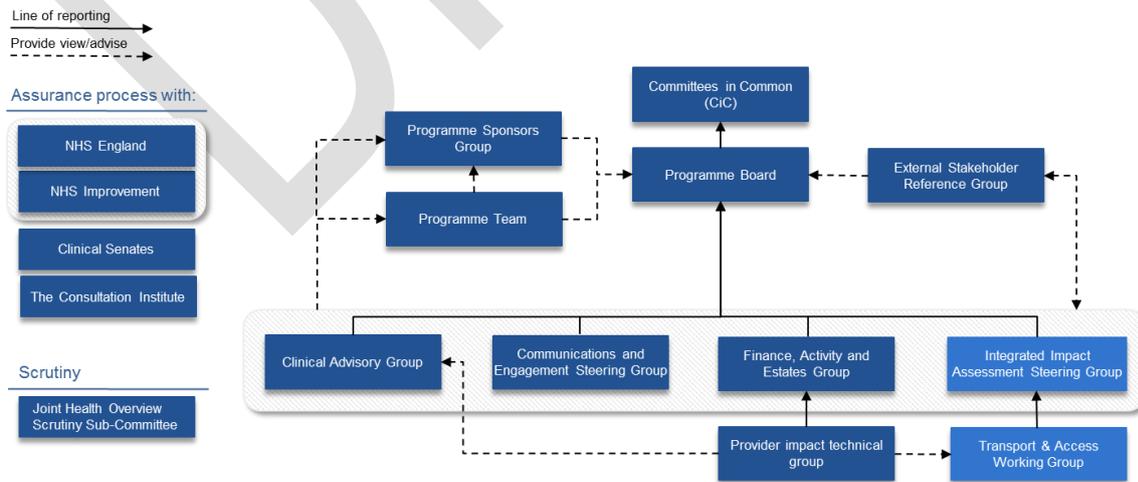
All decision-making takes place through a committees in common (CiC) of CCGs, formed by Surrey Downs, Sutton and Merton CCGs.

Recommendations are made to the CiC via a Programme Board, which has representation from CCGs, regulators and ESTH to provide strategic oversight of the Programme. The Programme Board is supported by governance groups which oversee relevant workstreams. These groups include:

- The external **Stakeholder Reference Group**, which provided advice, direction and assurance to the Programme Group on engagement and consultation and co-designed and assured the engagement and consultation strategy.
- The **Clinical Advisory Group**, which provided clinical leadership to the programme, ensuring development of robust clinical proposals for recommendation to Programme Board.
- The **Engagement and Communications Working Group** which coordinated communications and stakeholder engagement activity across the programme.
- The **Finance, Activity and Estates Group**, which ensured financial, capital, estates, activity and workforce implications were fully analysed and understood, and ensured that modelling assumptions and data were agreed amongst all impacted providers and commissioners.
- The **provider impact technical group**, which was established to provide technical challenge around the analysis of the programme’s impact on other providers. These groups reviewed and discussed provider impact analysis to inform further development by the programme task group. Membership of the group includes provider representatives (Croydon Health Services Trust, St George’s University Hospitals Trust, Surrey and Sussex Healthcare Trust, Royal Surrey County Hospital Trust, Kingston Hospital Foundation Trust and Ashford and St Peter’s Hospitals Foundation Trust), NHSI and London Ambulance Service (LAS) and South East Coast Ambulance (SECamb).

The full governance structure of the programme is shown in Figure 11.

Figure 11: Governance of Improving Healthcare Together 2020 – 2030



3.2 Process to develop the clinical model

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 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.

The CAG formed working groups of clinicians and other stakeholders from across primary and secondary care to develop the clinical model. This included representatives from local GP practices and ESTH. The working groups 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.

The development of the clinical model involved three phases, which included defining an emerging clinical model for public engagement, and a second phase of further development considering feedback received and further areas of work. The third phase focused on responding to the recommendations of the Joint Clinical Senate as a result of their review of the clinical model. At all stages of the development of the clinical model, the CAG and its working groups considered the available evidence in order to inform any recommendations.

3.2.1 Phase 1: Development of the emerging clinical model

The emerging clinical model was developed through subgroups, clinical workshops and the Clinical Advisory Group. It was subsequently published within the *Technical Annex* and tested with the public and with clinical senates.

As part of the development of the emerging clinical model, the CAG 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:** This group considered the evidence base behind any changes to urgent and emergency care pathways and the potential impact on patients, including initial considerations of district beds.
2. **Maternity:** This group considered the evidence base behind any changes to maternity pathways, including types of delivery through freestanding midwife-led units, alongside midwife-led units and obstetrician-led births.
3. **Paediatrics:** This group considered the evidence base and best practice around paediatrics, and considered key questions such as dependencies on critical care and emergency surgery for inpatient paediatrics and impacts of changes to urgent and emergency care.
4. **Planned Care:** This group developed initial planned care pathways and answered critical questions, including key dependencies of elective surgery on critical care and anaesthetics, the impact of emergency care on elective care and the method of delivering planned care.

Through a series of meetings, these subgroups refined pathways and impact 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.

The overall process for developing the clinical model in phase one involved:

1. Initial development of the high level clinical vision, patient pathways and critical questions, involving:
 - Establishing clinical standards and best practice guidance;
 - Creation of high level clinical vision and initial patient pathways; and
 - Identification of areas of focus for subgroups

2. Developing, iterating, agreeing clinical models and pathways, involving:
 - Agreement of clinical standards and best practice pathways guidance;
 - Agreement of the clinical case for change for each subgroup;
 - Agreement of the ‘as-is’ and ‘to-be’ patient pathway and associated issues;
 - Testing critical issues arising from agreed ‘as-is’ and ‘to-be’ clinical model / pathways; and
 - Consideration of interdependencies with other subgroups.
3. Further detailed work to iterate and finalise subgroup models, involving:
 - Testing, iterating and finalising responses to outstanding critical questions / issues; and
 - Continued engagement with stakeholders.
4. Finalisation of the emerging clinical model, involving:
 - Finalisation and agreement of the ‘to-be’ clinical model both in its totality and at pathway levels;
 - Confirmation of relevant assumptions for finance, activity and estates modelling; and
 - Interdependencies and necessary protocols for the overall clinical model.

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

3.2.2 Phase 2: Further development of the clinical model

Following approval for public engagement of the case for change, emerging clinical model and development of potential solutions, the CAG considered areas where further work should be undertaken to further define the clinical model.

These areas of work were established by considering:

- The initial outputs of the pre-consultation engagement;
- Feedback from an initial desktop review of the clinical model by the Clinical Senate.

Two task and finish groups were identified and two workstreams were mobilised to support the Clinical Advisory Group:

1. **District hospital task & finish group** was established to refine the district hospital services model, including:
 - The characteristics of the patient cohort;
 - Patient pathways; and
 - Staffing requirements for the district bed model.
2. **Maternity and paediatrics task & finish group** was established to review the work carried out by the maternity and paediatrics subgroup in phase one, and consider any further evidence and dependencies of maternity and paediatric services on major acute services. The work included:
 - Setting out the maternity pathway and paediatric pathway;
 - Considering co-dependencies of women’s and children’s services; and
 - Considering maternity and paediatric provision on sites without adult ED.
3. **Workforce workstream** which established the staffing requirements for major acute and district services, and any potential impacts on costs. This work included:
 - Additional staffing requirement for service developments (e.g. UTC, district beds); and

- Opportunities to utilise new clinical roles.
4. **Clinical benefits workstream** was established to describe the potential benefits of the clinical model on patient and staff experience, patient access and clinical outcomes. This work included:
- A focus on the benefits of the current clinical model and the impact of any changes; and
 - A quantitative and qualitative analysis of the evidence, considering disbenefits as well as links, dependencies and risks, using standard metrics for comparative purposes.

These subgroups and workstreams carried out this work to refine the emerging clinical model.

3.2.3 Phase 3: Clinical Senate review of the clinical model

Phase three of the clinical model development involved a detailed review of the clinical model by the Senate, followed by the development of responses to the recommendations made within a formal report. The Clinical Senate was supportive of the case for change and clinical model. A detailed action plan was developed to address each of the 94 recommendations made by the Senate.

CAG reviewed all of the Clinical Senate recommendations and set up working groups to respond to recommendations around specific areas of work. These groups included:

- Risk and benefits group (12 recommendations)
- Patient transfer group (5 recommendations)
- Maternity and paediatrics group (13 recommendations)
- 16 recommendations were also addressed through FAE.

The remaining recommendations were responded to by the CAG, which also reviewed the outputs of the working groups. The responses to these recommendations have been included within the clinical model and detailed within this pre-consultation business case. The Clinical Senate report can be found in Appendix □.

Based on this work, the CAG recommended the overall clinical model to the Programme Board. The model will be further tested with the public throughout the consultation process.

3.3 Process to develop the finance and activity model

The development of the finance and activity model was overseen by the finance, activity and estates group (FAE).

3.3.1 Developing the finance and activity model

Eight workstreams were established:

1. **Overall finance and activity model:** Development of an overall activity and financial model supported the financial evaluation of the short list of options.
2. **Establishing the baseline:** Agreement of the baseline for activity, beds and finances, and agreement of growth assumptions to produce a forecast.
3. **Out of hospital model:** Alignment between the clinical model and QIPP plans to ensure assumptions around activity shifts to out of hospital settings are evidenced.
4. **Options modelling:** Development of assumptions around demand shifts for the short list of options, including analysis around patient flow changes.
5. **Financial benefits:** Estimation of the financial benefits of the clinical model to support analysis of the short list of options, including opportunities of the clinical model.
6. **Estates:** Estimation of the space, estates requirements and capital costs for the baseline and each of the short list options.

7. **Financing:** An analysis of potential financing scenarios to source the capital requirement for each option, including the impact on affordability.
8. **Other provider impacts:** Estimation of the impact of the short list on other neighbouring providers in terms of activity, capacity, capital, finance and workforce.

The provider impact working group and a patient flow working group further reported into FAE. The finance and activity model was also driven through the development of the clinical model. CAG have therefore also been involved in the development of any assumptions which may be influenced by the clinical model, such as length of stay.

The provisional shortlisted solutions were fully modelled through this work, with a range of sensitivities applied. NHS England and NHS Improvement have been involved in the development of the finance and activity model, which will be further assured at a later stage in the process.

3.3.2 Establishing local provider impacts

We considered these impacts of changes in the combined geography on six local providers, excluding ESTH, specifically:

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

To support this, a Technical Group has been convened since July 2018, comprising provider Directors of Strategy from each provider, as well as representation from LAS and SECamb. The group considered the activity impact on affected Trusts including bed, theatre and diagnostics capacity and the resulting requirements for estates, finance (revenue and capital) and workforce. In addition, providers have worked with the programme via regular meetings with Chief Executives and the AOs and have reported outputs to Trust Boards.

3.4 Process for options consideration, testing and refinement

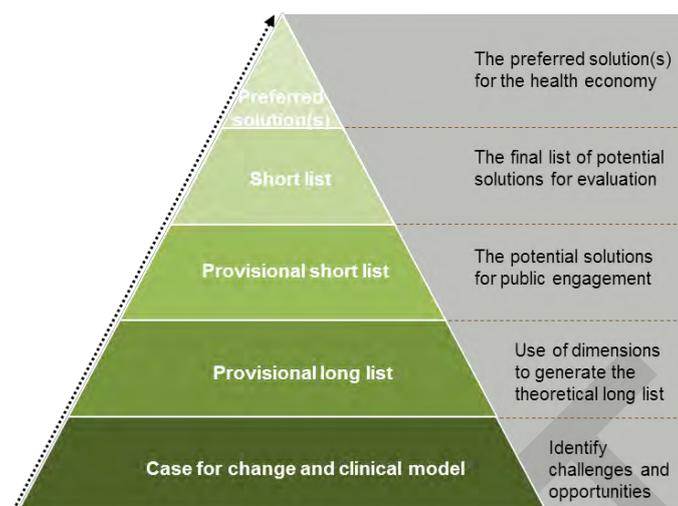
3.4.1 Approach to options development

We have adopted a standard approach to identifying potential solutions to address our case for change and deliver our clinical model.

To understand how we can address the issues identified in our case for change and deliver our clinical model, we undertook 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 12.

Throughout, this process was and will continue to be tested with the public through engagement and consultation.

Figure 12: Approach to solutions development and refinement



The approach had several stages:

- Based on our case for change and clinical model, a provisional long list was generated of all potential solutions.
- This was refined through a small set of initial tests to reach a provisional short list of potentially feasible solutions.
- This process was tested with the public before a final short list was agreed.
- This short list was then analysed in detail and evaluated against set criteria. Sensitivity testing was also undertaken to ensure the analysis was robust. The process of evaluation is set out in Section 3.5.

The CCGs will consider the outputs of the options consideration process as one of the pieces of evidence to determine a potential preferred option.

3.4.2 Process to reach a provisional short list

Initially we developed a process to define the long list of potential solutions and apply a series of initial tests to reach a provisional short list.

Wherever possible, we were informed by engagement with the public about potential solutions. This included 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 facing¹²¹. 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.¹²²

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

- Discussions with our Clinical Advisory Group about the ways in which we could 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 undertook and the long list, initial tests and provisional shortlist.

¹²¹ Campaign Company Report

¹²² *Epsom and St Helier 2020 - 2030 Your views* (2017) <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93jijm4n8161.pdf&ver=19815>

- 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 undertook and the long list, initial tests and provisional short list.

3.5 Process to assess the short list

The short list of options was assessed through non-financial and financial criteria.

3.5.1 Process for non-financial assessment of the short list of options

We have undertaken a standard process as recommended by The Consultation Institute for the development of the non-financial criteria and scoring of options against these criteria. This is based on previous experience of this process in Hywel Dda in Wales and Wolverhampton.

There were 3 steps to this process:

1. Pre-consultation engagement captured public priorities and feedback. Through this engagement people and staff across our geography were informed and / or asked to give their views on the work of the programme.
2. 3 groups of balanced representative people were identified, drawn from across the three CCGs (including the public and professionals), where:
 - The first facilitated group agreed non-financial criteria
 - The second facilitated group agreed what weighting each non-financial criterion should carry
 - The third facilitated group agreed scoring of shortlisted options against the non-financial criteria¹²³
3. Report to Programme Board and the Joint Governing Body of the outcome of the non-financial scoring process.

Part 2 of the process to assess the short list involved three workshops involving the public and stakeholders across our combined geographies. Each workshop included a different group of stakeholders to represent a range of perspectives and was guided by an independent facilitator.

Each workshop involved three groups of people with distinct roles.

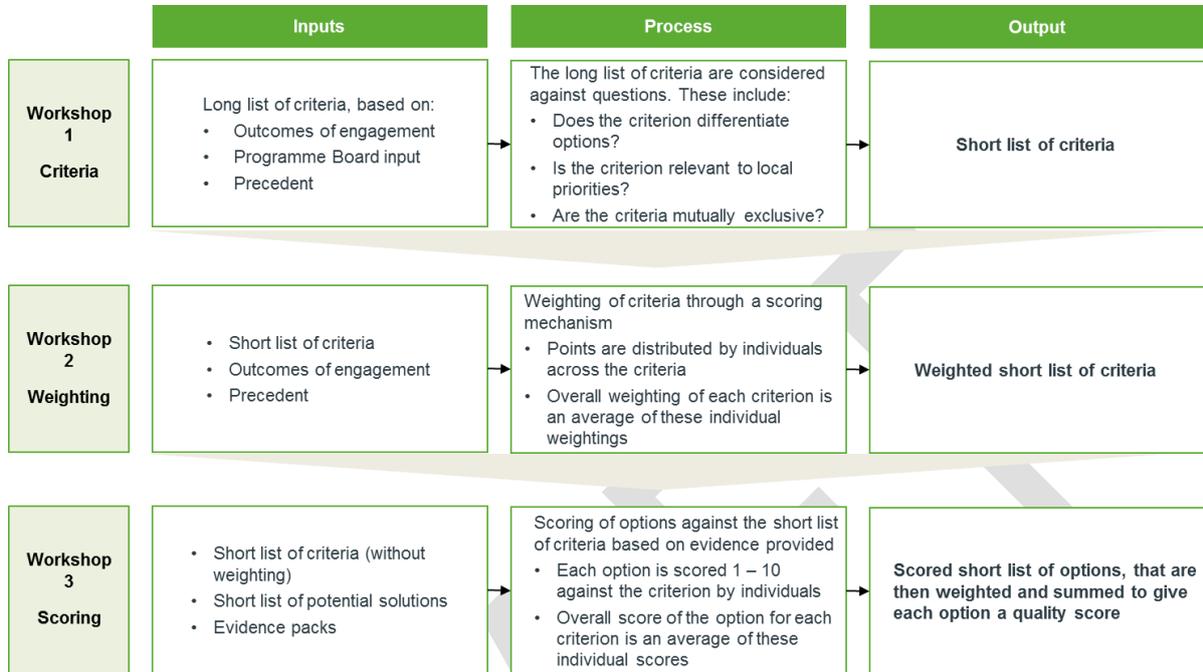
- **Participants:** Workshop participants were the decision makers, they weighed and discussed the evidence and issues presented, and made decisions on the criteria, weighting and scoring.
 - Each workshop was made up of around 60% community members and 40% professionals involved in the programme
- **Advisors:** Each workshop also had a smaller number of professional staff who provided evidence to inform the participants. Advisors did not have a decision-making role in the workshops.
 - Each workshop had appropriate advisors for the topics under discussion, drawn from the technical and clinical professionals supporting the programme
- **Observers:** In order to ensure that the process was fair and transparent a range of observers were invited to attend each workshop and oversee the process. Observers did not have a decision-making role in the workshop.

¹²³ Further information on the make-up of these groups can be found in the independent Traverse report on the Improving Healthcare Together website.

- Observers were drawn from the programmes Stakeholder Reference Group, local Healthwatch groups and JHOSC officers¹²⁴.

Figure 13 provides an overview of the process for each of the workshops.

Figure 13: Overview of the non-financial workshops



- The criteria workshop was attended by 11 community members and 8 professional participants.
- The weighting workshop was attended by 13 community members and 7 professional participants.
- The scoring workshop was attended by 14 community members and 10 professional participants.

The community participants of the workshops were identified by the independent organisation Traverse, using two methods:

1. Re-contacting previous participants in engagement events. Traverse contacted local community members who had previously participated in IHT engagement events run by Traverse.
2. Open advertisement through community groups, social media and newsletters. Local community members also responded to open advertisements to attend the workshops.¹²⁵

3.5.1.1 Process for further evidence development

Following these workshops in October and November 2018, as a result of further evidence development and assurance by NHS England, NHS Improvement and the Joint Clinical Senate, further work was undertaken in areas relevant to the scoring workshop.

This further evidence was assessed by the Clinical Advisory Group and Programme Board to establish whether there would be any impact on the scores for the options in the relevant criteria as part of the decision-making process (see Section 3.8).

¹²⁴ Traverse: Options consideration process, Improving Healthcare Together 2020-2030, November 2018

¹²⁵ Traverse: Options consideration process, Improving Healthcare Together 2020-2030, November 2018

3.5.2 Process for financial assessment of the short list of options

Alongside the non-financial process, the finance workstream reported a series of financial criteria for each option, including income and expenditure, cashflow, net capital expenditure, net present value and return on investment. System NPV was decided to be the core metric for evaluation by FAE.

The non-financial and financial criteria resulted in two independent ranking of options (the non-financial score and system NPV for each option) being reported to Programme Board and the Committees in Common. These scores are part of the evidence that will feed into any decision-making process.

3.6 Pre-consultation engagement

Through pre-consultation engagement, we tested whether the process we undertook was appropriate, including the initial tests we applied to develop the short list of potential solutions. All feedback has been considered and independent reports have been produced by The Campaign Company and Traverse.

The outputs of engagement have been described in Section 4.8.

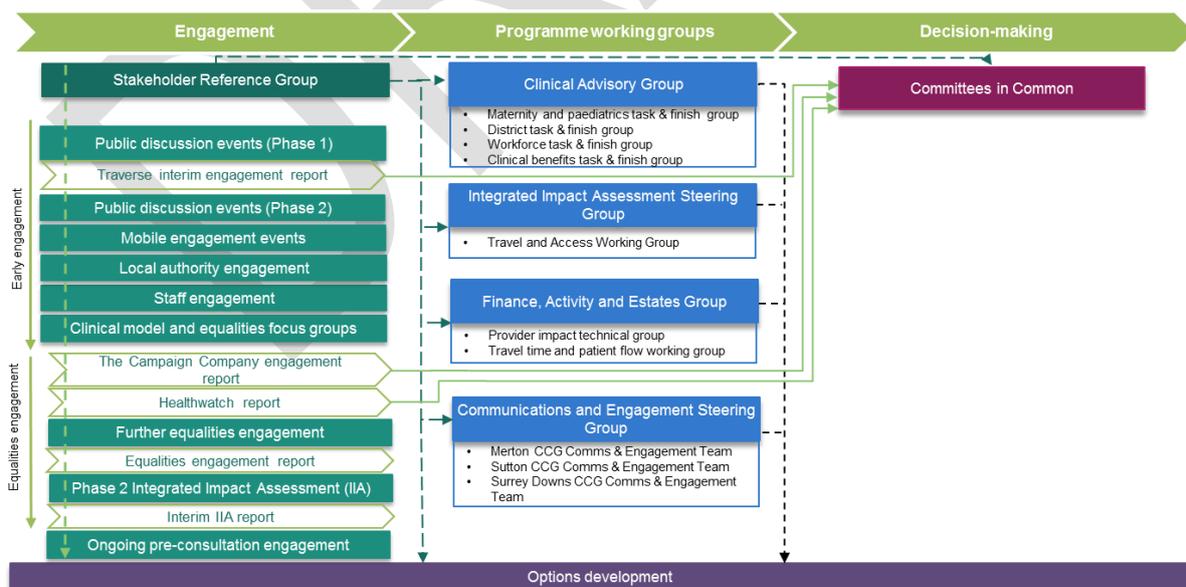
3.6.1 Our mandate

The programme agreed and adopted the following mandate at a Committees in Common meeting held on 21st June 2018:

“We the Committees in Common of the Surrey Downs, Sutton and Merton NHS Clinical Commissioning Groups need to understand the views of people in Surrey Downs, Sutton and Merton – to include patients, their families, carers, NHS staff and other key stakeholders – concerning the future of local acute care services so that the Committees in Common can make decisions so as to provide sustainable, high quality acute services locally and within allocated budgets.”

The following flowchart highlights how feedback received fed into every level of the Programme’s governance structure and working groups:

Figure 14: IHT engagement process flow chart



3.6.2 Quality Assurance

To ensure meaningful patient and public participation we commissioned the Consultation Institute (TCI) to advise on our process of engagement.

The quality assurance process led by TCI involved six stages:

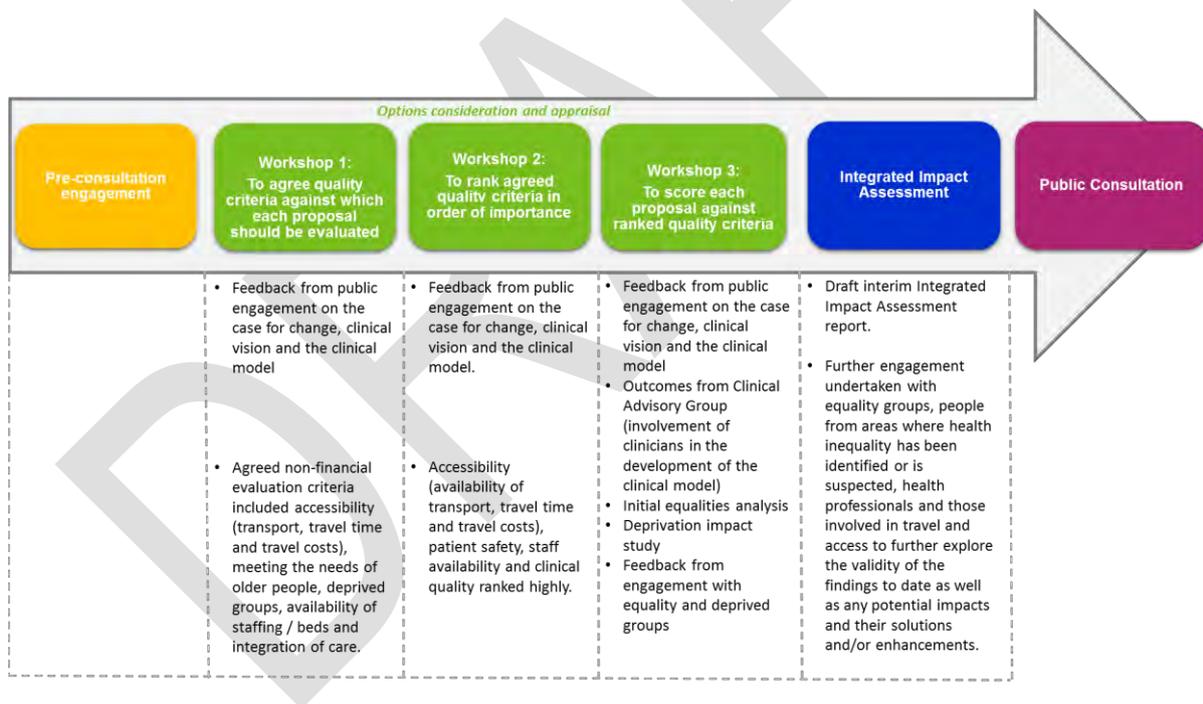
1. Scoping and governance
2. Project plan
3. Documentation
4. Mid-term review
5. Closing date review
6. Final report

Each checkpoint was cleared by TCI and is referenced throughout this chapter.

3.6.3 Impact and influence

The diagram below captures the impact and influence of our engagement activity on the options consideration process:

Figure 15: Engagement process



3.6.4 Groups involved in our early engagement

3.6.4.1 Stakeholder Reference Group

A Stakeholder Reference Group (SRG) was set up to challenge and provide feedback on the programme’s work. Over 100 voluntary, community, patient, carer and equality groups are members of the SRG in addition to Healthwatch bodies, local authorities, campaign groups and housing associations.

During the early engagement phase of the programme, the SRG met monthly and has been chaired by Sutton Healthwatch. The SRG was therefore involved as:

- A sounding board for the programme;
- A forum for the programme to reach out to further e-service users and seldom heard groups;
- Input into the production of the programme's website, subtitled animation video and mobile engagement work;
- Input to travel and access issues;
- Feedback on the initial equalities analysis; and
- Review of our options consideration process through making recommendations around the evaluation workshops. Members of this group were also directly involved in this process in an observer capacity.

The SRG will continue to be a network for the programme, through which engagement will continue to take place, including co-design of the public consultation process moving forward.

3.6.4.2 Healthwatch

The programme also worked closely with Merton, Sutton and Surrey Downs Healthwatch to reach communities - commissioning focus groups with older people over 65, carers and young carers, people with learning difficulties and black and ethnic minority communities.

Healthwatch also supported community participation in the options consideration workshops and participates in the SRG as both member and chair (Sutton). We worked with Healthwatch to co-design the public consultation process moving forward.

3.6.4.3 Engagement and Communications Steering Group

A dedicated engagement and communications steering group was established to oversee the delivery of our programme of early engagement as well as measure its impact. The group is composed of communications and engagement leads across the South West London Health and Care Partnership, Surrey Heartlands Health and Care Partnership and Merton, Sutton and Surrey Downs CCGs. This group ensures that clear and cohesive messages are presented and that stakeholders are engaged in a timely manner.

Figure 16: What we learned from our engagement with local people on our processes¹²⁶**What we learned from our engagement with local people**

Within our *Issues Paper* the key question for consideration was:

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

Key themes arising in response to this include:

- The need for transparency and inclusivity around the decision-making process; and
- The need for open and honest communications about the potential solutions and the reasons why certain solutions were being proposed

What we have changed

We have further developed our processes since the publication of the *Issues Paper*:

- We have developed an options consideration process which is recommended by the Consultation Institute and involves the public at each stage of the consideration process; and
- We have engaged widely since the publication of the *Issues Paper* through numerous channels to ensure we can be as transparent, inclusive and open as possible. How we have engaged with people is set out in detail in Section 4.

3.7 Integrated impact assessment

An integrated impact assessment was carried out by the Programme in order to:

1. Identify positive and negative impacts of any proposals;
2. Identify whether impacts are experienced disproportionately by particular community groups;
3. Comprehensively assess impacts (often includes health, equality, carbon and travel and access impacts); and
4. Recommend mitigations for negative impacts and identify opportunities for enhancing positive impacts¹²⁷.

3.7.1 Phases of the IIA

An integrated impact assessment usually involves:

- **Scoping phase objective:** Identify assessment areas and groups to be scoped in to the assessment
 - Desktop evidence review: Review clinical trends and identify protected characteristic groups which may have a disproportionate need for services, including deprived groups.
 - Demographic mapping: Map the distribution of residents from population groups likely to experience disproportionate effects.
 - Strategic engagement: Engage with local health and equality stakeholders.
 - Baseline travel assessment: Present baseline travel times for the services under review

¹²⁶ Improving Healthcare Together 2020 – 2030, Independent analysis of feedback from public engagement, The Campaign Company, 2018

¹²⁷ Mott MacDonald

- Scoping report: Set out which protected characteristics have been scoped in with the summary of evidence
- **Pre-consultation report objective:** Appraise positive and negative impacts, mitigation measures and enhancement opportunities
 - Initial scoping of health and equality impacts: Findings from the scoping phase and further desk research will be used to understand potential impacts from an outcomes and access perspective.
 - Engagement: Time to be used flexibly-activities can cover engagement fora, interviews meetings and/or focus groups with protected characteristic groups.
 - Detailed travel and access analysis: Travel time effects for the whole population, vulnerable groups and staff
 - Carbon impacts: Assessment of the likely changes to carbon emissions across; travel (patients and visitors), building energy use and goods and services.
 - Pre-consultation report: Appraisal of positive and negative impacts, mitigation measures and enhancement opportunities
- **Post consultation report objective:** Update report from any consultation findings
 - Review of public consultation: Identify all relevant findings from the public consultation
 - Production of the final report: The report will be updated.¹²⁸

Table 21: Description of components of the integrated impact assessment

	Components	Timing
Scoping report	Initial equalities analysis Baseline travel assessment	Travel and equalities analysis complete
Draft interim IIA	Travel impact assessment Equality impact assessment (including deprivation) Health impact assessment (including patient choice) Sustainability impact assessment	Can be undertaken after a shortlist of options have been confirmed OR when a preferred option has been confirmed. Travel analysis can be brought forward to inform options appraisal if required. This is dependent on confirmation of shortlist of options and receiving necessary data. The draft report can be completed in 6-8 weeks, this is to plan enough time for stakeholder engagement If the travel analysis was brought forward, approximately 4 weeks is needed to submit this analysis once data has been received. Draft report to be shared with internal stakeholders for comment and feedback
Pre-consultation interim IIA	Update of the initial draft IIA following feedback	Published just before the public consultation
Post-consultation IIA	Updated with any relevant information from the public consultation	Published after consultation Approximately 2-3 weeks is needed to update report once consultation has been received.

Phase 1 of the IIA has been completed and published. The findings of the first two phases of the IIA work were brought together within an independent pre-consultation interim (Appendix □). This report also detailed and completed the second phase of the IIA process. Following the completion of the

¹²⁸ Mott MacDonald

public consultation, the interim report will be further reviewed against the feedback from consultation and updated to reflect any additional impacts as well as mitigations and/or enhancements identified.

3.7.2 Governance process for the development of the interim IIA

Governance groups were established to support the development of the interim IIA. The role of these groups was to scrutinise the IIA programme of work, its findings and analysis. Two groups were established:

- **An Integrated Impact Assessment Steering Group** – This group provided advice to the Programme, agreed the IIA scope and oversaw and scrutinised the phase 2 of the IIA programme of work alongside the final IIA. To ensure a transparent and independent IIA process, the Steering Group was led by an Independent Chair and included within its membership representation from the local authorities, community organisations/ groups, as well as from the CCGs across the combined geographies. The Steering Group has reviewed, provided important feedback and agreed the findings of the interim report.
- **A Travel and Access Working Group** – This group provided advice to the Programme, scrutinised the travel and access analysis and reported to the IIA Steering Group. This group met fortnightly during the phase 2 of the IIA and played a key role throughout the phase two analysis. The group provided data and guided the analysis to ensure that issues and impacts in relation to travel and access were appropriately considered and mitigations and enhancements identified.

Throughout the IIA process the Programme has also worked closely with the Consultation Institute.

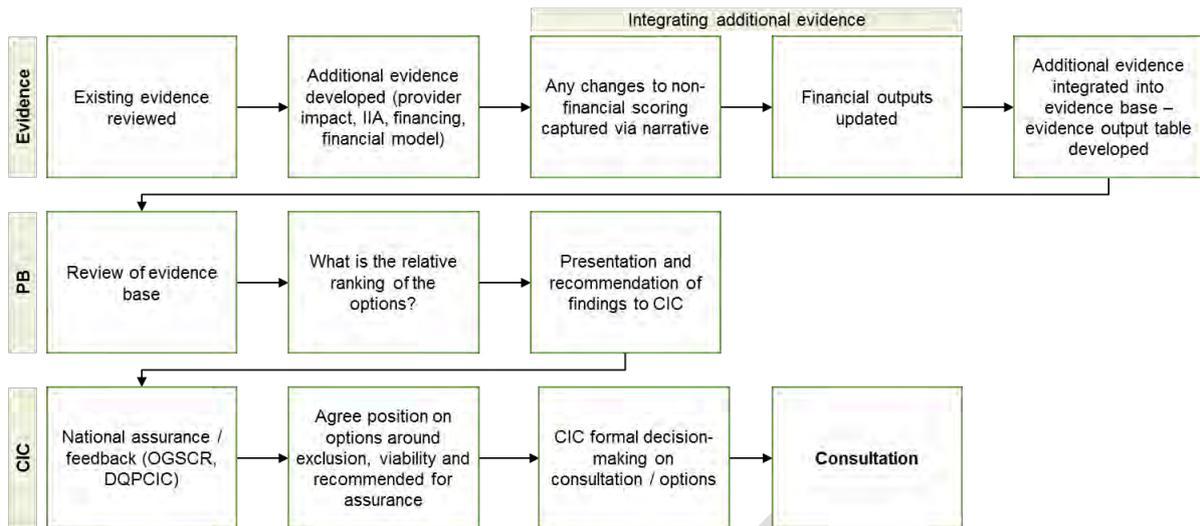
3.8 Decision-making process

This paper sets out the process for pre-consultation decision making. The overall process can be seen in Figure 17 below, and the elements of these are broken down in the following sections. The key parts of this process are:

1. Evidence review and integration – review of existing evidence and integration of additional evidence.
2. Programme Board review – review of the evidence by Programme Board and recommendation to national assurance.
3. Committees in Common decision-making – Committees in Common will consider the evidence and feedback from national assurance, and agree a position on consultation and options.

All evidence was presented at and considered by the Programme Board. Programme Board could reach any conclusions on this evidence, as long as there was clear rationale and justification.

Figure 17: Overview of the process of evidence review and consideration

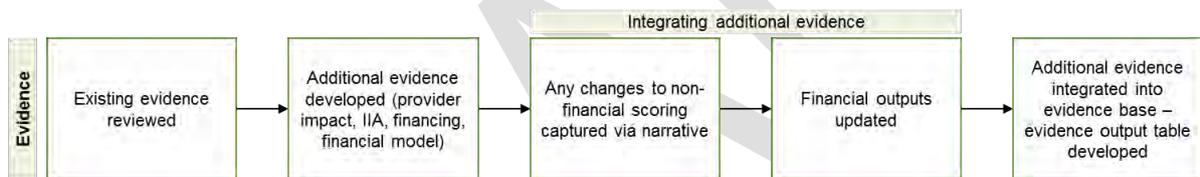


Within this section, we will discuss each of the three stages in turn.

3.8.1 Evidence review and integration

Evidence was updated and collated into a single evidence base, as shown in Figure 2.

Figure 18: Evidence review and integration



A significant body of evidence was developed and reviewed as part of this programme of work to contribute to the options workshops. As part of the further work of the programme, additional evidence was developed and added to the evidence base. This includes:

- Provider impact (Section 11)
- Interim IIA (Section 10.6)
- Financial analysis (Section 13)
- Financing options (Section 14)
- Assurance reviews (e.g. Clinical Senate) (Section 19.5)

This new evidence was integrated into the existing evidence base. This resulted in a summary evidence table, which incorporated the evidence to support the decision-making process. Alongside the evidence table there was also supporting evidence, including:

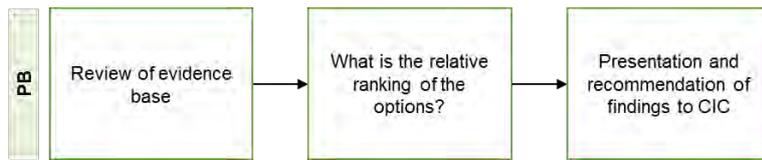
- Evidence supporting non-financial scoring and subsequent updates;
- Evidence supporting financial analysis.

To continue the decision-making process, the next stage included consideration of evidence by the Programme Board and Committees in Common.

3.8.2 Programme Board review

The revision of evidence supported Programme Board deliberations. The flow of deliberation is shown in Figure 19.

Figure 19: Programme board deliberation



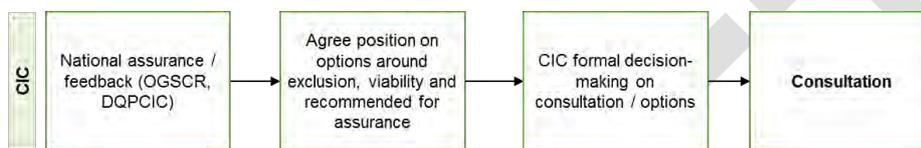
Following evidence development, the PB reviewed the revised evidence table including:

- Non-financial scores developed in late 2018.
- Revised financial outputs

3.8.3 Committees in Common decision-making

A public Committees in Common will make decisions around the options for consultation, following the process set out in Figure 20.

Figure 20: Committees in Common deliberation



The Committees in Common will consider the outputs of assurance and agreed a position on:

- Excluded options and viable options
- Proceeding to consultation

Decisions on these points will be made in public at the Committees in Common. No final decisions will be made until after consultation and a full review of the responses of consultation. Following consultation, a further decision-making process would make final decisions on any preferred option(s) or way forward.

3.9 Next steps

All of the work that the IHT Programme produced, including the options consideration outcomes, was subject to regulatory assurance by NHS England and NHS Improvement. Any new options or evidence can be considered at any stage in the process. No decisions will be made on any option until after any public consultation.

4 ENGAGEMENT

Our early engagement was undertaken as part of a four stage process which also included pre-consultation, and will include consultation and post consultation. During this stage, we engaged with a wide and diverse range of interest groups.

There was a particular focus on those groups most impacted by the potential changes to major acute services, such as users of paediatric, maternity and emergency services.

Our patient and public participation activity was undertaken with due and proper compliance with the:

- NHS Clinical Commissioning Group statutory patient and public participation duty; and
- NHSE Guidance

Through this engagement over 1,500 people and staff across our geography were informed and / or asked to give their views on the work of the programme. We captured a wide range of views from the public and wider stakeholders, and an independent report was produced that sets out the key themes that were heard.

Feedback gathered from pre-consultation engagement with local residents, patients, carers and equality groups informed each stage of the development of proposals. Local priorities and needs for healthcare services were gathered and fed directly into the options consideration process. This feedback included the views of equality groups potentially impacted by the proposals and their specific needs.

4.1 Introduction

We undertook a significant amount of patient and public engagement during our programme of early engagement. This ensured patients, carers and residents were fully involved in the development of the case for change, clinical model and potential solutions.

Our overarching aims in undertaking this engagement activity were as follows:

- To seek feedback on the emerging clinical model
- To seek feedback on the case for change – our vision and challenges
- To seek feedback on the potential solutions developed by the programme
- To seek feedback on how the short list of potential solutions may affect different groups

Our early engagement was undertaken as part of a four stage process which included pre-consultation, and will include consultation and post consultation. During this stage, we engaged a wide and diverse range of interest groups.

There was a particular focus on those groups most impacted by the potential changes to major acute services, such as users of paediatric, maternity and emergency services.

Our patient and public participation activity was undertaken with due and proper compliance with the:

- NHS Clinical Commissioning Group statutory patient and public participation duty; and
- NHSE Guidance

4.1.1 Engagement undertaken by Epsom and St Helier Hospital (ESTH)

Between July and October 2017 ESTH engaged with local communities around their challenges and potential scenarios for addressing these challenges. The outputs of this engagement activity were reviewed by the Consultation Institute (TCI) and published.

During the 13 week engagement period over 2,000 people participated in 47 local meetings and 31 internal drop-in sessions reached over 2,500 staff. The ESTH involvement exercise engaged interest groups ranging from GP practices, community organisations and resident associations to carer forums, patient groups and local councillors. A number of methods were used to encourage participation including a questionnaire (1,059 completed), website (11,977 visits) and video (6,310 views). 25,000 people actively took part overall. Epsom and St Helier asked three questions as part of their engagement:

- Do you agree with our aim to provide as much care as possible from our existing hospital sites at St Helier and Epsom and do this by working more closely with the other local health and care providers?
- Do you think we have made the case that we will improve patient care by bringing together our services for our sickest or most at-risk patients in a new specialist acute facility on one site?
- Do you think we should consider any other scenarios?

Key themes that were raised included:

- Access, public transport, parking and travel times and the impact for patients, relatives and visitors.
- Deprivation, healthcare needs and the location of acute hospitals.
- The need to understand which services will be in the specialist acute site and what will be kept local and the evidence of why this change will improve outcomes for patients.
- Concern over what will happen to the sites where the acute facility is not located in the long term.
- Need for assurance that this is for NHS patients not private patients.
- The impact on other hospitals.
- Where the £300 – 400m is going to come from to build the new acute facility and how much it will cost to borrow this money.
- The process of how a decision will be made.
- The timescale to get permission to build a new facility and what will happen to the sites and services in the short term.

At the end of its engagement process the Trust agreed to carry out further work and support commissioners in evaluating the relative merits of the different scenarios. As part of this the Trust recommended to commissioners that the following were considered in detail:

- Travel times and modelling travel time impacts for different groups of patients, relatives and visitors;
- Deprivation, healthcare needs and the location of acute hospitals;
- An assessment of any equalities impact; and
- The impact of scenarios on other providers.

4.1.2 Our early engagement

In undertaking its own engagement exercise, as a commissioner-led process, the IHT programme sought to build on the knowledge and insight gained by ESTH plus recommendations from The Consultation Institute's desktop review of the Trust's engagement activity (Review of Epsom and St Helier University Hospitals Trust pre-consultation activity - The Consultation Institute).

TCI's recommendations included the need to understand the service impact on:

- Protected characteristic groups (detailed in the initial equalities scoping report and the Key themes section below)
- Deprived communities experiencing health inequalities (explored in a Deprivation Impact Analysis attached as Appendix □)
- Neighbouring CCGs and associated Local Authorities (to understand the impact of patient flows to other Hospitals):
 - We have engaged with providers through the establishment of a Technical Group comprising provider Directors of Strategy to explore potential patient flows)
 - The establishment of the IHT Joint Health and Overview Scrutiny Sub-Committee (JHOSC) which includes representation from the London Boroughs of Sutton and Merton, and Surrey Council have involved specific discussions on any potential impacts of the proposed options.

In regard to TCI's recommendation of providing stakeholders with the opportunity to comment on the criteria proposed and suggest refinements, non-clinical stakeholders were provided with the opportunity to agree a set of criteria against which the options should be appraised (this process is further explored in the Engagement Undertaken section within this chapter).

4.2 Our approach to patient and public participation

4.2.1 Early Engagement Plan

An Early Engagement Plan was approved by the programme's Committees in Common in June 2018. This strategy detailed the programme's objectives, principles and approach to its patient and public participation work.

4.2.2 Engagement principles

Our engagement was underpinned by five principles which we committed to as follows:

- Transparency – information about programme, case for change and clinical model was made available online
- Inclusivity – extensive engagement was undertaken with seldom heard and equality communities through joint working with the voluntary sector, focus groups (over 15 held) and outreach work
- Listening – all the feedback received was included in an independent report presented to commissioners for response as part of the decision-making process
- Partnership – the establishment of a Communications and Engagement Steering Group as detailed above.
- Meeting best practice – our engagement approach was independently assessed by experts from The Consultation Institute.

4.3 Identifying our stakeholders

Initially the programme sought to identify all key stakeholders it needed to engage with. This process involved:

- Extensive desktop research, including a review of the previous ESTH engagement, TCI's paper review of the engagement activity undertaken by the Trust, and consultation with CCG senior leadership and communications and engagement teams.
- Stakeholder mapping to identify key stakeholders.

- Developing a stakeholder database with the help of CCG senior leadership, communications and engagement teams as well as the SRG to ensure a diverse range of stakeholders were engaged across geographies and demographics.

This mapping exercise addressed the gap identified by the TCI review of the ESTH engagement exercise around the need to involve those who had previously been engaged as part of the ESTH-led process, neighbouring CCGs, protected characteristic and health inequalities groups.

To support the engagement process, an engagement log to record all feedback received and/or sent plus social media and communication logs were set up.

4.4 Engagement tools

The programme used a range of engagement tools to engage our population, including seldom heard groups, as shown below.

Table 22: Engagement tools

Engagement materials	We have
Issues Paper, Technical Annex, and Summary pamphlet	Used to launch of our early engagement in June 2018. Throughout June – October we: <ul style="list-style-type: none"> • Distributed 4,300 Issues Papers across 300 locations including libraries, pharmacies, GP surgeries, Trust hospital buildings and other places • 5,000 summary pamphlets printed (and distributed at our public discussion and mobile engagement events as well as other forums)
E-newsletter	Regular programme updates and involvement and engagement opportunities shared through our monthly e-newsletter. Nine issues published to date through which we reached 900+ recipients. Our e-newsletters were read 1,677 times.
Improving Healthcare Together website	URL: https://improvinghealthcaretogether.org.uk/ We launched our website on 25th June 2018 and in June 2019 the content has been further updated and refreshed. This has been visited over 10,000 times by around 5000 people and: <ul style="list-style-type: none"> • hosted our key documents, animation video, online feedback form, news, an events page and FAQs. • provided details of our Freepost address and hello@improvinghealthcaretogether.org.uk email address allowing patients, carers and members of the public to provide feedback.
hello@improvinghealthcaretogether.org.uk	The tailored email address and Freepost address were a means for individuals and organisations to feed thoughts, questions and comments into the process.
Freepost address	We will endeavour to use evidenced based methods of engagement to make sure we deliver good value for money.
Feedback form	During the engagement period, stakeholders have had the ability to make submissions via the 'Feedback' facility on the Improving Healthcare Together website, with 14 responses received in this way. This online feedback form required respondents to provide answers to eight questions around the questions in the Issues Paper, in addition to their name and optional contact details. These questions were also included in a freepost paper survey which was circulated at some discussion events, containing the same questions.

Engagement materials	We have
Animation video	4 minute video published with subtitles to explain the challenges that the Epsom and St Helier Hospitals face and the case for change. This has been extensively used at our public discussion events and group discussions during engagement activity.
Easy Read version of Issues Paper	An accessible, easy read version of the Issues Paper was used to engage people with learning impairments and youth groups (e.g. Hearts and Minds in Merton and Bfree in Leatherhead). This was also published on the Improving Healthcare Together website.
Social media	<p>Social media was used to disseminate updates and publicise engagement opportunities as well as enhance opportunities to reach target stakeholders with information about the programme. Through our social media channels we also aimed to drive traffic to the website, amplify the reach of content produced for other channels and encourage and generate feedback from stakeholders.</p> <p>From 27th June 2018 to 14th June 2019:</p> <ul style="list-style-type: none"> • 972 people have followed our Twitter page. 2,851 engagements and over 810,416 impressions were registered via Twitter. • 915 people followed our Facebook page with 489,086 views. 2,069 engagements were further recorded via Facebook.
Media	The media coverage included digital, print and broadcast coverage as well as digital media campaigns and print media advertisements. This was used to disseminate updates, generate insight, advertise engagement opportunities and encourage feedback.
Flyers and posters	<p>In the run up to the public discussion events we distributed:</p> <ul style="list-style-type: none"> • 16,070 events flyers across 300 locations including libraries, pharmacies, GP surgeries, Trust hospital buildings and other places. • 450 posters and accompanying cover letters.
YouTube channel	We have launched a YouTube channel in September 2018. The audio recordings from the July – August public discussion events and the subtitled animation video are available on YouTube.

4.5 Engagement undertaken

Patient and public participation has taken place throughout the development of the programme. To contact our population across the combined geographies the programme linked in to existing networks and forums through local Healthwatch bodies and CCG communication and engagement leads.

A summary of the engagement undertaken between July – October 2018 is described below:

When	Engagement activity	Aims	Outcomes
Patients, carers, local residents and community groups			

When	Engagement activity	Aims	Outcomes
July - August 2018	<p>Six independently facilitated public discussion events held across:</p> <ul style="list-style-type: none"> • 2 x Surrey Downs (Epsom Methodist Church) • 2 x Merton (The Chaucer Centre and Tooting and Mitcham Community Football Club) • 2 x Sutton (Sutton Life Centre and Trinity Church). 	<p>To engage the public on key components of the Issues Paper including the case for change, clinical model, evaluation criteria, potential solutions and process of developing a solution.</p>	<p>185 participants attended including local MPs and councillors (e.g. Chris Grayling MP and Siobhan McDonagh MP).</p>
September 2018	<p>Six independently facilitated public discussion events held across:</p> <ul style="list-style-type: none"> • 2 x Surrey Downs (Banstead Methodist Church, Bookham Baptist Church) • 2 x Merton (Commonside Community Development Trust and Mitcham Parish Church) • 2 x Sutton (Sutton Masonic Hall and The Thomas Wall Centre) • This round of discussion events were built on the feedback and themes identified in the first round of engagement in July and August by members of the public. 	<p>To engage with the public on the core themes identified by participants at the July – August discussion events.</p> <p>The sessions were structured in a market place format with five stands staffed by independents experts around the following themes:</p> <ul style="list-style-type: none"> Introduction to the programme Clinical model and workforce Deprivation and equalities Travel Evaluation criteria 	<p>Over 100 participants attended these events.</p>
September 2018	<p>Six mobile engagement events held across:</p> <ul style="list-style-type: none"> • 2 x Surrey Downs (Epsom Hospital and Ashley Shopping Centre – Epsom) • 2 x Merton (Mitcham Market, and The Nelson Health Centre) • 2 x Sutton (St Helier Hospital and Asda – St Nicholas Way) 	<p>Engage local residents and patients (GP practice in Merton, Epsom Hospital and St Helier Hospital) in community focal points to hear a wider variety of voices.</p> <p>Seek public feedback on the challenges we face and potential solutions.</p> <p>Raise awareness of the September discussion events and give other ways of providing feedback.</p>	<p>80+ residents completed a survey with another 70 engaged.</p>
July – October 2018	<p>Online survey developed for staff. The questions were developed by the IHT programme team and the survey circulated by the Surrey Downs, Sutton and Merton CCGs as well as the Epsom and St Helier communications and engagement teams to all staff.</p>	<p>The staff survey aimed to encourage as much feedback as possible around the challenges, our vision, staff priorities and any other potential solutions.</p>	<p>200+ staff responded to the online survey.</p>

GPs, pharmacies, CCG and hospital staff

When	Engagement activity	Aims	Outcomes
July – October 2018	<p>Emails, briefings and presentations at staff forums</p> <p>Summary pamphlet displayed in Surrey Downs CCG office</p> <p>Programme updates and engagement opportunities included in CCG staff newsletters</p>	To encourage participation and raise awareness of the case for change plus clinical vision.	CCG and hospital staff kept informed and updated.
	GP locality meetings	To engage local clinicians, seek feedback and raise awareness of the programme.	Updates and agenda items at GP locality meetings e.g. Sutton CCG.
	Clinical Advisory Group	A Clinical Advisory Group was established to provide clinical leadership to the programme and ensure the development of robust clinical proposals for recommendation to the Improving Healthcare Together 2020 – 2030 Programme Board.	Two task and finish working groups were set up to support this work which involved clinician participation to develop and explore specific service models: maternity, paediatrics and A&E.
	Clinician and CCG chairs participation in public discussion events.	To share and explain the case for change with patients, carers and local residents.	Participants at public discussion events were informed about the clinical vision and current challenges from clinician perspective.
	Telephone interviews conducted with 12 clinicians as part of the Initial Equalities Analysis.	To understand equality impacts from clinician perspective.	Initial Equalities Analysis informed by local intelligence concerning community health needs and challenges.
MPs and local councillors			

When	Engagement activity	Aims	Outcomes
July – October 2018	<p>Our engagement with local authorities included:</p> <ul style="list-style-type: none"> • IHT Scrutiny Committee • Emails and meetings with council officers • Responses to incoming feedback • Emails sent to councillors • Councillors invited to discussion events • Local authorities were invited on to the SRG • Responses to incoming feedback • Monthly briefing meeting with the CCG managing directors • Mayor of London’s health advisor briefed • Briefed the GLA health team 	<p>To involve, secure feedback from and engage local Members, MPs plus other key partners (political and public sector)</p>	<ul style="list-style-type: none"> • The programme responded to several letters from Siobhan McDonagh MP (Merton) and one from Crispin Blunt MP (Surrey) to provide information and reassurance around issues and process. • Creation of a Joint Health Overview and Scrutiny Sub-Committee to allow for effective local government input. • Three meetings with the SW London and Surrey Joint Health Overview Scrutiny Sub-Committee (JHOSC) have taken place. • Councillors, Chief Executives, Leaders, Cabinet Members and Directors of Services briefed about programme and invited to discussion events.
Voluntary and community sector			
July – October 2018	<ul style="list-style-type: none"> • The Stakeholder Reference Group (SRG) - which engages over 100 community and voluntary organisations/groups. 	<p>To offer advice, views, suggestions or opinions on:</p> <ul style="list-style-type: none"> • The programme plan • Plans for public engagement, including pre-consultation engagement • Subsequent consultation activities that may be undertaken • Language, tone and style of public engagement and consultation materials • Which seldom-heard groups should be consulted and how 	<ul style="list-style-type: none"> • The SRG has met six times during our programme of early engagement. • At these meetings we have engaged with 59+ attendees. These included representatives from organisations such as Merton Mencap, Sutton Seniors Forum and Surrey Coalition for Disabled People.

When	Engagement activity	Aims	Outcomes
	<ul style="list-style-type: none"> • CCG Patient and Public Engagement leads 	<ul style="list-style-type: none"> • To ensure reach to local health, patient, voluntary sector and community groups and organisations through existing PPE contacts and networks. 	<ul style="list-style-type: none"> • The Merton CCG lead distributed flyers and leaflets to a wide range of local community groups as part of the Merton Commissioning Intentions exercise.
	<ul style="list-style-type: none"> • Community outreach with equality and seldom heard groups. 	<ul style="list-style-type: none"> • To understand the service impact on equality groups with a view to putting appropriate mitigations in place ensuring these groups are not disadvantaged or disproportionately impacted in terms of access. 	<ul style="list-style-type: none"> • Over 15 focus groups held with equality, seldom heard and deprived communities • Extensive community involvement through local support groups (122 service users engaged) • See Community outreach section below for key feedback provided
	<ul style="list-style-type: none"> • Worked closely with Healthwatch bodies across the three CCGs 	<ul style="list-style-type: none"> • To ensure the views of local health, patient, voluntary sector and community groups feed into and shape the options development process 	<ul style="list-style-type: none"> • Healthwatch delivered 11 focus groups with local equality groups • Chair and members of SRG.

When	Engagement activity	Aims	Outcomes
	<ul style="list-style-type: none"> • Engagement with voluntary and community groups. • The Issues Paper was posted to over 150 community and voluntary groups. • Emails sent concerning the Issues Paper and engagement opportunities as well as invitations to attend discussion events. • Articles and flyers were sent to voluntary and third sector organisations for their community newsletters and websites. • Flyers and posters advertising the discussion events were posted. 	<ul style="list-style-type: none"> • Raise awareness of the aims of the programme, case for change and clinical vision. • Encourage participation and gather local insights. 	<ul style="list-style-type: none"> • Voluntary and community groups recorded on our master stakeholder list (over 100) received copies of each e-newsletter. • Over 100 voluntary and community groups engaged through SRG • Local support groups involved through community outreach work to reach equality and seldom heard communities. • Attendance at external fora including the Surrey Downs CCG Participation Action Network (local forum of grassroots organisations) on 5th October 2018 and Cobham Residents Association AGM on 11th October 2018.
Campaign group (Keep Our St Helier Hospital)			
July – October 2018	<ul style="list-style-type: none"> • Members of SRG and participation in public engagement events. 	<ul style="list-style-type: none"> • Engage with and involve local interest groups. 	<ul style="list-style-type: none"> • The ‘Keep our St Helier Hospital’ group delivered a presentation to SRG in July 2018. • Written correspondence was submitted to clarify issues of concern. • Attendance at July and September listening events.
Maternity, paediatric and acute service users			

When	Engagement activity	Aims	Outcomes
October 2018	<p>Six focus groups were held to engage users of emergency care, maternity and paediatric services.</p> <p>Six in depth interviews conducted with emergency care service users.</p>	<p>These focus groups were designed to obtain feedback on how the proposed solutions might impact on key service users.</p>	<p>50 participants engaged including parents of children under the age of 11 and new mothers across the three CCG areas to understand the impact of potential solutions from the service user perspective: urgent treatment, bed model, planned care and choice / behaviour.</p>

A total of 459 stakeholders were briefed prior to the launch of the programme and 36 stakeholder meetings were also held.

4.6 Community outreach

4.6.1 Equality groups

During our programme of early engagement an initial equalities analysis was undertaken by Mott MacDonald to understand how the emerging clinical vision would impact on specific communities.

Further feedback was sought from the protected characteristic groups identified as potentially impacted by the proposals in order to:

- Understand this impact; and
- Put appropriate mitigations in place to ensure they would not be disadvantaged or disproportionately impacted in terms of access

This feedback was obtained through the Healthwatch focus groups, engagement with local service user support groups and focus groups held with parents and service users on the clinical model.

4.6.2 Seldom heard groups

Three focus groups with residents experiencing the highest health inequalities and deprivation were also held in October 2018 across the three CCG localities.

The following table records equality and seldom heard groups engaged between September - October 2018:

Table 23: Engagement with seldom heard groups

Protected characteristic	Surrey Downs CCG	Merton CCG	Sutton CCG
Older people over the age of 65	Healthwatch: Age UK	Healthwatch: Merton Seniors Forum	Healthwatch: South Sutton Hello
Black and minority ethnic communities	Surrey Minority Ethnic Forum	Healthwatch: BAME Voice and The Ethnic Minority Centre	Healthwatch: Sangam and ACHA

Protected characteristic	Surrey Downs CCG	Merton CCG	Sutton CCG
People with learning impairments	Healthwatch: Sunnybank Trust, The Grange, Mencap, Surrey Choices, Ashted Learning Disabilities Action Group and Queen Elizabeth Foundation	Merton Mencap	Sutton Mencap
People with physical impairments	Mid-Surrey Disability Network (working with Surrey Coalition of Disabled People)	Merton Vision and All Saints Resource Centre (service users)	Sutton Parents Forum, Oaks Way Centre and Sutton Lodge Day Centre
People in poor mental health	Mary Frances Trust and The Old Moat Garden Project (Richmond Fellowship)	Imagine Independence	Sutton Mental Health Foundation
LGBT+	Focus Group	Focus Group	Focus Group
Carers	Healthwatch: Action for Carers	Healthwatch: Carers Support	Healthwatch: Carers Centre and Young Carers
Children and young people	Bfree (North Leatherhead Youth Council)	Hearts and Minds (Young people and mental health)	Street Doctors (crime and reparation scheme), Children in Care Council and Sutton Youth Commissioners
Gypsy, Roma and Traveller community	The Forum	Not applicable	Not applicable
Pregnancy and maternity (women aged 16-44)	Clinical model focus group – maternity and paediatrics: recruitment via nurseries, family, parent and children’s groups: Epsom	Clinical model focus group – maternity and paediatrics: Newminster Child Health Clinic	Clinical model focus group – maternity and paediatrics: recruitment via Sutton Mencap, Sutton Family and social media
Deprived communities (residents living in wards with highest health inequalities)	Focus group held with local residents	Focus group held with local residents in Cricket Green	Focus group held with local residents
Initial Equalities Scoping	Six in-depth qualitative interviews with representatives of key user groups		

4.7 Responsive engagement

The programme responded to public feedback concerning the engagement process wherever possible to encourage participation. This included holding events at different times to accommodate work/life commitments, and in different locations to reach the isolated (e.g. in Surrey Downs), deprived and seldom heard (e.g. in Merton and Mitcham).

Based on feedback received concerning the need to reach seldom heard and deprived communities we also conducted street interviews at weekends to engage local residents at community focal points through our mobile engagement events.

Feedback was also received requesting further detail to enable participants to provide a more informed response. Our September listening events therefore adopted a 'market-place' format with five stands. These were staffed by independent experts based on key themes previously identified by the public as detailed above.

4.8 Key themes

Between July – October 2018 our early engagement activity reached over 800 people through the engagement channels and workstreams detailed above. All the feedback gathered through our various engagement activities was independently analysed by The Campaign Company and the findings captured in their engagement report. The key themes are summarised in Figure 21 below.

Figure 21: Key themes from engagement

The following themes emerged from our engagement:

- There is dissatisfaction with current health services and a recognition of key elements of the case for change, such as workforce challenges and the problems with current buildings.
- There was support given for the main areas of the clinical vision – such as the focus on integration and prevention. However, there were concerns over deliverability, specifically with regard to financial sustainability.
- There was not a clear consensus of the type of change that should be delivered, with comments made both in favour of consolidation of services and retaining the status quo.
- People tend to advocate for services they are familiar with and solutions that are closer to them with no clear consensus over a single site for acute services.
- There is a particular concern around the transport and accessibility between different sites, such as from St Helier to Epsom and vice versa. This included the need to consider bus routes, the impact of traffic on travel times, and the cost and availability of parking.
- It was felt that those who are perceived to be most in need, in particular older and less mobile people and those in areas of higher deprivation, would be most impacted by potential changes. Consideration of these factors was felt to be important when developing solutions.
- When consulting or engaging in the future, a need was expressed to use approaches and channels that allow all groups in the population to respond in ways that suit their circumstances. It was also felt that the process should be promoted more visibly and for clear, detailed information to be provided to ensure patients and communities can make informed contributions going forward.

The programme also received feedback from 100 people who responded to a separate survey conducted locally following a model survey template – key themes which emerged from this engagement included:

- Refurbish existing hospitals and build a new hospital on the St Helier site
- Improve hospital efficiency through energy savings, innovation and more staff
- Reduce costs: pay senior managers less, use volunteers and invest in social care

- Locate hospital close to those in need e.g. deprived groups (homelessness, low income, no car) and consider the impact of population density, population growth and other local hospitals
- Abolish training fees, pay staff more, recruit from abroad and use apprentice schemes
- The current vision for healthcare is not the right one and parking should be free
- Constant consultation has caused stress and anxiety – a decision should be made soon
- Other challenges: ageing population, mental health service demand and the need to connect community care to NHS need

4.8.1 Equality groups

Across the equality groups engaged by Healthwatch and the programme a number of common themes emerged:

- The impact of transport links, longer journey times, limited parking, parking costs and increased travel costs on people with mental health needs who struggle with anxiety, agoraphobia and panic attacks, people with learning impairments on a fixed income who do not drive or travel alone and people with physical impairments who rely on patient transport and public transport (buses more than trains).
- Disability-friendly – there is a need for specialist support for young people, people with mental health needs and people with a physical and/or learning impairment in a new acute service (e.g. specialist mental health and learning disability nurses).
- Family, friends and carers– people who are critically ill are vulnerable and need help with making decisions. If carers, friends and family cannot visit this has a serious, isolating and significant impact on the patient. Social contact is vital to recovery and information-sharing particularly for the vulnerable e.g. people with physical and/or learning impairments, people with a mental health need and children and young people. Visitors and carers also have needs of their own e.g. some are older or use a wheel-chair – once again cost of transport, distance and lack of available transport are key inhibitors.
- Cultural sensitivity – an impact was raised by some participants of black and minority ethnic origin around the need to meet food and language requirements (this concern was raised in relation to Epsom Hospital reflecting the population demographic in situ). Members of the Gypsy, Roma and Traveller community in Surrey Downs also highlighted the need for sensitivity to cultural needs which has been developed at Epsom Hospital eg community attendance to the dying.
- Residents living within deprived communities raised similar concerns to those already highlighted in relation to any potentially increased travel times, impact of traffic and increased traffic, impact of parking (availability and costs) and impact of public transport on the elderly and parents.
- Familiarity and reputation – across all the groups engaged quality of care, reputation (perceived issues at St Helier) and current access also played a part in determining which solutions were preferred. For adults and children with mental health needs and/or learning impairments consistency is key and change equals uncertainty - familiarity with a known hospital environment and staff is therefore important for these groups.
- Case for change – there was widespread recognition across all the equality and seldom heard groups engaged concerning the need to improve the status quo of staffing levels and old buildings.

Other:

- Some participants felt that St Helier had good transport links serving a larger, deprived population which would benefit from a new acute service – however, for some Merton and Surrey Downs residents the longer journey time is a concern.

- Availability of beds, population growth, impact of higher demand on waiting times, merits of accessing a centre of excellence, increased demand for ambulance services, need to focus on prevention and need for the elderly to access acute care was also raised.
- Low staffing levels, high building costs, service disruption, need for joined up care (carers, older people) and better information – sharing (carers, older people) were also raised as key issues.
- The above feedback mirrors key findings from our overall engagement around transport, traffic, parking and the impact of service change on the elderly, less mobile and deprived.

The feedback collected above was submitted in evidence packs and reviewed in the options consideration and appraisal workshops (see below).

4.9 Options consideration and appraisal

Following TCI best practice, the programme adopted its recommended process for working collaboratively with local people to evaluate the proposed options.

This options consideration process ensured patients, carers and the public played a full part in agreeing criteria, weighting criteria and scoring the final options based on a 60:40 attendee ratio of local people and professionals.

The Terms of Reference for community participation in the options development workshops were shared with the SRG members who were invited to attend these workshops as observers along with Healthwatch and lay members from all three CCG Governing Boards.

Representatives were selected to reflect a range of perspectives, including impacted service users (maternity, paediatrics, emergency), protected characteristic groups, carers and deprived communities.

4.10 Impact and influence

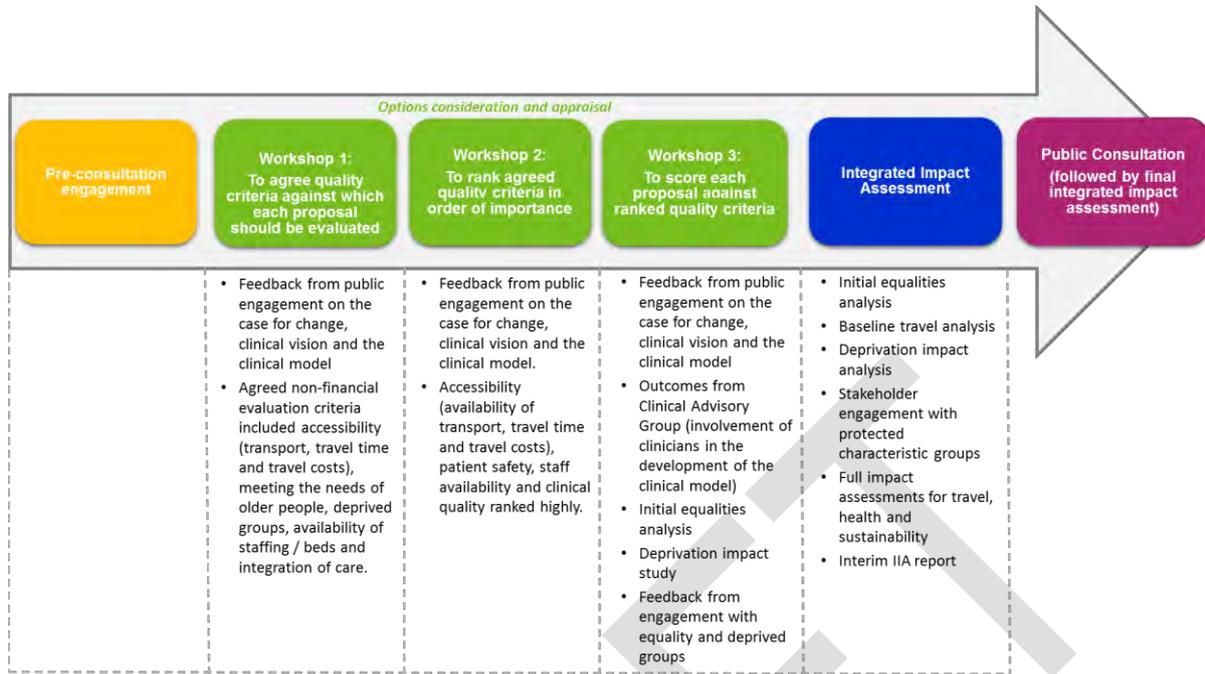
Feedback gathered from pre-consultation engagement with local residents, patients, carers and equality groups informed each stage of the development of proposals. Local priorities for acute healthcare were captured over the summer and autumn through a wide-ranging listening exercise and the feedback provided included the need to consider travel times and costs, older people and deprived groups.

This feedback fed directly into the development of the clinical model and options for consideration (this feedback also included the view of equality groups potentially impacted by the proposals and their specific needs). We also involved the public in developing and scoring a clear set of non-financial criteria against which each proposal was compared and scored by community representatives.

This process of co-design will continue when further engagement is undertaken as part of the Integrated Impact Assessment (see Section 10.6) and any public consultation undertaken.

Figure 22 captures the impact and influence of our engagement activity on the development of proposals at each stage.

Figure 22: Impact of each of the stages of the options consideration process



4.11 Pre-consultation

Programme engagement with key interest groups will continue to share the feedback that was provided, explain next steps and co-design any consultation process.

4.11.1 Interim integrated impact assessment

An Integrated Impact Assessment (IIA) will be undertaken to explore any potential impacts associated with the proposed options, and how best they can promote and protect the well-being of the local people. The IIA is carried out in several phases throughout pre-consultation and consultation, and evidence will feed into the process at different points. Further detail can be found in Section 10.6.

4.11.1.1 Engagement with local people

In December 2018 the process began to undertake an interim IIA to explore any potential health, equality, travel and access and sustainability impacts on the local population arising from the proposals for change at ESTH.

The IIA is designed to be an iterative process that can be revisited and take on board any new information that may be relevant up until any formal public consultation has finished. This work is being undertaken in three distinct phases. The full scope of each phase of the IIA, aims and its governance arrangements can be found in Section 3.7.

The second phase of the IIA was an exploration with a range of groups to identify considerations around option development and appraisal. This included:

- People that need to travel to services
- People from areas where health inequality has been identified or is suspected
- People with protected characteristics and their representatives as identified through the pre-engagement phase.

4.11.1.2 Engagement with protected characteristics and seldom-heard groups

Between February – March 2019, 12 focus groups with protected characteristic groups and residents in first quintile of deprivation in Merton and Sutton were held across the combined geography to inform this phase of the IIA work. The composition of these focus groups was based on cohorts

selected on the basis of the evidence already available on the demographics of local areas and need for services.

Table 24: Engagement with protected characteristics groups and deprived residents in Merton, Surrey and Sutton

CCG	Group number	Date of group	Location of group by ward	Composition	Number who attended
Merton	1	25th February 2019	Colliers Wood	Females aged 18-44, from a BAME background	8
Merton	2	25th February 2019	Colliers Wood	People from a BAME background	9
Merton	3	7th March 2019	Pollards Hill	People from deprived communities	6
Merton	4	7th March 2019	Pollards Hill	People with a limiting long-term illness (LLTI) including disability	8
Sutton	5	14th March 2019	Wandle Valley	Those aged 65 years old or older	10
Sutton	6	12th March 2019	Sutton Central	People from a BAME background	9
Sutton	7	14th March 2019	Wandle Valley	People from deprived communities	12
Sutton	8	12th March 2019	Sutton Central	Females aged 18-44	10
Surrey Downs	9	4th March 2019	Ewell	Those aged 65 years old or older	7
Surrey Downs	10	4th March 2019	Ewell	Parents	9
Surrey Downs	11	27th February 2019	Town	Those aged 18-24 years old	11
Surrey Downs	12	27th February 2019	Town	People with a limiting long-term illness including disability	9

Further engagement with seldom-heard groups which may have a disproportionate need for acute services continued, including:

- Carers
- People with a learning disability
- Gypsy, Roma and Traveller community

- LGBT+ community
- Residents in the second quintile of deprivation in Merton
- Staff at ESTH.

This engagement was undertaken via existing community networks, one-to-one interviews and meetings with professionals.

4.11.1.3 Engagement with public health representatives

In addition to the focus groups, interviews with Directors of Public Health in Merton, Sutton, Surrey Downs and Kingston upon Thames were held to further understand the health impacts of any changes. This was carried out to obtain views on the evidence required for the full IIA assessment, ensuring that the analysis is based on the most current and relevant evidence, statistics, and research nationally and locally.

4.11.1.4 Travel and access solutions workshop

On 8th April 2019 a solutions workshop was held to explore potential mitigation actions in relation to identified travel impacts. This workshop was attended by a mix of participants including nine representatives from local community organisations including Evolve Housing, which provides sheltered accommodation for young mothers in Merton, and Family Voice Surrey, which works with children, young people and families with complex and long-term needs.

The solutions workshop provided feedback based on local insights, experiences and needs. The mitigations identified in this workshop along with those which emerged from the focus groups are captured and detailed in the programme's interim IIA report).

4.11.2 Ongoing community outreach

Our outreach work has continued across Surrey Downs, Merton and Sutton to engage local community groups in the programme and capture feedback. The programme has engaged with 15 community forums ranging from the Epsom Maternity Voices Partnership and Sutton Night Watch to Merton Voluntary Services Council Involve Forum and the Preston Partner Network in Surrey Downs. Most of the feedback captured replicates feedback already highlighted by local communities around travel and access.

4.11.3 Learnings for public consultation

Key lessons learned from our early engagement activity which will be taken forward to any public consultation are:

- Continue monitoring the demographic profile of people engaged to ensure all voices are heard
- Promote transparency around the decision-making process
- Deliver open, clear, honest communications about the potential options, why they are being proposed and clinical case for change
- Continue promoting patient and public participation involvement at hospital sites, GP practices and other public places to reach patients as well as the wider community
- Use a variety of engagement methods to involve different groups of people
- Use accessible, simple language to engage seldom heard groups

Section 17 outlines our Consultation plan to deliver a public consultation.

Figure 23: What we learned from our engagement with local people on how we have engaged so far¹²⁹**What we learned from our engagement with local people**

Within our *Issues Paper* the key question for consideration was:

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

Key themes arising in response to this included:

- Using and offering a range of engagement channels to allow different audiences to respond in ways that suited their circumstances;
- Promoting involvement at hospital sites, GP practices and other public places to reach patients as well as the wider community; and
- Providing more detailed and clear information about the reasons for change to make sure people can make informed contributions.

What we have changed

We have further developed our process of engagement since the publication of the *Issues Paper*:

- The programme responded to public feedback to encourage participation, including holding events at different times to accommodate work/life commitments, and in different locations to reach the isolated, deprived and seldom heard groups.
- Based on feedback received concerning the need to reach seldom heard and deprived communities we also conducted street interviews at weekends to engage local residents at community focal points through our mobile engagement events.
- We have used a wide range of channels to communicate our engagement and set out our reasons for change, including mobile engagement events, an easy read version of the *Issues Paper*, public discussion events, through our website, newsletters and an animation video. This has ensured we have communicated widely with the public with clear messages.

¹²⁹ Improving Healthcare Together 2020 – 2030, Independent analysis of feedback from public engagement, The Campaign Company, 2018

5 CLINICAL MODEL

Our clinical model aims to ensure the very best quality of care is available to our populations and sets the direction for care in our combined geographies.

It describes how we will deliver **district hospital services** and **major acute services** to provide excellent care in the future.

- The aim of our **district hospital model** is to deliver a **community-facing, proactive health, wellness and rehabilitation service** in each of our two catchments to support people who do not require high acuity services but who still need some medical input. This includes district beds for patients 'stepping down' from a major acute facility, 'stepping up' from the community and directly admitted via an urgent treatment centre(s). For the district hospital model, access is therefore important due to the frequency of contact. Our clinical model keeps district services as local as possible and these services will continue to be delivered from both Epsom and St Helier Hospitals, while being further integrated with other services people use.
- **Major acute services are for the treatment of patients who are acutely unwell or are at risk of becoming unwell**, such as those treated within the emergency department. These are services that require 24/7 delivery and include the highest acuity services. We have considered the co-dependencies between these services, to define the minimum set of services that need to be co-located. For major acute services clinical standards of care and co-location are central to clinical outcomes due to the importance of consultant input and critical nature of the care – and the aim is to ensure these services are co-located appropriately.

We believe that this clinical model – where local access to district services is maintained and major acute services are co-located – will benefit the quality of our services and the experience offered to patients.

5.1 Vision

With our clinical model, we want to ensure the very best quality of care is available to our populations within our combined geographies.

As a group of local GPs, we considered from a clinical perspective how to address the overall 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 best to deliver care in the future. We are doing this with our partners from all health and social care providers in the area. We have agreed that:

- At the heart of our vision is wanting to keep our local population well, and for as much care to be delivered as close to your home as possible.
- We want to ensure the very best quality of care is available to our patients and communities, that it is sustainable into the future from buildings which are fit for purpose.
- We also need to ensure that when you are seriously unwell or at risk of becoming seriously unwell, you have access locally to the highest quality care, available at any time of day or night and on any day of the week.

We have considered how our hospitals fit into this vision. At the most basic level, hospitals have two main functions:

- Support clinicians working in the community and primary care to enable diagnoses, manage long term conditions, undertake planned care and provide rehabilitation. All these services need to be integrated into patients' local communities. **These services are defined here as district hospital services and comprise c. 85% of hospital-based care at ESTH (see Section 5.2.2).** The CCGs are committed to providing the full range of district hospital services set out in this chapter from both Epsom and St Helier hospitals.
- Treatment of patients who are acutely unwell or are at risk of becoming unwell, such as those treated within the emergency department. These are services that require 24/7 delivery, often only have brief contacts with patients and work in a network with other hospitals so that the most complex patients can be managed well. **These services are known as major acute services and comprise c. 15% of hospital-based care (see Section 5.2.3).**

We have outlined a clinical model in this pre-consultation business case which we believe will deliver this vision and provide excellent care in the future for these two main hospital services. When delivering this model, we are committed to maintaining all existing services within the combined geographies.

5.2 Overall model

Our clinical model aims to achieve this vision and sets the direction for care in our combined geographies. It describes how we will deliver district hospital services and major acute services to provide excellent care in the future.

As a result of our vision we have agreed three main principles that underpin our clinical model:

- 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, **we have developed this clinical model to the highest relevant standards** and are developing this business case to **invest in appropriate buildings** to deliver it.
- To keep you well, and for as much care to be delivered as close to your home as possible, we have developed a **district hospital model of locality-based care**. The **district hospital model** refers to the services around keeping people well, including enabling diagnoses, care for chronic conditions, planned care and rehabilitation (see Section 5.3). These are services that do not require critical care and/or services on which critical care depends. A definition of critical care is included below.
- To ensure that when you are seriously unwell or at risk of becoming seriously unwell you have access locally to the highest quality care, available at any time of day or night and on any day of the week, we have developed **clear expectations of the level of care provided by major acute hospital services** (see Section 5.5). **Major acute services** are reliant on the presence of critical care and/or services on which critical care depends.

5.2.1 Out of hospital services

Out of hospital services are essential to the delivery of care local to people's homes. Our out of hospital services across the geography will be integrated with the clinical model.

Within current models, often patients are admitted to hospitals when they may be better benefitted by services that can be provided outside of the hospital. Surrey Downs, Sutton and Merton CCGs have developed local health and care plans that describe initiatives across the geography, predominantly focusing on:

- Person-centred integrated care;
- Primary care networks; and
- Bed-based care.

These local services, initiatives and strategies are further described in Section 5.3.

5.2.2 The district hospital model

District hospital services are those that patients are likely to require more frequently, and often benefit from being strongly integrated with community health and care settings. This integration can provide benefits such as improved continuity of care and patient experience.

District hospital services include:

- Urgent treatment centres (appropriate for c. 99,000 patients p.a.);
- Endoscopy (used by c. 12,000 patients p.a.);
- Outpatients (used by c. 610,000 patients p.a.);
- Daycase surgery (used by c. 14,000 patients p.a.);
- Rehabilitation;
- Low risk antenatal and postnatal care (used by c. 3000 patients p.a.);
- Imaging and diagnostics;
- Dialysis (used by c. 2,400 patients p.a.);
- Chemotherapy (used by c. 1,500 patients p.a.); and
- As described in Section 5.4.3, district hospital beds (appropriate for c. 10,000 patients p.a.).

These services are defined and described further in Section 5.3. The table below shows the district hospital services that are delivered in the community, and in the hospital.

Figure 24: District hospital services in the hospital and the community

District services in the community	District services in the hospital
<ul style="list-style-type: none"> • 111 • Proactive community services • Reactive community services • Mental health services • Home births • Admission avoidance • Self-management • Social prescribing • Primary care at scale • Health visiting • End of life care • Rehabilitation • Community beds • Pharmacies • GP appointments 	<ul style="list-style-type: none"> • Urgent treatment centre • Endoscopy • Outpatients • Daycase surgery • Rehabilitation • Low risk antenatal and postnatal care • Imaging and diagnostics • Dialysis • Chemotherapy • District hospital beds

The district hospital services are among the most frequently accessed by patients at ESTH, and we are committed to continuing to provide these services from both Epsom and St Helier Hospitals.

5.2.3 Major acute services

Major acute services are required for the highest risk and sickest patients.

Figure 25: Major acute services



Major acute services include:

- Major emergency department – the areas of A&E for the sickest patients, including major emergencies, resuscitation and dedicated children's A&E (used by c. 53,000 patients p.a.);
- Acute medicine (used by c. 30,000 patients p.a.);
- Critical care (used by c. 300 patients p.a.);
- Emergency surgery (used by c. 2,800 patients p.a.);
- Births (excluding home births) (used by c. 4,800 patients p.a.); and
- Inpatient paediatrics (used by c. 2,100 patients p.a.).

These services are defined and described further in Section 5.5. We believe that this clinical model – where local access to district services is maintained and major acute services are co-located – will deliver our vision for patients and increase the quality of delivery of care across our combined geography.

5.3 Integrating with out of hospital services

5.3.1 Out of hospital care in Surrey Downs, Sutton and Merton

Over the last few years the health and care systems in Surrey Downs, Sutton and Merton have been developing increasingly integrated 'out of hospital' care with the aim of increasing the numbers of people who can be looked after at home and reducing the burden on the acute hospitals. Owing to this we can now demonstrate:

- Reduced number of inpatient beds being used for emergency care
- Shorter length of hospital stays and a major reduction in 'super stranded' patients
- More patients being looked after in community settings who would have been in hospital
- Prevented admissions as a result of proactive and preventative care

This section provides further detail on out of hospital and integrated care schemes and sets out achievements to date.

5.3.2 CCG health and care initiatives across the combined geography

The CCGs have been working on the integration of primary, community, social, mental and acute hospital care over the past few years. These strategies are localised to Surrey Downs, Sutton and Merton CCGs but there are consistent themes across them all.

At the heart of the approach in both Sutton and Surrey Downs is the creation of an alliance of the key providers of care. Together with the integrated locality teams and reablement model in Merton, this has meant that there is now a proactive and preventative model of community and out of hospital care across our combined geography.

For Surrey Downs and Sutton, two contractual joint ventures that include ESTH, GPs, community services, mental health and social care are being hosted by ESTH with GPs having key leadership roles. These initiatives are a partnership of equals which have been highly successful through involving lay partners, adopting a culture of co-design with patients, integrating a single IT system as the patient record (The GP IT systems), breaking down the barriers between professionals and organisations to create single teams, and organising services at locality level / PCN level.

As at September 2019 the following services are now included in these provider alliances:

- Sutton – adult community health, children’s therapy, children’s community health, sexual health, @home response service including council delivered reablement service
- Surrey Downs – adult community health, community hospitals, @home response service including council delivered reablement service, stroke care

The two alliances now have a workforce of c1,000 staff and a budget of c£50m.

Merton has been delivering integrated care across the area for the past few years using integrated locality teams (community services and social care aligned to GP practice clusters) to keep people well at home (avoiding admissions) and get people home more quickly (discharge support). Through the Merton Health and Care Together programme this is being further developed and the creation of a provider alliance is being actively explored. Merton has a well-established equivalent @home service (MERIT) and also runs HARI (holistic assessment rapid investigation) for older people which includes elderly care medicine, social prescribing, therapies, reablement and mental health input.

5.3.3 CCG out of hospital initiatives

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.

Plans broadly align to three key areas:

1. **Person-centred integrated care** – at scale community services that provides proactive, personalised, coordinated and more integrated health and social care. There is a clear commitment between providers and commissioners to provide services closer to home that focus on preventing people escalating too far up the acuity scale
2. **Primary care networks** – GP led services with the aim of improving access and patient outcomes at scale across local neighbourhoods / localities
3. **Bed based care** – intensive support provided to individuals who cannot be safely managed in their own home and for whom major acute services are unnecessary – covers step up and step down element. Service focuses on rehabilitation, and embedding independence to self-care and builds on the district hospital model.

A description of CCG out of hospital schemes is set out below.

Table 25: CCG out of hospital schemes

Domain	Scheme	Description
Person-centred integrated care	Making every contact count (MECC)	Ensuring opportunistic delivery of consistent and concise healthy lifestyle information e.g. promoting healthy eating, weight loss etc.
	Social prescribing	Linking people with sources of support across their local community
	Care navigation	Helping people get the right support, at the right time to help manage a wide range of needs e.g. support with LTCs, help with finances and signposting
	Risk stratification	Data driven approach (typically GP data set) to identify people at high risk of NEL admission
	MDT care planning and case management	Holistic care planning and MDT case management for people identified as high risk of NEL admission
	Tele-care / telehealth	Technology based solutions to support people to live well and manage their long term conditions as independently as possible
	Discharge to assess	Discharging patients who are medically optimised as quickly as possible and ensuring that they receive their full multi-disciplinary assessment and care planning at home or their usual place of residence
	Rapid response	Rapid multi-disciplinary support to individuals experiencing an acute health or social care crisis which can be managed safely within their own home and would otherwise result in a hospital admission.
	End of life support	Support to enable people to die comfortably and with dignity in their preferred place
Primary care networks (PCNs)	Improving access	Hub and spoke delivery model to increase same day access of GP appointments
	Healthy care homes	Enhanced, co-ordinated care delivery to care homes (linked GP)
	Urgent Treatment Centres (UTCs) / ambulatory care	GP led alternative to A&E service that can diagnose and deal with a range of minor medical emergencies
Bed based care	Community bed based care (step-up)	Short term bed based care for those individuals who have no need for acute care but need a level of ongoing care that cannot be immediately provided in their own home
	Community bed-based rehab (step-down)	Short term bed based care for those individuals who no longer require acute hospital care but cannot be managed safely at home

These schemes are aligned with the development of the long term plan.

Figure 26: CCG alignment to Long Term Plan

Long Term Plan domain	How CCGs will deliver this
<p>Doing things differently: we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services..</p>	<ul style="list-style-type: none"> • We will provide more joined up, integrated and holistic support for patients • We will ensure the opportunistic delivery of consistent and concise healthy lifestyle information e.g. promoting healthy eating, weight loss etc
<p>Preventing illness and tackling health inequalities: the NHS will increase its contribution to tackling some of the most significant causes of ill health, including smoking, drinking and Type 2 diabetes.</p>	<ul style="list-style-type: none"> • We will increase patient activation by improving the skills, knowledge and confidence for people to self-care
<p>Backing our workforce: we will continue to increase the NHS workforce, training and recruiting more professionals.</p>	<ul style="list-style-type: none"> • The workforce will be trained to work at the top of their licence
<p>Making better use of data and digital technology: we will provide more convenient access to services and health information for patients</p>	<ul style="list-style-type: none"> • We will better utilise health and social care data to identify local need and commission services • We will have a single Integrated health and care record that is accessible to professionals • will reduce the growth in demand for care through better integration and prevention
<p>Getting the most out of taxpayers' investment in the NHS: we will continue working with doctors and other health professionals to identify ways to reduce duplication and increase efficiency in how clinical services are delivered.</p>	<ul style="list-style-type: none"> • We will proactively target prevention at individuals to prevent them escalating up the acuity scale • We will provide as much care at, or as close to home, as possible

CCGs are currently delivering or are committed to delivering the vast majority of these schemes. Realisation of the full benefits are dependent on the schemes operating at full capacity and at scale across the patch.

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Figure 27: Progress of out of hospital schemes across our combined geography

Domain	Scheme	Surrey CCG	Sutton CCG	Merton CCG
1. Person centred integrated care	Making every contact count (MECC)		N/A	
	Social prescribing			
	Care navigation			
	Risk stratification			
	MDT care planning and case management			
	Tele-care / telehealth			
	Discharge to assess			
	Rapid response			
	End of life support			
2. Primary Care Networks (PCNs)	Improving access			
	Healthy care homes			
	Urgent Treatment Centres (UTCs) / ambulatory care			
	Community bed based care (step-up)			
	Community bed-based rehab (step-down)			

The figures below summarise the schemes and delivery vehicles which are already being delivered, and expanded, across our combined geographies, aligned to these areas.

Figure 28: Out of hospital schemes and overall system impact for Surrey Downs CCG

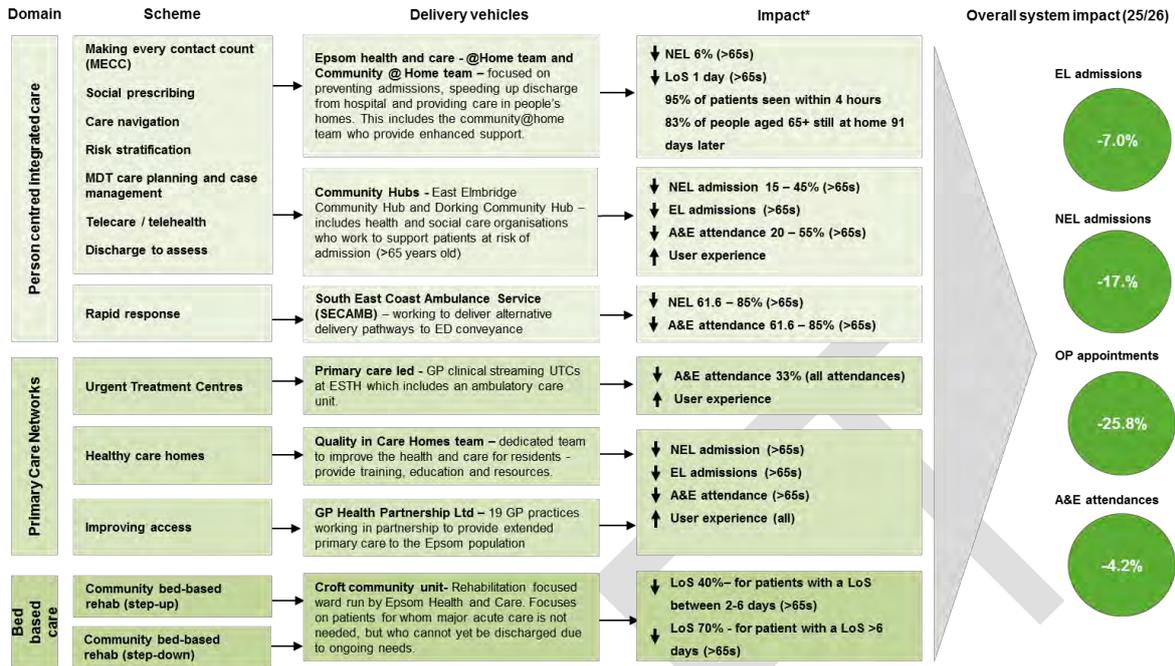


Figure 29: Out of hospital schemes and overall system impact for Sutton CCG

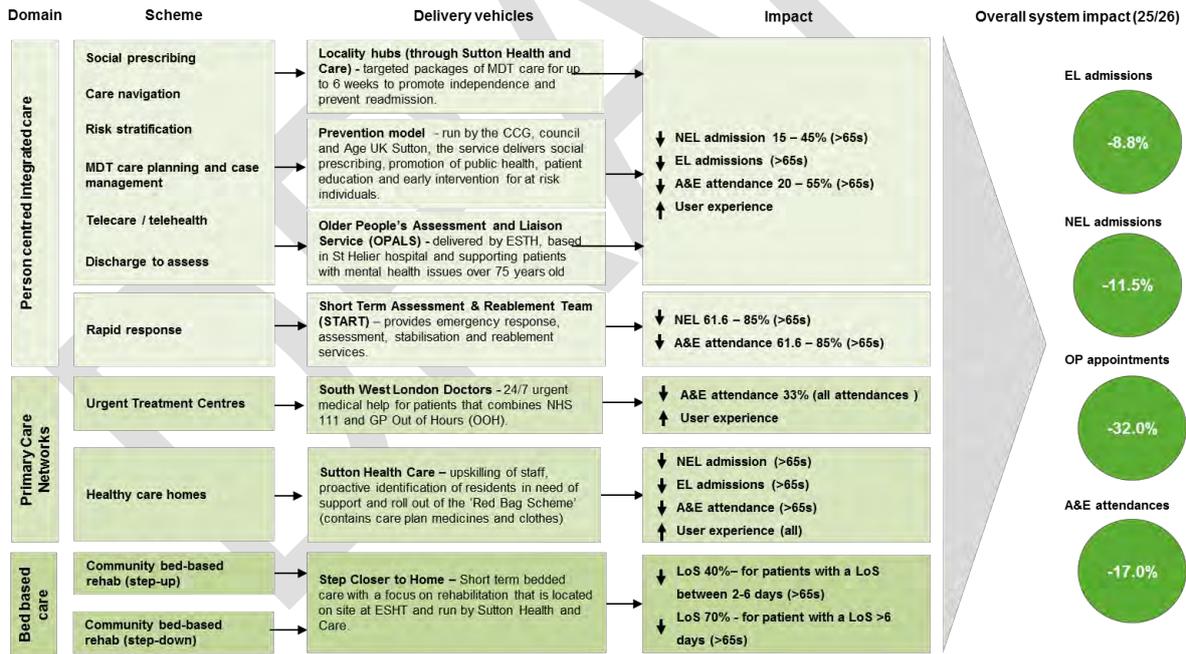
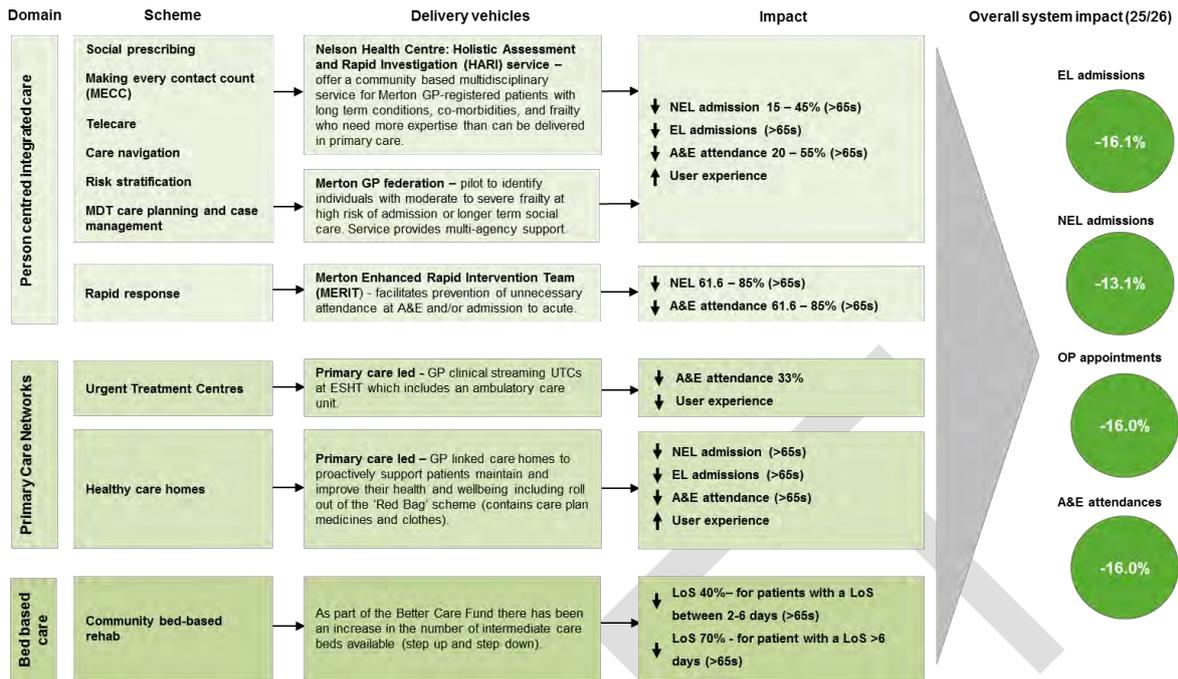
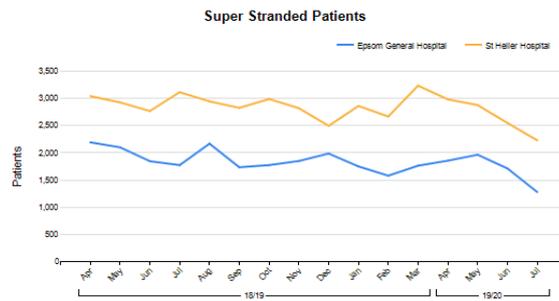


Figure 30: Out of hospital schemes and overall system impact for Merton CCG



5.3.4 Achievements to date

All of our areas have well-developed plans to deliver the potential of integrated community health and care services within the next few years, aligned to the NHS Long Term plan. We can now demonstrate some real achievements and patient benefits. In addition, staff have reported an improvement in their ways of working, with a positive impact on care but also within the integrated teams themselves.



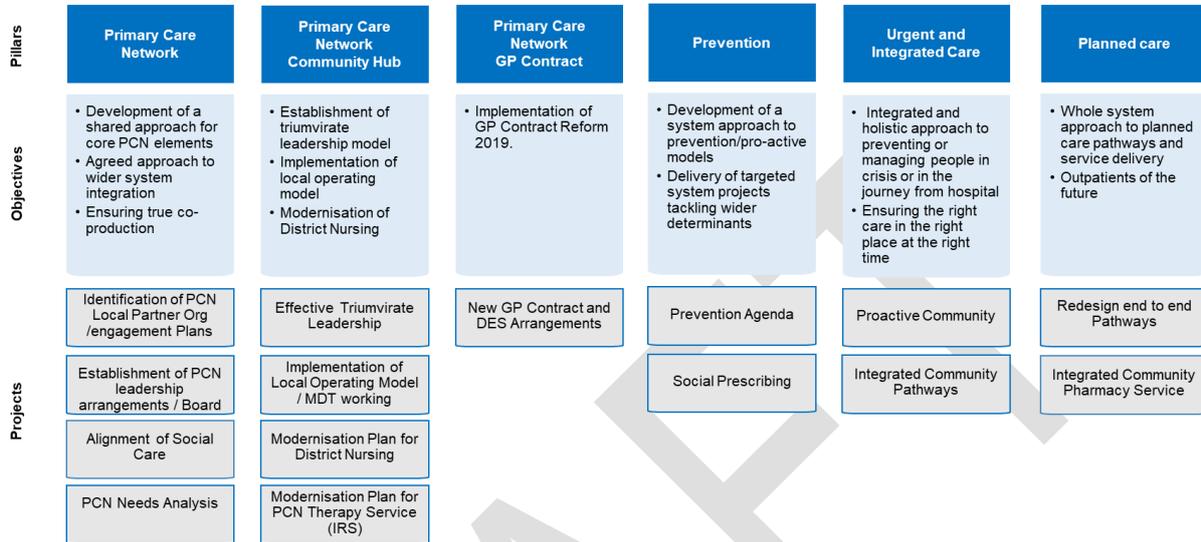
- All escalation beds have now been taken out of the ESTH due to improved impacts on LOS, avoidable admissions and accelerated discharges. This can also be seen in the decrease in stranded and super stranded patients, where there has been a reduction across ESTH of c. 30%.
- Surrey Downs Health and Care has reduced non-elective admissions to Epsom Hospital by 6% for patients over 65 years. On average, 3 patients remain at home and 2 are brought home sooner from hospital each day as a result of the service. This equates to a ward of patients being actively looked after at home.
- Patient satisfaction for Surrey Downs Health and Care – Patient satisfaction data is collected on a monthly basis. Of the 88 feedback responses received in June and July, 98% of responses were either extremely likely or likely to recommend the service to others.

5.3.5 Current developments – PCNs and District Hospital bed model

The CCGs are looking to progress the work already undertaken, and are looking to further two major developments in particular:

1. Community health integration with primary care – In every area CCGs have or will have locality teams linked to primary care networks with clinical leadership. In each of area CCGs are developing transformation plans that set about fully integrating primary and community health. This links in to the developments around the SWL Integrated Care System and local Integrated Care Partnerships.

Figure 31: Example: Surrey Downs Health and Care pillars underlying the integration of care across the geography



2. District Hospital bed model – the clinical model proposes a community facing inpatient rehabilitation model led by GPs and consultant grade ‘interface physicians’, as set out in the following Section. This is already being implemented:
 - Since October 2018, Surrey Downs Health and Care has run the Croft Community Unit on the Epsom Hospital site, including a new frailty pathway. Mean length of stay for these patients is now 7 days (vs. the hospital average of 12.3 days) and the readmission rate is 15.4% (vs. the hospital average of 23–29% and national average of 25%).
 - District hospital audit emerging data: A prospective audit of 392 St Helier Hospital admissions over 2 weeks revealed c. 19% of patients would be better managed in the district hospital, accounting for c. 33% of bed days. This includes patients who have had an acute episode who require rehabilitation, and those with a non-acute presentation where discharge home has been delayed.

This will continue to evolve and plans progress, and further work is undertaken as part of the Long Term Plan. For example, further detailed work is being undertaken on specific localities to understand the impact, benefits and costs of our out of hospital work in detail.

5.3.6 Funding the out of hospital model – capital and revenue

Given the out of hospital schemes across the geography are already being delivered, and demand is being managed appropriately, there is no further need for additional incremental capital to support these. Further developments will either be managed within existing capacity or are covered by separate business cases.

The initial benefits and costs of the out of hospital model are outlined in the table below. Our work shows that the c. 2-3% increase in funding to ESTH p.a. compares favourably to the c. 4% increase p.a. in allocations. The c. 1% p.a. of additional growth will be used to support other priorities including out of hospital investment at 60%. This work is ongoing as the target operating models are refined as part of the Long Term Plan. As a result, there will be a growing share of revenue allocated to out of hospital services and a declining share in acute services. Initial analysis indicates this would continue to be affordable to the CCGs.

Table 26: Affordability analysis

Sutton CCG spend, £m (nominal amounts)	Community	ESTH acute
19/20 plan recurrent spend	21	123
- Avg. activity growth + inflation p.a. (%)	5%	3%
Growth + inflation 6 years (£m)	7	24
- Agreed avg. QIPP p.a. (%)	2%	1%
- Agreed avg. QIPP 6 years (%)	12%	7%
Agreed QIPP 6 years (£m)	(3.0)	(8.9)
QIPP re-investment (£m) at 60% of total acute QIPP	9	0
25/26 indicative spend	34	138
Growth + inflation, less QIPP p.a. (%)	3%	2%
Growth + inflation, less QIPP p.a. (£m)	0.6	2.1

5.3.7 Capacity required on hospital sites

In estimating the capacity required for the hospital sites in future, we have considered CCGs current delivery of out of hospital schemes (including demand management), benchmarking (including RightCare) and other PCBCs.

Based on this, we have estimated within the PCBC an average of c. 3% annual reduction in acute activity (including c. 2% per annum for emergency admissions) through QIPP and a further c. 3% annual length of stay reduction through provider productivity improvements.

5.3.7.1 System track record

The CCGs have a strong track record of delivering out of hospital services over the last 3 years and have achieved reductions in acute activity and reduced length of stay. This includes ESTH reducing average length of stay as well as specific schemes, such as Surrey Downs Health and Care beginning to deliver c. 12% reduction in emergency admissions for older patients.

This demonstrates that the combined geographies are capable of delivering robust out of hospital schemes, which will further support our major acute services and district hospital model.

5.3.7.2 Benchmarking

Our assumptions of the impact of QIPP and length of stay have been calibrated to be prudent when compared to benchmarks:

- Benchmarking against peers shows an indicative 22% opportunity in elective admissions and 13% in non-elective admissions. In addition there is a length of stay opportunity of 12% and 10% respectively.
- Within our model, by 25/26, we estimate that demand management will deliver 19% QIPP, including 9% elective (vs. 22% RightCare), 14% non-elective (vs. 14% RightCare), 23% outpatients (vs. 22% RightCare) and 11% A&E (vs. 14% RightCare).

5.3.7.3 Overall impact

Overall, the efficiencies of the new clinical model and our planned out of hospital interventions are expected to manage the majority of demographic and non-demographic growth to 2025/26. In this way, our out of hospital schemes will further enable integrated district services and manage demand for major acute services.

5.4 Providing the district hospital model locally

We have very deliberately called our community-facing, proactive health, wellness and rehabilitation model the district hospital model. This future model builds on existing work and practice that is already happening across our combined geographies and is in line with the direction of travel for healthcare across the country.

As described above, **district hospital** services do **not** require critical care or services on which critical care depends. District hospital services are those that patients may require more frequently and should be accessible closer to patients' homes through close links with community health and care settings.

Acutely unwell patients need specialist care delivered by specialists, rather than generalists, to have the best outcomes. We also believe that joined-up specialist care is needed to support patients to recover and return home, as well as keep people well. This forms the basis of our district hospital model.

The numerous existing district hospital services that are a key part of local strategies and objectives will continue to be developed as our existing integrated primary and community services plans progress. 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 Five Year Forward View, the priorities established by our Sustainability and Transformation Plans (Surrey Heartlands and SWL), and the strategies of our individual CCGs.¹³⁰

In each of the communities we serve we are well on the way to delivering local, integrated care. Our model builds on current district services that are already being delivered across our geography to form the “district hospital” model. In our model the district hospitals are the centrepiece of the networks of care across our combined geographies.

Figure 32: Example of district hospital services: Northumbria Healthcare NHS Foundation Trust¹³¹

Northumbria Healthcare NHS Foundation Trust (NHCFT) covers the largest area of all NHS Trusts in England. Three quarters of its population reside in one third of the space, resulting in considerable areas with a very low population density (northern region), combined with a large and closely packed urban population to the south.

The general hospitals in NHCFT – Hexham, North Tyneside and Wansbeck now focus on the provision of diagnostic, sub acute and elective care services, supported by NHCFT's six community hospitals. These services include urgent care, outpatient clinics, care for patients transferring from the new specialist emergency care hospital and day surgery.

5.4.1 How the district hospital model is already being provided

Each of our CCGs has strategies to improve health and care for the local health economy. These strategies describe current and future services which demonstrate how we are already delivering the district hospital model across our combined geographies.

¹³⁰ 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>

¹³¹ <https://www.northumbria.nhs.uk/our-services/emergency-care/emergency-care/>

In our clinical model, district hospitals are the centre piece of the networks of care across our combined geographies. They will be where GPs, community health, public health, social care and mental health services come together with hospital clinicians. This will provide effective joined up health and care to keep people well and recover after an acute episode of care. This way of integrated working will become new specialism of the 2020s.

This has been the aim of many NHS changes. We are different from other areas and changes in that we are already developing this model across our combined geographies, delivering care in partnership with the other services needed to make it a success.

The following examples demonstrate how we are already delivering district hospital services across our combined geographies and how we have already achieved real outcomes for people.

Other proposals in the NHS have described such changes, however across our combined geographies we are already delivering them. This provides both the context and confidence that we can deliver the district hospital model and the range of services contained within it. There have been fewer admissions to hospital and reduced lengths of stay in hospital. We have had feedback from patients and their carers which shows they feel more supported and able to manage their ongoing health issues.

5.4.1.1 Surrey Downs health and care

Surrey Downs Health and Care is a formal partnership comprising of ESTH, GP Health Partners (a collection of GP practices around Epsom), Surrey County Council (providing social care) and Central Surrey Health (providing community services).

Surrey Downs Health and Care was formed in 2016. Since then the programme has grown substantially. By the end of March 2019 it had 320 employees with a budget of £8.7m.

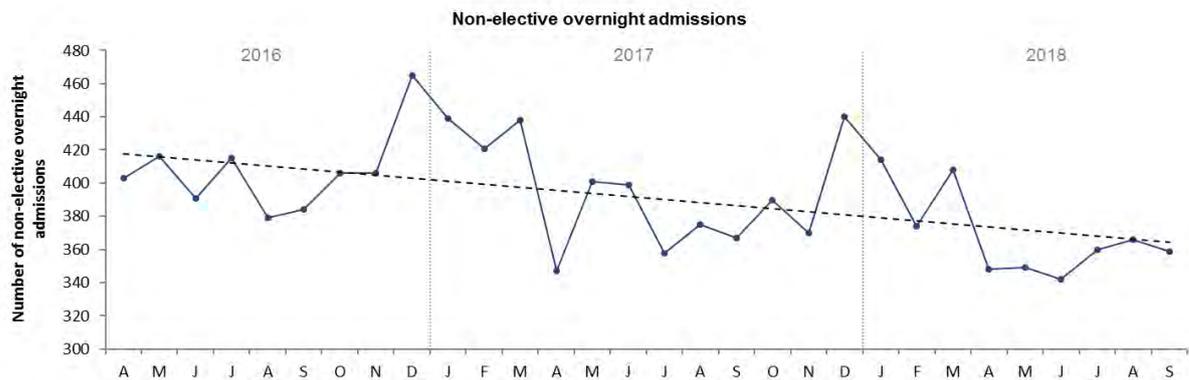
@home team

The @home team, based at Epsom Hospital, is focused on preventing admissions, speeding up discharge from hospital and providing care in people's homes. This includes the community@home team who provide enhanced support. All of the clinicians use the GP patient record, EMIS.

In 2016/17 there was a 6% reduction in emergency admissions for over 65s to Epsom Hospital compared to a 6% rise at St Helier. There has furthermore been a reduction in length of stay of 1 day for this patient cohort. Epsom Hospital has consistently delivered the emergency department target of seeing 95% of patients within 4 hours. The Trust has also brought back all its elective surgery from the private sector as there are many fewer medical patients in surgery beds.

Key achievements in 2017/18:

- 6% reduction in overnight NEL admissions to Epsom Hospital for patients over 65, and in comparison there was a 6% increase for the same type of cohort at St Helier hospital;
- A&E attendances for patients over 65 remained in line with expected demographic growth, and in comparison there was a 5% increase in A&E activity at STH;
- Over 1700 patients have received an enhanced package of care in the community by the team as an alternative to attending or remaining in hospital; and
- On average 3 patients remain at home and 2 brought home sooner from hospital each day as a result of the service. This equates to 1 ward of patients being actively looked after at home

Figure 33: Non-elective overnight admissions at Epsom Hospital for the Epsom Health and Care cohort

Croft Community Unit

In October 2018 Surrey Downs Health and Care took over the running of Croft Ward on the Epsom Hospital site. Croft Ward has traditionally been used as a ward where older people are cared for after their acute episode of care has finished, but who cannot yet be discharged. In 2017 the ward was run by the hospital with GP leadership rather than hospital clinician leadership. This resulted in increases in the quality of care that was being offered to patients and shorter lengths of stay. To substantiate this, the ward is now included within Surrey Downs Health and Care.

The ward has been renamed as the Croft Community Unit. Patients within this unit will be those for whom major acute care is not needed, but who cannot yet be discharged due to ongoing needs. Patients will still receive ongoing medical and nursing care including intravenous fluids and antibiotics, blood transfusions and further hospital (outpatient type) investigations. The focus of the Unit will be to support ongoing transition back to the community.

Surrey downs Health and Care principles of working will be applied to achieve this. Medical leadership on the unit is provided by GPs with access to specialist consultants from the hospital. The unit works in a multi-disciplinary way with a team comprising nurses, therapists, reablement workers, social care workers and pathway coordinators. The focus is on recovery and work is ongoing to enhance the therapeutic environment and encourage the role of volunteers and carers. There is an integrated approach across @home, integrated stroke services and the Croft unit, with staff moving between settings as appropriate.

GP Health Partners

With the support of GP Health Partners other initiatives are underway. GPs are now based in the Urgent Treatment Centre at Epsom Hospital 7 days a week. A community cardiology service is in operation where GPs can undertake echocardiography in their practices.

5.4.1.2 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.

The Vanguard was created in 2015 as one of a select group of areas in the country which proposed that creating a dedicated multi-disciplinary team to work with staff and residents in nursing homes would enable them to provide better care.

The Sutton Homes of Care Vanguard intended to build on what had been achieved and substantially increase the scope and impact. The theory of how change would be generated comprised three elements:

- Better integration between healthcare organisations and care homes would ensure residents received more timely, appropriate care from well-informed staff in the care home, with some support from other health and social care services
- Upskilling and motivating the care home workforce would enable care home staff to actively monitor their residents' health and wellbeing and know when and how to take appropriate action as well as raising staff job satisfaction and reducing turnover
- Sharing data and use of data in planning would ensure services were more aligned to the population's needs and proactive in identifying and tackling issues.

Sutton Health and Care 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 made the decision to enter into a transitional contract with Sutton Health and Care for the provision of community services from April 2019.

The "Red Bag scheme" has become the defining feature of this programme and it has been rolled out across the country. Residents from nursing homes in Sutton arrive in hospital with their Red Bag, containing their care plan, medications and clothes to wear on discharge.

The programme has been officially evaluated, with headlines including:

- A&E attendances, non-elective admissions and length of stay in hospital have fallen for nursing homes using the Red Bag.
- There has been an improvement for the average length of stay in hospital for patients in residential homes using the Red Bag, with a continued improvement in reducing the rate of residents attending A&E.
- The number of 999 calls have stabilised.
- There have been improvements in care home staff skills, as well as confidence and relationships with other healthcare organisations.

The improved relationships between care homes and other organisations are a notable achievement and will leave a legacy for future improvement initiatives.

Quotes from staff:

"Our whole ethos has changed at [care home]. Our staff have much more confidence." (Respondent to care home staff survey).

"I just wanted to say thank you for calling yesterday and following up on our residents at [care home]". (Care home manager).

"We really appreciate the input from The Vanguard Team since we have opened and it is reassuring to know we have you to call on when needed". (Care home manager)

"It really has been an amazing experience and certainly one of my best experiences working alongside a truly fabulous team of people. The passion is something I have not experienced elsewhere". (Programme partner).

Sutton health and care @home team

There is now a formal provider and commissioner partnership consisting of ESTH, Sutton GP services (the federation that brings all the practices in Sutton together), South West London and St George's Mental Health Trust and Sutton Council, with the Royal Marsden as a supporting partner. These providers have launched the @home service for Sutton, which is aiming to achieve the same results as its Surrey Downs counterpart. We expect that it will take two years to achieve the same results as in Surrey Downs. The Sutton area is going to be organised into 3 localities to support the proactive and preventative care parts of the model.

5.4.1.3 Merton

Only 10% of patients who use Epsom and St Helier live in Merton. Merton residents also attend St George's Hospital, Kingston Hospital and Croydon University Hospital. Merton CCG and Merton Council have launched a programme called Merton Health and Care Together. The programme has a number of key priorities, including a comprehensive out of hospital proactive care model across health and social care for the frail elderly; and a model of wellbeing for the East of the Borough, which faces relatively greater challenges of health inequalities and deprivation, based around the redevelopment of the Wilson Hospital.

Early successes in the programme have included a significant improvement in discharge management. MHCT has recently implemented a single point of access for community and social care acute discharge management teams and is continuing to develop an integrated health and social care model for older people based on integrated locality teams based in four areas of the borough.

5.4.1.4 Locality models

Networks of localities have been described by NHS England as: *“at the neighbourhood level, primary care networks collaborate to improve general practice resilience, share staff and assets and provide proactive multi-disciplinary care to population of between 30-100,000. At the place or locality level, often coterminous with district / borough councils, acute providers integrate their services with primary care networks, local government and mental health around those patients that could be kept out of hospital and empowered to look after themselves”.*

With a commitment to providing services as close to home as is appropriate, GP practices across Surrey Downs, Sutton and Merton have started to work together in groups, forming localities. These localities are broadly geographically aligned with local communities. By working in this way not only are GPs able to offer locality-based care such as extended access to GP appointments, but other services such as community nursing, therapies and social care can arrange their teams to the same configuration forming the truly multi-agency MDT of the future. Delivering services in this way also provides an opportunity to make links with local voluntary and third sector organisations and local communities.

Table 27: Localities within our CCGs

CCG	Locality
Surrey Downs	• Banstead
	• Epsom
	• Leatherhead
	• Integrated Care Partnership (network of GP practices)
	• Dorking
	• East Elmbridge
Sutton	• Carshalton
	• Sutton and Cheam
	• Wallington
Merton	• East Merton
	• West Merton

Building links with local communities embeds a preventative approach to healthcare which is based around local needs and resources. This supports and enhances self-care and community support. This approach is strengthened through initiatives such as social prescribing which provide the opportunity for people to explore what is important to them – be that a Book Club, a leisure centre or talking therapy.

For people with ongoing complex needs, the locality provides the opportunity to make sure that the individual and those who are important to them are the centre of their own care. Locality teams work by identifying people who are most at risk, due to deteriorating health, change in social circumstances

or social isolation. Teams work with these people to agree a care plan setting out their personal goals and the support they need to achieve them.

Identification of people most in need of this approach to care takes place using a variety of methods including special software on the GP IT system, identifying people who are not keeping regular appointments and through discussion by the members of the wider MDT. Through a series of multi-disciplinary team meetings coupled with easy access to specialist opinions including by the specialist clinicians 'in reaching' into the MDTs it is possible to provide much better joined up and co-ordinated care. This is supported by Care Coordinators who continue to support people to access the help they need.

This coordinated approach to care also continues following periods of acute illness when enhanced care is required to support people at home and ensure their recovery with the GP, community nurse, therapist, social care and reablement working as one coordinated team with easy access to generalists and specialists as required. It is also central to ensuring that people in the palliative stage of their lives can receive all the support they and their families require to continue to receive their care in their place of choice.

The localities are key components of the future system wrapped around the individual, their family and their community. A number of changes to enable this coordinated approach to care have already started in local areas to become the norm across the area:

- An integrated clinical IT system with the GP IT system as its foundation, allowing for real-time review of complete health and care records
- A care coordination approach to care with care planning at its centre using person-centric goals, reviewed at regular intervals and visible as required across the health and care system including in district and specialist hospitals
- A new approach to integrated team working supported by new ways of learning and training to support the flexible workforce of the future
- A new approach to working with local communities including voluntary and third sector.

The district hospital bed model is described in the following section.

5.4.2 Our plans for the district hospital model in the future

There are two main future components of the district hospital model.

1. The continuation and further development of the local, integrated district services described in Section 5.4.1 above.
2. Further development of district hospital services, where district hospitals are at the centre of the network for the delivery of district hospital services across our combined geographies. District hospitals will include:
 - District hospital beds (Section 5.4.3)
 - Urgent Treatment Centres (Section 5.4.4)

District hospitals are central to our vision of a **district hospital model of locality-based care** to keep you well, and for as much care to be delivered as close to your home as possible.

District hospitals will further enhance the delivery of the local, integrated district hospital services, and will allow the best joined up health and care to keep people well and recover after an acute episode of care. Our vision is that this way of integrated working across geographies, organisations and buildings is the future and will become the new specialism of the 2020s.

5.4.3 District hospital beds

The aim of the district hospital model is to support people who do not require high acuity services but who still need some medical input. This includes district beds for patients

‘stepping down’ from a major acute facility, ‘stepping up’ from the community and directly admitted via an urgent treatment centre(s).

As described above, district hospital services encompass a range of local services that will be provided in an increasingly integrated way. This includes the delivery of district hospital services from existing hospital sites at Epsom and St Helier hospitals. This includes urgent and emergency care, outpatients and diagnostics, elderly care and rehabilitation, integrated care, antenatal and postnatal care, and elective procedures.

Table 28: District hospital services that will continue to be offered within our combined geographies

Category	Service
Urgent and emergency care	<ul style="list-style-type: none"> ● Urgent treatment centre(s) ● Ambulatory care ● Frailty assessment unit
District beds	<ul style="list-style-type: none"> ● ‘District’ beds ● Direct admission beds ● ‘Step down’ beds ● Rehabilitation ● Imaging and diagnostics ● End of life care
Integrated primary and community care	<ul style="list-style-type: none"> ● Community beds ● Proactive community services ● Reactive community services ● Primary care at scale
Planned care	<ul style="list-style-type: none"> ● Day case ● Elective surgery ● Dialysis ● Chemotherapy ● Endoscopy ● SWLEOC ● Outpatients
Paediatrics	<ul style="list-style-type: none"> ● Community paediatrics ● Enhanced paediatric observation ● Paediatric ambulatory care
Maternity	<ul style="list-style-type: none"> ● Early pregnancy ● Antenatal care ● Postnatal care ● Home births
Diagnostics	<ul style="list-style-type: none"> ● X-ray ● CT ● MRI ● Phlebotomy

District site(s) include non-critical beds for a specified cohort of patients, staffed by doctors and supported by a range of health and care professionals. The cohort of patients can be admitted to district beds via:

- Direct admission from GP/UTC
- Step down from major acute inpatient care
- Step up from community services

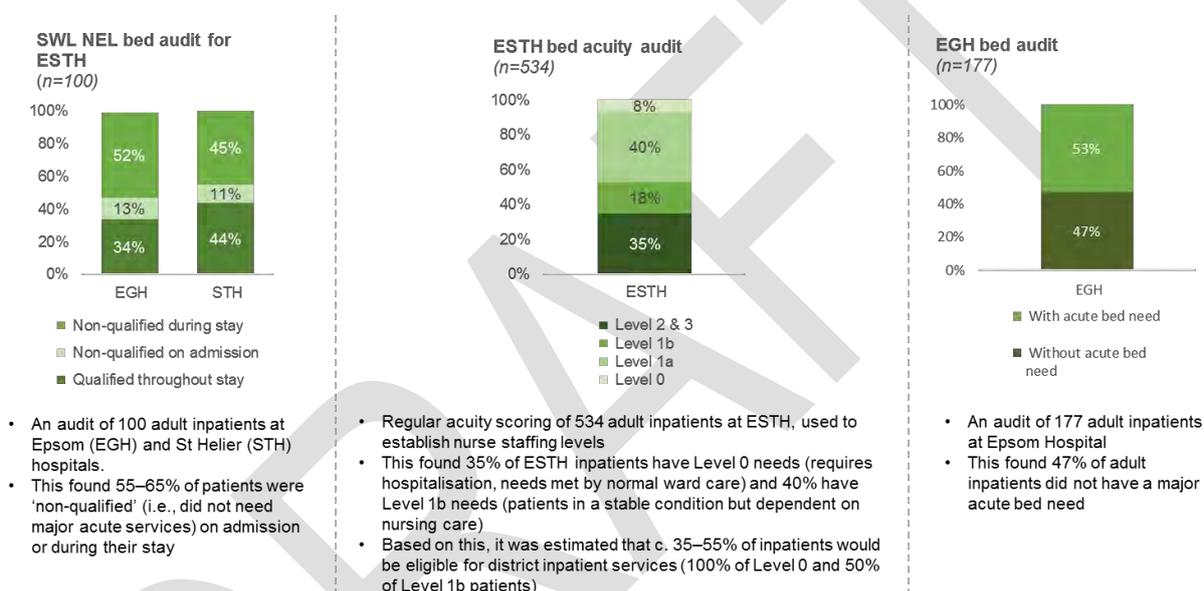
The characteristics of this patient cohort are described below.

5.4.3.1 Characteristics of the patient cohort for district 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 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 inpatient bed audits have demonstrated that there is a cohort of patients who need a hospital bed but 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.¹³² These ‘snapshot’ audits found that a large proportion of patients could be better treated for in alternative, lower-acuity settings with the right support.

Figure 34: Results from the South West London inpatient 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.



These audits suggest there is a patient cohort that needs inpatient care but within a lower acuity setting. In the figure above, non-qualified means that an acute hospital bed was not the most appropriate place to meet a patient’s needs, whereas qualified means that it was the most appropriate place.

Our 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.

The patient cohort includes the following characteristics:

- This patient cohort does not need any of the services offered at the major acute site
- Their care requirements are more than can be provided safely within their homes

Key principles for the patient cohort at district sites include:

- Patients require comprehensive assessment and review of their health and social needs
- Goal throughout is to restore/maintain ‘function’ and to either discharge to home (‘default’) or transfer to the lowest level of care that meets a person’s needs.

¹³² 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)

- There must be clarity of objectives of care between professionals and clear goals with patients and families with time limited opportunity for bed-based care.
- The pathway requires regular review regarding progress such that timely transfers of onward care are facilitated.
- Where required to support the patient to achieve their preferred place of care and death.
- Each setting of care patients are non-qualified if they do not meet eligibility criteria
- District services beds provide an alternative to acute hospital admission for patients who require nursing attendance especially overnight and facility to manage chronic conditions where community treatment has proved unsuccessful, or where diagnostic investigations can be achieved without resort to acute hospital admission.

We have defined criteria for patients who would be eligible for acute or district beds:

Figure 35: Patient criteria

Major acute care

- Medically unstable or at risk of becoming unstable
- Requires access to immediate medical cover 24/7 of on-site senior medical opinion
- Patient needs cardiac monitoring
- Needs observations (blood pressure/pulse/urine output) at least 4 hourly; and/or oxygen saturations or neurological observations.
- Needs arterial blood gases measured
- Needs central line insertion
- Requires access to 24/7 diagnostics
- Needs access to escalation to HDU/ITU
- Needs specialist medical / surgical input

District services

- Medically stable 'step down' - when the **primary complaint has been 'arrested, controlled or is stable'**.
- There is a need to further refine a treatment and further management of co-occurring conditions but not meeting eligibility for acute care
- Where access to diagnostics such as blood monitoring, X-ray and ultrasound is required
- Medically stable 'step up': where there is a need for bed-based care and investigations requiring access to multidisciplinary assessment and diagnostics as provided within the district services model
- For the patient with difficulties completing activities of daily living, including transfer, mobility and safety and where care cannot be managed via home support or in existing community hospitals
- **Exclusion criteria: patients who require acute care; those whose needs are entirely social care or could be managed at home**

The needs of these patients directly feed into the flow of patients between major acute services and district hospital services, and how these services are staffed. This is described in more in Sections 5.4.3.2 and 5.4.3.3 below.

To test these criteria, we have looked at existing patients in a number of ways, including piloting a similar model in the Croft ward and conducting multiple audits.

The Croft unit was set up to support patients whose needs that can be met outside of the acute setting. The eligibility criteria include that patients do not require acute hospital care and are medically optimised, but are unable to be cared for safely at home.

There were found to be five broad patient cohorts:

- @home: Patient has been assessed by the @home service and has agreed rehabilitation goals in place
- Neuro: Need for specialist neuro therapy input
- Complex rehabilitation: Patient has not regained pre-morbid level of function
- Complex discharge
- Palliative care / end of life care

In order to test whether these criteria were robust in identifying patients, a longitudinal, prospective audit was carried out at ESTH. This sequentially tracked the cohort of patients day by day, using the criteria as set for District Hospital care.

The audit aimed to identify whether the patient course fluctuated significantly from district hospital criteria to major acute criteria, and whether there were points when there was a clear consensus that patients could be transferred to a district site. The results of this initial audit at ESTH (carried out in April 2019) found that the criteria were accurate in identifying patient needs. Summary findings included:

- A large proportion of patients were discharged within 24 hours;
- The criteria were accurate in capturing whether the patients were suitable for major acute or district care;
- There was a very low incidence of patients who would have required a transfer from the district site to the major acute site.

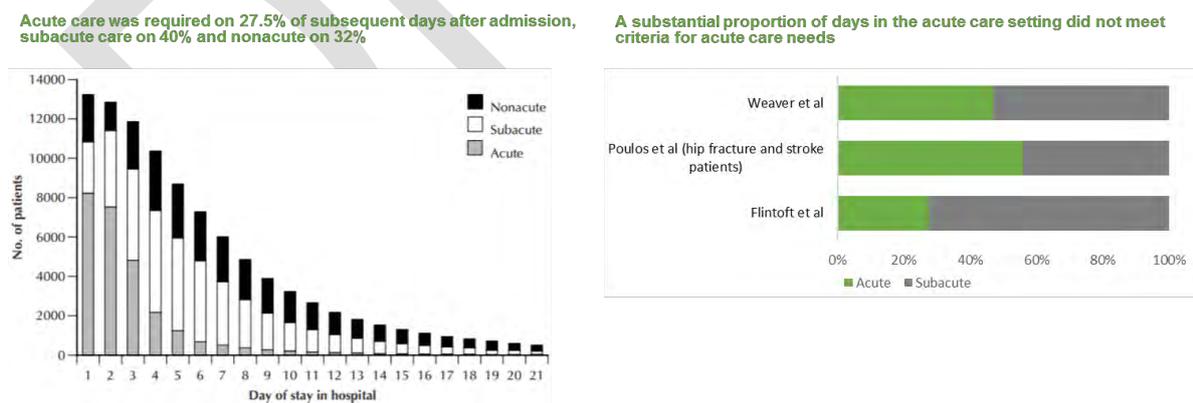
The pilot audit was then followed by an extensive 14 day audit in July 2019 which tracked non-elective inpatient admissions. This involved detailed review of patients daily against the district and major acute criteria. The results of the audit indicate that the criteria used are sufficiently specific to be able to identify patient suitability for major acute or district hospital care.

This is furthermore supported by several selected studies which have used a utilisation review to identify a subset of patients who could benefit from ‘subacute’ care. These selected studies found that the acuity on admission differed across the cohort, and that a proportion of the acute stay was subacute:

- 62% of admissions were considered acute on diagnosis, 20% subacute and 18% nonacute.
- >33% of patients had at least one subacute day, with an average LOS of 12.7 days, of which 6 days were acute and 7 days subacute;
- Patients 75 years of age accounted for more than 50% of bed days, but 74.8% of these bed days were regarded as being inappropriate for acute care

This varied by patient group, of which many were older, requiring post-acute care, skilled nursing or rehabilitation. Analysis carried out by these studies is shown in below.

Figure 36: Proportion of non acute, subacute and acute patients by day of stay and proportion of days meeting acute care after admission



A summary of these studies is shown in Table 29.

Table 29: Selected studies have undertaken an acute utilisation assessment

Author	Details	Results	Year
Flintoft et al.	Study determining the proportion of patients who required acute,	62% of admissions were considered acute on diagnosis, 20% subacute and 18% nonacute.	1997

	subacute and nonacute care.	Acute care was required on 27.5% of subsequent days, subacute care on 40% and nonacute on 32%. 71% of subacute days and 50% of nonacute days occurred within the first 7 days of hospital stay.	
Poulos et al.	Cohort study of patients in a large acute referral hospital in Australia followed with the InterQual utilization review tool	Days meeting acute level of care criteria were 56% (stroke, hip fracture and joint replacement patients) and 33% (other patients, from the time of referral). From when deemed medically stable for transfer by the acute care team, 28% of patients became unstable. From when deemed stable by the rehabilitation team or utilization review, 9% and 11%, respectively, became unstable.	2011
Weaver et al.	Retrospective chart review of 858 admissions to determine the prevalence of subacute patients in acute care beds in 43 Veterans Affairs Hospitals in the US	Over one-third contained at least one subacute day; with an average length of stay (LOS) of 12.7 days (SD = 12.4); of which 6.8 days were subacute. Patients with these admissions had significantly longer LOSs, were older, and were more likely to die or to be discharged to a nursing home. Diagnoses with subacute days included COPD, pneumonia, joint replacement, and cellulitis	1998
DeCoster et al.	Retrospective chart review of 3,904 patients in Canada	Found that, after one week, 53.2% of patients assessed as needing acute care on admission no longer required acute care. Patients 75 years of age accounted for more than 50% of bed days, but 74.8% of these bed days were regarded as being inappropriate for acute care.	1997
Poulos et al.	Consecutive acute care patients with a diagnosis of stroke, hip fracture or amputation were followed.	The percentage of days meeting criteria for acute care was highest for the patient group followed from admission, being 54% for hip fracture patients and 34% for stroke patients. For patients followed from the time of amputation, 31% of days met acute criteria.	2007
Carey et al.	To quantify and characterize delays in care which prolong hospitalizations for general medicine inpatients	13.5% of all hospital days were judged unnecessary for acute inpatient care, and occurred because of delays in needed services. Sixty-three percent of these unnecessary days were due to nonmedical service delays and 37% were due to medical service delays. The vast majority of nonmedical service delays (84%) were due to difficulty finding a bed in a skilled nursing facility. Medical service delays were most often due to postponement of procedures (54%) and diagnostic test performance (21%) or interpretation (10%)	2005
Young et al.	Older patients admitted acutely to an elderly care department in a DGH	Out of 1211 acutely admitted patients, 997 became medically stable and 312 (25.8% of admissions) were considered to require post - acute care, and of these, 251 (20.7% of admissions) needed post - acute rehabilitation care.	2003

Based on the criteria outlined in Figure 35, and the audits above, we expect c. 11,000 patients to be admitted into district beds every year.

5.4.3.2 Patient pathways

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

These are:

- **Direct admission beds:** Direct admission from GP or UTC for patients who do not require 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.

Patients of varying acuity levels will be cared for in the setting that most fits their needs, assuming:

- District hospital care needs to be provided from a bedded facility with access to ‘generalist’ input suited to patient requirements
- Major acute care needs to be provided on an acute facility with intensive consultant input

The ESTH sites will need to have robust transfer protocols in place to manage the following:

District to major acute – emergency transfers/paediatrics/step up treatment:

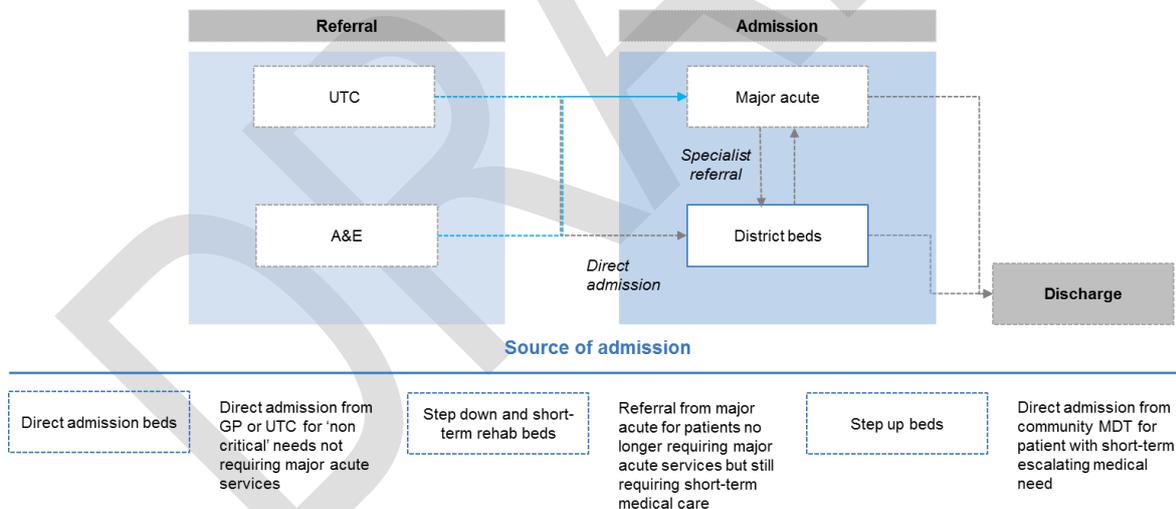
- If a critically ill ‘walk-in’ patient arrives at a district hospital facility they will need to be stabilised and transferred
- Paediatric patients who require inpatient treatment
- Patients at the district hospital who unexpectedly deteriorate

Major acute to district – step down transfer due to improvement in patient’s clinical status:

- Recovered patients who no longer require high intensity care and whose recovery would be more appropriately managed at a district site

The triage of patients from acute site to the district services can best be managed by routinely including an Advanced Nurse Practitioner (ANP)-style clinician in the morning ward rounds on relevant wards (e.g. the AMU).

Figure 37: Patient flow into district hospital beds within the clinical model



Patients would be admitted to district hospital beds through two main routes. Patients could initially present at either the UTC or the emergency department and be directly admitted into district beds if assessed as meeting the criteria described in Section 5.4.3.1. Alternatively, if patients are initially assessed as requiring major acute care, a specialist referral would result in a transfer of the patient from a major acute site to a district hospital bed when appropriate.

The district hospital site will provide proactive care, in the form that best meets patients’ needs. This will include acute rehabilitation, intensive input by therapists and nursing staff and a proactive approach to identifying the best place of care for patients, with appointed staff members responsible for enabling discharge.

The workforce will be supported with clear guidelines on the transfer and transition between acute and district hospital sites. This approach will ensure that patients are proactively managed towards recovery, and promote patient flow across appropriate settings of care. Patients within the district site will be continually reviewed by staff and proactively managed, ensuring that patients do not decondition and are not placed for prolonged periods of time in an inappropriate care setting.

5.4.3.3 Social care

As currently happens at ESTH, social care would be present on the district hospital site to allow for effective discharge planning and to ensure the needs of discharged patients are appropriately met, in their own homes where possible. Social care plays an essential role in enabling patients to leave hospital and is one of the drivers for reducing delayed transfers of care.

Health and care services in the area will be aware of patients within major acute and district services who are likely to require community or social care from the first day of admission. Some of these patients may be discharged from the acute site, however some will initially be transferred to the district hospital site.

It is furthermore likely that in the future the place-based system will be quite different, with increased collaboration between health and care services across a local area. This will be well-established by the time this clinical model comes into effect. This will enable us to do this even better to enhance care across the area.

5.4.3.4 Requirements for staffing the district hospital beds

Based on the defined patient cohort and the needs of these patients, it is expected that wards would be generalist-led with input from a range of health and care professionals.

We have defined the competencies and attributes that the “generalist” would require in the district services model. As the generalist would need to take clinical accountability for patients, the position could only be held by a medical doctor.

The term “interface physician” is the most accurate way of describing the type of generalist required for the district hospital beds part of the district services model. The interface physician should:

- Be a senior medical clinician at consultant/GP level
- Have clinical skills across both acute and primary care settings
- Be able to act as a clinical leader for the service
- Have admitting and discharge rights for the beds
- Be familiar and confident within the hospital environment

Interface physicians will also include Care of the Elderly (COTE) consultants, who would work across both the acute and district hospital sites on a rotational basis. This will provide a comprehensive set of skills on the district site and will enhance trust and confidence between both the interface physician and COTE consultant of their complementary perspectives of care provision.

District sites have three types of services that require staffing. Work on the staffing model has been developed in the most detail for district beds. A full list of the staffing of the district hospital can be found in Figure 38.

Figure 38: The proposed incremental ward cover for the district hospital beds

Area	Role	Description
Urgent Treatment Centre (open 24/7)	Generalist (lead)	GP (who could have a specialist interest in emergency medicine), working in conjunction with a consultant in emergency medicine (who would not be located on-site but would be available for telephone consultations)
	Emergency nurse practitioners	Support staff for generalists
	Allied health professionals	Support staff for generalists
District beds	Interface physician (lead), supplemented by COTE physicians	During daytime hours, wards would be interface physician-led who would be based at the district site; with ultimate responsibility for patients. Interface physicians would be supplemented by COTE physicians, who would be present on the district site on a rotational basis.
	Consultant ward rounds	<ul style="list-style-type: none"> • Specialist in-reach consultations built into job plans • Specialists on site delivering out-patient clinics • Rounds after initial consultation as deemed required • Specialist availability on call 24/7 with imaging
	Midgrade (MG) / Advanced nurse practitioner (ANP)	One MG and one ANP support, overnight
	Junior doctors (JD)	Ratio-based, drawn from existing resource
	Nursing	<ul style="list-style-type: none"> • 40:60 Registered Nurse : Health Care Assistant ratio • Specialist nursing for wound care available • Other in-reach for specialised nursing needs
	Allied health professionals	Physiotherapists, occupational therapists, speech and language therapists, dieticians, clinical pharmacists, specialist neuro-rehabilitation therapists, psychiatry
Outpatients / Day case / Ante- and postnatal clinics	Consultants	As per job plans
	Nursing	Support staff
	Allied health professionals	Support staff

The staffing of the district hospital beds would be different overnight than during the day. District beds will be led by an interface physician during the day with support from junior doctors, nurses and allied health professionals. Overnight, beds will be managed by a middle grade or advanced nurse practitioner, supported by nurses.

The Royal College of Physicians defines the medical staffing to maintain a 30-bed medical ward¹³³ (weekday and weekend) based on tiers of staff.

Table 30: Royal College of Physician staffing with enhanced skill mix

Tier	Description (current hospital grades)	RCP guideline (WTEs)	Our proposed staffing model for district beds (WTEs)	Notes
Tier 1	Junior doctor	18.0	22.0	Existing workforce
Tier 2	Middle grade	7.3	8.7	Incremental workforce

¹³³ Royal college of physicians, *Guidance on safe medical staffing*, July 2018

Tier 3	Consultant	7.4	11.0	8.7 incremental, 2.3 existing
Total		32.7	41.7	

The number of whole time equivalents has been calculated on the basis of the Royal College of Physicians analysis of the medical staffing requirement with an enhanced skill mix to reflect the needs of the patient cohort overnight, developed by CAG. This is shown in Table 31.

Table 31: District bed staffing

Staff	Description	WTEs
Interface physicians	Presence 12/7, comprising of a mix of additional IPs and existing COTE rotating from major acute site (minimum of 2 incremental IPs per site)	11
Consultant ward rounds	-ologist consultants (c. 200) who are likely to have outpatient clinics as part of their job plans	N/A
Middle grade / ANP	Overnight: 1 Midgrade and 1 ANP per site	8.7
Junior doctors	1:20 bed ratio	22
Nursing	Level 0: 1 WTE per bed; Level 1b: 1.7 WTE per bed; Based on pro-rata establishment	323.9

During the day there would be outpatient clinics, around which consultants could carry out reviews of in-patients. These consultants could be requested when required by interface physicians to review patients.

The use of middle grades and ANPs to lead the service overnight is in line with national models such as “hospital @ night”. These staff will have clear escalation policies and support infrastructure, providing a stable tier of staff and with the appropriate skills to manage a medically stable cohort of patients overnight.

To test the provision of overnight staffing, an audit was carried out by ESTH over a week long period to determine the number and quality of out-of-hours calls made by nursing teams for clinical support from general medical and step down wards at Epsom General Hospital.

The results of this audit showed there were only a small number of calls for clinical review out of hours. There were 11 out of hours requests for review recorded in the patients notes during the 7 day audit on 60 beds, which is the equivalent of 420 patient days. 7 requests were over the weekend and 4 were during the week. 9 were judged appropriate and 2 could have been resolved without calling for clinical review. The table below shows the reasons for calls.

Table 32: Result of the Epsom overnight audit undertaken in October 2018

Reason	Number	Appropriate
Deteriorating medical early warning signs	5	Yes
Review pathology results	2	Yes
Clinical problem (urinary retention)	1	Yes
Planned weekend review	1	Yes
Post procedure advice	1	No
Patient refused medication	1	No

None of the calls resulted in the transfer of a patient to a higher acuity ward. All patients were reviewed by a junior doctor, where the majority of issues could have been resolved by an ANP or through advice on the phone.

In an emergency situation, staff will be able to provide airway support. The criteria used to assess whether a patient needs major acute or district care will be the primary mitigation to prevent emergency situations.

Deteriorating patients will be transferred to the major acute site by ambulance or by PTS, depending on the acuity of the patients. In the rare event of a cardiac arrest or a severe and acute deterioration, a patient would be stabilised by an ANP or other staff member trained in ALS. A staff member with these skills will be available during the day and overnight. The patient will then be transferred to the major acute site.

5.4.4 Urgent Treatment Centres (UTCs)

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 Urgent Treatment Centres (UTCs) by December 2019, a deadline that has not been met by many areas across the country.¹³⁴ However it is expected that these will be in place by the time the clinical model comes into effect.

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

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 the following services should be included within the model, including:

- Emergency departments at district site(s) will be converted into a high specification UTC(s):
 - Led by generalists
 - Open for 111 booking, walk-ins and triaged ambulances (non blue light, with defined protocols)
- UTCs at district site(s) supported by ambulatory care unit, which are further supported by:
 - Existing imaging (e.g., CT, MRI) and pathology
 - ENPs, AHPs and PAs
 - Pharmacists
 - Networked radiologists

5.4.4.1 Access and diagnostics

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 UTCs, as defined by this emerging clinical model, will meet all national standards, and be open 24 hours a day, 7 days a week.

¹³⁴ 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>

All existing diagnostics, including CT, X-ray, MRI and pathology would be available to patients attending a UTC. The UTCs will work towards implementing the latest developments in diagnostics including access to 'at-home' and primary care test results.

Endoscopists will be present during the day for planned endoscopy procedures for day case surgery. Radiographers will be on site as per UTC guidelines. Radiologists will be on site to deliver the extensive planned care services that will be on site.

It is anticipated that district hospital patients are unlikely to need out of hours diagnostics due to their low acuity. As the clinical model develops further we will review the need for out of hours diagnostics, particularly around plain film x-ray accessibility at district sites.

Where facilities are not available on site, clear access protocols will be put in place. Where patients are indicated to be increasing in acuity and urgent diagnostics are required, these will be transferred to the major acute site.

Furthermore, national and regional investment set out in the Long Term Plan in a new digital diagnostic imaging service will enable clinical images from care settings close to the patient to be rapidly transferred to the relevant specialist clinician to interpret regardless of geography and speed up image reporting.

5.4.4.2 Streaming to UTCs

Streaming to UTCs and EDs should be an integrated function, as described by NHS guidance. Patients should be sent to a UTC according to explicit criteria based upon the complaint and basic physiology.

Examples of complaints may include:

- Strains and sprains, suspected broken limbs
- Feverish illness in children and adults
- Abdominal pain, vomiting and diarrhoea
- Minor head injuries, eye problems
- Cuts and grazes, bites and stings
- Minor scalds and burns
- Ear and throat infections
- Skin infections and rashes

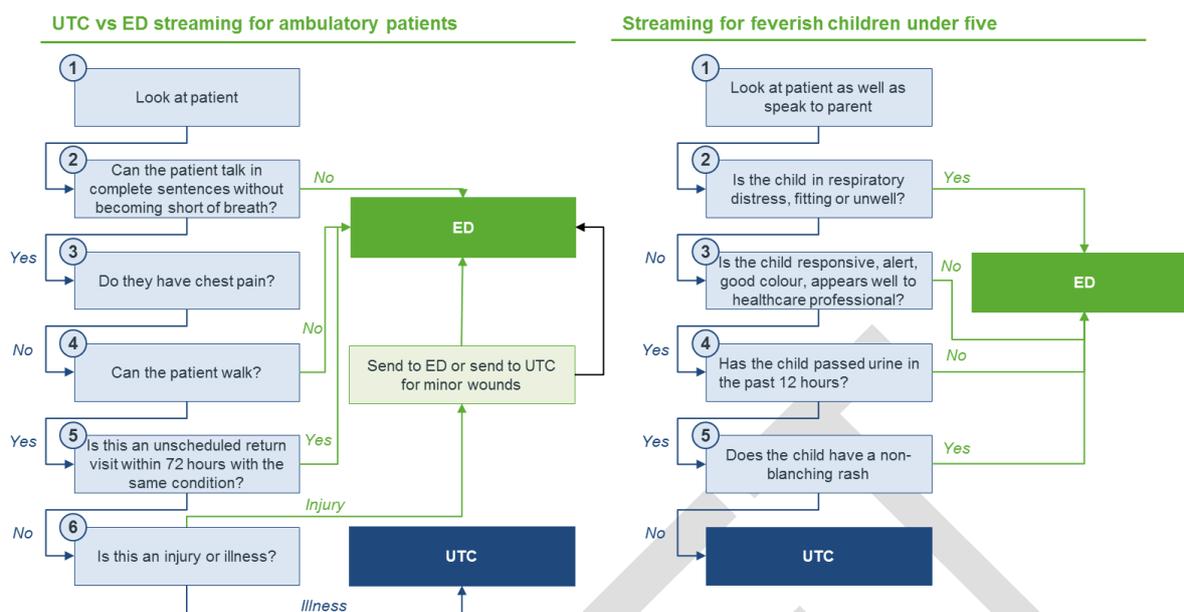
We will consider this as national guidance, which will continue to develop as the clinical model is further refined. The guidance states there are certain groups of patients who should be excluded because the risk is considered to be too great. These patients include all repeat attendances within 72 hours, all head injuries in children under 16 years, all traumatic injuries, all foreign bodies, and all patients requiring intervention or investigation in an ED.

For children under 6 months, these are considered suitable for a UTC if they are feeding normally, have no fever, are active and crying loudly, and have passed urine in the past 12 hours.

Streaming to ED or UTCs have been developed by other areas and endorsed nationally. Luton and Dunstable have developed protocols to implement UTC vs ED streaming for ambulatory patients and feverish children under five¹³⁵.

¹³⁵ <https://www.healthylondon.org/wp-content/uploads/2015/11/London-UEC-facilities-and-system-specifications-November-2017.pdf>

Figure 39: An example of UTC and ED streaming



High quality clinical triage will be essential to ensure patients are assessed in the right setting, first time. We will develop the guidance further as the clinical model develops further. There will be a multi-faceted approach to triage, across different points of access, including 111, GPs and walk-ins. Triage across multiple sites already takes place at ESTH, where patients are transferred from Epsom to St Helier when emergency surgery is necessary. There is a national move towards developing Urgent Integrated Care processes that will act as a single system for triaging prior to patients accessing UEC at the front door. 111 already includes health navigators who are clinically trained and follow set pathways to triage patients appropriately. As per RCEM recommendations¹³⁶ we will further ensure that:

- Triage patients is used appropriately where demand outstrips the resources required to make a detailed assessment in a timely fashion (usually within 15 minutes or less)
- Early Warning Scores in the ED are used as part of initial assessment processes.
- Clear Initial clinical assessment: This may be a part of triage or may occur subsequently. In order to allow the clinician to start any immediate treatment needed and to order relevant investigations prior to the definitive clinician assessment allowing a faster and more efficient pathway for the patient.
- Streaming: Patient will be allocated to specific patient groups and/or physical areas of a department. Streaming will match the patient needs to the practitioner so that the right skills are available to the patient at first point of contact.
- Triage standard: Triage will occur within 15 minutes of arrival or registration and be face-to-face
- Staff undertaking the triage role: Staff undertaking this role will be registered healthcare professionals experienced in emergency/urgent care who have received specific training.

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https://www.rcem.ac.uk/docs/College%20Guidelines/5m_Triage_April%202011_published_by_CEM_ENCA_FEN%20RCN.pdf

5.4.4.3 Requirements for staffing the UTC

UTCs require a different type of generalist from the district hospital bedded units. For UTCs, the generalist should be a GP (who could have a specialist interest in emergency medicine), working in conjunction with a consultant in emergency medicine who would be available for telephone consultations.

A multi-disciplinary team would support generalists, consisting of 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 carrying out responsibilities at the highest end of their qualifications and have access to specialists as required (either on-site or remotely), including mental health practitioners.

As per national guidance, if UTCs are co-located with an emergency department shared leadership with an ED consultant would be considered.¹³⁷

Figure 40: UTC staffing per site for minimum opening times (12/7)

Staff	Daytime staffing 12/7	Overnight staffing (12/7)	Whole time equivalents
Generalist	1.5	1.0	[5.5]

Figure 40 shows the staffing requirement for UTCs per site for 24/7 opening times. The impact on staffing numbers by the number of UTC sites is assessed further in Section 13.

5.4.5 Planned care

There are a number of key developments of the planned care pathway within the clinical model. These aim to meet the latest clinical standards and evidence based best practice for planned care.¹³⁸ 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. There is also a further direction for GPs to manage outpatients in their primary care networks or localities where appropriate.
- 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.

¹³⁷ 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>

¹³⁸ 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 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

The model for elective surgery is further described below.

5.4.5.1 Elective surgery

The Royal College of Surgeons (RCS) recommends separating elective surgical admissions from emergency admissions (particularly medical emergencies) wherever possible as this can reduce cancellations, achieve a more predictable workflow (resulting in an increase senior supervision of complex cases), provide training opportunities, increase senior supervision of complex/emergency cases, improve patient safety due to lower infection rates and therefore improve the quality of care delivered to patients.

The RCS also suggests that separating emergency and elective care can result in earlier investigation, definitive treatment and better continuity of care, as well as reducing hospital-acquired infections and length of stay¹³⁹.

Most elective surgery at ESTH is performed as a daycase (in 2017, 66% of all elective surgery was daycase).¹⁴⁰ This type of surgery does not require the support of higher intensity care units or critical care and therefore can be delivered as a district hospital service, closer to patients' homes where possible.

This differs for complex elective surgery (surgery that requires an inpatient bed), where the evidence suggests that any unit without comprehensive critical care facilities and consultant support should not be undertaking complex surgery or accepting 'high-risk' patients.¹⁴¹ The RCS states that providing complex elective surgery or minor/intermediate surgery for higher-risk patients with comorbidities will require 'sufficient critical care support appropriate to patient need'.

Therefore the more complex elective surgery 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.¹⁴² 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).

We would expect transfers after day case surgery to be very low as case selection would minimise risk. Those that do need to transfer would follow protocols for transfer from district sites to an acute site as discussed for previous recommendations. These patients could also potentially already have been stabilised with support of on-site anaesthetist, who would be present for the day case surgery.

SWLEOC would remain unchanged as this is a standalone unit that will continue to deliver elective orthopaedic surgery. The unit has dedicated facilities (including PACU) and does not require support from Epsom Hospital, meaning it is unaffected by any wider changes.

5.4.6 Maternity and paediatrics as a district service

This section describes some of the key services as part of the district hospital for maternity and paediatrics. A description of major acute services can be found in 5.5.6.

¹³⁹ 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

¹⁴⁰ ESTH

¹⁴¹ 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

¹⁴² ESTH

5.4.6.1 Community paediatrics

The community paediatric services team at ESTH currently work closely with other healthcare professionals to provide community services. The team offers specialist medical assessment and support for children and young people with:

- Developmental disorders, neurodisability
- Social communication disorders like autism and aspergers and special educational needs

ESTH offers support to children and young people in need of protection through medical assessment of recent physical injuries, as well children and young people who are in the care of the local authority. ESTH work is strongly supported through close ties with local healthcare professionals including GPs, CAMHS, Health visitors and school nurses.

ESTH also works closely with special educational needs and disability professionals in the borough, as well as social services who all help support the team. The team includes a designated doctor for safeguarding, a medical adviser to each borough's adoption agency, and a designated medical officer for special educational needs and disability.

Community paediatrics services will continue to develop in line with national guidance. ESTH will continue to develop its services in line with the Royal College of Paediatrics and Child Health recommendations.

Furthermore, work is ongoing around the development of community paediatrics pathways, including:

- The integration of CAMHS services with community paediatrics
- Establishing a specialist workforce – e.g. specialist asthma nurses focusing on preventing admissions and providing improved out of hospital care
- Integration of community paediatrics and public health
- Development of a Children's Development Centre as a hub for community paediatrics.

These interventions would further aim to improve community paediatric care through integration and out of hospital care.

5.4.6.2 Paediatric provision at UTCs

Streaming to ED or UTCs for children have been developed by other areas and endorsed nationally. For children under 6 months, these are suitable for a UTC if they are feeding normally, have no fever, are active and crying loudly, and have passed urine in the past 12 hours¹⁴³. This streaming process will be considered further as our clinical model is further refined.

Paediatricians and paediatric nurses would be present at the UTCs on a rotating basis:

- Paediatric nurses would need to be available for plaster for children
- Paediatricians would need to be on site to support the generalists.

5.4.6.3 Medical investigation units

The large number of outpatient appointments which generate investigations would mean medical investigation units are required on both sites. Medical investigation units as a district service would be integrated with other services rather than forming discrete units, with staffing rotations. In terms of pathology, samples could be sent over to a hot lab located on the major acute site.

5.4.6.4 CAMHS

CAMHS services will be provided as a district service. Over the next five years, the NHS will invest in CAMHS, as set out in the Long Term Plan:

¹⁴³ <https://www.healthylondon.org/wp-content/uploads/2015/11/London-UEC-facilities-and-system-specifications-November-2017.pdf>

- By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and Mental Health Support Teams. Over the coming decade the goal is to ensure that 100% of children and young people who need specialist care can access it.

Children and young people experiencing a mental health crisis will be able to access support they need.

- Expanding timely, age-appropriate crisis services will improve the experience of children and young people and reduce pressures hospital and ambulance services
- With a single point of access through NHS 111, all children and young people experiencing crisis will be able to access crisis care 24 hours a day, seven days a week.

St Helier has a 24/7 child and adolescent emergency mental health service that can assess patients in both the emergency department and on the paediatric wards. This is consistent with the aims of the NHS Long Term Plan. At Epsom, for child & adolescent psychiatry referrals, currently liaison psychiatry undertakes reviews only in the Emergency Department. These are discussed with CAMHS for advice.

5.5 Delivering major acute standards

The key changes to the clinical model aim to meet the latest clinical standards and evidence based best practice¹⁴⁴. This includes the co-location of major acute services including the emergency department, emergency surgery, acute medical services and critical care. Additionally, core 24 (24/7) liaison psychiatry is being introduced consistently as a major acute service.

5.5.1 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.

¹⁴⁴ 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-U-EC-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 41: An overview clinical standards for major acute services set out in the South West London Clinical Quality Standards for Acute Services¹⁴⁵

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

Co-dependencies between acute services define what the minimum requirement is for a set of acute services in a hospital, particularly where there is a need to support the emergency department. We consider the six major acute services, and where co-dependencies between them and other services mean that each should be co-located.

5.5.1.1 Groupings of major acute services

These major acute services can be organised in multiple ways. Within our clinical model, we have considered two groupings 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 grouped 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.¹⁴⁶

Where these services are provided 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 year¹⁴⁷ – the largest unit in the country – compared to the c. 5,000 hospital deliveries in our combined geographies¹⁴⁸; 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.

¹⁴⁵ *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-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>

¹⁴⁶ ESTH

¹⁴⁷ Liverpool Women's Hospital: <https://www.liverpoolwomens.nhs.uk/>

¹⁴⁸ ESTH

5.5.2 Emergency department

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

The emergency department relies on a number of major acute services that must be co-located to be viable, including:

- **Critical care:** Critical care provides treatment and monitoring for patients in a critically ill or unstable condition and therefore needs to be co-located with an emergency department.¹⁴⁹ Critical care must have the capacity to treat the small numbers (typically <2%) of attendances at the emergency department who are critically ill.¹⁵⁰
- **Anaesthesia:** Required for critically ill patients who present at the emergency department and may require pain relief or emergency surgery.
- **Acute medicine:** This service is required to be co-located with the emergency department to deliver rapid diagnosis, treatment and improved outcomes for adult patients with an acute medical illness. This requires a consultant-led team working within an acute medical unit (AMU) 7 days per week, for a minimum of 12 hours per day.¹⁵¹
- **Emergency surgery:** The Royal College of Anaesthetists state that without emergency surgery it is more difficult to staff critical care which may limit the type of emergency medical patients who can be admitted.¹⁵² Co-located emergency surgery and acute orthopaedics delivers rapid diagnosis, treatment and improved outcomes for adult patients with acute surgical and orthopaedic illness.¹⁵³
- **Liaison psychiatry:** Mental health problems are the presenting feature in 5% of all emergency department attendances. Readily accessible psychiatric expertise reduces admission and readmission rates in people with mental health problems. Evidence for co-location of liaison psychiatry shows that the most benefit is derived from services which are fully integrated with hospitals. Specialist teams offer increased benefits where they are focused on the emergency department and older people. The co-location and integration of psychiatric services will furthermore address the need for parity of esteem between physical and mental health care.¹⁵⁴

Ensuring that there is 24/7 access to these services is essential to improve patient outcomes. Hospitals with emergency departments with an unselective take of acute adult patients need these services. The emergency department therefore needs to be supported by those services which are required by these supporting major acute services. These supporting services therefore define what needs to be co-located with an emergency department at a minimum¹⁵⁵.

The emergency departments at Epsom and St Helier are used by c. 53,000 major acute patients per year.

¹⁴⁹ South West London Discussion Document: One Year On (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>

¹⁵⁰ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁵¹ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁵² 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

¹⁵³ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁵⁴ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁵⁵ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

5.5.3 Acute medicine

Acute medicine requires an appropriately staffed acute assessment unit to deliver rapid diagnosis, treatment and improved outcomes for adult patients with acute medical illness. To improve the outcomes of acute medical patients admitted to hospital immediate access to clinical and diagnostic services is needed. This requires a consultant-led team working within an acute medical unit (AMU) 7 days per week, for a minimum of 12 hours per day, as well as the co-dependent services listed below to deliver safe, sustainable acute medical care to unselected patients admitted on an acute hospital site¹⁵⁶.

Acute medicine relies on critical care and anaesthesia, and relies on an emergency department for its take.

- **Critical care:** Critical care is required to manage both acutely sick medical admissions and deterioration in existing medical inpatients¹⁵⁷. The Royal College of Physicians recommends that the acute medicine team, in conjunction with the critical care team, should co-ordinate medical care for patients who develop an acute medical illness while in hospital. In 2002 the RCP said that acutely ill medical patients should not be admitted to a hospital without critical care.¹⁵⁸
- **Anaesthesia:** There are clinical risks associated with a lack of access to critical care facilities or anaesthetic cover¹⁵⁹.
- **Emergency department:** Required for acute medicine take. The RCP recommends acute medicine teams should be co-located with the emergency department.¹⁶⁰ Co-location with the emergency department allows for rapid diagnosis, treatment and improved outcomes for adult patients with an acute medical illness.

Furthermore, acute medical care has been found to require onsite surgical support. The Royal College of Surgeons states there should be 24-hour on-site surgical opinion (ST3 level or above) in hospitals accepting unselected medical emergencies. Where surgical services are not on-site, the Royal College of Physicians recommends that hospitals should not admit patients who might require urgent surgical intervention and ensure accessible surgical opinions without needing to transfer a patient to a further site.

These co-dependencies were supported by the National Clinical Audit Team (NCAT), which states that the dependencies for acute medicine are radiology, critical care/anaesthesia and access to surgical opinion available 24/7.¹⁶¹ Acute medicine has a smaller selection of critical co-dependencies with other services than the emergency department, however to provide a comprehensive acute medicine service these are essential.

Acute medicine is used by c. 30,000 patients per year.

¹⁵⁶ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review (2014)*

¹⁵⁷ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review (2014)*

¹⁵⁸ 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

¹⁵⁹ 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

¹⁶⁰ 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

¹⁶¹ 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

5.5.4 Critical care

Critical care provides treatment and monitoring for patients in a critically ill or unstable condition and must be co-located with an emergency department. These patients need access to all major acute services; in addition, emergency services are dependent on critical care.

Most of these patients are too unwell to be transferred to further sites. Therefore the specialities these patients need should be co-located. The Intensive Care Society of the UK core standards furthermore provides clear guidance regarding the provision of rehabilitation services, speech and language, physiotherapy, pharmacy and dietetics on-site¹⁶².

Critical care is used by c. 300 patients per year.

5.5.5 Emergency surgery

Emergency surgery relies on:

- **Critical care:** Evidence suggests that a lack of access to critical care beds for emergency surgery can be a key factor in perioperative death. The RCS also requires hospitals undertaking surgery to have the appropriate critical care provision to support emergency surgical workload.
- **Anaesthesia:** The Royal College of Anaesthetists has developed specialty specific guidance which states that anaesthesia must plan for acute surgical intervention 24/7¹⁶³.
- **Emergency department:** The co-dependencies of the adult acute surgical take means there must be an emergency department on-site to allow appropriate investigations and triage to occur. This also requires appropriate support from acute medicine.¹⁶⁴

Surgical units need access to acute medicine for patients with comorbidities or who develop acute medical complications. As is the case for acute medicine, the NCAT recommended access to critical care, anaesthesia and acute medicine should be available 24/7 for emergency surgery.

2,800 patients require emergency surgery per year.

5.5.6 Obstetrician-led births

Obstetrician-led births rely on:

- **Critical care:** Critical care co-located with obstetrics is required by the profession's guidance in Safer Childbirth¹⁶⁵. Women can become critically unwell during their admission to a consultant led obstetric unit. Therefore arrangements need to be in place for critical care, midwifery and obstetric competencies within the service.¹⁶⁶
- **Emergency surgery for women:** Major bleeding complications, sepsis and pre-eclampsia are relatively common in obstetrics. Obstetrics must have close access to emergency surgery for complications occurring during birth, which include damage to bladder, bowel or major blood vessels. While this may not require co-location of an emergency surgery it does require 24/7/365 on call availability.¹⁶⁷

¹⁶² *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁶³ 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

¹⁶⁴ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁶⁵ 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

¹⁶⁶ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁶⁷ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

- **Interventional radiology:** Major bleeding complications may require interventional radiology¹⁶⁸ and should therefore be co-located.
- **Anaesthesia:** Pain relief during labour requires the presence of anaesthesia. Anaesthetists are involved in 60% of pregnant women. Safer Childbirth guidance states that obstetrics units must have access anaesthesia services. An anaesthetist must be on site in units offering epidurals for 24 hours. An on-call consultant anaesthetist should be available within 30 minutes of the delivery suite at all times. The NCAT recommends consultant-led obstetrics should be co-located with anaesthetic units in order to provide epidurals and monitoring during labour¹⁶⁹. Timely anaesthesia is furthermore crucial during emergencies and appropriate planning is needed to manage procedures and detect postoperative complications¹⁷⁰.
- **Neonatal services:** Obstetrics should be co-located with the appropriate neonatal capability to care for preterm or ill babies¹⁷¹. If the baby is born in a hospital setting the Safer Childbirth guidance states there must be immediate, on-site availability of clinicians (doctors, advanced neonatal nurse practitioners or midwives) with advanced neonatal life support skills. Without this level of support there may be unfavourable outcomes and care provision would fall below an acceptable standard.¹⁷² The capability of the neonatal unit will determine the case mix the consultant led obstetric unit can manage.¹⁷³

The SWL discussion document identifies that where obstetrics services are to be provided with unselected takes, they must be co-located with a level 3 ICU, anaesthetics and a Local Neonatal Unit.

NCAT also recommended that gynaecological services be provided on the same site as obstetric services.

There are a number of key developments of the maternity pathway within the clinical model, aiming to meet the latest clinical standards and evidence based best practice for maternity care.¹⁷⁴ 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.

¹⁶⁸ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁶⁹ 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

¹⁷⁰ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁷¹ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁷² 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

¹⁷³ *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

¹⁷⁴ 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>

- 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.

5.5.6.1 Models of delivery of maternity services

For pregnant women there are three options available for their delivery:

- Women can give birth **at home** with support from a midwife. This is a district service, as described in Section 5.3.
- **Midwife-led deliveries** can be provided from two types of unit: freestanding midwife-led units and alongside midwife-led units. Alongside midwife led units are co-located on the same site as an obstetric unit (see below) whereas freestanding units are not.
- **Obstetric-led 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 5.5.6).

The National Maternity Review¹⁷⁵ 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 led 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 led unit (MLU) 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.

The percentage of home births at ESTH is increasing, and is now at 2.5% - 3.5%. Through reconfiguration of the workforce, ESTH is also looking to meet the standards for continuity of care and reduce any level of risk for women. This could further encourage home births:

- ESTH is now achieving 20% continuity of care at St Helier and 14% at Epsom.
- Amalgamation of the team to provide further support to vulnerable women, e.g. those with diabetes.

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

5.5.6.2 Delivery units and different types of midwife-led unit

For low-risk¹⁷⁶ women, national evidence has captured the outcomes for women giving birth in different types of unit. These are described in Figure 42 and Figure 43 below for women giving birth to their first child and for those giving birth to a subsequent child.

¹⁷⁵ National Maternity Review, *Better Births* (2016), <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

¹⁷⁶ 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 42: Low-risk nulliparous (first child) women (c. 45%)¹⁷⁷

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	N/A
Babies without serious medical problems	991	995	995	995

Figure 43: Low-risk multiparous (second or subsequent child) women (c. 55%)¹⁷⁸

Rate/1,000 births	Home birth	Stand-alone MLU	Along-side MLU	Obs-led unit
Spontaneous vaginal birth	984	980	967	927
Interventions ¹⁷⁹	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.¹⁸⁰

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

For alongside midwife led units, these transfers are typically smooth, because of 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. Ambulance transfers to the major acute site would need to be carefully arranged, and while this transfer may be relatively quick, there is an increased risk compared to being transported within a major acute site.

There is currently a 25-30% transfer rate for home births to major acute services, which is similar for the current alongside MLUs. This is likely to increase as the increased travel time from MLUs to major

¹⁷⁷ Birthplace Cohort Study (2011), <https://www.npeu.ox.ac.uk/birthplace> ; Blix et al. (2012): <https://www.sciencedirect.com/science/article/pii/S1877575612000481>

¹⁷⁸ Birthplace Cohort Study (2011), <https://www.npeu.ox.ac.uk/birthplace> ; Blix et al. (2012): <https://www.sciencedirect.com/science/article/pii/S1877575612000481>

¹⁷⁹ 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>

¹⁸⁰ NICE Guidance CG190: Intrapartum care for healthy women and babies (2014) <https://www.nice.org.uk/guidance/cg190>

acute services would lower the threshold at which midwives would want to transfer patients who potentially require a higher acuity of care.

Furthermore, it is unlikely that there would be sufficient volume to pass through a freestanding MLU as women would only be triaged into a freestanding MLU when they meet home birth criteria.

National interventions and population demographics are also impacting on the number of women who would be eligible for a freestanding MLU, including:

- Increased rate of intervention to reduce risk of still births
- Increased rates of induction for reduced foetal movement
- Higher rates of obesity, older mothers and diabetes

This could further limit the number of women using a free-standing unit, resulting in a financially unsustainable unit.

The NCAT supported midwife-led units alongside consultant-led obstetrics units to provide choice of a non-obstetric birth setting for women at low risk of complications while minimising the risks associated with transferring to an obstetric environment during labour if this is required.

NCAT guidance stated that freestanding MLUs 'are unlikely to be cost-effective unless other services are offered on the same premises e.g. antenatal care and/or the midwifery team has flexible working patterns'. It suggests that midwives could be on call for births within the unit, however freestanding units are struggling to recruit midwives.¹⁸¹

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.¹⁸²

5.5.6.3 Volume and staffing for midwife-led units

Currently, approximately 15–20% of births at ESTH are midwife led.¹⁸³ 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.

5.5.6.4 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%¹⁸⁴ 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%¹⁸⁵ 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.

¹⁸¹ 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

¹⁸² NHS Choices (2018), www.nhs.uk/conditions/pregnancy-and-baby/where-can-i-give-birth

¹⁸³ ESTH

¹⁸⁴ *Birthplace Cohort Study* (2011) <https://www.npeu.ox.ac.uk/birthplace>

¹⁸⁵ ESTH

- 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 the best model for our local area to maintain midwife-led units alongside obstetrician-led units.

At ESTH, there are 4,800 births per year

5.5.7 Inpatient paediatrics

Within the SWL discussion document, it was established that all emergency departments in SW London or operated by a SW London trust needed at least to have facilities for children to be observed in a bed, stabilised, and transferred if necessary.¹⁸⁶

Emergency and inpatient paediatrics rely on:

- **Anaesthetics:** Where there is an inpatient paediatric service, there must be emergency services for children and young people and anaesthetics on the same site.
- **Interventional radiology:** Essential co-located services include X-ray and diagnostic ultrasound, CT, urgent haematology and biochemistry, and blood bank and transfusion¹⁸⁷.

Furthermore, general paediatric surgery units should have adult general and specialised surgery on the same site. Conversely, emergency services for children and young people can be delivered on a site without inpatient paediatric services. This includes departments that receive children, or short stay paediatric assessment units.

NCAT recommended that paediatric inpatient services should be co-located with obstetrics and neonatal units, and also recommends inpatient paediatrics should be co-located with emergency surgery. NCAT also recommended that paediatric inpatient units should be supported by critical care.¹⁸⁸

There are a number of key developments of the paediatric pathway within the clinical model. These aim to meet the latest clinical standards and evidence based best practice for paediatric care¹⁸⁹. 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).

¹⁸⁶ South West London Discussion Document: One Year On (2017) <https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf>

¹⁸⁷ The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review (2014)

¹⁸⁸ 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

¹⁸⁹ 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

Due to the additional expertise required, paediatric surgery patients under the age of nine are currently transferred to other providers for treatment.

Additional developments include:

- UTCs will 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.

As with Queen Mary's Hospital on the St Helier's Hospital site, major acute paediatrics services should be co-located in a bespoke self-contained paediatric unit.

It is important, however, that this self-contained unit is on the same site as other services, including adult services, and alongside maternity/obstetric services. Neonatal care should act as the 'bridge' between maternity and paediatrics units.

A paediatric unit should therefore have paediatrics ED, neonatology, and the in-patient wards within close proximity, to reduce the time spent travelling between these services by staff, thereby speeding up their response times and increasing their clinical face to face time with patients.

5.5.7.1 Clinical Support Services

There will be a pathology hot lab at ESTH, however as per NHS LTP and Lord Carter recommendations other pathology services will move to a centralised model, enabled by pathology networks¹⁹⁰.

The pathology networks will mean quicker test turnaround times, improved access to more complex tests at a lower overall cost and better career opportunities for healthcare scientists and clinicians.

In terms of pharmacy, ESTH will be moving to a single pharmacy model, which will potentially apply across SWL.

5.5.7.2 Co-dependencies

As major acute services include the highest acuity services, we have considered their co-dependencies, to define the minimum set of services that need to be co-located.

This has been informed by relevant national and regional guidance, best clinical practice and previous co-dependency mappings.¹⁹¹ Numerous attempts to describe this have resulted in the inclusion of the emergency department, acute medical care, critical care and diagnostics¹⁹².

In summary, some of the key dependencies for major acute services 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.

¹⁹⁰ NHS LTP

¹⁹¹ *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 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

¹⁹² 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

- **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 5.5.6.4)
- **Emergency and inpatient paediatrics** rely on anaesthetics and interventional radiology.

These co-dependencies mean these services are closely interlinked.

5.5.7.3 Co-locating major acute services

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

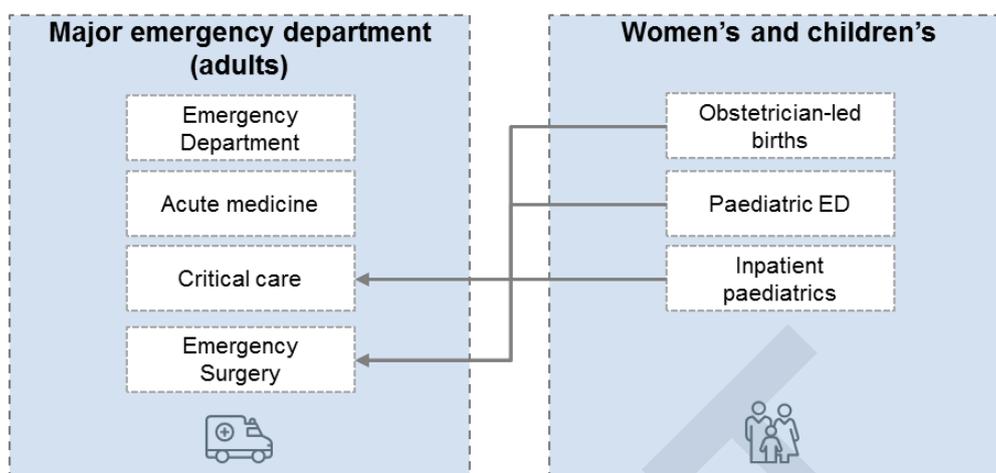
1. Major emergency department (adults): These services must be co-located to offer a viable major emergency department (emergency surgery can, in some circumstances, be closely networked but this could add additional risk to the pathway and is not desirable).¹⁹³
2. Women's and children's services alongside 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.

¹⁹³ 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 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/>

Figure 44: 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 7.

5.5.8 Associated services

There are a range of services upon which major acute services are dependent, and which need to be co-located. Some of these services are set out below.

5.5.8.1 Liaison psychiatry

National guidance has defined requirements for mental health psychiatric liaison. By 2020/21 all acute hospitals will have liaison teams in place in emergency departments and in-patient wards, with at least half providing this on a 24/7 basis in line with the Core24 standard.

Where the hospital has a 24/7 ED, then it should have a Core24 service level as a minimum to ensure 24/7 mental health cover. NICE have defined standards for an emergency and urgent pathway¹⁹⁴:

- Emergency pathway:
 - Any person experiencing a mental health crisis should receive a response from the liaison mental health service within a maximum of 1 hour of the service receiving a referral.
 - Within 4 hours of arriving at an emergency department or being referred from a ward, any person experiencing a mental health crisis should have received the appropriate response or outcome to meet their needs and have an evidence-based care package in place
- Urgent pathway:
 - An urgent and emergency liaison mental health service should respond to the referrer within one hour of receiving a referral from a general hospital ward to ascertain its urgency, the type of assessment needed and resources required for the assessment
 - The urgent and emergency liaison mental health assessment should start within 24 hours of receiving a referral.

The psychiatric mental health liaison team will adhere to national guidance¹⁹⁵ including:

¹⁹⁴ <https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf>

¹⁹⁵ <https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf>

- Enabling data, record and information sharing across mental health services, general hospitals, primary care and other health and social care services to ensure rapid, appropriate and safe treatment, timely and effective community-based follow-up and that patients' up-to-date histories and preferences are known.
- Liaison mental health services should have joint ownership and governance arrangements between acute trusts, mental health trusts and other local providers including senior clinical and operational leadership from those providers. This should improve partnership working by the liaison service and local providers of community, primary, social care, housing, public health (including drug and alcohol use) and voluntary sector services.

5.5.8.2 Ambulatory care

The major acute site and district sites will provide ambulatory care.

Patient selection is based on¹⁹⁶:

- Clinical stability – this is established by recording a NEWS score to support clinical discussion
- Same day emergency care (SDEC) being the best place to meet the patient's required clinical needs
- SDEC staffing and facilities being appropriate to meet the patient's functional needs and maintain their privacy and dignity.

To avoid inappropriate patient types being referred to SDEC, a clear process for patient selection and a robust gatekeeping system are needed. Patients who should not be managed in an SDEC service are:

- Patients needing the facilities of a discharge lounge
- Type 2 ED attenders (minors) and type 3 ED attenders who should continue to receive their care in ED within the four-hour A&E standard
- Clinically unstable patients – for example, NEWS >5
- patients who will breach the four-hour A&E standard but whose clinical care does not require a move to another team
- Patients overflowing from another service that does not have the capacity to manage their care.

5.6 Ensuring continuity of care

The clinical model will ensure that patients experience continuity of care between primary, community, district hospital and major acute services, as well as wider health and care services across the geography.

5.6.1 District hospital site location

District services are delivered in the same way regardless of location. While there may be synergies as a result of co-location of a district site with a major acute site, the sites will be functionally distinct with different ways of working and a different staffing model. The district hospital would therefore be operationally distinct from the major acute site if it is co-located. This is based on a number of principles:

- District sites should not be an overflow for acute as this may compromise the safety of care given the different staffing models.
- Learning from the SWLEOC and renal unit model indicates that an operationally and functionally distinct unit ensures that overflow from the acute site is disincentivised.

¹⁹⁶ https://improvement.nhs.uk/documents/2983/SDEC_guide.pdf

- A separate infrastructure and operational management would ensure patients only suitable for district hospital care would be located on the district site.

There is unlikely to be significant differences in the delivery of care between a co-located and non co-located sites, though there are some additional operational implications:

- We will develop UTCs to national guidance, offering diagnosis and treatment for most urgent care needs across all options and open 24/7. Where co-located with the major acute site, a UTC would be integrated with the ED and streaming carried out at the front door. In the option with a major acute hospital at Sutton, an additional UTC is provided alongside the emergency department (as per national guidance).
- The UTC will be supported by imaging and diagnostics (including MRI, CT). It is anticipated that patients are unlikely to need out of hours diagnostics due to their low acuity, however this could be accessible on a major acute site.
- Enhanced inpatient care at district sites may result in some minor differences in patient experience:
 - An interhospital transfer may be perceived as having a greater impact on patient experience than an intrasite transfer.
 - However the benefits of being transferred to a district site in terms of enhanced care suitable to needs is likely to mitigate against this.

Further work will also be carried out as the programme moves forward to assess whether the district hospital will be a separate building if is co-located with a major acute site.

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

Urgent, deteriorating cases are likely to be taken by ambulance, whereas PTS will transport stable patients. Depending on the case presented, it is likely that:

- Patients requiring step up services from a district site to the major acute site will require an ambulance – this number is expected to be low based on audits carried out to date
- Patients requiring step down services from the major acute site to the district site – this is expected to be carried out by PTS

The evidence around the impact of transfers on patient outcomes and experience are limited. Adequate training in inter- and intra-hospital transfers is delivered uniformly in the NHS. With the increasing move to integrated care, transfers between hospitals are likely to be more common place.

Training in the transfer of patients should be embedded into the curricular of both medical and non-medical practitioners. NICE provides recommendations for monitoring patients who are likely to require transfer¹⁹⁷:

- Record multidisciplinary assessments, prescribed and non-prescribed medicines and individual preferences in an electronic data system. Make it accessible to both the hospital- and community-based multidisciplinary teams, subject to information governance protocols.
- At each shift handover and ward round, members of the hospital-based multidisciplinary team should review and update the person's progress towards discharge.

¹⁹⁷ Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27

- Hospital-based practitioners should keep people regularly updated about any changes to their plans for transfer from hospital.
- Provide care for older people with complex needs in a specialist, geriatrician-led unit or on a specialist geriatrician-led ward.

Specific factors that therefore need to be considered include:

- Handovers and providing continuity of care – written (or IT based) handover should include:
 - Current inpatients
 - Accepted and referred patients due to be assessed
 - Accurate location of all patients
 - Operational matters, directly relevant to clinical care such as bed availability
 - Information to convey to the following shift
 - Patients whose ‘early warning scores’ are deteriorating (where appropriate).
- The following, as well as being included in the written handover, should be discussed within the handover meeting. This verbal handover is vital to highlight these issues:
 - Patients with anticipated problems, to clarify management plans and ensure appropriate review
 - Outstanding tasks, associated with their required time for completion.
- Medication continuity
 - Health care professionals transferring a patient should ensure that all necessary information about the patient’s medicines is accurately recorded and transferred with the patient, and that responsibility for ongoing prescribing is clear.
 - When taking over the care of a patient, the healthcare professional responsible should check that information about the patient’s medicines has been accurately received, recorded and acted upon
 - Systems should focus on improving patient safety and patient outcomes. Organisations should consistently monitor and audit how effectively they transfer information about medicines.

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’.

Transfer protocols are already in place between Epsom and St Helier as there is no general ITU at Epsom. This has worked well with no issues identified. We will have robust assessment and transfer arrangements in place to ensure patients receive care in the appropriate place. There will be a proactive approach on the district site to ensure that patients are continuously assessed in order to manage:

- A transfer to the major acute site if a patient may be deteriorating
- Enable proactive discharge planning for patients where appropriate.

A transfer to the district site where acute rehabilitation is possible would therefore deliver further benefits to patients, in addition to receiving care closer to home.

There will be robust clinical governance in place:

- Governance will include incident and significant event reporting and investigation procedures
- Where appropriate, observations will be performed and an early warning score calculated

The workforce would be supported with clear guidelines on the transfer and transition between acute and district hospital sites. This will develop further as the clinical model progresses and agreed with ambulance providers.

Where an emergency transfer is required from the district site to the acute site, the patient would be stabilised by staff on-site, and would then be transferred to the major acute site by ambulance in the presence of a paramedic. This is a clinically safe process which is currently used when patients need to be transferred between sites.

5.6.3 Repatriation from other providers

The district hospital site will be an appropriate facility for patients who live within the combined geography to be transferred to from other providers in the local area. For example, this could include a patient local to Epsom who was initially treated at St George's Hospital for the major acute part of their stay, but who now meets the criteria for district hospital care and can be more appropriately treated closer to home.

Repatriation of patients in this way already occurs locally, regionally and nationally, with patient pathways being split across different settings depending on their benefits. Some examples of this are shown in Table 33.

Table 33: Current examples for splitting patient pathways to achieve benefits

Pathways	Length of stay in major acute settings	Benefits
Stroke pathways	24 – 48 hours	<ul style="list-style-type: none"> • More than 95 extra lives are saved every year in London • Absolute reduction in mortality of 3% • An additional 6% of people to achieve independent life at home after a stroke.
Neurorehabilitation		<ul style="list-style-type: none"> • There is increased prevalence of neurological conditions in older people. • Rehabilitation intervention reduced the need for continuing care, reducing overall costs particularly in more dependent patients • Intervention from the Northern Devon Healthcare Trust stroke therapy team reduced length of stay by 6 days from 22 days, saving £833,700.
Frailty pathways – Northumbria FT	On admission	<ul style="list-style-type: none"> • In Elderly Assessment Units, 50% of patients now go home, 20% to a rehabilitation facility and 30% with an acute admission.
Emergency care – Northumbria FT	48 hours	<ul style="list-style-type: none"> • A 14% reduction in emergency admissions to hospital resulting in a £6 million saving • 15% increase in overall urgent and emergency care activity • 7% of all ambulance arrivals waiting over half an hour to handover patients • Northumbria healthcare being one of only a handful of trusts nationally to meet the four hour standard for patients to be seen within four hours during the whole of 2015/16
Trauma pathways	24 – 48 hours	<ul style="list-style-type: none"> • There are three key parts of the networked major trauma pathway as developed through a centralised review: <ul style="list-style-type: none"> ○ Acute trauma care and surgery ○ Ongoing care and reconstruction ○ Rehabilitation

Repatriation has been discussed with other providers across the area to ensure appropriate handover of patients and enable continuity of care between providers.

5.6.4 Discharge planning

Supporting people to go home will be the default pathway from either major acute services or district hospital services. The benefits of being discharged from hospital applies to both major acute and district services. These include:

- People’s health outcomes improve as more people will be able to live at home for longer if services are designed for discharge to home to be the default.
- Reducing length of stay has been shown to reduce deconditioning and improve outcomes significantly since 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80¹⁹⁸.

This will be supported by home first schemes and discharge to assess, allowing health and social care to work together for the best outcomes, improving system flow by enabling patients to access urgent care at the time they need it and sharing responsibility, risks and skills across partners leads to innovative and creative solutions that deliver safe, effective care and support.

Discharge planning can help to reduce length of stay and increase throughput. There are currently whiteboard meetings at ESTH every day within the AMU to assess potential discharges. This is also carried out within the out of hospital schemes such as Sutton Health and Care. When planning for discharges we will look to align to key processes as per national guidance, including:

- Specifying a date and time of discharge as early as possible within the period of care.
- Identifying whether a patient has simple (using the Pareto principle, this will be 80% of all patients) or complex discharge planning needs.
- Identifying what individual patients needs are and how these needs will be met.
- Defining the specific clinical criteria that a patient must meet for discharge¹⁹⁹.

5.6.5 Consideration of risks and mitigations of the clinical model

The overall risks and benefits of the clinical model can be found in Figure 45 below.

Figure 45: Risks and mitigations of the clinical model

Risk	Benefit
Discharge from the district hospital – superstranded patients	Discharge planning will take place from day 1 to ensure patients are proactively managed and discharged from the district hospital site. We will always work from a basis of ‘home first’, which applies to patients at the acute site as well as at the district site.
Discharge planning – impact on community / social care	Health and care services in the area will be aware of patients who are likely to require community or social care from the first day of admission. Some of these patients may be discharged from the acute site, however some will initially be transferred to the district hospital site. It is furthermore likely that in the future the place-based system will be quite different, with increased collaboration between health and care services across a local area. This will be well-established by the time this clinical model comes into effect.
Transferring from a different health or care setting to the major acute or district hospital site	Explicit criteria that have been tested will be in place to establish whether a patient is suitable for district hospital care or major acute care. This will be used across the system to ensure patients are treated in the right place at the right time. The district hospital audit verified that these criteria are accurate in identifying patients who require major acute or district care.

¹⁹⁸ <https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf>

¹⁹⁹ <https://improvement.nhs.uk/documents/2100/discharge-planning.pdf>

Medical risk aversion of sending patients to DH	The district hospital site will not be a 'step-down' site, rather it will provide proactive care, in the form that best meets patients needs. This could include acute rehabilitation, intensive input by therapists and nursing staff and a proactive approach to identifying the best place of care for patients, with appointed staff members responsible for enabling discharge. This approach will ensure that the perception of the district site as a step down site will be minimised, and therefore limit medical risk aversion to a transfer. Patients within the district site will be continually reviewed by staff and proactively managed. The district hospital should be geared to ensuring that patients do not decondition and prevent long lengths of stay.
Developing interface physician skills	The interface physician role is essential to ensure the district hospital is appropriately staffed to manage patient needs. There is an increasing national focus on developing generalist skills, and we will be liaising with Health Education England and the RCGP to monitor the progress of developing a future pipeline of interface physicians.
Patient experience of transfers	The evidence around the impact of transfers on patient outcomes and experience are limited. Adequate training in inter- and intra-hospital transfers is delivered uniformly in the NHS. With the increasing move to integrated care, transfers between hospitals are likely to be more common place. We will have robust assessment and transfer arrangements in place to ensure patients receive care in the appropriate place. There will be a proactive approach on the district site to ensure that patients are continuously assessed in order to manage transfers. A transfer to the district site where acute rehabilitation is possible would therefore deliver further benefits to patients, in addition to receiving care closer to home.
Viability of a L2 neonatal unit	A L2 neonatal unit requires a minimum of 365 respiratory care days for babies <1500g in order to be a sustainable unit.

5.7 Conclusion

This clinical model has been designed to align with our local plans and objectives, particularly around integrated care, however it has a specific focus on hospital services – an area where we currently have challenges.

As a result, the 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).

The clinical model additionally outlines our plans to develop our district hospital services. We are already delivering district hospital services across our geography, and these will continue to develop as further plans are realised.

The model describes our current position on a number of important areas including **urgent treatment centres, district hospital beds, and planned care**. 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 to 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.

Within major acute services, we have created two clusters of services based on the interdependencies between 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 clinical model.

We believe that this clinical model will 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 is described in the following section.

DRAFT

6 BENEFITS

The clinical model is expected to bring a wide range of positive impacts, including clinical benefits, workforce benefits, technology benefits and estates benefits.

Overall this should translate into improved clinical outcomes for patients, an improved way of working for staff, opportunities for the implementation of new technology, fewer patient falls and transfers, fewer adverse drug events and infections, an improved patient experience and shorter stays in hospital.

6.1 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.

We have detailed the benefits of the clinical model within this chapter. In summary, these include:

- **Clinical benefits:**
 - Delivering district services in the integrated, networked way as described in Section 5.3 will result in a broad range of benefits across patient pathways through the integration of primary, community and acute services.
 - Meeting standards for major acute services, including SWL clinical standards and seven-day service standards, and enhancing consultant cover.
- **Workforce benefits:** A sustainable workforce impacts directly on the quality of care that is delivered and outcomes for patients. Our clinical model ensures that the workforce will be enabled to deliver the best possible care.
- **Technology benefits:** A new model creates the opportunity to use cutting edge technology to support care, including electronic patient records, use of robotics, electronic monitoring in wards and critical care, and an online patient portal to ensure patients are involved in their care.
- **Estates benefits:** Fit for purpose facilities also offer clinical benefits. Such facilities offer direct benefits by being more efficient and easier to maintain and clean, and ensuring a much reduced risk of hospital-acquired infection as well as offering a better environment for healing.

These are general benefits of the clinical model. Specific ways of delivering the clinical model may have specific benefits. This is outlined in Section 13.5.

6.2 Clinical benefits

We used a consistent benefits framework to identify intended impacts of changes from the clinical model.

This has been used to understand the impact of changes to be understood across the clinical model. The framework considers the inputs, outputs and outcomes of the emerging clinical model:

- **Inputs:** The elements of change within the new clinical model. This included, for example, pathway redesign, changes to opening hours or new models of working.
- **Outputs:** What the changes achieve. This included, 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 included, for example, reduced avoidable deaths, morbidity, improved satisfaction and team work.

The overall benefits of the clinical model are outlined in the figure below.

Table 34: Applying the benefits framework to the overall clinical model

Benefit	Input	Output	Outcome
Improving patient experience	<ul style="list-style-type: none"> • 21st century estates that improve the care environment for patients and working environment for staff 	<ul style="list-style-type: none"> • Patients treated in most appropriate care settings, closer to home where possible 	<ul style="list-style-type: none"> • Improved patient satisfaction • Reduced number of complaints
Improving patient access	<ul style="list-style-type: none"> • Improved access to multi-professional teams, including introduction of Core24 psychiatry services • Patients treated in most appropriate care settings, closer to home where possible 	<ul style="list-style-type: none"> • Decisions about treatment are made earlier by senior clinicians 	<ul style="list-style-type: none"> • Meeting NHS Constitution targets (4 hour A&E target, 18 ww targets) • Improved support for patients with mental health co-morbidities
Decreasing unwarranted variation in quality, safety and outcomes		<ul style="list-style-type: none"> • Reductions in number of investigations undertaken • Reductions in average lengths of stay • Reduced admission and readmission rates • Reduced number of serious incidents • Reduced healthcare acquired infection rates 	<ul style="list-style-type: none"> • Compared with peer trusts: • Reduced mortality rates • Reduced morbidity rates • Reduced lengths of stay
Solving workforce challenges	<ul style="list-style-type: none"> • Co-location of major acute services • Improved consultant presence on major site • Reduced staff sickness/turnover 	<ul style="list-style-type: none"> • Improved workflow • Improved training and supervision for junior staff 	<ul style="list-style-type: none"> • Brings teams closer together • Reduces gaps in rotas • Improved multi-disciplinary approach to care • Improved staff satisfaction

Data for outputs and outcomes were compared between ESTH, surrounding non-specialist trusts and national peer comparator trusts. In particular, ESTH's performance was compared against the top 25% performing organisations for each metric.

National data sets have been used across the five domains within the benefits framework to define the potential benefits of the clinical model. Whilst, in general, ESTH performs well against its peers, there are opportunities in each domain where the clinical model could improve outputs and outcomes towards becoming 'best in class'.

Moreover, in those areas in which ESTH compares favourably with peers (such as patient experience), the proposed clinical model has been tested to ensure its strong performance can be maintained as pressures (such as from increasing case-mix complexity) continue.

The analysis against the domains is set out below.

6.2.1 Improving patient experience

We have used the Friends and Family Test (FFT) to establish areas where it might be possible to improve patient experience. The percentage improvement that may be possible to achieve to reach the peer quartiles is shown below.

Table 35: Areas for improving patient experience

Metric	ESTH value (ESTH Quartile)	Top quartile result (regional peer)	% improvement to regional peer quartile	Top quartile result (most similar peer)	% improvement to most similar peer quartile
Inpatient experience	93% (Q4)	97%	5%	98%	5%
Outpatient experience	92% (Q4)	96%	4%	97%	5%
Maternity experience	96% (Q3)	100%	4%	99%	3%

The FFT asks people if they would recommend the services they have used and offers a range of responses. The FFT has produced more than 48 million pieces of feedback so far making it the biggest source of patient opinion in the world.²⁰⁰

Further benefits of the clinical model for patient experience include:

- Patients presenting at the emergency department requiring emergency surgery and/or ITU would not require a transfer due to the co-location of services.
- Core24 psychiatry introduced as a major acute service with liaison psychiatry (in reach) as a district service better integrates mental health services. Classifying mental health services as district hospital services allows enhanced access and improves quality for patients with mental health needs.
- Improved consistency, continuity and efficiency of district services, with enhanced personalisation and integration improving the quality and of care across the pathway.
- Support for and alignment with local plans to improve maternity services across the area. Low risk antenatal care and postnatal care delivered as a district hospital service and offered closer to home.

For ESTH, it is clear that patient experience could be improved across inpatient, outpatient and maternity services to reach the upper quartile of its peers. Changes to the clinical model could result in improvements to patient experience, through increased consultant presence to clinical standards for major acute services, as well as being able to access outpatient and maternity services closer to home as part of the district services model.

6.2.2 Improving patient access

Co-location of major acute services and improved consultant cover to clinical standards can improve efficiency, which may therefore result in a reduction in median waiting times for elective admissions and interventions.

Consultant-led Referral To Treatment (RTT) waiting times, which monitor the length of time from referral through to elective treatment, has been compared for ESTH against its regional and most similar peers as per the table below.

Nationally the target is for 92% of patients to be treated within 18 weeks of referral.

²⁰⁰ <https://www.england.nhs.uk/fft/>

Table 36: Areas for improving patient experience

Metric	ESTH value (ESTH Quartile)	Top quartile result (regional peer)	% improvement to regional peer quartile	Top quartile result (most similar peer)	% improvement to most similar peer quartile
General surgery median waiting time (weeks)	7.82 (Q3)	6.67	15%	5.66	28%
General medicine median waiting time (weeks)	6.18 (Q2)	5.61	14%	5.06	18%
General surgery referral to treatment 18 week target	85% (Q3)	93%	9%	93%	9%
General medicine referral to treatment 18 week target	86% (Q3)	99%	14%	99%	14%
Total (all specialties) median waiting time (weeks)	7.04 (Q3)	6.20	12%	5.91	16%

The analysis shows that there is an opportunity for ESTH to improve its performance to peer quartiles. The median waiting times for general surgery and general medicine in particular are below those of its top quartile peers. Changes to the clinical model to allow planned care to be planned more effectively through better use of the workforce can positively impact on the ability for these targets to be met, and thereby improve both patient experience and outcomes. Earlier diagnosis and treatment of conditions can only be beneficial to patients and our clinical model will allow this.

The table shows the opportunity that a different, more effective clinical model can provide. Enhancing consultant cover across these key specialties and ensuring that rotas are staffed appropriately allows for more effective management of waiting lists, leading to a reduced referral to treatment time.

In addition, the proposed changes within the district services model are expected to have a positive impact on the care offered to patients. This includes:

- The urgent care needs of patients are met locally through UTCs with a specification that goes beyond national standards. 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. This also reduces the need for patients to travel multiple times, improves utilisation of resources, increases throughput and reduces cancellations, and can improve speed of diagnosis.
- Offering dedicated district services for planned care, maintaining access and offering care close to home, and maintaining the highly effective SWLEOC model.

6.2.3 Decreasing unwarranted variation in care, quality and outcomes

There are wide variations in healthcare across the NHS. In some cases, there are good reasons for variation, but in other cases the reasons for variation are unwarranted which offers opportunities for improvement.

The table below shows how ESTH is comparing for key metrics of care and where there is variation. The hospital standardised mortality ratio (HSMR) focusses on deaths that occur within hospital and adjusts for factors such as social deprivation. 28 day readmission data shows where patients have had to return to hospital following a previous admission within 28 days.

The reasons for variation in these metrics are complex and there will be many factors contributing to these figures. However it does suggest that ESTH can improve patient outcomes to become 'best in class'.

Table 37: Areas for decreasing unwarranted variation

Metric	ESTH value (ESTH quartile)	Top quartile result (regional peer)	% improvement to regional peer quartile	Top quartile result (most similar peer)	% improvement to most similar peer quartile
HSMR (across specialties)	95.07 (Q3)	77.24	19%	95.88	-1%
28-day readmission (across specialties)	108.81 (Q4)	91.98	15%	Insufficient data	Insufficient data
Deaths after surgery (across specialties)	53.13 (Q1)	55.85	-5%	86.23	-62%
Complications of care (across specialties)	4.09 (Q4)	2.85	30%	2.60	36%

These metrics are shown as a range as there is variation across specialties as to the extent to which performance could improve to peer quartile levels. These figures are an indication of what could be possible, however as stated above reasons for variation are complex.

6.2.3.1 Length of stay considerations

Reductions in LOS are expected to be driven by a number of factors:

1. Meeting clinical standards: Meeting acute clinical standards (including seven-day service standards) and enhancing consultant cover in key specialties (emergency department, critical care, acute medicine, emergency surgery) increases the timeliness and appropriateness of decision-making, leading to reductions in both length of stay and rates of admission (Knowles et al., 2018; NHS England, 2013; Imison et al., 2015).
2. District hospital services: Offering district hospital beds as part of a two-tiered model means both 'step-up' and 'step-down' beds are available, enhancing patients flow through hospital to reduce overall lengths of stay (National Audit of Intermediate Care Provider Report, 2014; Imison et al, 2015).
3. Out of hospital services: Enhanced integrated community provisions helps support discharge planning and ensure patients are discharged in a timely manner. To date, the enhanced discharge team that forms part of the @home team at Epsom Hospital has reduced average length of stay by 1 day and looks after a ward of patients in their own homes.
4. Enhanced adjacencies: Redesigning hospital facilities enables key departments to be located next to each other, reducing the time needed for patients to flow through the hospital (e.g., locating diagnostics next to the emergency department).
5. Improved facilities: The design of fit-for-purpose hospital buildings offers improvements in patient flow and length of stay (The Hastings Centre 2011). These include:
 - Reducing direct length of stay by up to 10% through enhanced recovery, including larger windows, improved natural light, noise-reducing measures and a healing environment.
 - Reducing patient transfers by up to 60% through acuity-adaptable rooms.

- Reducing adverse drug events by up to 20% through larger private rooms, acuity-adaptable rooms, medication task area lighting, noise reduction measures and e-ICU.
- Reducing healthcare acquired infections by up to 20% through larger rooms, hand-hygiene facilities, HEPA filtration and improved indoor air quality.

6. BAU: The Trust will continue to deliver its CIPs and performance improvement initiatives to reduce LOS.

6.2.3.2 Review of clinical benefits on decreasing unwarranted variation

District hospital beds enable patients to be treated closer to home, enhance the flow through hospitals (reducing length of stay) and reduce demand for major acute services²⁰¹. A reduction in the length of stay is achieved through the step up (prevention of deterioration that could lead to an admission to hospital) and step down pathway from major acute services. As a result, it has been estimated that England needs double the current capacity for district beds to meet demand²⁰². The areas with the highest bed use have been found to have longer lengths of stay for patients who were in hospital while transitioning between home and a place that meets their current health and care needs²⁰³. District hospital services may enable this transition and thereby reduce overall length of stay.

Delivering major acute standards and co-location of major acute services will result in benefits for patients and staff through improved quality of care. The clinical model will ensure that major acute standards are met to ensure consultant cover and associated quality benefits. This includes:

- In the **emergency department**, there is evidence care provided where senior doctors are supervising is more effective than care provided by more junior doctors. There is also evidence to suggest consultant presence in the emergency department overnight can reduce length of stay and rates of admission.²⁰⁴
- In **acute medicine**, lack of consultant input has been found to be a contributor to poor-quality care. The Royal College of Physicians recommends early senior review of patients admitted as an emergency. There is a wide variation in the number of consultants per head of the population across the country, and the RCP has found a correlation between consultant staffing levels and hospital standardised mortality ratios²⁰⁵. Co-location of acute medicine with emergency surgery in hospitals accepting unselected medical emergencies is recommended by the Royal College of Surgeons in case urgent surgical intervention is required. If surgery is off-site it says that strictly audited clinical pathways must be in place²⁰⁶. A recent study by the Nuffield Trust recommended that as a core principle smaller hospitals will need to be able to deal with all types of emergency medical cases and need to have the capability to deal safely, quickly and expertly with all patients for at least the first 2 to 3 hours of their care.²⁰⁷
- For **critical care**, the evidence is more mixed, however there is evidence that mortality risk is sensitive to a strained intensive care unit capacity.²⁰⁸

²⁰¹ National Audit of Intermediate Care Provider Report, 2014

²⁰² National Audit of Intermediate Care Report, 2017

²⁰³ Imison C, Poteliakhoff E, Thompson J. *Older People and Emergency Bed Use: Exploring Variation*. London: The King's Fund; 2012

²⁰⁴ Knowles E, Shephard N, Stone T, Bishop-Edwards L, Hirst E, Abouzeid L, et al. *Closing five Emergency Departments in England between 2009 and 2011: the closED controlled interrupted time-series analysis*. Health Serv Deliv Res 2018;6(27).

²⁰⁵ Royal College of Physicians. *Hospital Workforce. Fit for the Future?* London: RCP; 2013.

²⁰⁶ Royal College of Surgeons of England. *Emergency Surgery: Standards for Unscheduled Care: Guidance for Providers, Commissioners and Service Planners*. London: RCS; 2011

²⁰⁷ *Rethinking acute medical care in smaller hospitals*, Nuffield Trust, October 2018

²⁰⁸ Hall et al, *Association between afterhours admission to the intensive care unit, strained capacity, and mortality: a retrospective cohort study*, Crit Care. 2018 Apr 17;22(1):97.

- For **emergency surgery**, consultant-led emergency surgery has been associated with improved provision of care, resulting in timely management and improved clinical outcomes²⁰⁹.
- Delivering standards for **obstetrician-led births** will mean emergencies can be responded to safely at all times. Obstetricians provide interventions in emergencies to ensure good outcomes for mother and baby, such as caesareans and instrumental deliveries. However, obstetricians have traditionally not been present during the night, and there is evidence of worse outcomes when delivery takes place out of hours. Interventions and delivery complications have been found to be more likely to occur out of hours. Delivery outside the normal working week has been associated with increased risk of neonatal death due to extreme oxygen deprivation during birth. It is argued that the lack of consultant presence offers an explanation for the poorer outcomes. Two other studies found that more consultants were associated with improved outcomes, including fewer stillbirths and fewer readmissions²¹⁰.

Further benefits include:

- Maintaining co-dependencies to ensure a safe service. For example, this includes co-locating the emergency department, emergency surgery and critical care facilities to ensure the availability of key services in an emergency.
- 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.
- Obstetric led births is co-located with emergency surgery and critical care for all births in case these services are required.
- There will be continued provision of a separate neonatal rota, ensuring dedicated staff are available.

6.3 Addressing workforce challenges

Central to the delivery of high quality care is the workforce. The NHS staff survey is carried out annually and provides an overview of staff satisfaction by organisation. Several of these metrics most relevant to our challenges have been analysed against ESTH's peers, as in the table below.

²⁰⁹ Shakerian et al, Outcomes in emergency general surgery following the introduction of a consultant-led unit, 2015
<https://doi.org/10.1002/bjs.9954>

²¹⁰ Imison

Table 38: Areas for improving workforce sustainability

Metric	ESTH value	Top quartile result (regional peer)	% improvement to regional peer quartile	Top quartile result (most similar peer)	% improvement to most similar peer quartile
Improvement in staff sickness and absence rate	5.20 (Q4)	3.59	31%	4.50	14%
Percentage of staff satisfied with flexible working patterns	48% (Q3)	54%	13%	54%	14%
Staff recommendation of the organisation as a place to work or receive treatment	3.70 (Q2)	3.99	8%	3.84	4%
Staff satisfaction with resourcing and support	3.23 (Q2)	3.43	6%	3.38	5%
Staff satisfaction with the quality of work and care they can deliver	3.88 (Q2)	4.04	4%	3.99	3%

Our clinical model aims to make best use of the workforce. It will:

- Decrease the unsustainable strain on clinicians by increasing the level of cover to recognised standards;
- Improve training opportunities for junior clinicians through greater access to specialists;
- Provide a wide range of career opportunities across all clinicians, including allied health professionals, doctors and nurses, with opportunities to take on new and evolving roles;
- Reduce sickness and absence rates with a decreased workload reducing stress and tiredness;
- Enhance attractiveness and recruitment through providing additional opportunities for training, a beneficial work environment and career opportunities;
- Reduce use of bank and agency through more effective cover of the rotas through existing staff; and
- Change the skill mix of the workforce by ensuring consultant cover meets major acute standards.

A sustainable workforce impacts directly on the quality of care that is delivered and outcomes for patients. Our clinical model ensures that the workforce will be enabled to deliver the best possible care and thereby increase staff satisfaction.

The clinical model will enhance training opportunities resulting in improved skills across the workforce and improved recruitment and retention.

- There will be additional sustainable specialist 24/7 on call consultant rotas, that might include an acute physician medical take, on site emergency endoscopy, cardiology, paediatrics, critical care and other services.
- There will also be larger teams with more opportunities for teaching, training and support, with higher activity levels on the major acute site for some services with a more varied and specialist case mix.
- As the clinical model progresses, and national guidance is established, nurses and AHPS will develop new ways of working and develop further competencies.

- The clinical model also describes new roles for physician associates and health care assistants
- Training opportunities from the Royal College would be improved with greater exposure to a larger take. This will improve the view staff have of the care they are delivering and work satisfaction rates.

6.4 Technology

With re-designed facilities, ESTH would have the opportunity to invest in and implement the latest technologies, to improve the quality and efficiency of healthcare. This would include investment across a number of areas.

- **Electronic Patient Records (EPRs)**, to deliver a paperless record for each patient that can be shared with other providers. This can reduce errors, help to improve the integration of care across different providers and reduce the need for paper, supporting the environment.
- **Use of robotics** to deliver services, including robotic pharmacy stores. This will improve the efficiency of clinical services, reduce clinical errors and ensure patients receive care as quickly as possible.
- **Electronic surveillance systems** in wards and critical care units, to allow doctors and nurses to improve care and shorten patient stays in hospital; as well as help to ensure effective monitoring of patients in single rooms.
- **The development of an online portal**, for provider and patient communication, as well as appointment scheduling. This would help to improve patients' experience by giving patients greater visibility and control over their care.

Digital links between hospitals sites are already in place and have resilience and redundancy built in. The future architecture, likely to be wholly secure cloud-based would ensure even greater resilience and availability of data as there would be no single points of failure.

Aligning with the NHS LTP and our digital strategies, we will ensure clinicians can access and interact with patient records and care plans wherever they are, and create straightforward digital access to NHS services, and help patients and their carers manage their health.

ESTH already has a proven track record of effectively operating across multiple hospital sites and teams. The current infrastructure and applications allow for seamless working for clinicians accessing digital care records at which ever site they are treating patients. There is a single infrastructure that permits this, including with access to imaging via PACS.

One of the constraints of the current systems is that some records (such as inpatient notes) are paper based. This is mitigated to a degree with all digital material being available in core outpatient settings, even those away from the main hospital sites. Plans for a replacement PAS/EPR would be fully digital thereby mitigating this issue completely. While plans are being developed for a PAS/EPR replacement, including exploring opportunities for a collaborative solution across south west London, our current digital strategy is based around 3 themes:

- Fixing the basics
 - Rolling programme for network, server, data centre infrastructure and PC replacement
- Building on existing investments
 - ePrescribing on top of the existing PAS/EPR
 - automation to import e-referral letters directly
 - auto-creation of ED letters using existing technologies
 - using existing systems to run virtual fracture clinics
- Innovating where possible:

- electronic whiteboards on adult wards highlight at risk patients
- aid patient flow visualising patient data from disparate systems

In 2019/20 ESTH will have an Enabling IT cross cutting work stream, maximising investments beyond those traditionally managed within the IT function.

As per SEC clinical senate recommendations, the system will ensure that amongst other methods:

- The production of clinical pathways and guidelines co-designed by primary care, all relevant specialities and patient representation should be prioritised
- Each specialty/department will have a single point of telephone access
- For urgent calls to on call specialists, trusts should ensure their telephony systems have a single point of access for GPs (and other clinicians)
- We will aim to develop Integrated Digital Care Records (IDCRs) that integrate key patient related data

ESTH is committed to delivering the significant digital enhancements in advance of, and as preparation for new ways of working that will be maximised in a new single acute facility. ESTH has modelled in its current draft five year plan, aligning with SWL LTP and Surrey Heartlands LTP and digital strategies, the delivery in a collaborative way a replacement PAS/EPR during the next five year period. Through this route, ESTH aspires to attain HIMSS level 6.

ESTH is in the process of deploying new clinical IT within Surrey Downs Health and Care to enable greater integration of primary and community care, and is planning the same approach for Sutton Health and Care in 2020/21. This will enable GPs and community staff to view records seamlessly and have tasking functionality across different settings built in.

This will align with local plans for sharing of records more widely such as through the SWL HIE, London LHCRE and Surrey Heartlands LHCRE. This approach will enable the district hospital approach for elective and non-elective care to be pursued ahead of the move to a single acute facility for major acute services.

6.5 Estates

Fit for purpose facilities itself will also offer clinical benefits. Such facilities offer direct benefits by being more efficient and easier to maintain and clean, and ensuring a much reduced risk of hospital-acquired infection such as *methicillin-resistant Staphylococcus aureus* (MRSA) or *Clostridium difficile* (C. Diff), as well as offering a better environment for healing.

Epsom and St Helier hospitals both have significant estates challenges, as shown in the most recent PLACE report in Figure 46.

Figure 46: St Helier and Epsom Hospital scores against the national average



The Trust would adopt features of hospital design that evidence suggests should improve care:

- Larger single rooms: Using single-patient rooms to reduce infection, reduce adverse drug events and patient falls, and improve patient satisfaction. Larger rooms will also allow family members to stay overnight, increasing their involvement in care.
- Acuity adaptable rooms: By providing infrastructure for monitoring equipment in patient rooms the Trust intends to avoid diagnostic and treatment delays, reduce medical errors and patient falls, reduce staff workload, and increase satisfaction

- Larger windows: By providing better natural light and views, patient recovery and patient experience should be improved.
- Enhanced indoor air quality: The trust will improve air filtration by exhausting air after a single use, aiming to reduce infection rates
- Decentralised nursing substations and larger wards: The Trust will use decentralised stations which allow nurses to see into patient rooms and respond to problems quickly, reducing falls and enabling nurses to spend more time delivering direct patient care.
- Hand-hygiene facilities: By providing access to sinks in all patient rooms and other points of care, the new facilities will help reduce the spread of pathogens.
- Medication task area lighting: The Trust will improve the lighting in medication task areas, intending to reduce medication errors as clinicians will be able to read medication labels and prescriptions more accurately.
- Noise-reducing measures: The Trust will reduce the noise in hospital for patients and staff through a combination of sound-absorbing acoustical ceiling tiles, using carpeting where possible, utilising sound-absorbing finishes, building noise and vibration-isolated mechanical rooms, giving staff wireless pagers, offering space for private discussion, reducing alarm sounds, and building single-patient rooms. This can contribute to patients having a better night's sleep, recovering more quickly and having a better experience.
- Art and gardens: The Trust will use art, music and garden design to reduce anxiety and depression in patients, speed recovery and offer patients and their family's restorative contact with nature and positive distractions.²¹¹

Overall this should translate into fewer patient falls and transfers, fewer adverse drug events and infections, an improved patient experience and shorter stays in hospital.²¹²

Refurbished and new hospitals create an improved estate, which reduces the cost of managing these buildings. Specific improvements are expected to include:

- Energy: efficient buildings, including energy-conserving features, fuel-efficient heating and cooling, improved glazing and heat recover systems, reduce energy costs and CO2 emissions
- Water demand: Features such as low-flow fixtures, rainwater captures, and high-efficiency food service equipment reduce demand for water.
- Maintenance: A new building requires less maintenance, and the Trust will be able to move from reactive to proactive maintenance.
- Cleaning: New buildings are easier to clean, with fewer odd corridors and rooms.
- Patient transfers: Fewer patient transfers means lower portering and lift costs.

²¹¹ Fable Hospital 2.0: The business case for building better health care facilities, 2011, The Hasting Centre

²¹² Fable Hospital 2.0: The business case for building better health care facilities, 2011, The Hasting Centre

Figure 47: What we learned from our engagement with local people on the clinical model²¹³

What we learned from our engagement with local people

Within our Issues Paper, the key question for consideration was:

- Do you think our vision, based on greater prevention of disease, improved integration of care and the delivery of enhanced standards in major acute services, is the right vision for this area?

Key themes arising in response to this include:

- Broad support for the vision and in particular the benefits of integration of care and the need for more focus on prevention; and
- Concerns expressed about how realistic it is to deliver the vision given current structures and ways of working, the financial situation in primary and secondary care and staff shortages across the NHS.

We also held focus groups for specific areas of the clinical model.

For the emergency department:

There was concern that locating acute services to one of the three hospitals only would place more pressure on the 'chosen' hospital for example, increases in waiting times at A&E (especially based on current experience). However, there was also a view that if these solutions were being proposed to alleviate pressure on A&E services then there should be more education to stop people using A&E as a 'walk-in' centre.

For maternity services:

Some participants used neighbouring hospitals so did not feel they would be impacted by this. Some others felt that as long as they could get somewhere then it would not be an issue. Travel and childcare were seen as important considerations when making a final decision about potential solutions.

For paediatric services:

There was concern about the impact of all the solutions on travel times and potentially increased waiting times. While the benefits of having specialist services in one place (a "super" hospital) was recognised, there was also a feeling that the scope of paediatric services was so vast that patients might lose out from centralisation and that there would be a benefit in retaining both sites. Some also felt that "super hospitals" would work if they were centrally located but none of the proposed solutions were.

What we have changed

We have reviewed the clinical model since the publication of the *Issues Paper*:

- We have reviewed the UTC opening hours to ensure they are in line with national guidance and open 24/7;
- We established a maternity and paediatrics task and finish group which has further assessed the potential impact of any changes on patients;
- We have developed a workforce model which assesses the impact on staff numbers required; and
- We have reviewed the provision of out of hospital care to ensure that we can provide a model that is aligned to wider initiatives that will enable the integration of care between different services and organisations.

²¹³ Improving Healthcare Together 2020 – 2030, Independent analysis of feedback from public engagement, The Campaign Company, 2018

7 OPTIONS TO DELIVER THE CLINICAL MODEL

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

Our case for change (see Section 2) is clear that clinically, our issue is with supporting emergency department and acute medicine services. Due to the co-dependencies described in Section 5.5.7.2, this means all major acute services need consideration.

Therefore, to develop our potential solutions, two assumptions were made: that service co-dependencies must be maintained and 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.

To create a long list of potential solutions that could address our case for change and deliver our clinical model, we considered four ways that services can be organised. These dimensions can be combined in any way. This generated our long list, which is every combination of the different responses to each dimension.

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

7.1 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 included addressing our case for change and delivering our clinical model.

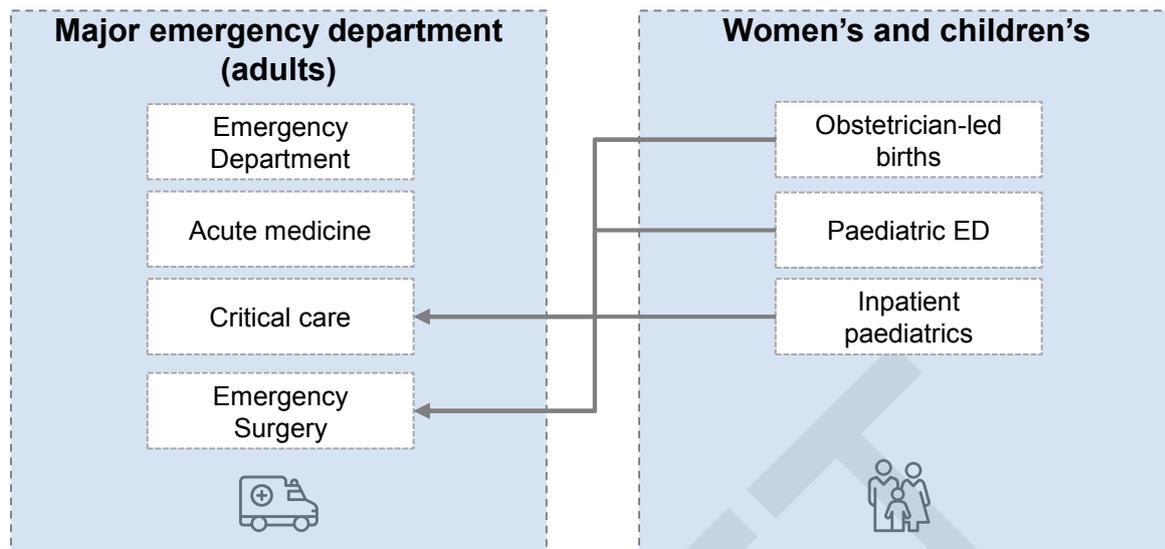
Our clinical model (see Section 5) identified that there is a difference between district hospital services and major acute hospital services.

- Within the clinical model, **the provision of district hospital services on existing sites will continue or be enhanced**. 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 48: Selected major acute hospital service dependencies



7.1.1 Focus of potential solutions development

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

Our case for change (see Section 2) is clear that clinically, our issue is with supporting emergency department and acute medicine services. Due to the co-dependencies described in Section 5.5, this means all major acute services needed consideration.

However, there was 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 considered investments in estates to support ongoing delivery of these services, but this does not require major service change. Therefore, potential solutions development did not consider changing the location of district hospital services.

Therefore, to develop our potential solutions, two assumptions were 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.

7.2 Identifying potential solutions

7.2.1 Identifying potential solutions

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

We 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 were focused on the widest range of potential solutions. The feasibility and appropriateness of these potential solutions was considered at later stages, through both our initial tests (see Section 9.1.2) and subsequent analysis of a shorter list of potential solutions.

7.2.2 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 9.1), 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 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.

7.2.3 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 5.5.7.2) 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 7.2.2. 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.

7.2.4 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 identified two options:

- Consultants employed within the combined geographies only are used, meaning we rely on the expected workforce within the combined geographies. This included 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.

7.2.5 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.²¹⁴ 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 had 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 had more than one major acute hospital within our combined geographies would need more than one site. Any potential solution that did not have a major acute hospital within our combined geographies would not need a site (these are described in Section 7.2.2.).

7.2.6 Potential solutions

The four ways that services can be organised (dimensions) are summarised in Figure 49.

Figure 49: 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.

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

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

²¹⁴ *London Cancer Hub* <https://www.londoncancerhub.org/>; *The London Cancer Hub* <https://www.opportunitysutton.org/sutton-for-investment/the-london-cancer-hub/>

As we could not analyse in detail this long list of 73 potential solutions, and many of these potential solutions would not be feasible, we needed to apply our initial tests to identify potential solutions that merit further detailed consideration. This is set out in Section 9.1.

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8 PROCESS FOR ASSESSMENT OF OPTIONS

The combination of the dimensions (the number of major acute hospitals in the combined geography, the major acute services offered, using additional workforce and sites used) resulted in a comprehensive long list of 73 options based on the aspects we have considered.

In order to assess the options for addressing the case for change and delivering the clinical model, we continued to follow the standard approach for options consideration. This involved defining the initial tests to apply to the long list to establish a short list, as well as non-financial and financial evaluation criteria to evaluate the short list.

To enable us to understand the relative strengths of the different options available, we needed to assess the options against each other and against continuing with the current configuration of services. This meant we needed to move from a long list of 73 options to a shorter list we could analyse in detail, and then assess these shortlisted options against defined criteria.

To enable us to do this we continued to follow the standard approach for considering options and:

- Defined and applied a series of initial tests to eliminate options that we do not believe are deliverable or feasible. This resulted in a short list of options.
- Defined and applied a set of non-financial criteria to the short list, co-designed and jointly applied by the public and professionals. This resulted in a set of non-financial scores for the different options.
- Applied a set of financial metrics to the short list, based on regulatory requirements and best practice. This resulted in a set of financial metrics for the different options.

In addition, we also considered the impact on local providers of each of the short listed options.

Our process for evaluation and short listing was open and involved the public. Our initial tests and consequent short list were described in the Issues Paper and tested through public engagement (see Section 4). Our non-financial criteria and non-financial scoring were developed with and by members of the public through a best practice process of co-design (see Section 3.4). All our analysis and scoring was transparent and will be further tested through consultation (see Section 17).

These tests, criteria and supporting analysis are described in the following sections:

- The initial tests and their application are described in Section 9, followed by the resulting short list in Section 10.
- The non-financial criteria and associated scoring are described in Section 12.
- The financial metrics and results are described in Section 13.

All this information was considered by our Governing Bodies when making any decisions.

9 INITIAL TESTS

Our long list was refined by testing the viability of potential solutions against three initial tests. We applied these tests, aligned to our case for change, to this long list to reach a shorter list we considered in detail. The most important of these concerns was our collective commitment to maintaining services within our combined geographies, so long as a viable potential solution was available. Our other two tests concerned deliverability based on available workforce and estates.

9.1 Initial tests for potential solutions

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

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

9.1.1 Principles for initial tests

Initial tests provided a consistent framework through which potential solutions were refined.

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

Initial tests had to:

- 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 ensured we had an effective set of tests that supported our local aims and meaningfully helped 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 passed our tests.

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

9.1.2 Three initial tests

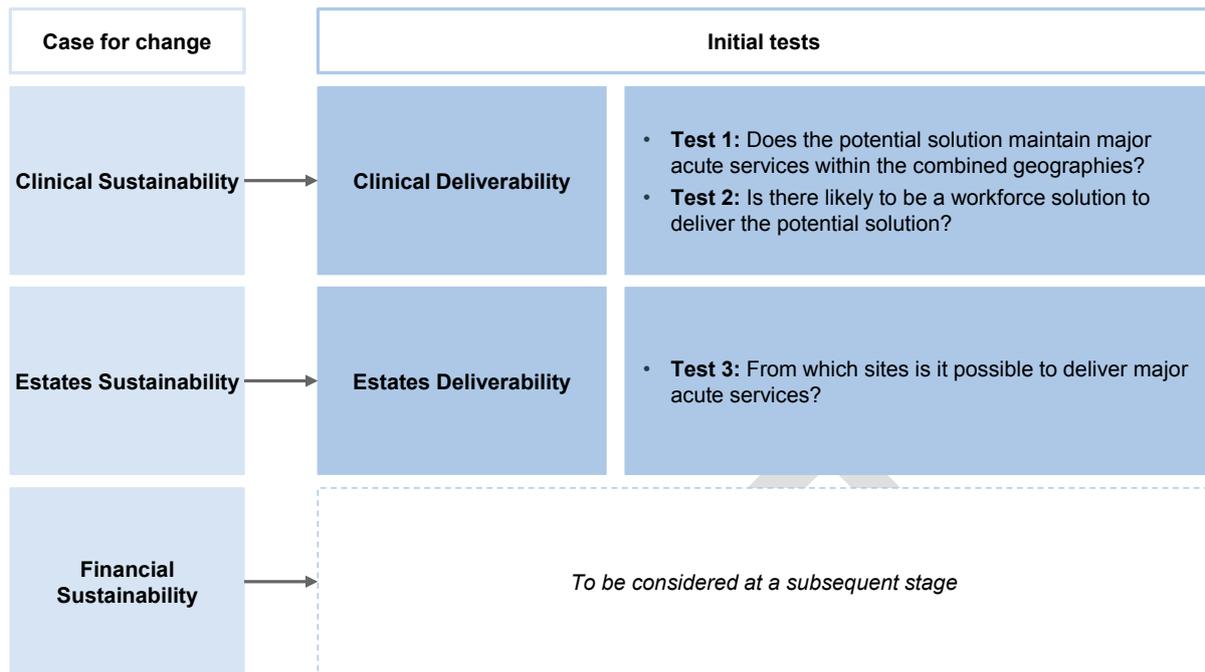
We identified three initial tests that align to the case for change and focus on ensuring potential solutions are feasible.

Based on clinical and estates deliverability, we 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 50. We did not at this stage included any initial tests of financial sustainability (including affordability and impact on the overall system financial position). This was considered at a subsequent stage of the analysis.

Figure 50: Initial tests



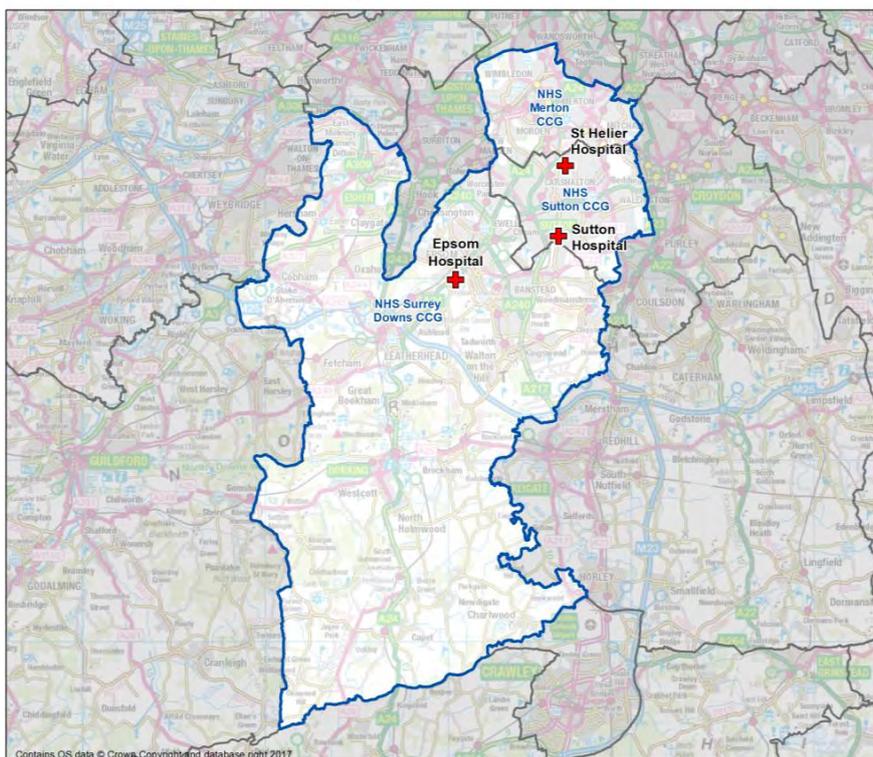
Each of these tests was applied sequentially – that is, potential solutions that failed a previous test were ruled out of consideration for subsequent tests.

It was agreed that these initial tests may be revisited if no shortlisted potential solutions were viable.

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

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

We 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 51). This commitment is reiterated in our case for change, where we commit to maintaining the provision of acute services within our combined geographies.

Figure 51: Combined geographies of Surrey Downs, Sutton and Merton ²¹⁵

We understand that maintaining services in our local areas is important. This was 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.²¹⁶

In addition to the importance of providing these services to our population, maintaining major acute services within the geography is needed to minimise travel times for the population as well as minimise the impact of increasing demand on other providers.

- The impact on travel time for the population of removing major acute services from the geography would be substantial. Initial analysis shows that average car travel times would double, and the impact on those travelling by public transport would be even greater.
- Analysis showed that the impact of removing major acute services from the geography has a significant impact on other providers which is unlikely to be sustainable. Delivering district services and major acute services elsewhere would have an even greater impact on other providers.
- The strategic intent within the SWL discussion document is clear that at least four major acute sites within the geography is required.²¹⁷
- Evidence from the literature suggests that major acute services should be provided to a population of 500,000, which means that these services need to be provided in the local area²¹⁸.

²¹⁵ Improving Healthcare Together 2020-2030 analysis.

²¹⁶ Epsom and St Helier 2020 - 2030 Your views (2017) <https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93jijm4n8161.pdf&ver=19815>

²¹⁷ SWL discussion document

²¹⁸ Delivering High-quality Surgical Services for the Future, Royal College of Surgeons (2006)

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.

9.1.2.2 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.

This gap in consultant staffing is based on the standards set by SWL STP.²¹⁹ 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 16/7.²²⁰ RCEM recommends 12–16 consultants to provide cover 16/7.²²¹ 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 12**).²²² 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.

Table 39: Consultant hours of cover and headcount to meet standards²²³

Service	Hours of cover	Min number of consultants on rota (per site)
Emergency department²²⁴		
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

²¹⁹ *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.

²²⁰ *Epsom and St Helier University Hospitals NHS Trust: Quality report* (2018) http://www.cqc.org.uk/sites/default/files/new_reports/AAAH0093.pdf

²²¹ *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>

²²² *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>

²²³ *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.

²²⁴ Emergency department requirement expressed in WTE.

Service	Hours of cover	Min number of consultants on rota (per site)
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
Paediatrics²²⁵		
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	10 ²²⁶
Acute medicine²²⁷		
Requirement to meet the standards	14/7	12
Intensive care²²⁸		
Requirement to meet the standards	12/7	9

9.1.2.3 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 was a preliminary assessment. Detailed space and site planning followed 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).

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

A number of potential solutions included 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

²²⁵ Minimum hours also require on call.

²²⁶ Separate specialist paediatrics rota.

²²⁷ Minimum hours also require on call.

²²⁸ Minimum hours also require on call.

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 failed our first test.

Each of these potential solutions meant 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 did not meet our requirement of this first test; these potential solutions are therefore ruled out.

This reduces our list to 50 potential solutions.

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

We needed 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 was based on our standards. However, the expectation of c. 12 emergency department consultants per unit also aligns with national guidance from the RCEM.²²⁹

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

Table 40: ESTH consultant headcount against standards²³⁰

Service	Total requirement (two sites)	Current consultant staffing	Gap (two sites)
Emergency department ²³¹	24	14	10
Obstetrics	22	26	-

²²⁹ 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) <https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf>

²³⁰ *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.

²³¹ Emergency department requirement expressed in WTE.

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) relied 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.

9.3.1 Training new consultants

It did 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 2021.²³²

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 41. 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.

Table 41: SWL projected gaps to standards and expected availability of new consultants²³³

Service	Projected SWL gap	Total availability of new consultants in SWL to cover all new posts
Emergency department ²³⁴	21–29	18–21
Obstetrics	2	11
Emergency general surgery	2	7
Paediatrics	3–7	12–16
Acute medicine	23	29

²³² 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>

²³³ 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.

²³⁴ Emergency department requirement expressed in WTE.

9.3.2 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).²³⁵

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.²³⁶

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.²³⁷

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.²³⁸

²³⁵ *Securing the future workforce for emergency departments in England* (2017)

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

²³⁶ *Securing the future workforce for emergency departments in England* (2017)

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

²³⁷ *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>

²³⁸ *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>

Table 42: Medical and dental vacancies (medical and dental pay scales only), WTE, selected specialties, October 2016–September 2017²³⁹

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 ²⁴⁰	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.
- **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.

²³⁹ 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>

²⁴⁰ Excluding –ologies and surgery.

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.

9.3.3 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 18):

- 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.

9.3.4 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 only considered 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 needed to meet our standards with 14 emergency department consultants and 11 acute medicine consultants.

Based on our standards, and relevant RCEM guidance, this supported 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 meant 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 reduced our list to four potential solutions:

- 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.
- A single major acute site at another site, 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.

Table 43: Consultant workforce requirement for two sites and one site

Service	Current consultant staffing	Min requirement (two sites)	Gap (two sites)	Min requirement (one site)[*]	Gap (one site)
Emergency department^[1]	14	24	10	12	None
Acute medicine	11	24	13	12	1
Intensive care	7	9	2	9	2
Emergency general surgery	10	10	0	10	None
Paediatrics	26	24	0	12	None
Obstetrics	26	22	0	12	None

[*] emergency department, obstetrics and paediatrics volume dependent

^[1] Emergency department requirement expressed in WTE.

Table 44: Consultant staffing against clinical standards, SWL trusts²⁴¹

Consultants	Acute trust	Emergency department	Obstetrics	Emergency general surgery	Paediatrics	Acute medicine ²⁴²	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 ²⁴³	24	22	10	24	24	9
	SWL	72–80	71	40	62–66	60	54
Current gap (2017)²⁴⁴	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	30–31 ²⁴⁵	9	9

²⁴¹ 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)

²⁴² Dedicated acute care physicians only.

²⁴³ ESTH requirement for two sites.

²⁴⁴ Gaps calculated on a site-by-site basis.

²⁴⁵ General paediatric consultants only.

9.4 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 7.2.5) in the combined geographies would require locating a suitable site and building of a new hospital.

We 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.²⁴⁶

This suggested existing sites would need to be used for any potential solution.

9.5 Short list of options

This reduced our list to three options:

- 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.

In addition, HM Treasury guidance requires that any provisional list must include a ‘no service change’ counterfactual as an additional potential solution for comparative purposes.²⁴⁷ Therefore, we have included this as a fourth potential solution.

The Treasury Green Book identifies a ‘business as usual’ option that provides a counterfactual to compare alternative options. The Treasury Green Book sets out that an appropriate counterfactual needs to be identified within the short list against which potential solutions can be compared.

Within the Green Book this is referred to as the “Business As Usual” counterfactual, which is defined as following:

“Understanding Business As Usual, or the status quo, provides the basis for an effective intervention. Business As Usual is the continuation of current arrangements as if the intervention under consideration were not to be implemented. This does not mean doing nothing, although it is often referred to as the Do Nothing option, but continuing without making any changes. It is necessary to work out what the consequences of inaction would be (even if unlikely to be acceptable), as it provides the relevant counterfactual to compare alternative options.”

Therefore the “Business As Usual” counterfactual within our short list means that:

- There would be no change to services, as per:
 - “Continuation of current arrangements”
 - “Continuing without making any changes”

²⁴⁶ NHS property and estates: Naylor review (2017) <https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review>

²⁴⁷ 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

This would therefore include any assumptions that otherwise would have been applied “as if the intervention under consideration were not to be implemented”, i.e.:

- Demand growth
- QIPP assumptions
- CIP assumptions

This therefore did not include assumptions around retention rates, activity shifts, reconfigurations or additional catchments.

Therefore the counterfactual is described as a ‘no service change’ comparator where investment into estates is made and there is sufficient workforce available.

This was due to:

- The counterfactual having to address the three challenges of workforce, estates and finance
- No other counterfactual is useful as a comparison without addressing these issues.

The counterfactual in this scenario is hypothetical, as the status quo does not pass the initial tests.

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Figure 52: What we have learned from our engagement with local people on our initial tests²⁴⁸

What we learned from our engagement with local people

Within our Issues Paper, the key questions for consideration were:

- 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 final short list?
- Do you think there are other important things we should consider as we take this work forward?

Key themes arising in response to the first question include:

- The importance of quality of care received - across the whole patient journey - as a test;
- The need to take into account accessibility and transport infrastructure supporting the sites;
- Making sure the proposals are sufficiently future-proofed to take into account the needs of growing local populations and not just meet current needs

Key themes arising in response to the second question include:

- Universal support that transport and accessibility are the most important things to consider particularly for those who are more isolated or less mobile
- Making sure that the needs of people in deprived communities were understood and addressed
- Making sure the needs of older people and people with disabilities were also

What we changed

We reviewed the process of developing the long list and evaluating the short list since the publication of the *Issues Paper*:

- We incorporated quality of care and access into our evaluation criteria, which were identified by the participants of the evaluation criteria workshop as important. These criteria were also amongst the most heavily weighted by the participants of the weighting workshop. The scoring of the options against these criteria have therefore impacted on the overall scores for each of the options.
- We carried out extensive analysis and modelling on how we will need to meet the needs of our growing population. This included within the non-financial criteria an assessment of:
 - Bed availability
 - The needs of our deprived communities;
 - Health inequalities; and
 - Older people;
- As part of the financial analysis, we assessed the activity that may flow to our hospitals in the future, and how that may change as a result of demographic and non-demographic growth, and the impact that any changes in travel times may have on our neighbouring providers.

²⁴⁸ Improving Healthcare Together 2020 – 2030, Independent analysis of feedback from public engagement, The Campaign Company, 2018

10 SUMMARY OF SHORT LIST OF OPTIONS

The application of the initial three tests resulted in a short list of options and an additional no service change counterfactual option. In this Section, the options are summarised across some areas to provide an overview of each. This includes:

- The configuration of services;
- Expected activity levels;
- Number of beds required and provided on different sites; and
- Key deliverability considerations.

Following application of the three tests, three potential solutions passed all the tests. These were 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).

As a result, our short list is:

- **The ‘no service change’ comparator:** 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.

Each of these options are summarised below, including:

- the configuration of services;
- expected activity levels;
- number of beds required and provided on different sites; and
- key deliverability considerations.

Detailed analysis and the impact of each of the options is described further in Sections 12 and 13.

A summary table is shown below.

Table 45: Summary of options

Metrics	No service change	Epsom	St Helier	Sutton
Expected total activity (000s)	828.2	640.3	794.8	808.2
Number of beds (25/26)	1,082	1,052	1,052	1,052
Decanting costs (£m)	-	11.8	24.7	6.2
Time to build (years)	5	6	7	4

10.1 Key configurations and baseline activity for the short list of options

Within this section the configuration and baseline activity and deliverability considerations are described for each of the options. The methodology for establishing these metrics is described below.

10.1.1 Methodology

Each of the metrics described in the summary table above were developed using a distinct methodology. A brief description of this is provided in the sections below.

10.1.1.1 Configuration of services

The configuration of services across sites differ depending on the location for major acute services. This is described for each of the options.

10.1.1.2 Activity

In order to determine future activity and the number of beds required, we modelled demographic and non-demographic growth and any further assumptions that may impact these factors such as length of stay. Future beds and activity are further impacted by our out of hospital strategies, which have three main pillars, supporting a shift in care away from acute settings:

- Enhanced primary care (Section 1.4.3)
 - Primary care networks: Development of federations of practices, working together more effectively to manage demand across geographies
 - Primary care hubs: shared clinical services to enhance the scale and scope of primary care
 - Primary care at scale: Extended access to services through improved joint working of primary care
- Integrated community care (Section 5.4.1)
 - Community initiatives, integrated with primary and acute care to manage demand across the system
 - Focusing in particular on the frail, older population to reduce A&E attendances, admissions to hospital and length of stay.
- Prevention (Section 1.4.2)
 - An increased focus on prevention can result in reductions in the incidence of long-term conditions and improvements in patients' abilities to manage existing long-term conditions. This can reduce escalation of need resulting in decreased demand for the need for urgent and emergency care.

Total activity and beds for the future were therefore estimated by applying activity growth, QIPP and length of stay assumptions. These have been applied to the CCG-level input income and activity data

that was provided by ESTH. Where assumptions were only provided up to 2021/22, the average of the past four years were carried forward to forecast the 25/26 assumptions.

10.1.1.3 Beds

As described in Section 5.4.1, district services across our geographies have already started to deliver. These services and further out of hospital initiatives are expected to reduce hospital activity over the next seven years, as described through QIPP assumptions and LOS efficiencies.

The increase in bed numbers is due to the contribution of the following factors (see Figure 57):

- **Occupancy rate:** Due to improvements made through the clinical model, it is assumed that the national recommended occupancy rate of 85% will be achieved, resulting in an increase of 8 beds.
- **Demographic growth:** Growth in the population as a result of more births than deaths and net migration. This further includes the growth in the need for services (non-demographic growth), for example as a result of increasing expectation and demand for healthcare services, improving access to care, and changes in disease profile. This accounts for an increase of 129 beds.
- **QIPP delivery:** Quality, Innovation, Productivity and Prevention (QIPP) programmes are intended to result in quality improvements while driving efficiency by providing more care out of hospital. The impact of schemes across our geography is expected to result in a decrease of 68 beds.
- **LOS improvement:** Due to improvements made through the clinical model, it is assumed that the average length of stay will be decreased to the top quartile of peers.
- **Private patient beds:** The private patient activity at the Trust is expected to continue.
- **Community beds:** Some community beds will move into ESTH as a result of the clinical model.
- **Contingency district beds:** This includes additional capacity for district beds if required.

For the options the number of beds required is slightly lower than the no service change counterfactual due to further LOS efficiencies as a result of the co-location of services and increased consultant cover to standards.

10.1.1.4 Deliverability considerations

Any significant new hospital build or refurbishment may need patients and/or services to be relocated (this is also known as a decant). This can impose a significant additional cost. Some options may require temporary accommodation to provide services while other spaces are redeveloped. Refurbishment of sites can only begin once new areas are available due to space requirements.

Some options are expected to be more complex to build as they take place on an operational hospital site. The build of a hospital is complex and takes many years. This often requires patients in wards to be moved temporarily and can cause disruption to services. The number and sequencing of moves, and the breadth of refurbishments necessary impacts on the complexity of the build and the time taken to build.

10.2 Configuration of services

Table 46 shows the configuration of services across ESTH sites for the no service change comparator. In this option:

- Epsom Hospital and St Helier Hospital would provide all major acute services; and
- Epsom Hospital and St Helier Hospital would provide district hospital services.

Table 46: Configuration of services across ESTH sites

Service	Major acute services	District services
Epsom	<ul style="list-style-type: none"> • Acute medicine • Major emergency department • Critical care • Obstetrician-led births • Inpatient paediatrics • SWLEOC 	<ul style="list-style-type: none"> • Urgent treatment centre • Endoscopy • Outpatients • Daycase surgery • Rehabilitation • Low risk antenatal and postnatal care • Imaging and diagnostics • Dialysis • Chemotherapy • District hospital beds
St Helier	<ul style="list-style-type: none"> • Acute medicine • Major emergency department • Critical care • Emergency surgery • Obstetrician-led births • Inpatient paediatrics 	<ul style="list-style-type: none"> • Urgent treatment centre • Endoscopy • Outpatients • Daycase surgery • Rehabilitation • Low risk antenatal and postnatal care • Imaging and diagnostics • Dialysis • Chemotherapy • District hospital beds
Sutton	N/A	N/A

The configuration of services across sites will differ depending on the location for major acute services.

For the Epsom option, Epsom Hospital would provide all major acute services and Epsom Hospital and St Helier Hospital would provide district hospital services.

Table 47: Configuration of services across for major acute services at Epsom

Service	Major acute services	District services
Epsom	<ul style="list-style-type: none"> • Acute medicine • Major emergency department • Critical care • Emergency surgery • Obstetrician-led births • Inpatient paediatrics 	<ul style="list-style-type: none"> • Urgent treatment centre • Endoscopy • Outpatients • Daycase surgery • Rehabilitation • Low risk antenatal and postnatal care • Imaging and diagnostics • Dialysis • Chemotherapy • District hospital beds

St Helier	N/A	<ul style="list-style-type: none"> • Urgent treatment centre • Endoscopy • Outpatients • Daycase surgery • Rehabilitation • Low risk antenatal and postnatal care • Imaging and diagnostics • Dialysis • Chemotherapy • District hospital beds
Sutton	N/A	N/A

Where St Helier is the location for major acute services, services would be located at sites across ESTH as per Table 48. In this option St Helier Hospital would provide all major acute services and Epsom Hospital and St Helier Hospital would provide district hospital services.

Table 48: Configuration of services across ESTH sites for major acute services at St Helier

Service	Major acute services	District services
Epsom	N/A	<ul style="list-style-type: none"> • Urgent treatment centre • Endoscopy • Outpatients • Daycase surgery • Rehabilitation • Low risk antenatal and postnatal care • Imaging and diagnostics • Dialysis • Chemotherapy • District hospital beds
St Helier	<ul style="list-style-type: none"> • Acute medicine • Major emergency department • Critical care • Emergency surgery • Obstetrician-led births • Inpatient paediatrics 	<ul style="list-style-type: none"> • Urgent treatment centre • Endoscopy • Outpatients • Daycase surgery • Rehabilitation • Low risk antenatal and postnatal care • Imaging and diagnostics • Dialysis • Chemotherapy • District hospital beds
Sutton	N/A	N/A

Where Sutton is the location for major acute services, services would be located at sites across ESTH as per Table 49. In this option Sutton Hospital would provide all major acute services and Epsom Hospital and St Helier Hospital would provide district hospital services.

Table 49: Configuration of services across ESTH sites for major acute services at Sutton

Service	Major acute services	District services
---------	----------------------	-------------------

Epsom	N/A	<ul style="list-style-type: none"> • Urgent treatment centre • Endoscopy • Outpatients • Daycase surgery • Rehabilitation • Low risk antenatal and postnatal care • Imaging and diagnostics • Dialysis • Chemotherapy • District hospital beds
St Helier	N/A	<ul style="list-style-type: none"> • Urgent treatment centre • Endoscopy • Outpatients • Daycase surgery • Rehabilitation • Low risk antenatal and postnatal care • Imaging and diagnostics • Dialysis • Chemotherapy • District hospital beds
Sutton	<ul style="list-style-type: none"> • Acute medicine • Major emergency department • Critical care • Emergency surgery • Obstetrician-led births • Inpatient paediatrics 	<ul style="list-style-type: none"> • Urgent treatment centre • Imaging and diagnostics

10.3 Activity

The total demand that ESTH will have to manage in 25/26 for the no service change comparator is shown in Table 50.

Table 50: Total activity at ESTH 25/26

Bed type	Unit	Total ESTH
Elective	Admissions (000s)	51.4
Non-elective	Admissions (000s)	50.4
Emergency department	Attendances (000s)	151.1
Outpatients	Attendances (000s)	565.5
Births	Births (000s)	4.9

As a result of an increase in activity due to demographic and non-demographic growth, overall required bed numbers are expected to grow from c. 1,048 in 16/17 to c. 1,082 in 25/26.

Table 51 shows the activity for the Epsom option. As this option has a smaller catchment than the no service change comparator, and both the St Helier and Sutton option, the amount of activity is the lowest within the short list of options.

Table 51: Activity for Epsom option in 25/26

Point of delivery	Unit	Epsom	St Helier	Sutton	Total ESTH
Elective	Admissions (000s)	23.6	25.1	0.0	45.3
Non-elective	Admissions (000s)	31.0	0.2	0.0	31.3
Emergency department	Attendances (000s)	67.5	64.9	0.0	132.5
Outpatients	Attendances (000s)	224.3	336.5	0.0	560.8
Births	Births (000s)	2.9	0.0	0.0	2.9

For major acute services at St Helier, as the catchment is slightly larger than for the Epsom option, activity is slightly higher across points of delivery.

Table 52: Activity for St Helier option in 25/26

Point of delivery	Unit	Epsom	St Helier	Sutton	Total ESTH
EL	Admissions (000s)	18.9	31.2	0.0	50.1
NEL	Admissions (000s)	0.3	40.3	0.0	40.6
AE	Attendances (000s)	33.4	104.4	0.0	137.8
Outpatient	Attendances (000s)	213.3	349.1	0.0	562.4
Births	Births (000s)	0.0	3.9	0.0	3.9

For major acute services at Sutton, as the catchment is slightly larger than for the Epsom and St Helier option, activity is slightly higher across points of delivery.

Table 53: Activity for Sutton option in 25/26

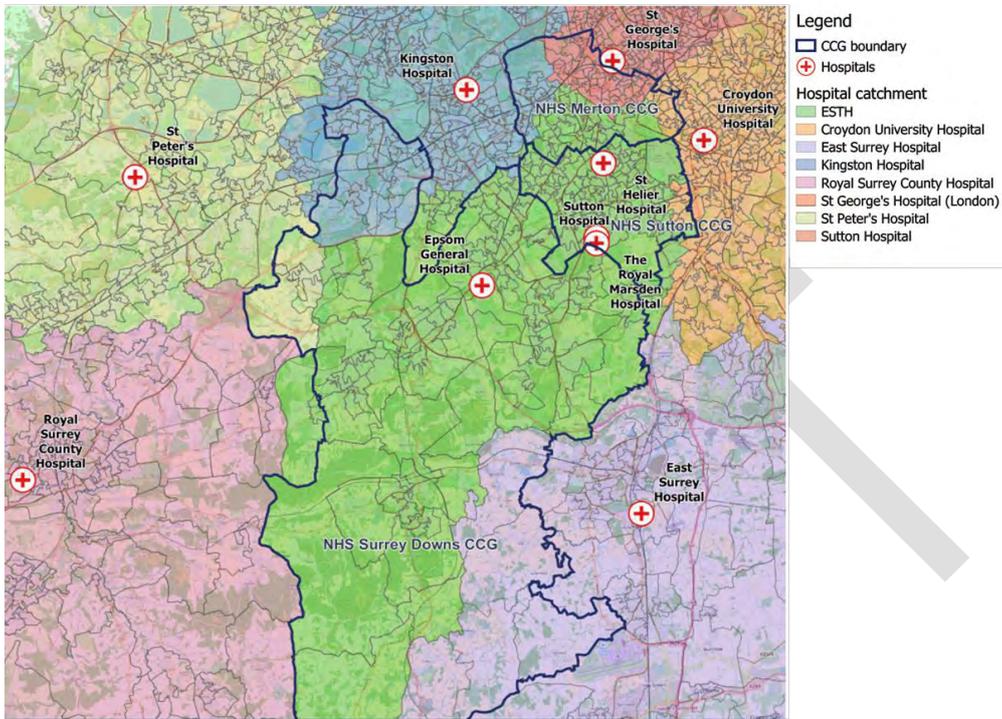
Point of delivery	Unit	Epsom	St Helier	Sutton	Total ESTH
EL	Admissions (000s)	18.9	25.1	5.9	49.9
NEL	Admissions (000s)	0.3	0.2	43.1	43.7
AE	Attendances (000s)	33.4	64.9	49.5	147.8
Outpatient	Attendances (000s)	220.1	342.6	0.0	562.7
Births	Births (000s)	0.0	0.0	4.1	4.1

As described in Section 12.2.1, we modelled a core scenario where patients are expected to travel to the nearest site (based on travel time) offering major acute services. This changes the flow of patients locally. Stylised representations of the changes in catchment implied by this travel time model are included below – these are intended to be indicative of the broad areas that may move.²⁴⁹

²⁴⁹ Visualisations are intended to be stylised representations of broad areas. Only the catchment/flow for services affected by each option is shown – i.e., major acute services only. District services catchments are unaffected. Catchment areas are based on the closest hospital by travel time for major acute services for each LSOA. Actual patient flows may vary.

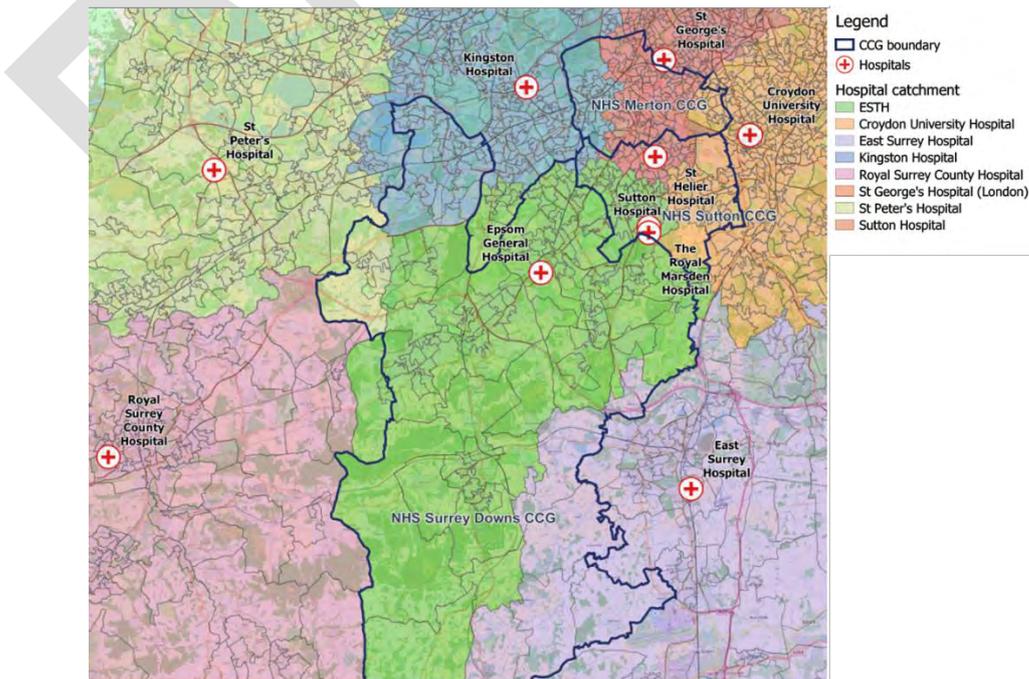
The current Trust catchment covers much of the combined geographies, where currently ESTH receives patients from across Sutton, Merton and Surrey Downs.

Figure 53: No service change major acute catchment



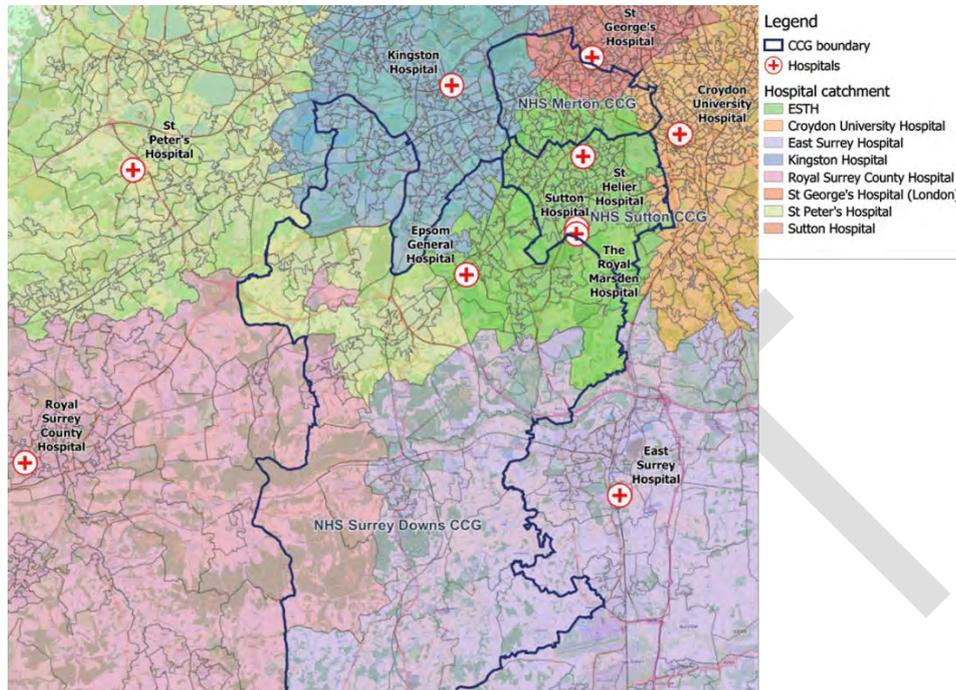
If Epsom Hospital becomes the major acute site, major acute services are no longer offered at St Helier Hospital. These patients instead use the next closest hospital, which is usually one of the London sites. For the Epsom option, as Epsom Hospital does not currently offer emergency surgery, providing all major acute services from Epsom Hospital would mean this service is added to the site. This means there will be an inflow from patients living near to Epsom Hospital requiring emergency surgery and who are currently using sites in Surrey and to the west.

Figure 54: Epsom Hospital major acute catchment



Consolidating major acute services at St Helier Hospital means catchment in Surrey is lost.

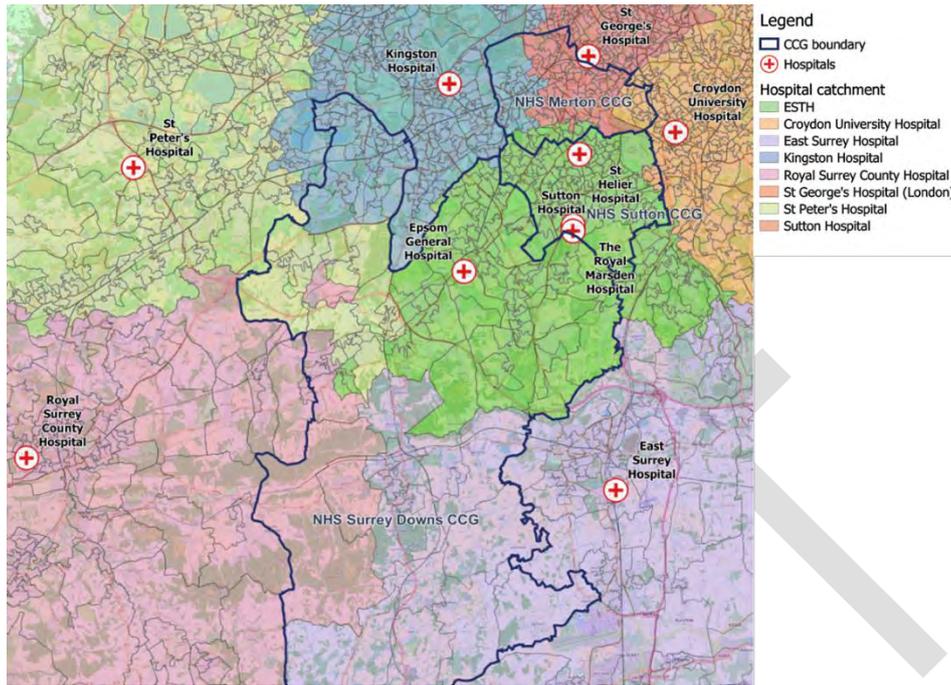
Figure 55: St Helier Hospital major acute catchment



If St Helier Hospital becomes the major acute site, major acute services are no longer offered at Epsom Hospital. These patients instead use the next closest hospital, which is usually one of the Surrey sites.

If Sutton Hospital becomes the major acute site, two flows change. Major acute services are now offered at Sutton Hospital. Patients in the east close to Sutton therefore start to use this site instead of their current site (currently Croydon University or East Surrey Hospital). Major acute services are also no longer offered at Epsom Hospital or St Helier Hospital. These patients instead use their next closest hospital, which is either Sutton or one of the other nearby sites.

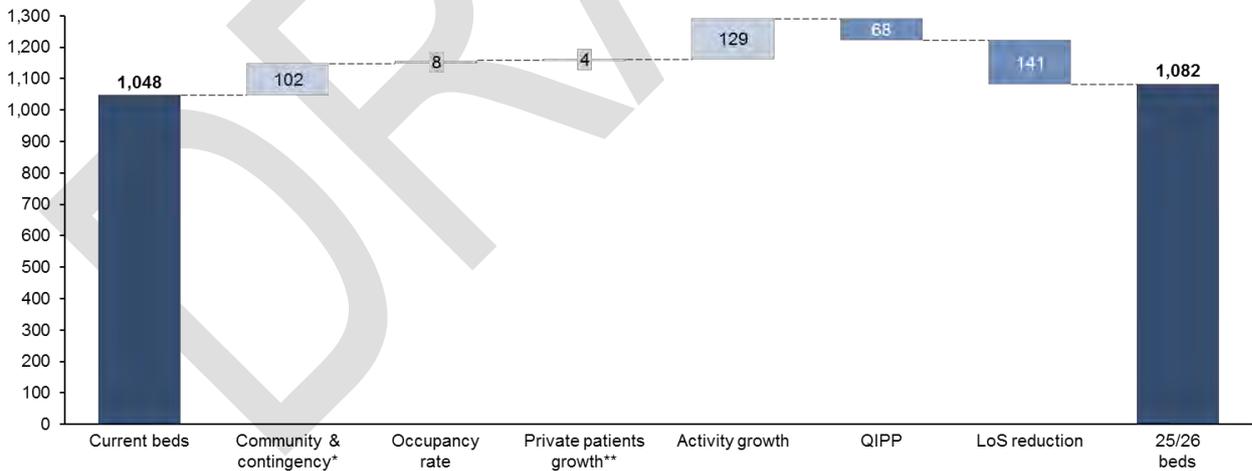
Figure 56: Sutton Hospital major acute catchment



10.4 Beds

Bed numbers are expected to grow for the no service change comparator despite increased efficiencies, as shown in Figure 57.

Figure 57: Bed numbers for ESTH to 25/26²⁵⁰



²⁵⁰ Notes and sources: The bridge implies current occupancy is on average c. 85%

*This includes 62 community beds and 40 contingency sub-acute beds included in the draft PCBC

**Private patient activity growth included in the baseline, independent of options – i.e. excluding any strategic expansion – reflects c. 12 beds currently, expanding to c. 16 based on activity growth.

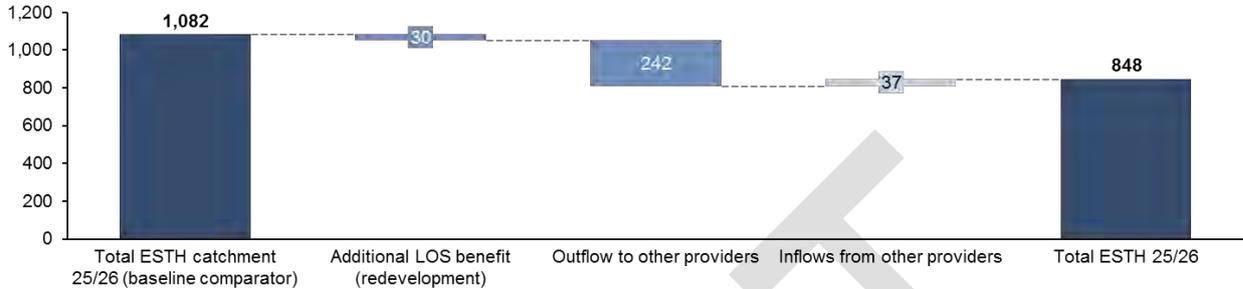
***Notes on methodology LoS for benchmarking analysis:

- Source: 2016/17 Reference Costs: <https://improvement.nhs.uk/resources/reference-costs/>
- The benchmarking identifies length of stay improvement opportunity at a specialty level, as identified in Reference Costs
- Peer group selection includes 'large acute trusts' as identified in Reference Costs

Therefore, largely due to demographic and non-demographic growth, and despite efficiencies driven by the clinical model, it is expected that the total bed requirement for ESTH in 25/26 is 1,082 beds.

For the Epsom option, due to the high density population in Merton and Sutton, the location of major acute services means this population is more likely to attend hospital at other providers, resulting in an outflow to other providers of 242 beds, with an inflow of 37.

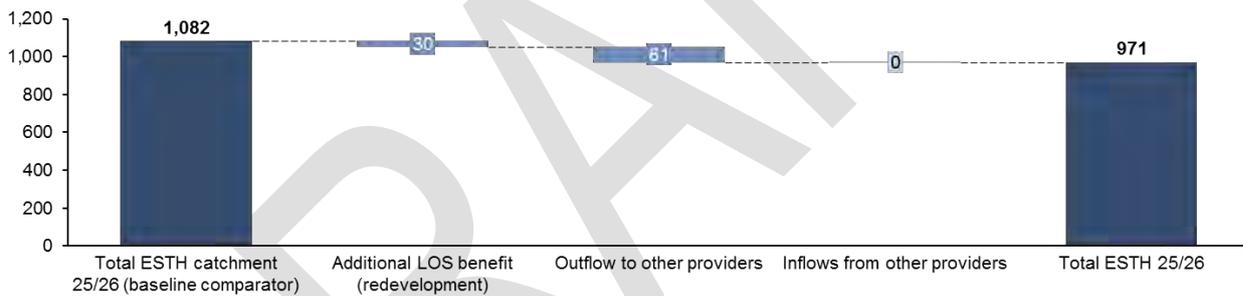
Figure 58: Number of beds for Epsom option



For the Epsom option, the total number of beds at ESTH in 25/26 will therefore be 848, with a net total of 205 beds flowing to other providers.

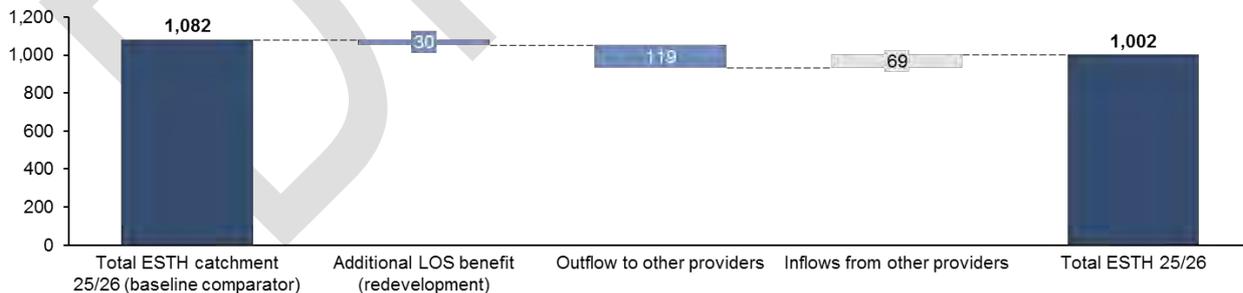
For the St Helier option, a substantial amount of the emergency catchment in Surrey is lost, however the impact on other providers is lower.

Figure 59: Number of beds for St Helier option



The emergency catchment for Sutton is largest, and has the smallest net impact on other providers.

Figure 60: Number of beds for the Sutton option



- A simple outlier detection methodology has been implemented: the estimation includes activity only from those trusts who had at least 20% of average activity / beddays in a given specialty
- A 85% occupancy rate has been assumed.

% totals are relative to base case beds in model.

A breakdown of these beds by option is shown below.

Table 54: Bed numbers at ESTH in 25/26 by category and option

Bed type	Description	No service change	Epsom	St Helier	Sutton
NEL Overnight	Beds required for non-elective admissions where an overnight stay is required	335	222	289	320
EL Overnight	Beds required for elective admissions where an overnight stay is required	44	26	36	34
Maternity	Beds required for maternity services	106	55	90	86
Critical Care	Beds required for critical care	23	13	19	21
District hospital	District hospital beds for patients not requiring major acute services but still in need of medical care	242	217	214	218
Elective Day	Beds required for elective admissions where an overnight stay is not required	102	100	102	101
NEL Day	Beds required for non-elective admissions where an overnight stay is not required	36	22	28	30
SWLEOC	Beds required for the elective centre at Epsom	75	75	75	75
Private Patients	Beds required for private patient activity	16	16	16	16
Community beds	Some community beds will move into ESTH as a result of the clinical model	62	62	62	62
Contingency beds	Additional capacity for beds if required	40	40	40	40
Total		1,082	848	971	1,002

10.5 Deliverability considerations

For the no service change comparator, there would be mostly refurbishment of existing buildings. A temporary decant building would be required at St Helier. Due to space constraints, refurbishment would be undertaken over a number of phases.

The phasing for Epsom is expected to be:

- New ward block required at Epsom Hospital.
- Decanting of services required from buildings prior to construction. Demolition of existing buildings may require changes to access points.
- Refurbishment can take place when new building opens with some decant required.

St Helier is a large operational site and therefore it is expected to be relatively complex to deliver. A large decant facility would be required at St Helier which may need to be located in main car park, displacing staff parking. Refurbishment can take place when new building open with some decant required. For major acute services at Sutton there is mostly clear land with only a small amount of

demolition required. Refurbishment can take place when new building open with some decant required.

Table 55: Decanting and temporary accommodation costs for each of the options

Major acute site	No service change	Epsom	St Helier	Sutton
Decanting and temporary accommodation costs (£m)	15.0	11.8	24.7	6.2

The complexity of decanting impacts on the number of years to build each of the options:

- For the no service change comparator, redevelopment requires multiple phases over 5 years.
- Due to its complexity, the build for major acute services at Epsom will therefore require multiple phases over 6 years.
- Due to its complexity, the build for major acute services at St Helier will therefore require multiple phases over 7 years.
- As Sutton is a mostly clear site with little operational activity, delivering this option is relatively simple, with redevelopment requiring multiple phases over 4 years.

Table 56: Number of years to build for each of the options

	No service change	Epsom	St Helier	Sutton
Major acute site	5	5	7	3
Overall time	5	6	7	4

10.6 Integrated impact assessment

The interim integrated impact assessment was carried out to assess the potential impacts of each of the options across key areas. These findings are summarised below, and contributed to the options appraisal process.

The IIA is a continuous process that explores local issues and evidence in relation to any potential positive and negative impacts to changes in local services. A finalised report will not be completed until after the feedback from a full public consultation has been considered.

An impact assessment does not determine the decision but assists decision-makers by giving them better information on how best they can promote and protect the wellbeing of the local communities they serve. This assessment takes place in three phases.

Phase one produced an:

- Initial equalities analysis, which analysed the groups which are considered most vulnerable to changes in health services; mapped these groups to understand where they are highly concentrated across the three CCGs; and set out the approach to identifying impacts, solutions, and opportunities.
- Baseline travel assessment was also completed to explore current travel times for residents when accessing acute services.
- Deprivation impact analysis, which explored the potential impact the proposed options for change may have on deprived communities in the local area.

The second phase of the IIA was overseen by an independently chaired Steering Group with representation from CCGs, local authorities, voluntary sector and other key stakeholders. The IIA explored equalities, health, travel and environmental impacts and includes in-depth engagement with

a range of local people from different backgrounds and protected characteristic and seldom heard groups (this includes deprived communities and carers).

The second phase of the IIA used information collected as part of phase one on equality, deprivation, travel, health and sustainability, and does more detailed assessments. The report was based on the phase one evidence gathered above, and the following research tasks:

- Desk based research;
- Socio-demographic data collection and mapping;
- In-depth interviews with health professionals and representatives of local community groups;
- Focus groups with local protected characteristic groups (12 groups covering 108 individuals);
- Travel and access analysis; and
- Air quality and carbon emissions analysis

The third and final phase is completed after a public consultation where any relevant information provided is included in a final IIA report and published prior to any decision making.

10.6.1 Summary of potential impact

A summary of the key impacts identified through the second phase of the IIA process is provided below. The key findings are detailed in full at Appendix □.

10.6.1.1 Benefits of the new clinical model

Overall benefits of the clinical model found within the phase two IIA include:

- **Patient experience** – Patient experience will be enhanced in the long term. Making sure patients are consistently seen by the right specialists and services when people need them in an emergency, seven days a week, every day of the year, so patients get the best quality health care and treatment. What this means is patients will be diagnosed quicker, spend less time in hospital and are less likely to be readmitted.
- **Clinical quality** – Better clinical quality and standards for our sickest patients and those most at risk of becoming seriously ill, with consultant cover that meets regional and national safety standards. The district hospital model will provide as much care delivered as close to people's homes as possible, for example in every option all outpatient appointments and rehabilitation beds will be provided at both Epsom and St Helier hospitals.
- **Estates** – With redesigned facilities brought together onto a single site the Trust has the opportunity to invest in the latest technology to support treatment and care. Modern buildings are better for patient care, because they are more efficient and easier to maintain and clean. For example, this reduces the risk of hospital-acquired infections, provides a better environment for healing and a better place for staff to work.

10.6.1.2 Health inequalities

Deprivation is a key factor linked to health inequalities. A positive impact on reducing health inequalities for deprived communities within the combined geographies will likely come from concerted effort in addressing the wider determinants of health. The IIA found that it is likely that in making changes to the way acute services are commissioned will accelerate the growth and improvement of district services within both the Epsom and St Helier hospital sites.

District services can play an important role in reducing health inequalities. District services delivered across both existing hospitals and the community are centred on providing a proactive focus on health and wellbeing, empowering people to take greater responsibility for managing their own health. These build on local strategies and will continue to be developed as part of integrated primary and community plans. Locally, this includes the development of strategies and services focused on:

- Enhanced prevention (with a focus on risk stratification)
- Primary care at scale

- Integrated locality teams
- Integrated or reactive urgent care
- Proactive care (including community hubs and locality teams)

These local strategic priorities have clear alignment in seeking to reduce health inequalities through increased access to local primary or community care, a focus on prevention, as well as targeted initiatives to manage patients with risk factors around diabetes or high blood pressure and supporting behaviour change. District hospitals will be at the centre of the networks of care and will provide effective joined up health and care to keep people well and recover after an acute episode of care.

As such, the developments to district services proposed as part of the service redesign may result in improved health outcomes for those from areas of high deprivation, helping to tackle health inequalities.

As the highest densities of deprived communities exist within Merton and Sutton, the Epsom Hospital option may impact on a slightly greater proportion of deprived communities compared with the other options as it will result in longer journey times for those in Merton and Sutton. Given that all communities are likely to engage more frequently with district hospital services, keeping these services as local as possible and transforming the way they work may go some way in reducing any potential negative impact from deprived communities having to travel further to access acute services.

10.6.1.3 Journey times

The majority of patients will be treated in district hospital services which will continue to be provided at both Epsom and St Helier hospitals. This means in most cases travel requirements for patients and visitors will not change. However, as all options involve moving acute services from two sites to one, all but the St Helier option would likely to result in longer journey times when accessing acute services for some of the patients within the Merton. Those engaged with as part of this work also highlighted that longer travel times and difficulty in accessing acute services may adversely impact patients' outcomes and reduce the health and wellbeing outcomes for visitors.

However, across the options over 99% of people (across the whole study area) will still be able to access an acute service within 30 minutes by either car or blue light ambulance; similar to the current situation. Therefore, given the lack of change at 30 minutes, for these modes of transport the study looked at the impact of journey times at 15 minutes, this is where the impacts had variations for people in the different CCG areas. As public transport journey times tend to be longer on average than car and blue light ambulance the analysis focused on the impact of journey times at 30 minutes.

Table 57: Journey impact times for access to acute services for patients

Epsom		St Helier		Sutton	
Likelihood	Magnitude	Likelihood	Magnitude	Likelihood	Magnitude
High	Marginal adverse – increases for a proportion of the population living largely in Merton and around Sutton. Will likely have a greater impact on those from deprived communities. However, scale of impact likely to be offset by the availability of other providers for these groups to access	High	Marginal adverse - increases for a proportion of the population largely covering Surrey Downs. Will likely have a greater impact on older people living within this area.	High	Marginal adverse - short increases for a large proportion of the population living across the study area

10.6.1.4 Summary of the findings across the three CCG areas

The phase 2 IIA found that:

- The district hospital model could help address health inequalities as part of a wider local strategy that focuses on well-being and prevention. For example, by providing virtual outpatient clinics which support people with long term conditions by improving their access to healthcare and patient experience.
- Hospital facilities will be designed in a way which enables key departments to be located next to each other supporting the flow of patients through the hospital; for example, with the diagnostics department located next to the A&E department.
- Patient choice is unlikely to be impacted for the majority of services. There is an impact on patient choice for 24 hour urgent care as two A&Es come together on one site. However, there will be either two or three Urgent Treatment Centres in the area (three for the Sutton option) which are open 24 hours a day, seven days a week. Patient choice may also be felt to be reduced in relation to inpatient elective surgery and hospital births (obstetrician-led births) due to their co-location onto the single site. However, in practice, the majority of inpatient elective surgery, and high risk births, are already consolidated on a single site given the inter-dependencies with intensive care and emergency surgery.
- The research suggests marginal impact in travel times for older people (65 years old and older) living in Surrey Downs if St Helier or Sutton were chosen as the location of the site for major acute services. The Epsom site option is expected to see greater increases in journey times for deprived residents in Merton and Sutton.
- Research indicates that across the proposed options the increase of journey times would likely lead to more complex and more expensive journeys when accessing acute services.
- It is expected that any implementation of the options for change will require some adjustment for local communities. Some groups may be adversely impacted in term of adjusting to new and unfamiliar surroundings. This however, can be mitigated to some extent by clear communication and signposting prior to any new service opening. New or refurbished hospital facilities may offer improvements in physical accessibility. This is likely to particularly impact older people and those with a disability.

- We will need to recruit staff to new roles, and they will need to adjust to new ways of working, which means there are possible impacts in the early days of the new model of care. However, there will also be new job roles, training opportunities and the advantages of working as part of larger, more sustainable teams.
- Neighbouring hospitals are likely to experience an increase in patients as a result of any changes. The Epsom hospital option would have the most impact on other hospitals and the Sutton hospital option would have the least impact on other providers. However, there are likely to be fewer emergency transfers needed.
- All options are likely to have some impact on air quality and greenhouse gases, although these are expected to be low. The Sutton option is the only one which could result in improved air quality in some areas.

10.6.1.5 Overall option impacts

The IIA indicated there is no one option which has a significantly greater impact than others, but there are small differentiating factors. These are outlined in the table below.

Table 58: IIA option consideration

Area	Detail
Health inequalities	<ul style="list-style-type: none"> • The district hospital model will potentially positively impact on health inequalities. • Option 1: Epsom likely to result in the greatest proportion of people from deprived communities experiencing longer journey times.
Longer journey times for patients and visitors	<ul style="list-style-type: none"> • Option 1: Epsom Hospital - Merton and Sutton particularly likely to experience longer journey times by car and blue light ambulance, and public transport • Option 2: St Helier Hospital - Surrey Downs particularly likely to experience longer journey times by car and blue light ambulance, and public transport • Option 3: Sutton Hospital - All areas expected to see increases in journey times by car, blue light ambulance and public transport but small proportion in Sutton who may see journey time decreases.
Patient provision	<ul style="list-style-type: none"> • The movement of the ED onto a single site will result in some services no longer being locally available to some patients. This will likely be perceived as limiting their choice.
Other providers	<ul style="list-style-type: none"> • Option 1: Epsom predicted to result in the greatest increases in patient flows to other sites and will therefore have the most significant impact on providers. • Option 3: Sutton modelled to have the least impact with smaller proportions of patients predicted to flow to other providers
Wider sustainability	<ul style="list-style-type: none"> • Option 1: Epsom Hospital - Air quality impact likely to have a greater impact than other options due to patients flow being increased to area of existing poor air quality. • Option 2: St Helier Hospital - GHG expected to be the worst under this option due to a higher proportion of local residents having to travel further to access acute services. • Option 3: Sutton Hospital - Slight improvements in air quality expected due to the movement of patients away from areas of poor air quality.
Transportation cost and accessibility of acute services	<ul style="list-style-type: none"> • Option 1: Epsom - Merton and Sutton particularly likely to experience increased costs and complex journeys • Option 2: St Helier - Surrey Downs particularly likely to experience increased costs and complex journeys • Option 3: Sutton - Merton and Surrey Downs particularly likely to experience increased costs and complex journeys

10.6.2 Summary of solutions to potential impacts

The aim of phase two of the IIA was to also identify any potential solutions the CCGs could take to protect and promote the health and wellbeing of the local population. The IIA identified 25 potential solutions, each one linked to the impact areas identified, these can be summarised as:

- Clear communication with the local population about the changes to services and new patient pathways.
- Raise awareness of new and existing transport options to and from hospitals, as well as site specific transport offerings.
- Work with local councils and transport providers to support the development of community transport options and make the community aware of what is available.
- Explore the possibility of more personalised transport support to assist visitors with more complex journeys.
- Make sure there is sufficient parking capacity on the hospitals' sites.
- Continue to undertake detailed work with neighbouring NHS providers to understand their ability to accommodate any changes in activity and the implications for them.
- Continuously review the service model to make sure it meets the health needs of the protected characteristic groups and seldom heard groups.
- Make sure there is the appropriate workforce in place to deliver the new clinical model.
- Introduce appropriate emergency transfer and handover protocols between sites and reduce the need for transfers between sites.
- Make sure the district services hospitals are joined up with local strategies by working closely with CCGs, providers, local councils, other services and hospitals.
- Introduce and encourage more sustainable and green travel for visitors and staff.

10.6.3 Next steps

During the next phase of the IIA, further engagement with a number of seldom-heard groups which have been identified as potentially having a disproportionate need for acute services, as well as staff at Epsom and St Helier Hospital University Trust will continue. These groups include: people with a learning disability, carers, LGBT+, and Gypsy, Roma and Traveller communities.

The phase two report will be further reviewed and refreshed in light of the findings from public consultation to ensure that fair coverage and consideration is given to:

- the full range of potential impacts likely to be experienced by the local community and specific community groups within this;
- any additional data sources which may support analysis of impacts; and
- any further mitigation actions which may help to alleviate the effects of the some of the impacts identified.

This will form Phase 3 of the integrated impact assessment work programme.

This work will conclude with the production of a final report for consideration as the programme moves to the next phase of work following consultation.

10.7 Further analysis of options

The following sections detail the options further, including:

- Application of non-financial criteria, with supporting evidence (Section 12);
- Expected impact on other providers (Section 11); and
- Application of financial metrics, with supporting analysis (Section 13).

Figure 61: What we have learned from our engagement with local people on our potential solutions²⁵¹**What we learned from our engagement with local people**

Within our Issues Paper, the key question for consideration was:

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

Alternative proposals identified included:

- Keeping the status quo
- Investing in transport solutions to make it easier for patients in less accessible areas (eg free shuttle buses between sites)
- Looking at other ways to raise money (e.g. taxes, lobbying Government, etc)

What we have changed

We have considered all feedback as part of our options consideration process, and included the no service change counterfactual within our non-financial and financial evaluation of options.

As the programme progresses we will continue to assess the impact of, and any financing options for, the options. This will include an integrated impact assessment, which will look into the positive and negative impact of the options and suggest mitigations, such as for patients living in less accessible areas.

²⁵¹ Improving Healthcare Together 2020 – 2030, Independent analysis of feedback from public engagement, The Campaign Company, 2018

11 IMPACT ON LOCAL PROVIDERS

To understand the wider impact of the options, an analysis of the impacts of the short list on local providers in the area was undertaken. We considered impacts on six local providers, excluding ESTH; specifically:

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

To support this, a Technical Group was convened in July 2018, comprising provider Directors of Strategy from each provider, as well as representation from LAS and SECamb. A series of working principles and an overall process was agreed with providers. The group considered the activity impact on affected Trusts including bed, theatre and diagnostics capacity and the resulting requirements for estates, finance (revenue and capital) and workforce. In addition, providers worked with the programme via regular meetings with Chief Executives and the AOs and reported outputs to Trust Boards.

11.1 Approach to provider impact assessment

All providers co-designed and agreed a consistent approach to the analysis of impacts, which included:

- The development of a single, detailed activity model for all providers, including expected changes in patient flow in an agreed core scenario, based on travel time. Only major acute activity was expected to flow to other providers; district hospital service activity was assumed to remain unchanged.
- The clinical model involves a proportion of patients spending the first part of their spell in a major acute non-ESTH hospital site, before being repatriated to an ESTH district site for the second part of their spell. A 7 day step down point for all non-elective general medicine patients was agreed as an initial assumption. Two targeted IHT Clinical Advisory Group meetings were undertaken with representation from two nominated medical director and nursing directors from non-ESTH providers to help develop this assumption. Further work has confirmed this to be a reasonable assumption, following the detailed district hospital audit described in Section 5.
- Development of a series of sensitivities to test the impact of changing key assumptions.
- Presentation of the core scenario and a range of expected impacts (minimum and maximum) as the basis of impact analysis.
- Analysis of the impact of potential changes in patient flow on capacity (wards, theatres, A&E and other), estates and capital, costs and workforce. These components were estimated by individual provider trusts based on a consistent and agreed set of assumptions. This included, for example, an agreement that providers would only include within their estimates the incremental impacts which are directly associated with changes related to IHT proposals, rather than a broader ask for capital more widely as part of other plans.
- Reporting back to the programme of these impacts, based on the core scenario, and a standard report format for consistency.

11.1.1 Limitations to the repatriation model

There are a number of limitations to the repatriation model developed, which were recognised by the CAG and chief executives group. These included:

- The 7 day assumption is a top down assumption applied to a broad patient cohort rather than analysis of individual pathways;
- Some patients may be appropriately repatriated at a shorter or longer length of stay than the 7 day average number of days;
- The cohort appropriate for repatriations may be broader than just the general medicine specialty, and / or some patients in the general medicine cohort may not be appropriate for repatriation;
- Differences in coding practices (to the general medicine specialty) could lead to different patient cohorts being identified as appropriate to be repatriated; and
- Operational implications are not explicitly modelled at this stage, including transport implications, co-ordination required between providers, and any length of stay and patient impacts associated with transfers.

To recognise the limitations of the repatriation model as well as a number of other risks, the chief executives agreed further work would be undertaken, including:

- Further audits will be needed to identify the patient cohort and the point at which their reliance on major acute services decreases;
- Further examples will be needed of patients who would fit within the district bed cohort;
- Operational implications require further discussion; and
- The focus was on the development of top down assumptions, with a discussion of detailed pathways to be undertaken at a later stage, including identifying a specific frail / elderly cohort and specialty level trim points.

This work has been undertaken and included within this PCBC, and will be further detailed as the programme progresses.

11.2 Activity impact

Based on changes in catchment, a range of changes in activity are expected. These flows were based on forecast 2025/26 activity, including growth and delivery of demand management. Activity flows affected by changes in services include:

- A&E attendances;
- Non-elective (NEL) (emergency) activity, including surgery and medicine;
- Elective (EL) surgery (inpatient activity where there is a dependency on critical care);
- Outpatient activity (associated with elective surgery); and
- Births.

The outputs below are net of inflows and outflows based on the core travel time scenario. As the baseline option has no incremental impact, it is not included here.

11.2.1 Major acute services at Epsom Hospital

Consolidating major acute services at Epsom Hospital results in a range of flows. Activity primarily flows to providers to the north, mainly St George's and Croydon University Hospitals.

There is a small inflow of emergency surgery from St Peter's and Royal Surrey County Hospitals, reflecting the provision of emergency surgery at Epsom Hospital (not currently offered).

Table 59: Net changes in activity for major acute services at Epsom Hospital (core travel time scenario, 25/26)

Point of delivery	Unit	St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon	Total
A&E	<i>Attends (000s)</i>	0.0	1.1	0.0	0.1	10.2	7.2	18.6
Non elective	<i>Admissions (000s)</i>	0.0	0.9	-0.1	-0.2	10.3	8.3	19.1
Elective	<i>Admissions (000s)</i>	0.0	0.2	-	0.0	1.3	1.2	2.7
Outpatient	<i>Appts (000s)</i>	0.0	0.3	-	0.0	2.3	2.1	4.7
Births	<i>Births (000s)</i>	0.0	0.1	-	0.0	1.0	0.9	2.0

11.2.2 Major acute services at St Helier Hospital

Consolidating services at St Helier Hospital means outflows to multiple providers. Consolidating major acute services at St Helier Hospital results in additional flows for multiple sites, and in particular St Peter's, Kingston, East Surrey and Croydon University Hospitals. As major acute services are currently offered from St Helier Hospital, there are no inflows.

Table 60: Net changes in activity for major acute services at St Helier Hospital (core travel time scenario, 25/26).

Point of delivery	Unit	St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon	Total
A&E	<i>Attends (000s)</i>	4.9	4.7	1.2	2.2	0.1	0.2	13.3
Non elective	<i>Admissions (000s)</i>	3.8	3.0	0.9	1.7	0.1	0.2	9.7
Elective	<i>Admissions (000s)</i>	0.4	0.4	0.1	0.2	0.1	0.2	1.3
Outpatient	<i>Appts (000s)</i>	1.0	0.9	0.3	0.4	0.2	0.4	3.1
Births	<i>Births (000s)</i>	0.3	0.4	0.1	0.2	0.0	0.1	1.0

11.2.3 Major acute services at Sutton Hospital

Consolidating services at Sutton Hospital means outflows to a number of providers and inflows from Croydon University Hospital. Activity from Epsom and St Helier Hospitals flows to multiple sites, in particular St Peter's, Kingston and St George's. The addition of major acute services at Sutton results in inflows from Croydon Hospital.

Table 61: Net changes in activity for major acute services at Sutton Hospital (core travel time scenario, 25/26)

Point of delivery	Unit	St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon	Total
A&E	<i>Attends (000s)</i>	2.9	1.8	1.0	1.0	1.7	-5.1	3.2

Non elective	<i>Admissions (000s)</i>	2.4	1.4	0.8	0.8	2.0	-0.7	6.7
Elective	<i>Admissions (000s)</i>	0.4	0.3	0.1	0.1	0.3	0.2	1.4
Outpatient	<i>Apts (000s)</i>	0.9	0.6	0.3	0.2	0.5	0.3	2.8
Births	<i>Births (000s)</i>	0.2	0.1	0.0	0.1	0.2	0.1	0.9

11.3 Bed capacity impact

Changes in catchment also imply changes in bed capacity. Based on these changes in catchment, a range of changes in beds are also expected. These flows are based on forecast 2025/26 beds, including growth, delivery of demand management and length of stay improvements.

Bed categories affected by changes in services include:

- Non-elective inpatient (NELIP);
- Elective inpatient (ELIP);
- Maternity;
- Critical care;
- Elective day beds (ELDC); and
- Non-elective day beds (NELDC).

The outputs below are net of inflows and outflows based on the core travel time scenario.

11.3.1 Major acute services at Epsom Hospital

Consolidating services at Epsom Hospital implies large increases in beds at Croydon University and St George's Hospitals which would require capacity for c. 105 and 108 beds respectively. Impacts on other sites are less than 15 beds.

There are small reductions in capacity implied at Royal Surrey County and East Surrey Hospitals as emergency surgery activity moves to Epsom Hospital.

Table 62: Net changes in beds for major acute services at Epsom Hospital (core travel time scenario, 25/26)

Point of delivery	St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon	Total
NELIP	0	2	-3	-14	63	61	110
ELIP	0	1	-	0	7	9	17
Maternity	0	3	-	0	24	24	51
Critical care	0	0	-	-	5	4	10
ELDC	0	0	-	0	1	1	3
NELDC	0	1	-	0	8	5	14

11.3.2 Major acute services at St Helier Hospital

Consolidating services at St Helier Hospital implies increases in capacity across multiple providers.

These are dispersed across multiple providers, with impacts on St Peter's and Kingston of c. 39 and 23 bed respectively. Impacts on other sites are fewer than 15 beds.

Table 63: Net changes in beds for major acute services at St Helier Hospital (core travel time scenario, 25/26)

Point of delivery	St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon	Total
NELIP	27	12	7	6	-5	-1	46
ELIP	2	2	1	1	0	1	7
Maternity	6	6	1	3	0	1	17
Critical care	1	1	0	1	0	0	3
ELDC	0	0	0	0	0	0	1
NELDC	3	3	1	1	0	0	8

11.3.3 Major acute services at Sutton Hospital

Consolidating services at Sutton Hospital implies increases in capacity across multiple providers and a reduction in capacity at Croydon University Hospital.

These are dispersed across multiple providers, with impacts on St Peter's, Kingston and St George's Hospitals each ranging from c. 12-27 beds. Impacts on other sites are fewer than 10 beds.

Changes in activity also implies a net reduction in capacity at Croydon University Hospital of c. 12 beds.

Table 64: Net changes in beds for major acute services at Sutton Hospital (core travel time scenario, 25/26)

Point of delivery	St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon	Total
NELIP	18	5	6	-2	3	-19	12
ELIP	2	1	1	1	1	4	10
Maternity	4	3	1	2	6	4	20
Critical care	0	0	0	0	1	-0	2
ELDC	0	0	0	0	0	0	1
NELDC	2	1	1	1	2	-0	6

11.4 Local provider impact assessments

11.4.1 Process to understand local provider impact

The programme asked providers to assess their impacts based on the common activity and bed information, agreed rubric to estimate capacity and costs, as well as each organisation's own analysis and deliberation. Each provider returned a report in a standard format to the programme, summarising the impact of each option on:

- Capacity (including A&E, theatres, wards, support services);
- Estates and capital;
- I&E;
- Workforce; and
- Deliverability.

Impact was assessed based on a scale of low (L), medium (M) and high (H), with providers offering further description and rationale as appropriate. Impact was considered for the three shortlisted options, each describing the additional (i.e. incremental) impact above the 'no service change' baseline comparator. It should be noted that, regardless of any impact as a result of this programme, there is a need for further capital investment in these providers as part of their core infrastructure. This investment requires funding outside of any impacts as a result of this programme.

As part of the process, providers shared draft impacts with the programme team and presented their work as part of two peer review sessions to test and review the impacts. These sessions were chaired by a senior estates lead supporting the CCGs, to provide independent challenge and validation. Following the meetings, the chair wrote a post peer-review observation note, including commentary on provider submissions.

Following this feedback, providers considered revisions to their impacts and took papers for approval, with any updates as necessary, through their boards in May and June. All provider boards have agreed these impact assessments.

11.4.2 Local provider assessments

Local impact assessments are summarised below.

Table 65: Number of responses by level of impact and option, based on initial provider impact assessments

Domain	No service change (baseline comparator)			Major acute at Epsom			Major acute at St Helier			Major acute at Sutton		
	L	M	H	L	M	H	L	M	H	L	M	H
Capacity	6	0	0	4	0	2	3	3	0	1	5	0
Estates and capital	6	0	0	4	0	2	3	2	1	2	4	0
I&E	6	0	0	4	0	2	4	2	0	2	4	0
Workforce	6	0	0	3	2	1	2	3	1	2	3	1
Deliverability	6	0	0	4	0	2	3	3	0	1	5	0
Total	30	0	0	19	2	9	15	13	2	8	21	1

11.4.3 Key messages

Providers also offered supporting narrative and rationale for these assessments. All providers stated that all options would be deliverable with the right level of investment (capital and revenue) and mitigations. Multiple providers expressed a requirement for capital and revenue consequences to be met by commissioners and this remains a clear expectation from providers.

Overall, impacts are mixed depending on the location of the provider and the option under consideration. A number of key messages are included in the following subsection. The programme recognises the risks, issues and concerns raised by local providers and work will continue to further understand this.

11.4.3.1 Ashford and St Peter's Hospitals NHS Foundation Trust

The Ashford and St Peter's Board believed all scenarios are technically deliverable, although there is a significant risk in relation to the St Helier and Sutton options relating to the availability of workforce to support increased demand at Ashford and St Peter's which is exacerbated by adherence to current care models. The Board was therefore strongly of the view that all opportunities to develop new care models, incorporating new technologies and workforce solutions, must be fully explored and exploited to provide assurance over deliverability to all stakeholders, including the public.

11.4.3.2 St George's University Hospitals NHS Foundation Trust

St George's identified that providing major acute service at Epsom would have a high impact, Sutton a high / medium impact and St Helier a low impact. This included a significant capital investment requirement. In particular, the Trust recognised that there is an element of the required investment for its emergency department that is a result of years of under-investment in the facilities at St George's, and this is a contributing factor to the ability of the organisation to respond to both the IHT impact and expected demographic growth for the MA Sutton option.

This means that the ability of the organisation to accept marginal growth is materially challenged; this impacts on the ability to take more activity, and the ability of the estate to continue to function safely and effectively.

11.4.3.3 Kingston Hospital NHS Foundation Trust

The Kingston Board agreed impacts for each option, and considers both the core and maximum impact sensitivities as deliverable. The Trust expected broadly consistent impacts across the options, with limited differentiation between them.

In addition to the direct capital implications of the IHT proposals, there are a number of other aspects of Kingston's critical infrastructure that need to be addressed over the next ten years regardless of how IHT progresses. This additional enabling capital cost was estimated by the Trust to be c. £55m, and includes the development of a modernised 21 bedded critical care facility, two new theatres, as well as replacement work to existing theatres.

11.4.3.4 Croydon Health Services NHS Trust

Croydon identified a low impact for the major acute at St Helier option, medium for the Sutton option and a high impact for the Epsom option. It stated that while all three options are deliverable, there is a financial cost within the various options, and particular challenges with the Epsom option (significant inflows), which would require significant capital investment.

11.4.3.5 Surrey and Sussex Healthcare NHS Trust

East Surrey expect overall impacts to be low for the Epsom option, medium for the St Helier option (due to additional emergency demand) and medium for the Sutton option (due to additional emergency demand). Both the St Helier and Sutton options require capital investment to support an expansion.

East Surrey agreed that the core model is deliverable. However, it noted risks associated with the core model including the impact of QIPP, seasonality, LOS, repatriation and the likelihood that a combination of the sensitivities would be needed (rather than a range of individual sensitivities).

11.4.3.6 Royal Surrey County NHS Foundation Trust

The Royal Surrey Trust Board agreed the following with regard to the activity impacts of the IHT programme:

- The core scenarios of each option and the max sensitivity of the Epsom option are deliverable.
- The max sensitivity for the St Helier and Sutton options are not deliverable but the Trust does not believe the sensitivities modelled to be material as the likelihood of them happening is deemed to be small.

This approval was predicated on the Programme providing:

- Assurance that the capital, cost of capital and operational costs required to deliver the incremental activity will be met by commissioners.
- A satisfactory model for how repatriation of NEL general medical patients will work and any additional cost this incurs to RSCH that cannot be modelled at this time.

11.4.4 Areas of high impact

Several areas of high impact were identified by providers.

For the Epsom option:

- **Capacity:** A high impact is expected by St George's and Croydon (due to increased non-elective demand). St George's impact is due to a number of estates costs including expansion of its emergency department
- **Estates and capital:** A high impact is expected by St George's (mainly linked to bed requirement) and Croydon (due to increased non-elective demand).
- **I&E:** A high impact is expected by Croydon and St George's (due to increased non-elective demand).
- **Workforce:** A high impact is expected by Croydon (due to increased non-elective demand).
- **Deliverability:** A high impact is expected by St George's and Croydon (due to increased non-elective demand).

For the St Helier option:

- **Workforce:** Ashford and St Peter's expect the required workforce to be above current plans and to not be available. This leads to an identified deliverability issue if TUPE is not available.
- **Capital:** East Surrey has estimated the capital costs needed to build a new ward, as well as an access road which will be needed to support the new block.
- East Surrey noted high risks across domains if ambulances did not cross geographical boundaries. Ambulance services currently cross boundaries to access the closest suitable hospital where relevant and it is expected that planning will support cross border ambulance flows in appropriate cases under any option.

For the Sutton option:

- **Estates and capital:** St George's expected a medium impact – due to a number of estates costs including expansion of its emergency department. East Surrey estimated the capital costs needed to build a new ward, as well as a road which will be needed to access the new block.
- **Workforce:** Ashford and St Peter's expect the required workforce to be above current plans and to not be available. This leads to an identified deliverability issue if TUPE is not available.

St George's also expect a high impact. Workforce remains a shared concern across the 6 providers and across all types of staff.

- East Surrey notes high risks across domains if ambulances did not cross geographical boundaries. Ambulance services currently cross boundaries to access the closest suitable hospital where relevant and it is expected that planning will support cross border ambulance flows in appropriate cases under any option.

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Table 66: Initial provider impact assessments (L=Low; M=Medium; H=High; *=no/other response provided)

Domain	No service change (baseline comparator)						Major acute at Epsom						Major acute at St Helier						Major acute at Sutton					
	Ashford and St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon	Ashford and St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon	Ashford and St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon	Ashford and St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon
Capacity	L	L	L	L	L	L	L	L	L	L	H	H	M	M	L	M	L	L	M	M	L	M	M	M
Estates and capital	L	L	L	L	L	L	L	L	L	L	H	H	M	L	M	H	L	L	M	L	M	L	M	M
I&E	L	L	L	L	L	L	L	L	L	L	H	H	M	L	M	L	L	L	M	L	M	L	M	M
Workforce	L	L	L	L	L	L	L	M	L	L	M	H	H	M	M	M	L	L	H	M	M	L	L	M
Deliverability	L	L	L	L	L	L	L	L	L	L	H	H	M	L	M	M	L	L	M	L	M	M	M	M

11.5 Further opportunities with the Royal Marsden Hospital

The programme has been working with the Royal Marsden Hospital (RMH) to determine the impact of any changes or opportunities within the short list of options. In particular, for the Sutton option, RMH has confirmed their involvement in and support for the potential synergies that could be realised through a new build co-located with the RMH Sutton site in a letter to ESTH.

These synergies can be summarised across three main areas. The financial impact of these have been further described in Section 13.5.

1. Estates, facilities management and clinical support services
2. Clinical service synergies; and
3. Potential savings (as yet unquantified) including a cancer hub for South West London (SWL).

Each of these areas have been further expanded on below.

11.5.1 Hard & soft facilities management (FM) and clinical support services

ESTH and RMH reviewed soft and hard FM as well as a few areas of clinical support. The areas agreed at that time as likely to deliver savings through collaboration were cleaning, inpatient catering, and laundry in FM and patient transfers, theatre consumables and shared clinical support services (e.g. Cardiology, Endocrinology, etc.). In addition to the areas of collaboration ESTH identified estates and maintenance savings from a more efficient new build (e.g. utilities and waste). RMH is supportive of the principles behind these savings including areas where joint working is required.

11.5.2 Additional clinical synergies

Additional clinical synergies could be realised through improved economies of scale or collaborative procurement approaches. RMH has confirmed its support for collaborating on the areas identified and the principles behind the savings calculations. The precise efficiency available (including the value of benefits for RMH) requires further detailed work as the programme progresses.

11.5.3 Integrated Cancer Model – SWL Cancer Hub

There is a clear commitment from ESTH, St George's and RMH to work more closely together. The Sutton option presents an opportunity to develop a more integrated cancer service model, drawing on the complementary strengths of each organisation and supported by the world leading research already undertaken at Sutton. RMH and the Institute of Cancer Research (ICR) have made significant investments in the Sutton site over the last decade including developments in radiotherapy, paediatrics, diagnostics services and laboratory and research facilities. The institutions are also opening a £70m Centre for Cancer Drug Discovery (ICR) and a £90m Oak Cancer Centre for ambulatory care and research (RMH) over the next 3 years which will be central to the development of the London Cancer Hub vision for the Sutton site, led by the London Borough of Sutton. This investment is entirely consistent with the further development of the Sutton site for NHS services.

RMH have identified that a key opportunity may be the consolidation of cancer surgery in a joint dedicated facility at Sutton to provide sufficient modern capacity for South West London in a similar fashion to that of the SWL Elective Orthopaedic Centre model. RMH would work with SWL partners to explore how services such as the large haemato-oncology unit and cancer surgical service could form part of a joint facility and would welcome the opportunity to examine this in more detail.

The impact of any further developments of this have not been considered by the programme at this stage.

11.5.4 Incorporating RMH impacts into the provider model

The specialty level activity modelling specification carried out by the programme and providers did not include any wider changes to pathways, including specialised care pathways such as cancer. This

was discussed and agreed through the provider impact group and meant that no changes in cancer flows were assumed or played into the model.

The potential for wider joint working in SW London, including the potential opportunity to enhance joint working between ESTH, RMH and St George's to improve cancer care in South West London were not been included in programme plans or modelling – rather they are areas to potentially explore further and will require further discussions between providers before any decisions to include them is made.

11.6 Inputting the provider impacts in to the overall financial model

The impacts on providers were required as an input to estimate a number of the financial metrics which are needed to inform the overall appraisal of options. This required the CCGs to interpret the information submitted by providers and ensure the most appropriate information is included in the financial appraisal.

11.6.1 Incremental and enabling capital

Based on regulator feedback and the agreed approach and principles, providers identified two categories of capital investment:

1. Incremental capital, describing capital investment which would be needed as a direct result of IHT proposals, to be included in the IHT financial appraisal of options and part of the direct capital 'ask' for IHT; and
2. Enabling capital, describing broader changes that would be needed over the next ten years to support any incremental changes and will need to be in place before any IHT options can be delivered – i.e. IHT impacts are dependent on these other plans.

In order to ensure a robust financial appraisal, only incremental capital was included in the financial model. Including additional enabling capital in the financial model would distort the financial appraisal.

Table 67 shows the incremental provider capital, which has been included in the overall financial model.

Table 67: Incremental options capital at other providers

Option: capital £m, 25/26 – incremental items	Ashford and St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon
MA Epsom	-	4	-	-	114	56
MA St Helier	17	7	7	13	-	-
MA Sutton	12	4	6	3	14	-

Broader changes – outside of the incremental capital required at other providers as a result of IHT – are being explored through commissioner capital planning and STP plans. Additional enabling capital identified by providers which includes current plans by providers which have not had capital approved and allocated.

11.6.2 I&E impacts and additional cost pressures

The financial model developed to support the options appraisal assumes that the overall annual funding available to the system is the same across all options. Similarly, based on a range of assumptions agreed with the FAE group, our regulators and in line with the NHS Long Term Plan, the

funding available to acute providers for delivering services within the combined geographies is also consistent across options.

A number of providers in their submissions indicated negative I&E impacts or cost pressures associated with delivering additional activity. There is a risk that these additional costs for providers may be greater than ESTH’s costs on average. In order to reflect this risk, a specific sensitivity (see section 13.10 for details) was developed to test the impact of higher running costs for other providers.

This sensitivity and its impact are shown below (also see section 13.10 for details).

Table 68: Description of sensitivities

Sensitivity	Description
13. Other provider cost pressures	Additional cost pressures on other providers as a result of activity outflows

The overall system NPV reduces across all options for this sensitivity.

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12 NON-FINANCIAL ANALYSIS OF OPTIONS

The initial steps of the options consideration process resulted in a short list and a set of weighted non-financial evaluation criteria.

For the scoring of the short list against the non-financial evaluation criteria, the participants of the third and final workshop were provided with evidence for each shortlisted option and the no service change comparator as developed by the programme. This evidence is described in the sections below.

This part of the options consideration process resulted in the programme board receiving a **non-financial score** for each of the short listed options, scored out of 10 based on weighted non-financial criteria, developed through workshops supported by evidence provided from engagement and the Programme. This was further supplemented by evidence developed after the workshop as a result of further analysis of local provider impacts (Section 11), the interim integrated impact assessment (Section 10.6) and assurance of the clinical model by the Joint Clinical Senate (Section 3.2.3).

The non-financial evidence provided through the options consideration process and the additional evidence developed was incorporated as part of the decision-making process (Section 16).

As part of the options consideration process two core metrics were developed for an initial appraisal of the options:

- A non-financial score of the options, scored out of 10 based on weighted quality criteria, developed through workshops and supported by evidence provided from engagement and the Programme.
- A finance score, where the core metric was the NPV of the options, developed through financial analysis from FAE and tested by Programme Board.

These metrics formed part of the evidence for CCGs to consider as part of any decision-making process.

As described in Section 3.4, the non-financial options appraisal involved identifying 3 groups of balanced representative people, drawn from across the three CCGs (including the public and professionals), where:

1. The first facilitated group agreed non-financial criteria
2. The second facilitated group agreed what weighting each non-financial criterion should carry
3. The third facilitated group agreed scoring of shortlisted options against the non-financial criteria

This process resulted in three outputs:

1. **Non-financial evaluation criteria:** The non-financial aspects that should be assessed to understand the relative merits of different options.
2. **Criteria weightings:** The relative importance of each criteria when assessing options.
3. A mean average non-financial score for each option.

This formed the basis of the non-financial evaluation of options described below. Available evidence was provided to participants to inform the non-financial options appraisal, which is included in Section 12.2 to Section 12.7 below.

This evidence was considered by Programme Board, following which further evidence was developed as described above. This was then considered as part of the decision-making process.

In addition, a number of additional financial metrics were reported, set out in Section 13.1.

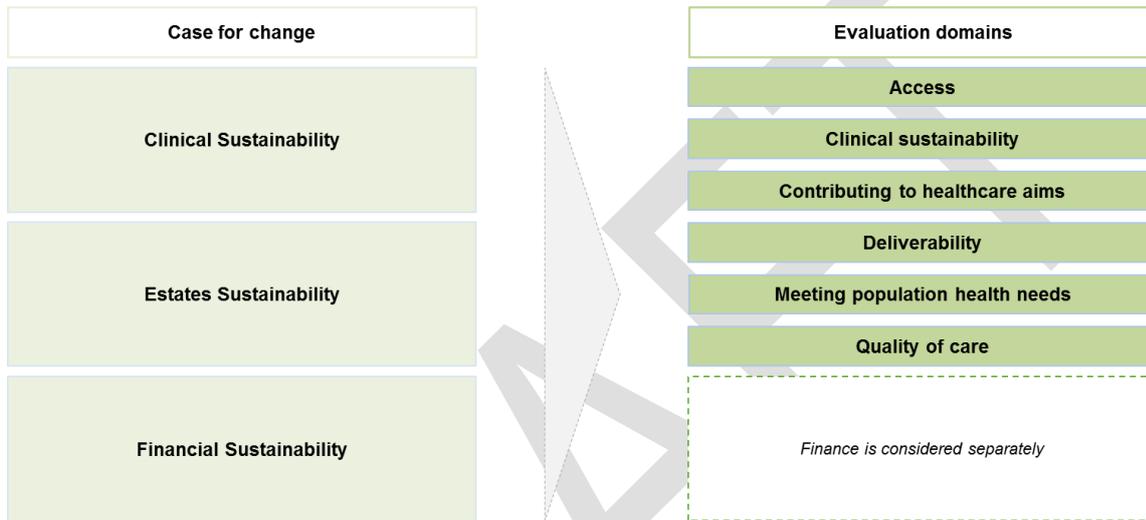
12.1 Non-financial criteria and weighting

12.1.1 Non-financial evaluation criteria

The public process undertaken resulted in the identification of 16 non-financial evaluation criteria, reflecting public priorities for assessment. These formed the basis of non-financial assessment and cover non-financial aspects as identified by the public.

These non-financial criteria were grouped into six domains as per the below figure:

Figure 62: Non-financial evaluation criteria domains



The non-financial evaluation criteria that were developed by the public are described below. The non-financial criteria and their definitions were agreed through the public engagement process and reflect local priorities.

Table 69: Non-financial evaluation criteria developed by participants in workshop 1

Domain	Non-financial criteria
Access	<ul style="list-style-type: none"> • Accessibility: The extent to which the option allows patients, staff and visitors to access the site whether using public or private transport, in terms of travel time and cost
Clinical sustainability	<ul style="list-style-type: none"> • Availability of beds: The extent to which the option allows for an appropriate number of beds to meet the needs of the population • Delivering urgent and emergency care: The extent to which the option allows patients to access urgent and emergency care when needed • Staff availability: The option can be staffed appropriately, meeting rota requirements • Workforce safety, recruitment and retention: The extent to which the option retains a sustainable level of staffing with good staff experience and reduced sickness and absence rates

Domain	Non-financial criteria
Contribution to healthcare aims	<ul style="list-style-type: none"> ● Alignment with wider health plans: The extent to which this option supports local, regional and national healthcare goals ● Integration of care: The extent to which this option improves patient journeys through the health and social care systems via effective discharge planning, better communication between professionals and patients, and clarity about pathways
Deliverability	<ul style="list-style-type: none"> ● Complexity of build: How challenging is the build of the option, considering the impact on existing services and the local community ● Impact on other providers: Impact on finance and workforce for other health and social care providers ● Time to build: Length of time taken to build the option
Meeting population health needs	<ul style="list-style-type: none"> ● Deprivation: The extent to which this option affects the most deprived communities in the area ● Health inequalities: The extent to which this option helps to reduce health inequalities ● Older people: How well this option meets the needs of the aging population
Quality of care	<ul style="list-style-type: none"> ● Clinical quality: The extent to which the option prevents people from dying prematurely, enhances quality of life and helps people recover from episodes of ill-health ● Patient experience: The extent to which the option ensures patients are confident they are being treated by the right staff and are empowered in decision-making about their treatment and care, are treated with dignity and respect in an environment that is welcoming ● Safety: The extent to which the option ensures patients are treated safely, with fewer serious incidents and lower excess mortality

12.1.2 Weightings

Public participants then assessed the relative importance of the non-financial criteria, which was converted into an overall group weighting for each of the non-financial criteria based on the average for the group. This is set out in Table 70 and reflects the priorities of local people.

Table 70: Weighting of evaluation criteria

Domain	Criteria	Weighting
Access	<ul style="list-style-type: none"> ● Accessibility 	8.4%
Clinical sustainability	<ul style="list-style-type: none"> ● Availability of beds 	5.0%
	<ul style="list-style-type: none"> ● Delivering urgent and emergency care 	8.6%
	<ul style="list-style-type: none"> ● Staff availability 	7.1%
	<ul style="list-style-type: none"> ● Workforce safety, recruitment and retention 	6.9%
Contribution to healthcare aims	<ul style="list-style-type: none"> ● Alignment with wider health plans 	3.9%
	<ul style="list-style-type: none"> ● Integration of care 	6.8%
Deliverability	<ul style="list-style-type: none"> ● Complexity of build 	5.0%
	<ul style="list-style-type: none"> ● Impact on other providers 	5.3%
	<ul style="list-style-type: none"> ● Time to build 	3.0%

Domain	Criteria	Weighting
Meeting population health needs	• Deprivation	6.3%
	• Health inequalities	6.0%
	• Older people	6.0%
Quality of care	• Clinical quality	7.8%
	• Patient experience	6.6%
	• Safety	7.3%
Total		100.0%

These criteria were used as the basis of the non-financial assessment of options.

This Section describes part 3 of the options consideration process, where the final workshop of the series aimed to score each of the options against the non-financial evaluation criteria. This workshop was attended by members of the public and professionals, who scored each of the options out of 10 against each of the criteria.

It is important to note:

- The outputs of this process are the conclusion of a public process of considering criteria and assessing options against them based on the evidence available;
- Group discussions on criteria and the overall deliberations within the workshops can be summarised;
- There is no rationale for individual weightings as this was not requested; and
- Similarly, the scores for each of the options against criteria were anonymous with no rationale requested.

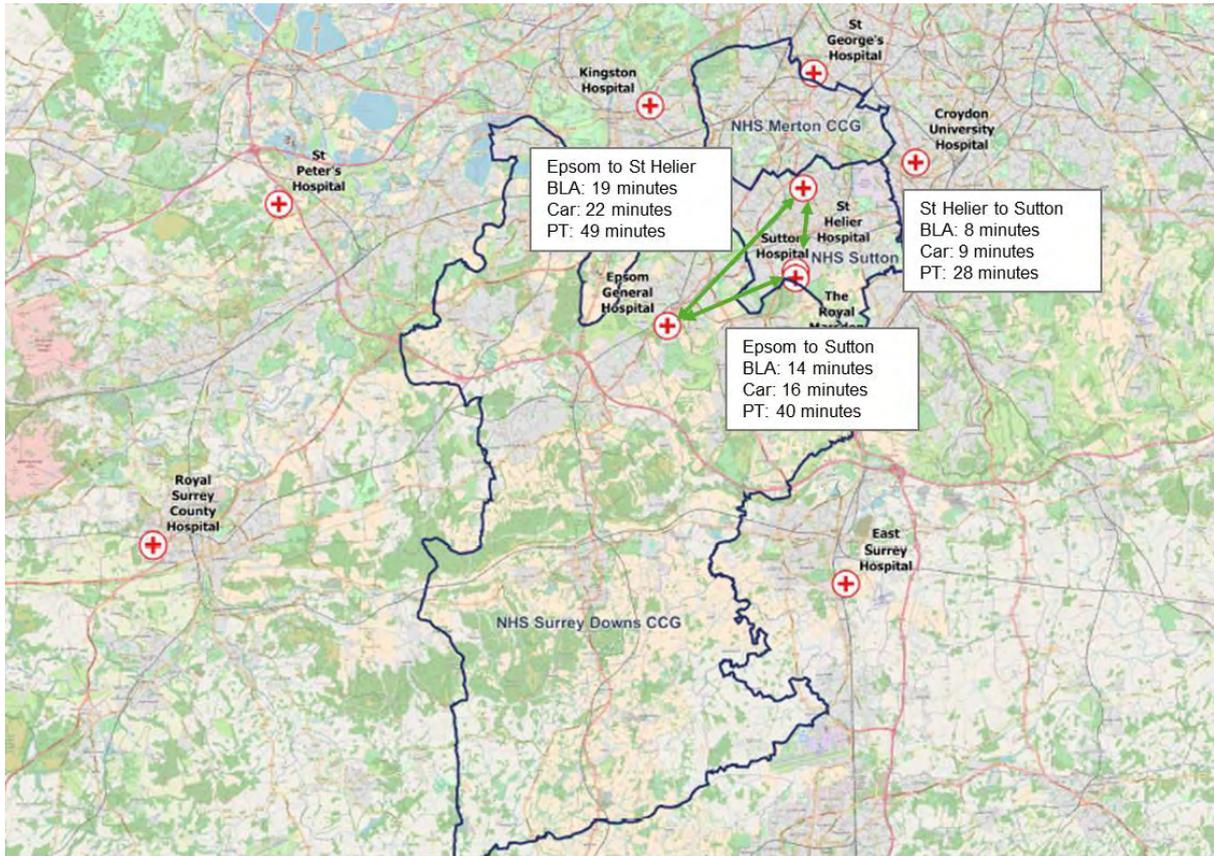
It is therefore not possible to provide a specific overall rationale for any average score and associated weighted score. However we can explain how these scores were developed and the deliberative process undertaken, as set out in Section 3.5.

12.2 Access

Access was highlighted both through the public engagement (Section 4) and through the weighting workshop as an important criterion for the location for major acute services. The process of defining criteria led to several factors being assessed as important, including public transport, accessibility for staff and the potential cost of travel.

An overview of the geography and travel times between hospital sites is shown in Figure 63.

Figure 63: ESTH hospital sites and average travel time between them (mins), by blue light ambulance (BLA), car and public transport (PT)



12.2.1 Accessibility: The extent to which the option allows patients, staff and visitors to access the site whether using public or private transport, in terms of travel time and cost

Whether the major acute site is located at Epsom, St Helier or Sutton impacts on travel times for people to access major acute services. Travel times to the district hospital sites remains the same as these services will remain in place at both Epsom and St Helier hospitals.

A table is provided which sets out the preliminary analysis for travel time by car, public transport and blue light ambulance. Travel times are presented below as a mean average, where four time periods (morning peak, interpeak, afternoon peak and off-peak) are added up and divided by the number of periods, i.e. four.²⁵²

Travel times are shown for different modes of transport:

- Car;
- Public transport; and
- Blue-light (i.e. emergency) ambulance (BLA).

Public transport measures any mode of public transport, for example bus and train, and accounts for changing transport modes and any associated waiting times. It assumes that the method with the shortest transport time is chosen.

It is assumed that non-emergency ambulances would require the same amount of travel time as cars.

²⁵² Mott MacDonald, data extracted from: PT: Triline National Dataset and Association of Train Operating Companies (ATOC) – Quarter 2 2018; Car & BLA: TM-Speeds (Trafficmaster derived journey time network) - 2017

Travel times were calculated based on lower super output areas (LSOA) to understand the different travel times from all parts of the area. LSOAs are geographic areas defined by the Office for National Statistics (ONS) which are designed to improve the reporting of small area statistics in England and Wales. LSOAs are automatically generated to be as consistent in population size as possible, with the minimum population being 1,000 and the mean 1,500.²⁵³

The table below shows the baseline travel times for the population and the change in travel time for each option. This is shown as percentiles. A percentile is a measure that indicates the value where a given percentage of ordered values will fall below. For example, the travel time by car for the 50th percentile is 10 minutes in the baseline, +3 minutes in the Epsom option, +2 minutes in the St Helier option and +1 minutes in the Sutton option. This means that for 50% of people in the combined geographies, travel times will increase from up to 10 minutes currently to up to 14 minutes in the Epsom option, 12 minutes in the St Helier option and 11 minutes in the Sutton option.

The values for the 80th and 95th percentiles reflect the highest travel times and changes for 80% and 95% of people respectively.

Travel times for major acute services are affected by the options however change from the baseline is small. For example, the 50th percentile for blue light ambulance in the status quo is 9 minutes (i.e. 50% of other travel times for LSOAs will fall below this). This increases by 3 minutes for where major acute services are at Epsom and by 1 minute for where major acute services are at St Helier or Sutton. **Table 71** gives 50th, 80th and 95th percentile for each of the options and the no service change across the three different modes of transport which was provided at the scoring workshop. This was then updated following the workshop as a result of further analysis as shown in **Table 72**. The variance between the workshop travel times and updated travel times are shown in **Table 73**.

Table 71: Original travel times for LSOAs in Surrey Downs, Sutton and Merton CCGs by percentile²⁵⁴

	<i>Travel time (mins)</i>			<i>Change from 'No service change' travel times (mins)</i>								
	No service change			Epsom			St Helier			Sutton		
Percentile	50 th	80 th	95 th	50 th	80 th	95 th	50 th	80 th	95 th	50 th	80 th	95 th
Car	9	13	18	+4	+4	+1	+2	+6	+5	+2	+2	+5
Public transport	21	32	52	+8	+5	+1	+6	+14	+13	+5	+7	+8
Blue light ambulance	8	12	16	+4	+4	+1	+2	+5	+5	+2	+2	+4

Table 72: Updated workshop travel times for LSOAs in Surrey Downs, Sutton and Merton CCGs by percentile²⁵⁵

	<i>Travel time (mins)</i>			<i>Change from 'No service change' travel times (mins)</i>								
	No service change			Epsom			St Helier			Sutton		
Percentile	50 th	80 th	95 th	50 th	80 th	95 th	50 th	80 th	95 th	50 th	80 th	95 th
Car	10	14	18	+4	+3	+1	+2	+5	+5	+1	+1	+5

²⁵³ https://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions//lower_layer_super_output_area_de.asp?shownav=1

²⁵⁴ Mott MacDonald, data extracted from: PT: Traveline National Dataset and Association of Train Operating Companies (ATOC) – Quarter 2 2018; Car & BLA: TM-Speeds (Trafficmaster derived journey time network) - 2017

²⁵⁵ Mott MacDonald, data extracted from: PT: Traveline National Dataset and Association of Train Operating Companies (ATOC) – Quarter 2 2018; Car & BLA: TM-Speeds (Trafficmaster derived journey time network) - 2017

	<i>Travel time (mins)</i>				<i>Change from 'No service change' travel times (mins)</i>							
	No service change				Epsom		St Helier			Sutton		
Public transport	23	34	53	+6	+4	0	+4	+12	+12	+3	+6	+7
Blue light ambulance	9	13	17	+3	+3	+1	+1	+5	+5	+1	+1	+4

Table 73: Variance in original workshop and updated travel times for LSOAs in Surrey Downs, Sutton and Merton CCGs by percentile²⁵⁶

	<i>Travel time (mins)</i>			<i>Change from 'No service change' travel times (mins)</i>								
	No service change			Epsom			St Helier			Sutton		
Percentile	50 th	80 th	95 th	50 th	80 th	95 th	50 th	80 th	95 th	50 th	80 th	95 th
Car	+1	+1	-	-	-1	-	-	-1	-	-1	-1	-
Public transport	+2	+2	+1	-2	-1	-1	-2	-2	-1	-2	-1	-1
Blue light ambulance	+1	+1	+1	-1	-1	-	-1	-	-	-1	-1	-

The key points to note on travel time are:

- The travel times across the area are relatively low;
- There are only small differences between the options; and
- The updated analysis does not differ significantly from the scoring workshop travel times, and any changes are largely driven by an increase in the travel time for the no service change.

St. Helier has the largest increases in average travel times of 12 minutes for public transport, with average travel times close to or just over one hour. All other changes across modes and options are, on average, fewer than 10 minutes. This was further analysed through the IIA, which also describes mitigating actions for those most affected by the impact of longer and more complex journeys.

Regarding public transport in the future, several proposals may impact on travel times through:

- Planned changes, such as a proposal from TfL outlining an additional tram line between Wimbledon, St Helier and Sutton²⁵⁷ or the capacity increase of South West Rail at Waterloo station.²⁵⁸ These are examples of proposals with many more planned for the area, which are subject to confirmation.
- This has not been included in the calculations of travel time at this stage as it is not possible to predict at this stage what the impact will be.

In addition, capacity for parking at each of the options will be assessed through estates planning at a later stage in the process.

²⁵⁶ Mott MacDonald, data extracted from: PT: Traveline National Dataset and Association of Train Operating Companies (ATOC) – Quarter 2 2018; Car & BLA: TM-Speeds (Trafficmaster derived journey time network) - 2017

²⁵⁷ Trams for growth, TfL, April 2016 <http://content.tfl.gov.uk/trams-for-growth-presentation.pdf>

²⁵⁸ Surrey County Council, Surrey rail strategy, 2013

12.2.1.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 74: Mean average participant scoring of the options against the accessibility criteria

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Access	Accessibility	6.70	5.39	5.26	6.17

12.3 Clinical sustainability

The outputs of workshop one confirmed the importance of the solutions being able to address clinical sustainability challenges as set out in the case for change. Four different criteria were grouped under this domain for scoring. This included:

- Availability of beds
- Delivering urgent and emergency care
- Staff availability
- Workforce safety, recruitment and retention

12.3.1 Availability of beds: The extent to which the option allows for an appropriate number of beds to meet the needs of the population

An analysis of the change in the number of beds required to meet the needs of the population was carried out by the programme, of which there are currently 1,048 beds at ESTH. Across all the options the programme is planning that the appropriate number of beds will be the same across the system provided either by ESTH or by other providers.

Whether the location for the site is at Epsom, St Helier or Sutton may mean that patients may choose to go elsewhere, as the major acute site may no longer be their closest hospital. Therefore we further modelled the likely future bed requirements based on our work in developing the clinical model, options and travel time.

We expect to need 1,052 – 1,082 beds for the population in 25/26. Currently there are 1,048 at ESTH. All options will provide 1,052 beds in the future other than the no service change option, which is expected to be less efficient than the other options and mean a requirement for 30 additional beds (1,082).

The number of beds in the future are distributed differently for each option:

- **Epsom as the major acute site:** There would be 293 district beds and 342 major acute beds at Epsom Hospital, 213 district beds at St Helier Hospital and 205 beds moving to other providers as a result of changed travel times impacting on the ESTH catchment.
- **St Helier as the major acute site:** There would be 225 district beds and 469 major acute beds at St Helier Hospital, 277 district beds at Epsom Hospital and 81 beds moving to other providers.
- **Sutton as the major acute site:** There would be 496 major acute beds at Sutton Hospital, 285 district beds at Epsom Hospital; 221 district beds at St Helier Hospital, and 50 beds moving to other providers.

These totals are shown below.

Table 75: Number of beds by option

Major acute site	Epsom	St Helier	Sutton	Other providers	Total beds needed for the population
Current beds	454	594	-	-	1,048
No service change (25/26)	470	612	-	-	1,082 ^[1]
Epsom (25/26)	634	213	-	205	1,052
St Helier (25/26)	277	694	-	81	1,052
Sutton (25/26)	285	221	496	50	1,052

The impact on other providers is considered as a separate criterion.

12.3.1.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 76: Mean average participant scoring of the options against the beds availability criteria

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Clinical sustainability	Availability of beds	5.65	6.57	7.39	7.48

12.3.2 Delivering urgent and emergency care: The extent to which the option allows patients to access urgent and emergency care when needed

EDs are for genuine life-threatening emergencies. In all options, the major acute site will offer an ED which will be open 24/7 with support from critical care, acute medicine and emergency surgery. EDs will be staffed by consultants and meet relevant standards (see Section 5.5).

The EDs at Epsom and St Helier are used by c.53,000 patients per year.

UTCs are considered to be district services within the clinical model and would ensure that patients' urgent care needs are met within a local setting. In all options, Epsom and St Helier will offer 24/7 UTCs to provide access for patients requiring urgent medical attention with access for walk-in, triaged ambulances and NHS 111 bookings and adhere to the national UTC guidance.²⁵⁹

- If Epsom or St Helier were the major acute site, they would offer a UTC alongside an ED. There would be no UTC at Sutton. Therefore for these options, **there would be two UTCs across the geography.**
- If Sutton were the major acute site, it would also offer a UTC alongside the ED, operated by the acute ED. Therefore for this option, **there would be three UTCs across the geography.**

^[1] The no service change counterfactual requires more beds as it is expected to be less efficient.

²⁵⁹ <https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf>

UTCs will be staffed by GPs, with support from emergency departments where needed. The UTCs will meet national standards for access and be open 24/7. In addition, GP out of hours, 111 and the emergency department will be available 24/7.

All options provide access to an ED and UTCs.

- In all options, Epsom and St Helier will offer UTCs to provide access for patients requiring urgent medical attention with access for walk-in, triaged ambulances and NHS 111 bookings.
- In all options, the major acute site will offer an ED open 24/7 with support from critical care, acute medicine and emergency surgery.

Service configuration and blue light ambulance times for each of the options is shown below.

Table 77: Urgent and emergency care provision by option

Major acute site	Epsom	St Helier	Sutton
No service change	ED (24/7) + UTC (24/7)	ED (24/7) + UTC (24/7)	–
Epsom	ED (24/7) + UTC (24/7)	UTC (24/7)	–
St Helier	UTC (24/7)	ED (24/7) + UTC (24/7)	–
Sutton	UTC (24/7)	UTC (24/7)	ED (24/7) + UTC (24/7)

Table 78: Blue light ambulance times by option (mins)²⁶⁰

	<i>Travel time (mins)</i>			<i>Change from 'No service change' travel times (mins)</i>								
	No service change			Epsom			St Helier			Sutton		
	Percentile	50 th	80 th	95 th	50 th	80 th	95 th	50 th	80 th	95 th	50 th	80 th
Blue light ambulance	9	13	17	+3	+3	+1	+1	+5	+5	+1	+1	+4

12.3.2.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 79: Mean average participant scoring of the options against the delivering urgent and emergency care criteria

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Clinical sustainability	Delivering urgent and emergency care	5.65	5.86	6.23	7.00

12.3.3 Staff availability: The option can be staffed appropriately, meeting rota requirements

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

²⁶⁰ Mott MacDonald, data extracted from: PT: Travaline National Dataset and Association of Train Operating Companies (ATOC) – Quarter 2 2018; Car & BLA: TM-Speeds (Trafficmaster derived journey time network) - 2017

attempts to change the roles and skill mix needed, drawing on local best practice. However there are still significant rota gaps which are unlikely to be filled given current growth rates in consultants²⁶¹. This is described in detail in Section 9.1.2.2.

CAG has concluded that all options which consolidate major acute services will have sufficient staff to fill the rotas and meet standards. This includes:

- Meeting minimum standards for the number of consultants (as described in Section 2.2.3).
- Consolidating existing rotas to reduce pressures on middle grades, junior doctors, nurses and AHPs (as described in Section 13.5).

Table 80 sets out the staffing requirements against standards for each of the options (see Section 9.3.4). These are based on standards that define requirements per site offering a major acute service.

For the no service change comparator, standards must be met over two sites, meaning more staff are needed than are currently available. As described in Section 9.3.4, these are not expected to be available. Therefore, while this cost would be required in this comparator scenario, this is not expected to be deliverable.

Each of the consolidation options means standards need to be met on one site rather than two. Therefore, the minimum staffing required per site to standards (shown in the second column) can be met when major acute services are consolidated onto one site for each of the short listed options.

Table 80: Staffing requirement by option

Service	Total minimum requirement per site	No service change requirement (two sites)	Epsom	St Helier	Sutton
Emergency department	12-16	24	20	20	20
Obstetrics	12-16	22	20	20	20
Emergency general surgery	10	10	10	10	10
Paediatrics	12-16	35	24	24	24
Acute medicine	12	24	12	12	12
Intensive care	9	9	9	9	9

CAG concluded that there is not expected to be a material difference in staff availability across the options, as:

- There is the same staffing requirement against standards for all options.
- Similar levels of rota consolidation can be achieved in all options.
- For the no service change comparator, it is assumed that sufficient staff can be recruited to fill the requirement for two sites.

12.3.3.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

The mean average results of each of the individual participants' scoring of options are shown below.

²⁶¹ HEE

Table 81: Mean average participant scoring of the options against the staff availability criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Clinical sustainability	Staff availability	3.22	7.48	7.91	7.83

12.3.4 Workforce safety, recruitment and retention: The extent to which the option retains a sustainable level of staffing with good staff experience and reduced sickness and absence rates

A sustainable workforce impacts directly on the quality of care that is delivered and outcomes for patients. Our clinical model aims to ensure that the workforce will be enabled to deliver the best possible care.

Staff satisfaction metrics for ESTH are compared with similar Trusts in Section 6.3 – this suggests there may be room for improvement.

The clinical model aims to make best use of the workforce. The CAG has concluded that it may:

- Decrease the unsustainable strain on clinicians by increasing the level of cover to standards;
- Reduce sickness and absence rates with a decreased workload reducing stress and tiredness;
- Enhance attractiveness and recruitment through providing additional opportunities for training, a beneficial work environment and career opportunities;
- Reduce use of bank and agency through more effective cover of the rotas; and
- Change the skill mix of the workforce by ensuring consultant cover meets major acute standards.

The CAG concluded that there is not expected to be a material difference in workforce experience across the options, as the clinical model is expected to be delivered in the same way, providing the same workforce benefits.

The clinical model is expected to be able to be staffed by all groups, regardless of option. There is insufficient evidence to determine which option may be preferable for staff recruitment and retention.

There is a risk that Epsom have difficulty in attracting obstetricians and neonatologists, due to the low numbers of births for this option.

12.3.4.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

The mean average results of each of the individual participants' scoring of options are shown below.

Table 82: Mean average participant scoring of the options against the workforce safety, recruitment and retention criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Clinical sustainability	Workforce safety, recruitment and retention	4.00	6.52	6.74	6.91

12.4 Contribution to healthcare aims

The contribution the options made to wider health plans and integration of care were defined as important criteria by the participants of workshop one, as it was considered that new plans would be less likely to be successful where they did not align to local, regional and national strategies.

Therefore two criteria were defined under this domain:

- Alignment with wider health plans
- Integration of care

12.4.1 Alignment with wider health plans

NHS England, together with other national bodies, has developed a Long Term Plan (10 years) to supersede the Five Year Forward View. The priorities include:

- Boosting out-of-hospital care
- Emergency care services will also be expanded and reformed to help ensure patients get the care they need faster, relieve pressure on A&E departments
- Digitally-enabled primary and outpatient care will go mainstream
- More NHS action on prevention and health inequalities
- To cut smoking, to reduce obesity, to limit alcohol related A&E admissions, to lower air pollution.
- Further progress on care quality and outcomes
- NHS staff will get the backing they need
- Digitally-enabled care will go mainstream across the NHS
- Taxpayers' investment will be used to maximum effect

Other relevant strategies are the five year forward view (FYFV) and five year forward view next steps.

Building on this, and as set out in Section 1.3.1, our STPs identified key areas of focus:

- **In Surrey Heartlands**, these include aims to achieve consistent clinical pathways and remove unwarranted variation; deliver a system which is sustainable and designed to deliver quality, efficiency and access in care.
- **In SWL**, these include principles such as 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.

Taking local context, national context and the healthcare needs of our populations into account, we have identified aims for the future of healthcare locally, set out in Section 5.1. CAG has developed a clinical model that intends to achieve these aims (See Section 5.1).

CAG does not expect there to be a material difference in contribution across the options, as these aims are delivered by the consistent clinical model.

12.4.1.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 83: Mean average participant scoring of the options against the alignment with wider health plans criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Contribution to wider healthcare aims	Alignment with wider health plans	2.74	6.91	6.74	7.17

12.4.2 Integration of care

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. This is described in Section 1.4.3. CAG does not expect there to be a material difference in contribution across the options, as integration of care is progressing outside the hospital and is not site dependent.

12.4.2.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 84: Mean average participant scoring of the options against the integration of care criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Contribution to wider healthcare aims	Integration of care	5.30	6.17	6.17	6.74

12.5 Deliverability

This domain encompasses a number of criteria as defined by participants from workshop one, ranging from estates considerations to the impact on the wider healthcare system.

12.5.1 Complexity of build: How challenging is the build of the option, considering the impact on existing services and the local community

There are no further viable locations for a major acute site beyond the options described, as set out in Section 9.4. Any significant new hospital build or refurbishment may need patients and/or services to be relocated (this is also known as a decant). This can impose a significant additional cost. Some options may require temporary accommodation to provide services while other spaces are redeveloped. Refurbishment of sites can only begin once new areas are available due to space requirements.

Some options are expected to be more complex to build as they take place on an operational hospital site:

- No service change:
 - Mostly refurbishment of existing buildings.
 - Temporary decant building required at St Helier. Due to space constraints, refurbishment will be undertaken over a number of phases.
- Epsom:
 - New ward block required at Epsom.
 - Decanting of services required from buildings prior to construction. Demolition of existing buildings may require changes to access points.
 - Refurbishment can take place when new building open – some decant required.
- St Helier:
 - Large decant facility required at St Helier. Decant building may need to be located in main car park, displacing staff parking.
 - Refurbishment can take place when new building open – some decant required.
- Sutton:

- Mostly clear land with only a small amount of demolition required at Sutton.
- Refurbishment can take place when new building open – some decant required.

Table 85: Decanting and temporary accommodation costs for each of the options

Major acute site	No service change	Epsom	St Helier	Sutton
Decanting and temporary accommodation costs	15.0	11.8	24.7	6.2

12.5.1.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 86: Mean average participant scoring of the options against the complexity of build criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Deliverability	Complexity of build	4.61	5.91	5.00	8.04

12.5.2 Impact on other providers: Impact on finance and workforce for other health and social care providers

We have developed initial estimates of impact based on bed and capacity requirements; detailed work is ongoing.

Impacts were based on changes in travel time, where beds have been used as a proxy for impact. Specific analysis of impacts requires detailed work, but initial views have been developed based on programme analysis.

Each option is expected to lead to some differential impacts on different providers:

- Epsom:
 - Significant flow of patients currently using the St Helier site, particularly to St George's and Croydon.
 - Some inflows from emergency surgery patients currently using Surrey Trusts to the Epsom site.
 - Scale of impacts may create delivery challenges at both Trusts.
 - For the London Ambulance Service, this may result in a refurbishment at Sutton Ambulance Station or new premises.
- St Helier:
 - Flow of patients currently using the Epsom site to multiple providers (Ashford St Peter's, Kingston, Surrey and Sussex, and Royal Surrey).
- Sutton:
 - Flow of patients currently using the Epsom and St Helier sites to multiple providers (Ashford St Peter's, Kingston, St George's).
 - Some inflows from patients currently using Croydon to the new Sutton site.

Table 87: Inflows and outflows from other providers as a result of the option for major acute services

	No service change	Epsom	St Helier	Sutton
Inflow	-	37	-	69
Outflow	-	242	81	119
TOTAL Net	-	205	81	50

Detailed work on the impact of these changes on providers is complete, and impacts estimated by providers are set out in Section 11. However, we have provided an initial indication of potential impacts based on some broad estimates. This was not considered in detail for I&E, capital, workforce and deliverability which will follow from providers.

These initial estimates are based on impact on capacity, using bed changes as a proxy for impact. Table 88 describes the indicative levels of impact assumed for different levels of scale and the rationale.

Table 88: Key describing impact on other providers

Impact	Indicative scale	Rationale
L	<25 beds	<1 ward, likely to require refurbishment
M	25-75 beds	c. 1-3 wards, likely to need a new block
H	>75 beds	>3 wards, likely to need significant building work

The levels of impact for different providers across the options are described in Table 89.

Table 89: Impact on other providers (measured by number of beds)²⁶²

Site	Epsom	St Helier	Sutton
Croydon	H (105)	L (1)	L (-11)
Kingston	L (7)	L (23)	L (12)
St George's	H (108)	L (-5)	L (14)
St Peter's	L (0)	M (39)	M (26)
Royal Surrey	L (-3)	L (10)	L (8)
East Surrey	L (-13)	L (12)	L (1)

12.5.2.1 Updates following further evidence development

The information that was presented at the scoring workshop was the preliminary analysis as carried out by the programme. More detailed analysis took place to determine more accurate impacts by speciality on these providers as set out in Section 11.

The programme asked providers to assess their impacts based on the common activity and bed information, agreed rubric to estimate capacity and costs, as well as each organisation's own analysis and deliberation. Overall, impacts are mixed depending on the location of the provider and the option under consideration. However, with the right mitigations, all providers have indicated that solutions would likely be deliverable.

²⁶² Estimates are based on programme analysis and have not been agreed with provider Boards. Estimates are based on a single scenario and do not include sensitivities. More detailed analysis is required before decision-making.

Table 90: Incremental options capital at other providers

Option: capital £m, 25/26 – incremental items	St Peter's	Kingston	Royal Surrey	East Surrey	St George's	Croydon	Total
MA Epsom	-	4	-	-	114	56	174
MA St Helier	17	7	7	11	-	-	44
MA Sutton	12	4	6	1	14	-	39

12.5.2.2 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 91: Mean average participant scoring of the options against the impact on other providers criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Deliverability	Impact on other providers	5.59	3.52	6.48	6.70

12.5.3 Time to build: Length of time taken to build the option

The build of a hospital is complex and takes many years. This often requires patients in wards to be moved temporarily and can cause disruption to services. The number and sequencing of moves, and the breadth of refurbishments necessary impacts on the complexity of the build and the time taken to build.

Due to their complexity, some options will take more time to build:

- No service change: Redevelopment requires multiple phases over 5 years
- Epsom: Redevelopment requires multiple phases over 6 years
- St Helier: Redevelopment requires multiple phases over 7 years
- Sutton: Redevelopment requires multiple phases over 4 years

Table 92: Number of years to build for each of the options²⁶³

	No service change	Epsom	St Helier	Sutton
Major acute site	5	5	7	3
Overall time	5	6	7	4

12.5.3.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

²⁶³ Turner and Townsend

Table 93: Mean average participant scoring of the options against the time to build criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Deliverability	Time to build	4.87	5.70	4.61	7.57

12.6 Meeting population health needs

Participants from workshop one wanted to ensure that the options were assessed against the needs of more vulnerable groups who may require more access to major acute services or are less likely to be able to access major acute services. This includes:

- Deprivation
- Health inequalities
- Older people

12.6.1 Deprivation: The extent to which this option affects the most deprived communities in the area

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The national Index of Multiple Deprivation shows that overall, Sutton, Merton and, in particular, Surrey Downs are not significantly deprived when compared to the rest of England.

- The issues increasing the deprivation score in Merton and Sutton are primarily the living environment and crime, whilst in Surrey Downs it is barriers to housing;
- In relation to the health elements Merton, Sutton and Surrey Downs score relatively well;
- However, there are eleven localised areas, 4 in Merton and 7 in Sutton, with a total population of 17,500 people that are within the most deprived areas of the country; and
- All areas are relatively close to the proposed solutions being considered with better than national average access to major acute services.

An independent review²⁶⁴ found that decisions about the major acute service locations are likely to only have marginal impacts on health outcomes for deprived communities because:

- Health outcomes decline with increasing deprivation, but there is less evidence linking deprivation with the need and usage of the specific major acute services;
- The deprived areas within the combined geography are in relatively close proximity to the proposed solutions.

Evidence suggests that a greater impact on health outcomes for deprived communities would be more likely to come from concerted effort earlier in the health and care service pathways prior to need for major acute services.

The geographical area of Sutton and Merton, which contains the pockets of deprivation, is fairly concentrated resulting in a relative ease of access to major acute services. Initial proposals for any changes to locations of major acute services are likely to have relatively marginal impact on access.

The interim IIA has found that the Epsom option may impact on a greater proportion of deprived communities. The increases in journey times expected for a small proportion of this group is between 15 and 30 minutes extra travel time by blue light ambulance. For those from deprived communities who are travelling as a visitor or via public transport in some instances this is expected to exceed 30 minutes. The Epsom option may therefore result in longer journey times for patients from deprived

²⁶⁴ Deprivation impact analysis, independent report prepared by Cobic/Nuffield Trust/PPL

backgrounds and longer, more complex or costly journeys which may exacerbate existing health inequalities.

12.6.1.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 94: Mean average participant scoring of the options against the deprivation criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Meeting population health needs	Deprivation	4.87	4.13	5.30	5.57

12.6.2 Health inequalities: The extent to which this option helps to reduce health inequalities

The criterion was discussed in the context of prevention.

It is estimated that 80% of health outcomes are affected by out of hospital care²⁶⁵. Alongside the 20% from acute care, 20% of a healthy lifespan is determined by genetics, 30% is the environment, and 30% is what people can do themselves – the choices they make.

The clinical model developed by CAG is supported by a range of prevention initiatives, including:

- Integration of health and wellbeing services supported by care navigation, health visiting and social prescribing
- Enhanced patient education
- Screening and early intervention
- Immunisation and vaccination programmes.

As described under the quality of care domain, CAG expects experience, quality and safety to be consistent across all the options. The prevention initiatives set out in the clinical model developed by CAG are further described under Section 1.4.2²⁶⁶.

The IIA carried out an assessment of potential health inequality impacts. It found:

- A positive impact on reducing health inequalities for deprived communities within the combined geographies will likely come from concerted effort in addressing the wider determinants of health. The IIA found that it is likely that in making changes to the way acute services are commissioned will accelerate the growth and improvement of district services within both the Epsom and St Helier hospital sites.
- The developments to district services proposed as part of the service redesign may result in improved health outcomes for those from areas of high deprivation, helping to tackle health inequalities.
- Given that all communities are likely to engage more frequently with district services, the changes these services may bring in terms of reducing health inequalities may go some way in reducing any potential negative impact from deprived communities having to travel further to access acute services.

²⁶⁵ DHSC, <https://www.gov.uk/government/speeches/primary-care-is-crucial-to-preventing-ill-health>

²⁶⁶ Improving Healthcare Together 2020-2030 Initial equalities analysis of major acute services

12.6.2.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 95: Mean average participant scoring of the options against the health inequalities criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Meeting population health needs	Health inequalities	3.52	3.70	3.87	4.13

12.6.3 Older people: How well this option meets the needs of the ageing population

Our equalities impact scoping report²⁶⁷ concludes that older people tend to have a higher need for/use of emergency acute services such as: A&E, acute medicine and emergency general surgery.

Generally, linked to age, this group experience a range of health concerns which would bring them into contact with acute services and which tend to be exacerbated by a high proportion of old people living longer with complex co-morbidities.

The independent deprivation study²⁶⁸ concludes that age is the largest contributor to acute health need, and any future model of care needs to consider the older population as a key component.

CAG has developed a clinical model that specifically addresses the needs of older people, including the development of the district bed model, integration of care for long term conditions and enhanced frailty assessment.

The interim IIA carried out an assessment of potential health inequality impacts. It found that for the St Helier option, older people are expected to be disproportionately impacted by longer, more complex and more costly journeys. This is due to larger densities of this group being located in the more rural south of Surrey Downs.

12.6.3.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 96: Mean average participant scoring of the options against the older people criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Meeting population health needs	Older people	5.43	6.35	5.57	5.91

12.7 Quality of care

The quality of care domain includes a number of criteria assessed as important by the participants in workshop one:

- Clinical quality
- Patient experience
- Safety

²⁶⁷ Improving Healthcare Together 2020-2030 Initial equalities analysis of major acute services

²⁶⁸ Deprivation impact analysis, independent report prepared by Cobic/Nuffield Trust/PPL

12.7.1 Clinical quality: The extent to which the option prevents people from dying prematurely, enhances quality of life and helps people recover from episodes of ill-health

This relates to the provision of care, for example how rapid access is to the appropriate level of care and the right specialists. Several measures of clinical quality have been described in Section 6.2.3. It is likely that improvement against some areas is possible. Performance of ESTH within the current clinical model will however not be directly comparable with the future clinical model.

The CAG concluded that:

- An effective consultant-led model of care has been shown to lead to quicker and more appropriate decision making. This can result in a decreased length of stay, more efficient use of beds, decreased rates of readmission and decreased need for patient follow-up.
- Options where there is a consolidation of services onto an acute site will have benefits of increased consultant cover and co-located services (See Section 6.2.3).

The CAG does not expect there to be a material difference in clinical quality across the options, as:

- The clinical model is expected to be delivered in the same way, including offering increased consultant-delivered care and integrating services.
- Refurbishment is expected to be functionally the same as a new build, offering similar quality benefits (e.g., co-locating departments).

12.7.1.1 Options evaluation workshop outcome

The mean average results of each of the individual participants’ scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 97: Mean average participant scoring of the options against the clinical quality criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Quality of care	Clinical quality	3.74	6.48	6.91	6.35

12.7.2 Patient experience: The extent to which the option ensures patients are confident they are being treated by the right staff and are empowered in decision-making about their treatment and care, are treated with dignity and respect in an environment that is welcoming

This relates to patient experience of the provision of care. Primarily this is driven by the clinical model, which is consistent across options. As for clinical quality, it is difficult to assess future impacts on patient experience.

The Friends and Family Test is used nationally to assess patient experience. While the clinical model may result in an improvement to patient experience, it is difficult to assess how this may differ across the options.

The CAG discussed that benefits of the clinical model for patient experience may include:

- Improved consistency, continuity and efficiency of district services, with enhanced personalisation and integration improving patient experience.
- Increased consultant presence to clinical standards for major acute services, as well as being able to access outpatient and maternity services closer to home.

Digital healthcare is expected to be enhanced across all options.

There is not expected to be a material difference in patient experience depending on site configuration, as:

- The clinical model is expected to be delivered in the same way, including patient pathways.
- Refurbishment is expected to be functionally the same as a new build, offering similar experience benefits (e.g., quality of environment).

Given the design of the clinical model, transfers would be needed for patients stepping down from the major acute to district care. While many aspects will be consistent across options, there may be some differences:

- Epsom: Patients either transfer within Epsom site (trolley transfer) or transfer to St Helier site (ambulance transfer).
- St Helier: Patients either transfer within St Helier site or transfer to Epsom site.
- Sutton: Patients transfer to Epsom or St Helier site; some acute oncology patients may not need to transfer for cancer care as RMH co-located.

Transfers may have an effect on patient experience but the evidence is inconclusive.

12.7.2.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 98: Mean average participant scoring of the options against the patient experience criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Quality of care	Patient experience	4.30	6.04	6.65	6.26

12.7.3 Safety: The extent to which the option ensures patients are treated safely, with fewer serious incidents and lower excess mortality

The safety of healthcare provision is a result of the quality and efficacy of the clinical model. Among others, this is related to workforce capacity and capability, infection control, access to care and diagnostics.

Mortality indicators are one of the ways to measure safety, alongside many others including serious incidents and medication errors. Considering one of the most important measures, the standardised hospital mortality indicator (SHMI) and hospital standardised mortality ratio (HSMR), this can be used to assess whether the number of deaths linked to a particular hospital is more or less than expected. SHMI includes deaths within hospital, and deaths that occur within 30 days of being discharged. HSMR focusses on deaths that occur within hospital. This is set out in Section 6.2.3.

The CAG believes that all the options can deliver safety benefits:

- There are some areas such as general medicine where mortality outcomes could be improved.
- The RCP has found a correlation between acute medicine consultant staffing levels and hospital standardised mortality ratios.
- Options where there is a consolidation of services onto an acute site are expected to have benefits of increased consultant cover and co-located services.
- The district beds are expected to enable patients to be treated separately, and reduce the likelihood of hospital acquired infections.

The CAG does not expect there to be a material difference in safety across the options, as:

- The clinical model is expected to be delivered in the same way, including meeting clinical standards.

- Refurbishment is expected to be functionally the same as a new build, offering similar safety benefits (e.g., infection control).

12.7.3.1 Options evaluation workshop outcome

The mean average results of each of the individual participants' scoring of options are shown below. The scores are out of 10, where 10 is high.

Table 99: Mean average participant scoring of the options against the safety criterion

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Quality of care	Safety	4.61	7.04	7.39	7.43

12.8 Summary impact of further evidence development

There have been small changes as a result of updated analysis or further evidence which support the initial ranking of the options. This has been summarised below for each of the domains.

12.8.1 Impact of the Clinical Senate review

There are several areas where the Clinical Senate highlighted where the CAG should consider whether there may be differentiation between the options.

- **Co-location of the major acute site and district hospital site** – The Senate considered potential differentiation in options pertaining to co-location of the major acute site and district hospital site. Having reviewed these recommendations CAG does not view this as a differential, as the sites will be operationally distinct and transfer protocols will be in place. Explicit criteria will be in place to establish whether a patient is suitable for district hospital care or major acute care, and there will be robust assessment and transfer arrangements in place to ensure patients receive care in the appropriate place.
- **Number of births for the Epsom option** – The Senate raised considerations around births at Epsom if this was chosen as the major acute site. Although this option has the lowest number of births, this would be mitigated by ensuring academic and training links were established with other units to attract staff to the unit. The predicted birth rates are in line with BAPM standards to provide a L2 neonatal unit, although this is close to the minimum requirement.
- **UTC provision** – There would be an additional UTC at Sutton if this is chosen as the location of the major acute site.

The Clinical Advisory Group did not view there to be any major impact on the options within the non-financial domains as a result of this review.

12.8.2 Impact by domain

Table 100: Summary impact of further evidence development

Criteria	Initial evidence base	Updates to evidence base	Impact
Accessibility	Average travel times by car, public transport and BLA for LSOAs by percentile	Small changes to travel times as a result of updated analysis	Supports initial ranking – no further differentiation in options
Availability of beds	Number of beds by option needed for the population for 25/26	Small changes to bed numbers as a result of updated analysis	Supports initial ranking – no further differentiation in options

Delivering UEC	Number of EDs and UTCs by option; blue light travel times by option	Small changes to travel times as a result of updated analysis; further definition of Sutton option UTC	Supports initial ranking – further potential benefits identified
Staff availability	Total staff requirement across major acute specialities by option to meet standards	No change	N/A
Workforce safety, recruitment and retention	Staff satisfaction metrics and description of clinical model benefits for workforce	Evidence base strengthened, with additional risk raised around staffing the maternity unit for the Epsom option	Supports initial ranking – further differentiation, as Epsom option may appear to be less favourable than other options. Epsom scored the lowest of the options in the workshop, which suggests a working hypothesis that has been strengthened by the evidence.
Alignment with wider health plans	Description of alignment with the current local, regional and national strategies	Updated following publication of the NHS long term plan	No further differentiation in options as expected to be equal across all
Integration of care	Description of alignment with the current local, regional and national strategies	No change – further evidence compiled	No further differentiation in options as expected to be equal across all
Complexity of build	Decanting and temporary accommodation requirements and associated costs	No change	N/A
Impact on other providers	Inflows and outflows from other providers by option; bed requirements and indicative high-level impacts	Detailed activity changes and capital requirements for other providers based on specialty-level data	Supports initial ranking – Epsom option continues to be less favourable than other options, with a much higher capital ask than other options.
Time to build	Number of years to build for each of the options for the major acute site and the overall time	No change	N/A
Deprivation	Description of findings of deprivation review and impact on health outcomes, concluding that interventions earlier in the care pathway had a greater influence than major acute services.	The IIA has indicated that the Epsom option may have a greater impact on deprived groups due to the increased length of journey, and increased complexity and costs of the journey for deprived areas which are predominately located in Sutton and Merton.	Supports initial ranking – Epsom option is further differentiated from the St Helier and Sutton option as being less favourable for deprived communities
Health inequalities	Description of how the clinical model will enhance prevention initiatives	The IIA reconfirms the evidence base for the importance of district services in impacting positively on reducing health inequalities.	N/A

Older people	Description of the equalities impact scoping report and how the clinical model meets needs.	The IIA has indicated that the St Helier option may have a greater impact on older people due to the increased length of journey, and increased complexity and costs of the journey for older communities which are predominately located in Surrey Downs	Supports initial ranking – St Helier option is further differentiated from the Epsom and Sutton option as being less favourable for older communities
Clinical quality	Description of the benefits of the clinical model.	No change – further evidence compiled around benefits of the model Potential further upsides of Sutton option identified through working with RMH	All options deliver the clinical model and associated benefits – further evidence provides further support of this
Patient experience	Description of the benefits of the clinical model for patient experience and consideration of the evidence base for transfers.	No change – further evidence compiled around benefits of the model	All options deliver the clinical model and associated benefits – further evidence provides further support of this
Safety	Description of the benefits of the clinical model.	No change – further evidence compiled	All options deliver the clinical model and associated benefits – further evidence provides further support of this

Across the criteria, the further evidence supports the initial ranking implied by the non-financial scoring.

12.9 Result of the non-financial evaluation

The scoring workshop resulted in a mean average score for options against the criteria, against which the weightings were applied. A table is shown below with the mean average scores for each criterion and the weightings. The total row at the bottom shows the score for each of the options once the weightings were applied. The scores are out of 10, where 10 is high.

Table 101: Average scores of scoring workshop

Domain	Criteria	No service change	Epsom	St Helier	Sutton
Access	Accessibility	6.70	5.39	5.26	6.17
Clinical sustainability	Availability of beds	5.65	6.57	7.39	7.48
	Delivering urgent and emergency care	6.36	5.86	6.23	7.00
	Staff availability	3.22	7.48	7.91	7.83
	Workforce safety, recruitment and retention	4.00	6.52	6.74	6.91
Contribution to wider healthcare aims	Alignment with wider health plans	2.74	6.91	6.74	7.17
	Integration of care	5.30	6.17	6.17	6.74
Deliverability	Complexity of build	4.61	5.91	5.00	8.04

Domain	Criteria	No service change	Epsom	St Helier	Sutton
	Impact on other providers	5.59	3.52	6.48	6.70
	Time to build	4.87	5.70	4.61	7.57
Meeting population health needs	Deprivation	4.87	4.13	5.30	5.57
	Health inequalities	3.52	3.70	3.87	4.13
	Older people	5.43	6.35	5.57	5.91
Quality of care	Clinical quality	3.74	6.48	6.91	6.35
	Patient experience	4.30	6.04	6.65	6.26
	Safety	4.61	7.04	7.39	7.43
Total		75.52	93.78	98.23	107.26

Sutton had the highest average score across 11 criteria out of 16, followed by St Helier with the highest average score across 3 criteria and Epsom and no service change with the highest average score across 1 criterion.

The table below shows the average scores once weightings were applied, and the total scores for each of the options.

Table 102: Average scores of scoring workshop with weightings applied to show total average score

Domain	Criteria	Weighting	No service change	Epsom	St Helier	Sutton
Access	Accessibility	8.4%	0.56	0.45	0.44	0.52
Clinical sustainability	Availability of beds	5.0%	0.28	0.33	0.37	0.37
	Delivering urgent and emergency care	8.6%	0.55	0.50	0.54	0.60
	Staff availability	7.1%	0.23	0.53	0.56	0.55
	Workforce safety, recruitment and retention	6.9%	0.28	0.45	0.47	0.48
Contribution to wider healthcare aims	Alignment with wider health plans	3.9%	0.11	0.27	0.26	0.28
	Integration of care	6.8%	0.36	0.42	0.42	0.46
Deliverability	Complexity of build	5.0%	0.23	0.30	0.25	0.40
	Impact on other providers	5.3%	0.29	0.19	0.34	0.35
	Time to build	3.0%	0.15	0.17	0.14	0.23
Meeting population health needs	Deprivation	6.3%	0.31	0.26	0.33	0.35
	Health inequalities	6.0%	0.21	0.22	0.23	0.25
	Older people	6.0%	0.33	0.38	0.33	0.36
Quality of care	Clinical quality	7.8%	0.29	0.50	0.54	0.49
	Patient experience	6.6%	0.29	0.40	0.44	0.42

Domain	Criteria	Weighting	No service change	Epsom	St Helier	Sutton
	Safety	7.3%	0.34	0.51	0.54	0.54
	Total	100%	4.79	5.89	6.21	6.65

The non-financial score was one of the factors that fed into the CCGs' decision-making process.

DRAFT

13 FINANCIAL ANALYSIS OF OPTIONS

To determine the financial impact of the shortlisted options, a range of financial metrics were reported by the Finance, Activity and Estates workstream. These metrics were produced to provide further information or inform any decision-making for Programme board, Governing Bodies and the Committees in Common.

These metrics include:

- Income and expenditure (I&E)
- Capital investment required
- Return on investment (ROI)
- Net present value (NPV)

These metrics were produced to determine the affordability, value for money and feasibility of delivering the options.

As set out in Section 3.5, alongside the non-financial options consideration process, the finance workstream reported a series of financial criteria for each option, including I&E, cashflow, net capital expenditure, system NPV and ROI.

System NPV was decided to be the core metric for evaluation of options by FAE.

The finance and activity work has been overseen by the finance, activity and estates group (FAE), including signing off assumptions and outputs – membership includes ESTH, commissioners, and NHSE/I. Eight workstreams were established, covering:

1. Overall finance and activity model: Development of an overall activity and financial model to support the financial evaluation of the short list of options, as well as a range of sensitivities.
2. Establishing the baseline: Agreement of the baseline for activity, beds and finances, and agreement of growth assumptions to produce a forecast. This baseline is consistent to 19/20 plans and control totals.
3. Out of hospital model: Alignment between the clinical model and QIPP plans to ensure assumptions around activity shifts to out of hospital settings are evidenced and supported by a clear logic model and strategy.
4. Options modelling: Development of assumptions around demand shifts for the short list of options, including analysis around patient flow changes. Industry standard travel time analysis approaches were used to develop these assumptions.
5. Financial benefits: Estimation of the financial benefits of the clinical model to support analysis of the short list of options, including opportunities of the clinical model; broken down in to c. 15 categories.
6. Estates: Estimation of the space, estates requirements and capital costs for the baseline and each of the short list options – undertaken by independent advisors and according to best practice methods. This includes allowances for optimism bias, contingency and inflation (as per PUBSEC indices).
7. Financing: An analysis of potential financing scenarios to source the capital requirement for each option, including the impact on affordability. This included developing a preferred route for PDC financing for the full amount; as well as an alternative mixed financing scenario, should public financing be unavailable.

8. Provider impacts: Estimation of the impact of the short list on other neighbouring providers in terms of activity, capacity, capital, finance and workforce, using detailed activity data from all providers in SWL and Surrey.

13.1 Financial metrics

The finance workstream reported a series of metrics for each option. Financial evaluation includes a number of standard metrics, including:

- **System net present value:** The net present value of each option considers the total benefits (operating income; financial benefits from the clinical model; and other savings); less the investments required and the costs (operating and non-operating expenditure; capital investment required; and transition costs); at current values, by applying a discount rate to weight the relative value of future cash flows.
- **Return on investment:** ESTH and system ROI, including accounting for the potential additional investment at neighbouring hospitals (i.e. capital investment at other providers) and the associated revenue cost of capital based on public borrowing at 3.5%. Work on financing options in section 14 considers alternative financing options where the capital cost is not 3.5%.
- **Net capital requirement:** The total capital investment at ESTH over the period which is required for the scheme in each option (including new build and refurb elements), less the financing which has already been secured, either through existing loans or cash set aside.
- **Income and expenditure:** ESTH income and expenditure, but also accounting for the potential additional investment at neighbouring hospitals (i.e. capital investment at other providers) and the associated revenue cost of capital based on public borrowing at 3.5%.

To meet regulatory and assurance requirements, additional financial metrics were reported. These include capital availability, impact on CDEL, cash position and ESTH I&E.

Each option was assessed against each of these metrics. These are reported alongside the quality evaluation in Section 12.

13.2 ESTH income and expenditure

ESTH is expected to be in a c. £23m deficit by 25/26 based on continuing to run services as they currently operate. The majority of finance metrics are reported to 25/26 as this is expected to be the first year of operation for any implemented option. Definitions and outputs for each of these metrics are described below.

13.2.1 ESTH 25/26 income

Income at ESTH to 25/26 is based on current ESTH income and an agreed set of forecast assumptions reflecting:

- Activity growth based on demographic and non-demographic growth in Surrey Downs, Sutton and Merton;
- Income (tariff) growth based on national assumptions; and
- Activity and income changes as a result of the changes to major acute services for each option.

Table 103: Output for income metric

Category	Metric	No service change	Epsom	St Helier	Sutton
Finance	ESTH 25/26 income (£m)	538	485	512	521

13.2.2 ESTH 25/26 expenditure

Expenditure at ESTH to 25/26 is based on current ESTH expenditure and an agreed set of forecast assumptions reflecting:

- Activity growth;
- Inflation and cost pressures based on national assumptions;
- Cost improvement plans based on ESTH efficiency plans;
- Activity and cost changes as a result of the changes to major acute services for each option, including financial benefits driven by the clinical model; and
- Costs associated with borrowing the capital requirement based on a c. 3% loan from DHSC (see Section 14).

This means expenditure is likely to increase in comparison to 16/17.

Table 104: Output for expenditure metric

Category	Metric	No service change	Epsom	St Helier	Sutton
Finance	ESTH 25/26 expenditure (£m)	(560)	(474)	(501)	(504)

13.2.3 ESTH 25/26 in year income and expenditure

This describes the income for ESTH in 25/26, less the expenditure for ESTH in 25/26. This provides an estimate of any surplus or deficit for each of the options. It is based on the financing costs described above and therefore the borrowing of the capital required with a 3% loan from DHSC.

The options have an improved I&E position relative to the no service change counterfactual, as described in Section 2.5.1.1. While there are additional financing costs compared to the no service change comparator due to the capital investment required, this improvement is driven by the benefits from consolidating major acute services.

The system is clear that failure to secure the capital investment needed to support the development of its proposed clinical model, will result in continued overspends of over c. £20m per annum, which will require central revenue support, such as through the financial recovery and provider sustainability funds.

Table 105: Outputs for finance metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Finance	ESTH 25/26 in year I&E (£m)	(22.6)	10.9	11.3	17.0

13.3 Estates and capital

The estates and capital work resulted in overall outputs for each of the option for net capital requirement for ESTH, as well as capital investment required for other providers. Total capital

investment includes any financing which has already been secured, e.g. internal financing which reflects Trust accumulated cash.

Capital requirements for ESTH under each option have been calculated by expert estates advisors based on best practice and relevant standards and guidance, including DHSC Health Premises Cost Guides (HPCG). The estimates include the costs required for new buildings and any refurbishment needed, across all relevant sites.

This included:

- Estimating the space required for the activity required on each site under each option and, of this, the refurbishment or new build space required; and
- Estimating the capital requirement for this new build and refurbished space for each site under each option, including completion of OB1 cost forms.

Space requirements

Space requirements (gross internal floor area (GIFA)) are estimated at departmental level (e.g., A&E, inpatient wards, critical care, theatres, maternity, etc.) and include:

- Space required for service delivery;
- Communication and circulation space (e.g., corridors, waiting areas); and
- Space for facilities infrastructure (e.g., plant, pipes and ducting, extraction facilities).

Based on this, indicative massing reflects the footprint of the building and land required.

Capital costs

Capital requirements were then used to estimate the cost of providing this space, including:

- Costs for each department: Cost of new build and refurbished space, based on the departmental GIFA and HPCG-compliant cost of this, adjusted as necessary to reflect the nature and scale of the function and project-specific drivers.
- On-costs: Additional allowances to cover external building and engineering works associated with any construction (e.g., drainage, site layout, water, electricity) as well as option specific requirements not allowed for within the HPCG base costs.
- Location factors: Adjustments to costs to reflect the cost of hospital construction in the local area.
- Fees: Costs for professional fees associated with construction (e.g., architects, engineers, quantity surveyors, planners, project management).
- Non-work costs: Adjustments to cover a range of other costs (e.g., planning fees, decanting, temporary accommodation, transfer costs).
- Equipment costs: Costs for equipment required for any site.
- Planning contingency: A standard allowance to provide contingency in capital estimates.
- Optimism bias: A standard allowance to reflect the risk of under-estimating the cost of construction.
- Inflation: Adjustments to the nominal cost to capture inflation to 2025/26, based on PUBSEC 195 forecast to 2025/26.

13.3.1 Net capital investment

Net capital investment measures the total capital investment required at ESTH. This was calculated for the length of time required for each option including time required for any new build or refurbishment. This investment includes any financing which has already been secured, e.g. internal financing which reflects Trust accumulated cash.

Table 106: Capital investment for options

Capex (£m, to 25/26)	Epsom	St Helier	Sutton
Total gross capex ESTH	337	440	529
Internal financing (ESTH)	34	34	34
Potentially reduced capital driven by updated planning assumptions	2	4	8
Additional land sales provided by ESTH	8	16	15
Total ESTH external financing required	292	386	472

Table 107: Estates and capital metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Estates and capital	ESTH net capital investment (£m)	225	292	386	472

13.3.2 Capital investment in other providers

Based on regulator feedback and the agreed approach and principles, providers identified the incremental capital requirement. This describes the capital investment which is needed as a direct result of IHT proposals, to be included in the IHT financial appraisal of options and part of the direct capital 'ask' for IHT. This investment is summarised in the table below.

Table 108: Estates and capital metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Estates and capital	Capital investment other providers (£m)		174	44	39

13.4 25/26 financing costs

The cost of financing has an impact on income and expenditure for ESTH to 25/26, associated with borrowing the capital requirement based on a c. 3% loan from DHSC. Sensitivities have been applied which estimate the financing costs based on a range of different sources of financing with different arrangements.

Table 109: Outputs for finance metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Finance	25/26 financing costs (DHSC loan) (£m)	(10)	(14)	(18)	(22)

13.5 Financial benefits

The clinical model and consolidation of key services is expected to result in a range of financial benefits by 25/26. These are described below and include estimated cost reductions and a number of income improvements.

We have worked to quantify the benefits of the clinical model which are described in Section 6. The options are expected to deliver financial benefits of c. £33 - 49m per annum by 25/26. These include, for all options:

- Design related benefits -nursing
- Technology
- Other workforce
- Design related benefits - non pay
- Length of Stay
- Consultants
- Junior doctors
- District hospital investment
- Nursing Workforce
- Estates consolidation
- Medical agency spend
- Private care
- Delivering the clinical model at scale

In addition, co-location with the Royal Marsden site at Sutton is expected to offer additional benefits, including:

- Clinical synergies and support services; and
- Shared facilities management.

Table 110: Financial benefits driven by the clinical model per annum by 25/26

Benefit	Description	Epsom	St Helier	Sutton	Basis of estimate
Design related benefits -nursing	By redesigning facilities, the environment provides a safer environment for nursing staff, resulting in reduced nursing turnover and fewer staff injuries	0.9	0.9	1.0	International evidence, supplemented w / Trust data
Technology	Utilising new technologies will offer benefits, particularly around reducing administrative workforce from an integrated electronic patient record implementation. In the Sutton option, there are additional savings from the ability to provide on-site deep storage space.	6.7	7.4	7.6	Similar NHS business case
Other workforce	Consolidation savings through reduction in number of porters and bed managers required to provide care to the sickest patients across two acute sites.	0.3	0.3	0.3	Trust bottom up work
Design related benefits - non pay	Improvements in building design result in financial benefits, particularly through the avoidance of adverse events.	0.1	0.1	0.1	International evidence, supplemented w / Trust data
Length of Stay	By redesigning the clinical model, improving patient flow and building new facilities, the Trust hopes to be able to achieve top quartile length of stay. Improvements vary however by the amount of new build in each option as new buildings afford a better opportunity for best practices in floorplan design.	2.1	2.3	2.4	Benchmarking across NHS data
Consultants	The changes in WTE medical staffing associated with consolidation of acute services to care for the sickest patients on a single acute site could result in reduced workforce costs, particularly thorough the avoidance of the increased cost of meeting clinical standards that a single consolidated acute site allows. Additional savings may be had in the Sutton option where urgent treatment centres savings are adjusted for the three site model.	11.3	11.3	11.3	Trust bottom up work, to meet SWL standards
Junior doctors		5.8	6.4	6.6	Trust bottom up work, to meet SWL standards
District hospital investment	Incremental workforce requirement for district hospital beds and UTCs	-1.6	-1.8	-2.4	Trust bottom up work, to meet SWL standards
Nursing Workforce	The changes in WTE nurse staffing will reduce nursing workforce costs, particularly through changes in skill mix ratios applied across the Trust.	0.9	1.0	1.1	Trust bottom up work, to meet SWL standards
Estates consolidation	The improvements in estates performance will offer benefits in the cost of maintain and operating the estate, including efficiencies in energy utilisation, maintenance costs, lifts cleaning and intra-Trust patient transfers.	0.9	0.9	0.9	Benchmarking across NHS estates data, subject to Trust review
Reduced depreciation		1.3	2.1	2.4	

Recurrent cost pressures	In addition to costs directly associated with activity, the Trust faces a number of unplanned cost pressures each year, such as unplanned workforce demand. A number of these unplanned cost pressures are associated with the estate and current service delivery model, and as such would be mitigated in the options, reducing the annual increase in cost pressures faced by the Trust.	5.5	5.5	5.5	Unplanned cost pressures can be reduced, particularly based on a new build site
Additional transport costs		-0.5	-0.5	-0.5	
Below the line economies of scale	Economies of scale benefits have been estimated based on a long run total cost elasticity, based on a mid-point from available evidence.	-0.7	3.1	5.8	
Subtotal		32.9	39.1	42.1	
Clinical synergies	The synergies aim to improve productivity by avoiding unnecessary tests and patient transfers	0.0	0.0	0.6	
Clinical support services	Sharing support services will improve utilisation and reduce wastage. There are also expected to be additional economies of scale across diagnostics and reduced costs through improved purchasing power.	0.0	0.0	2.1	Trust bottom up work, with RMH, supported with data from both Trusts. A letter from RMH supporting the co-location synergies is included as part of the annex material
Shared facilities management	Sharing support services – including facilities management – could reduce support costs. Specific improvements include: cleaning, laundry, energy cost, water utilisation, etc.	0.0	0.0	3.3	
Expanding private care	Improved margin for private care and increased demand through access to RMH private catchment.	0.0	0.0	1.0	
Subtotal		0.0	0.0	7.0	
Total		32.9	39.1	49.1	

A number of the financial benefits from consolidation were scaled to reflect the impact of catchment size on the potential efficiencies which could be achieved. Where the overall level of demand and population catchment size (defined as an ESTH site being patients’ nearest emergency centre) was higher, there were expected to be greater economies of scale and scope opportunities and therefore increased consolidation savings.

The scaling of savings was estimated based on activity and cost shares (fixed, semi-fixed and variable) and applied to granular savings components. This adjustment allowed the methodology to reflect that where savings reflect mostly fixed costs which do not vary with activity, the level of savings are not scaled as they do not increase proportionately with activity.

Table 110 includes expected workforce benefits. This has been developed in detail with input from the CAG and FAE. This is further explained in Section 13.5.1.

13.5.1 Medical workforce benefits

The current shape of the workforce and the impact of consolidation will impact on whether clinical standards can be met.

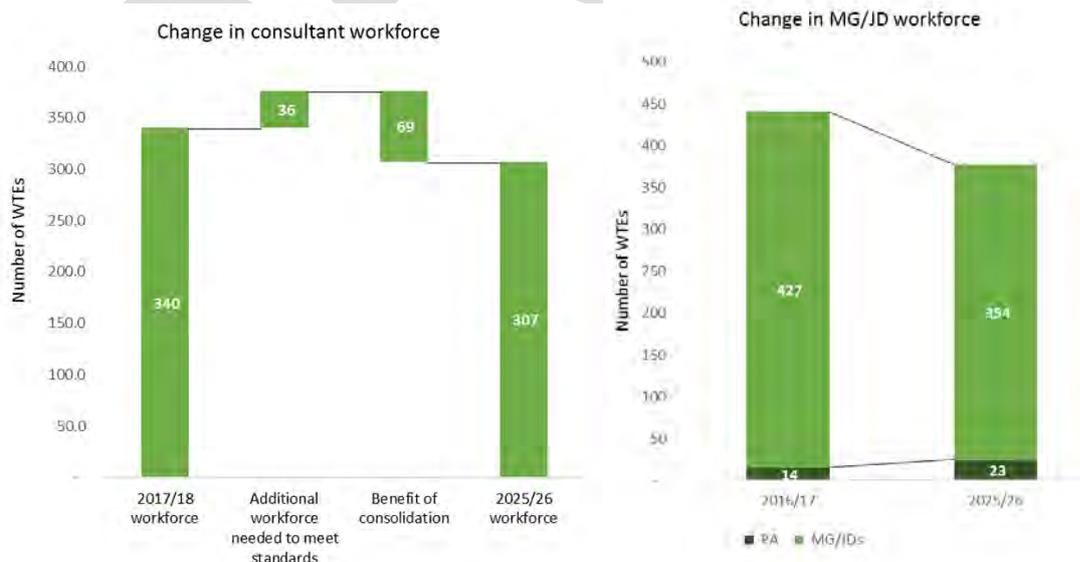
In order to determine whether clinical standards can be met now and in the future we considered:

- The current gap in consultants, junior doctors and middle grades based on current establishment; and;
- The impact on consolidating major acute services on the future requirement of consultants, junior doctors and middle grades.

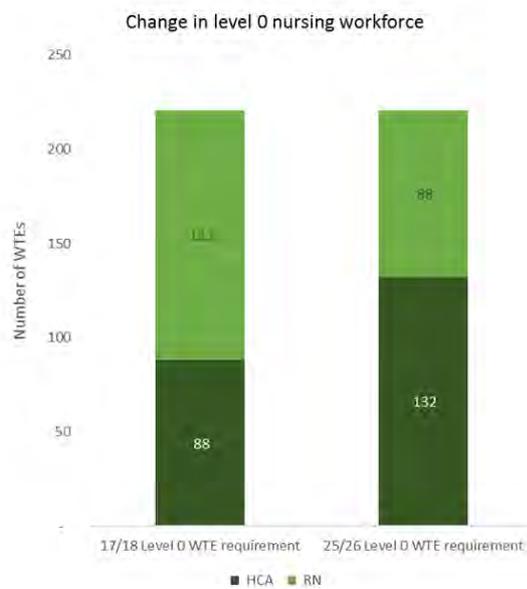
Our analysis suggests that the consultant and midgrade and junior doctor workforce requirements of a consolidated acute site will release workforce. This is driven by:

- The requirement to meet clinical standards;
- Consolidation of major acute services on one site;
- A greater role for physician’s associates;
- Scaling by option; and
- Allocation of existing workforce to district sites.

Figure 64: Change in overall consultant and middle grade and junior doctor workforce



13.5.2 Nursing workforce benefits



By moving lower acuity patients to the district site an improved nursing skill mix is possible.

The number of nursing staff required at the district site was determined by assuming that 22% of staff would be required with 1 WTE covering level 0 acuity (as set out by the safer nursing care tool).

The respective number of HCAs and registered nurses at the district site has been calculated by assuming a changed skill mix of 60:40 HCA:RN, compared to the current 40:60 HCA:RN ratio.

This opportunity is scaled by option.

13.5.3 Workforce summary by option

The workforce numbers for each of the options are shown in the tables below. This has been further described below:

- ESTH currently has c. 2,364 WTEs, including c. 340 WTE consultants.
 - The Trust does not meet clinical standards for acute medicine, critical care and emergency department consultant staffing.
 - Overall, meeting clinical standards requires c. 376 WTE consultants – an increase of c. 36 compared to the current establishment – and has pressures across doctor staffing.
 - These staff are not expected to be available.
- The clinical model consolidates major acute services – including acute medicine, critical care and the emergency department – onto a single site.
 - Staffing this site requires c. 1,210 – 1,760 WTEs – c. 600 – 1,100 fewer than the current establishment.
 - This staffing can be broadly met from existing staff.
 - This includes c. 212 – 307 consultants – meeting clinical standards in all specialties without the need for additional consultants.
- Alongside the major acute site, services are retained as district hospital sites.
 - These services would require c. 480 WTEs to operate at Epsom and St Helier hospitals.
 - Of these, most would be drawn from existing staff.
 - c. 30 are incremental, including new interface physicians (c. 12, of which 2 are recruited and 2 are advertised), UTC GPs (c. 6 – 10, of which 6.6 are in plans) and radiographers (c. 0 – 7).
- In total, c. 1,690 – 2,237 WTEs are needed for the model.
 - Mostly, this can be staffed from the current establishment – there is an overall decrease of c. 130 – 550 compared to a current establishment.
 - An additional c. 35 WTEs would be needed in specific areas, mainly for the district site – these additional staff are expected to be available locally.

Table 111: Workforce for the Sutton option

Category	Role	Major acute site	District (Epsom)	District (St Helier)	Total	Current total	Variance
Doctors	Int. physician	0	6	6	12	2	+10
	Consultants	307	-	-	307	340	-33
	Middle grades	292	2	2	296	360	-64
	Junior doctors	62	6	6	74	77	-3
	PAs	23	-	-	23	14	+7
	GP (UTC only)	3	3	3	10	0	+10
Nurses	ANP	22	2	2	27	27	-
	ENP	12	-	-	12	12	-
	RNs/HCAs	696	182	141	1020	1049	-29
	Midwives	231	-	-	231	249	-18
AHPs	Dietician	7	4	3	15	15	-
	OTs	18	10	8	36	38	-2
	Physiotherapists	24	14	11	49	51	-2
	Sp. & Lng therapy	5	3	2	11	11	-
	Radiographers	57	33	26	128	121	+7
Total		1760	266	211	2237	2366	-129

Table 112: Workforce for the Epsom option

Category	Role	Major acute site	District (Epsom)	District (St Helier)	Total	Current total
Doctors	Int. physician	0	6	6	12	2
	Consultants	212	0	0	212	340
	Middle grades	201	2	2	206	360
	Junior doctors	43	6	6	55	77
	PAs	16	0	0	16	14
	GP (UTC only)	0	3	3	6	0
Nurses	ANP	22	2	2	27	27

	ENP	12	0	0	12	12
	RNs/HCAs	480	188	136	804	1049
	Midwives	147	0	0	147	249
AHPs	Dietician	5	4	4	13	5
	OTs	12	11	10	33	12
	Physiotherapists	17	14	10	41	17
	Sp. & Lng therapy	4	3	2	9	4
	Radiographers	40	34	25	98	121
Total		1210	273	207	1690	2366

Table 113: Workforce for the St Helier option

Category	Role	Major acute site	District (Epsom)	District (St Helier)	Total	Current total
Doctors	Int. physician	0	6	6	12	2
	Consultants	290	0	0	290	340
	Middle grades	276	2	2	280	360
	Junior doctors	59	6	6	71	77
	PAs	22	0	0	22	14
	GP (UTC only)	0	3	3	6	0
Nurses	ANP	22	2	2	27	27
	ENP	12	0	0	12	12
	RNs/HCAs	658	179	145	982	1049
	Midwives	241	0	0	241	249
AHPs	Dietician	7	4	3	14	5
	OTs	17	10	8	35	12
	Physiotherapists	23	13	11	47	17
	Sp. & Lng therapy	5	3	2	10	4
	Radiographers	54	32	26	112	121
Total		1686	260	215	2161	2366

The overall outputs for the finance metrics are shown in Table 114.

Table 114: Output for financial benefits metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Finance	- 25/26 financial benefits from consolidation (£m)		33	39	49

13.6 ESTH return on investment

This describes the change in the 25/26 ESTH in year income and expenditure position compared to the no service change comparator, measured relative to the capital investment required for each option.

This metric therefore estimates the financial benefit of the option compared to the capital investment required. As the options are measured relative to the no service change comparator, the no service change comparator itself does not have a return on investment.

Table 115: Outputs for finance metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Finance	ESTH return on investment 25/26 (%)	-	11.5%	8.8%	8.4%

13.7 Financing options

To understand how the capital requirement may be financed, we have also undertaken an initial appraisal of potential financing sources.

The main financing scenario we have explored is drawing on PDC to secure the financing – this is our preferred financing route. As an alternative, should public financing routes be unavailable, we have also considered a mixed financing approach – drawing on a number of sources, including leveraging LA financing.

To understand the potential cost of different financing options, we measured the change in the income and expenditure position for ESTH in 25/26 due to financing the capital through the different routes, compared to the position based on borrowing the capital required with a 3% loan from DHSC (described in Section 14.1.1)).

This therefore provides an estimate of the change in costs as a result of financing the capital requirement from different routes.

Table 116: Financing options

Category	Metric	No service change	Epsom	St Helier	Sutton
Financing options	ESTH 25/26 in year I&E, with PDC financing (preferred route) (£m)		11.1	12.2	16.3
	ESTH 25/26 in year I&E, with mixed financing (£m)	-	6.5	5.2	12.7

The total ESTH income and expenditure position by 25/26 is greatest for the Sutton option. This is driven by the additional benefits (including co-locating with RMH) outweighing the higher annual capital costs needed to pay for a new build facility.

13.8 System impact

The system impact considers the impact on other local providers as well as ESTH. These changes were measured in terms of the return on investment and net present value for each of the options.

13.8.1 System return on investment

This is the same metric as the ESTH return on investment described in Section 13.5.2, but also accounting for the potential additional investment required for other providers. This includes the associated cost of capital based on public borrowing at 3.5%.

As the options are measured relative to the no service change comparator, the no service change comparator itself does not have a return on investment.

Based on regulator feedback and the agreed approach and principles (see Section 12), providers identified the incremental capital requirement. This describes the capital investment which is needed as a direct result of IHT proposals, to be included in the IHT financial appraisal of options and part of the direct capital 'ask' for IHT. This is included within the system impact.

It was assumed that the cost of running services at other providers is the same as ESTH, given these are based on tariff costs. A specific sensitivity (see section 13.10) has been developed to test the impact of higher running costs for other providers.

Table 117: System impact

Category	Metric	No service change	Epsom	St Helier	Sutton
System impact	System return on investment 25/26 (£m)		5.3%	7.4%	7.3%

13.8.2 System net present value

Net present value (NPV) is used as best practice within The Green Book²⁶⁹ as an objective measure for comparing total benefits for different options over an extended period of time, as it is less likely to be skewed by financial accounting treatments and rules. NPV considers the total benefits for each option, including:

- operating income (e.g. ESTH income received);
- financial benefits from the clinical model (see Section 13.5); and
- other income (e.g. education and research funding).

The system NPV is then less the investments required and the costs at current values, including:

- operating and non-operating expenditure (e.g. ESTH costs of providing services);
- capital investment required; and
- transition costs (e.g. cost of temporary buildings and double-running of some services in the intervening period).

A discount rate of 3% for the first 30 years and 3.5% onwards has been applied to weight the relative value of future cash flows in line with best practice guidance in The Green Book.

²⁶⁹ The Green Book, Central government guidance on appraisal and evaluation, HM Treasury, 2018

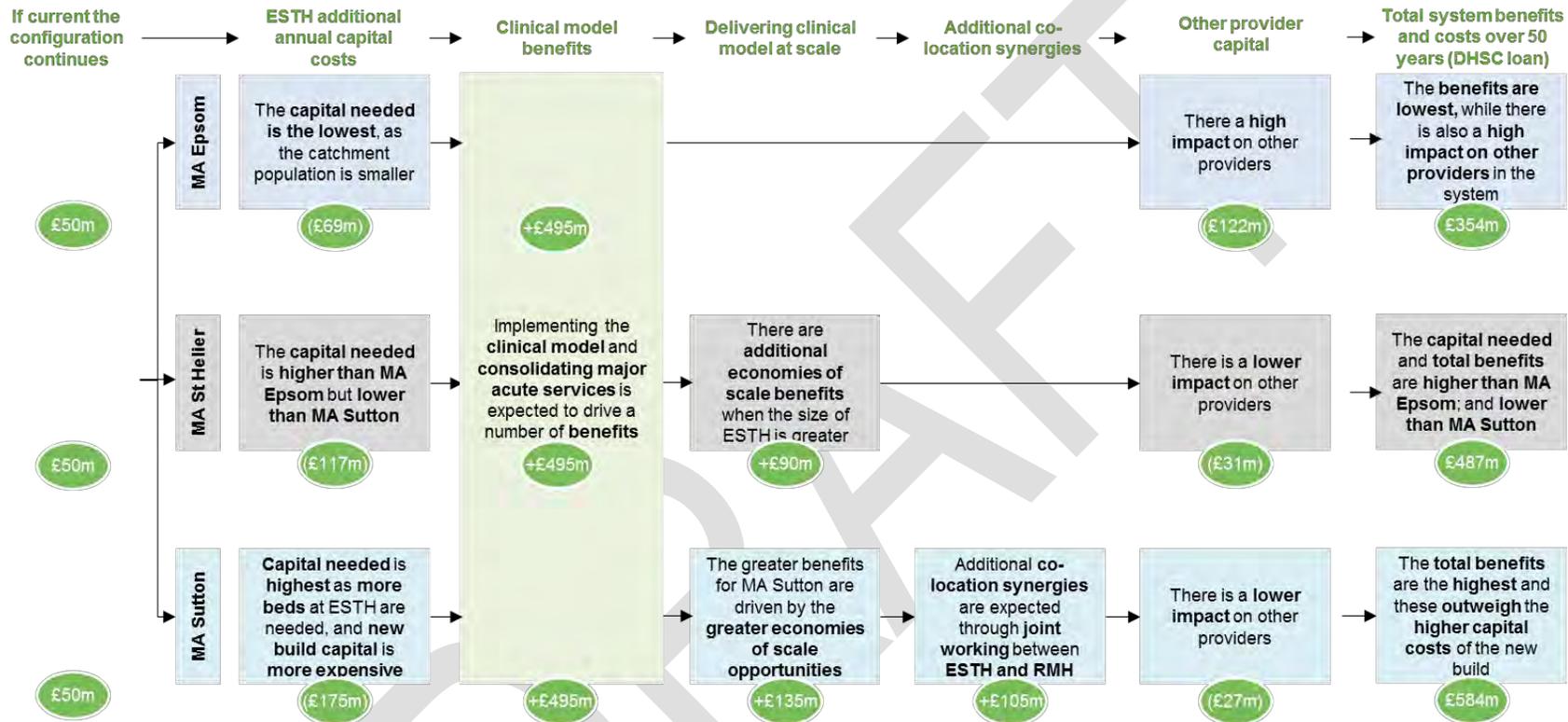
Table 118: System impact

Category	Metric	No service change	Epsom	St Helier	Sutton
System impact	System net present value (50 years) (£m)	50	354	487	584

Figure 65 below provides a narrative description of how different factors impact on NPV for each of the options.

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Figure 65: Factors impacting on system NPV for each of the options



13.9 Results of financial analysis

Table 119 below shows the outputs of the FAE workstreams as set out in Section 13.1 by financial metric for each of the options.

Table 119: Summary finance table

Category	Metric	No service change	Epsom	St Helier	Sutton	
Activity	Emergency catchment (000s)	474 – 505	312 - 316	331 - 360	404 - 422	
	Total beds 25/26 (of which, beds required at other providers) - current ESTH beds 1,048	1,082	1,052 (205)	1,052 (81)	1,052 (50)	
Estates and capital	ESTH net capital investment (£m) *	(225)	(292)	(386)	(472)	
	Capital investment other providers (£m)		(174)	(44)	(39)	
Finance	ESTH 25/26 income (£m)	538	485	512	521	
	ESTH 25/26 expenditure (£m)	(560)	(474)	(501)	(504)	
	- 25/26 financial benefits from consolidation (£m)		33	39	49	
	- 25/26 financing costs (DHSC loan) (£m)	(10)	(14)	(18)	(22)	
	ESTH 25/26 in year I&E (£m)	(22.6)	10.9	11.3	17.0	
	ESTH return on investment 25/26 (%)	-	11.5%	8.8%	8.4%	
Financing options	ESTH 25/26 in year I&E, with mixed financing (£m)		-	6.5	5.2	12.7
	ESTH 25/26 in year I&E, with PDC financing (preferred route) (£m)		11.1	12.2	16.3	
System impact	System return on investment 25/26 (£m)		5.3%	7.4%	7.3%	
	System net present value (50 years) (£m)	50	354	487	584	

*ESTH net capital investment reflects capital required net of internal financing, land sales and revised growth. Gross capital is detailed in Table 106 in 13.3.1.

13.10 Sensitivity analysis

A number of sensitivities were developed to test the impact of flexing key assumptions on the options. These are set out in Table 120.

Table 120: Description of sensitivities

	Sensitivity	Description
Baseline	1. Overall income (GDP assumptions)	1% per annum tariff inflator (rather than 1.7%)
	2. Variance to activity	Increase net activity growth by 1% per annum
	3. CIPs	Decrease CIP achievement by 25%
	4. Technology benefits	Technology benefits apply to baseline
Options	5 Patient flow assumptions	Capital costs for other providers increase by 25%
	6. Capital costs	Increase ESTH capital costs of options by 25% (capital / income ratio in brackets)
	7. Financial benefits	Impact of reducing financial savings by 25%
	8. Scaling	Increase / decrease economies of scale benefit from additional activity from 0.88 to 0.95 / 0.8
	9. Length of stay	Decrease total length of stay reduction by 25% (all options achieve LoS reduction below top quartile)
	10. RMH	No additional RMH co-location synergies
	11. Economies of scale	No economies of scale benefits from additional activity
	12. Private patients	No private patient benefit
	13. Other provider cost pressures	Additional cost pressures on other providers as a result of activity outflows
	14. RMH upside	RMH benefits increase by 25%
	15. 24 hour UTCs	UTC opening times extended to 24/7

The outputs of this sensitivity analysis summarise the impact of flexing various assumptions on the relative ordering of options and overall affordability.

Table 121: Impact of sensitivity analysis

Category	Sensitivity	Is system NPV option ordering maintained	Is the 25/26 ESTH I&E positive?		
			Epsom	St Helier	Sutton
Baseline	1. Overall income (GDP assumptions)	✓	x	x	x
	2. Variance to activity	✓	✓	✓	✓
	3. CIPs	✓	x	x	✓
	4. Technology benefits	✓	✓	✓	✓
Options	5 Patient flow assumptions	✓	No impact	No impact	No impact
	6. Capital costs	✓	✓	✓	✓ / x
	7. Financial benefits	✓	✓	✓	✓
	8a. Scaling increase	✓	✓	✓	✓
	8b. Scaling decrease	✓	✓	✓	✓
	9. Length of stay	✓	✓	✓	✓
	10. RMH	✓	✓	✓	✓
	11. Economies of scale	✓	✓	✓	✓
	12. Private patients	✓	✓	✓	✓
	13. Other provider cost pressures	✓	No impact	No impact	No impact
	14. RMH upside	✓	✓	✓	✓
15. 24 hour UTCs	✓	✓	✓	✓	

This shows that the Sutton option still has the highest NPV if the c. £6m RMH co-location synergies (Sensitivity 10) are removed – the red outline indicates values which change as a result of the sensitivity.

In addition to this, as part of the assurance, regulators requested an analysis of a combination of sensitivities which could change the ordering of the NPV ranking. As an example, if the economies of scale and RMH benefits are removed, the St Helier option would have the highest NPV.

13.11 Transition costs

Transition costs reflect the additional non-recurrent (i.e. one-off) costs which could be incurred between today and the planned completion, to implement changes. Two types of transition costs were included in the analysis.

- **Capital transition costs.** These costs reflect temporary accommodation requirements as well as sequencing and decant costs. These costs were included in the estates and capital costing analysis for each option and therefore the total capital ask for external funding.
- **Revenue transition costs.** Revenue transition costs reflect the additional running costs from temporarily delivering some services across both the existing major acute sites and the planned new major acute site, during the transition period; and the phasing in of new services, including accounting for stranded costs. These costs also include the costs of changing provider structures, as well as the costs of de-commissioning and re-commissioning of services. An allowance was made in the financial analysis for these costs, based on other PCBCs. A consistent methodology has been applied across options and the costs are included in the NPV calculations. The system is committed to working together to ensure these costs are minimised.

The system believes that the revenue costs of the service transition are likely to be affordable within existing plans. As such, it does not expect that additional revenue funding will be required to finance the transition of services and it will ensure that finances as a system are re-organised to ensure that these costs are funded.

Subject to identifying a preferred option, as part of any next stage business case, a Management Case will be developed, which will include details of the planned service transition. Based on this, components of the service transition will be identified, and overall transition costs will be estimated in greater detail.

The transition costs discussed here are distinct from any transitional funding requirement (such as an interim revenue loan) to bridge ESTH's deficit to financial balance over the period – the interest costs of this are included in the finance model as agreed with regulators. These costs are also distinct from the ESTH structural deficit analysis, which is progressing separately to this.

14 FINANCING SCENARIOS

To understand how this capital requirement may be financed, we also undertook an initial appraisal of potential financing sources and considered their advantages and disadvantages as well as tested the affordability of a short list of potential financing scenarios.

Our preferred financing scenario was drawing on public dividend capital (PDC) to secure the financing for the full amount. This was based on a number of advantages, including simplicity, affordability and availability of financing.

As an alternative, should public financing routes be unavailable, we also considered a mixed financing approach – drawing on a number of sources, including leveraging local authority financing. Further analysis on this alternative scenario has been shared separately with regulators.

Initial analysis suggests that all financing scenarios could help to drive a positive income and expenditure for the options.

The purpose of considering financing options at this stage is on an initial basis, to develop the confidence needed that financing is likely to be available to support a scheme. This will allow the programme to proceed to consultation should that be agreed by the Committees in Common.

This chapter undertakes an initial appraisal of potential financing sources, considers their advantages and disadvantages and tests the affordability of a short list of potential financing scenarios.

14.1 Capital availability

As set out in Section 13.3, in order to deliver the significant benefits expected, a large capital investment in the hospital sites is required across all options. In particular, capital investment of between £292m and £472m is likely to be required (including at other hospitals) after accounting for financing already secured (including existing loans and planned sales of surplus land).

14.1.1 Financing options

We initially developed a long list of financing based on targeted interviews with stakeholders and precedent around recent large public-sector programmes. Based on this initial review and engagement with stakeholders, ten sources of finance have been identified which are summarised below.

Table 122: Long list of potential financing sources

Source of finance	Summary description
1 LIFT	The NHS LIFT Programme (Local Improvement Finance Trust) is a DHSC sponsored partnership between the public and private sectors. LIFT is a delivery vehicle for capital works available to Primary Care hospitals. The local LIFT is the South West London Health Partnership (SWLHP) that covers the borough of Sutton covering Sutton and St Helier hospitals but not Epsom.
2 Private public partnership (PPP)	Public Private Partnerships (PPP) that seek to provide access to wider sources of equity and debt finance. PPP seeks to improve value for money, allow for risk transfer and speed up and reduce the cost of the procurement process. A typical PPP arrangement would involve the creation of a Special Purpose Vehicle (SPV) /Private Partner which would manage the Design, Build, Finance and potentially Operate and Manage (DBFOM) stages of the building.
3 Co-investment with other hospitals	ESTH has been in high level discussions with The Royal Marsden NHS Foundation Trust regarding the possibility of co-investing at the Sutton acute site.
4 Public Dividend Capital	Public Dividend Capital (PDC) is capital finance that the Trust could borrow from the DHSC.
5 NHS Prudential Borrowing	The NHS is able to borrow from a wide variety of other sources, such as banks. However, this must demonstrate that the borrowing meets the prudential code that requires it to be affordable and prudential and would require DHSC approval. Foundation Trusts have greater prudential borrowing powers than ESTH as a Trust.
6 Local Authority including Prudential Borrowing	Investment from local authorities (LAs) may be a possible source of financing, and has been considered in other areas of the country. Therefore we are in the process of speaking to each of the local authorities on their potential involvement across the solutions. This could take the form of a loan ²⁷⁰ from the LA or a Joint Venture (asset backed vehicle) to the Trust that would be paid off quarterly over a period of time. All LAs in the combined geographies have been invited for discussions. LBS has been particularly supportive in exploring how it might play a role in financing solutions in the borough of Sutton – including MA Sutton and MA St Helier options. Discussions have also been undertaken with Surrey County Council (SCC).
7 Energy Efficiency financing	Trusts can benefit from energy efficiency programmes that provide finance to public sector bodies. The most prominent schemes are Salix, Mayor's Energy Efficiency Scheme (MEEF) and RE:FIT.
8 Land Receipts & Internal Financing	Land receipts generated through sales can be used. The Trust should restrict the use of land receipts in making down payments or advanced payments to PPP suppliers as this can reduce any agreed risk transfer to the private partner/SPV.
9 Charitable Donations	The majority of NHS trusts raise additional money via charitable donations to specific Charitable trusts. The Trust has a charitable trust that manages 146 separate funds and had an income of approx. £380k in 2017.
10 NHS Digital	It is anticipated by the Trust that capital financing may be made available by NHS Digital to support some of the new IT systems and infrastructure that will be required, for example an EPR system.

The different financing sources are associated with different borrowing costs, which impact overall affordability. In assessing different sources, additional financing costs should be set against the

²⁷⁰ Local Authorities are required to make loans with due consideration to the Guidance on Local Government Investments (effective from 1 April 2018) that sets out key investment criteria and under which any investment would need to be made in a site that had wider public use and benefit the public realm

degree of risk transfer as part of an overall assessment of value for money. Table 123 sets out indicative financing costs and a consideration of risk transfer for each of the sources on the long list.

Table 123: Indicative financing costs for sources of finance

	Source of finance	Indicative financing costs	Risk transfer
1	LIFT	4% - 6%	Yes
2	Private Public Partnership (PPP)	4% - 6%	Yes
3	Co-investment with other hospitals	3%+	TBC
4	Public Dividend Capital (PDC)	3.5%	No
5	NHS Prudential Borrowing	2% - 3%	No
6	Local Authority including Prudential Borrowing	4% - 6%	Yes
7	Energy Efficiency financing	0% - 2.5%	Yes
8	Land Receipts & Internal Financing	0	No
9	Charitable Donations	0	No
10	NHS Digital	tbc	tbc

The financing costs vary significantly when considered over the life-time of the project and the potential scale of capital required. LIFT and PPP have more expensive financing costs but do involve a risk transfer.

14.1.1.1 Wider considerations and constraints

Initial stakeholder engagement and precedent highlights a number of relevant factors which needed to be considered in developing the financing scenarios.

- Refurbishments and PPP financing:** There is significant uncertainty around the future of PPP, particularly in the context of the Treasury infrastructure review. This includes PF2, LIFT and other forms of PPP. As a result, while we have included an example scenario to demonstrate that a PPP solution is likely to be affordable, we recognised that this financing route is unlikely to be available.
- Local Authority applicability to sites:** In order to access LA financing, the development would need to demonstrate wider local benefit. Further, LAs may require some control over part of the building and would typically only fund if the investment is within their Borough or Council. Initial discussions have highlighted that LAs are more likely to support such developments should it be part of a wider economic redevelopment plan. However, the uncertainty around PPP also applies to LA financing – given the way any deal would be constructed is likely to be similar to a PPP arrangement. As a result, while we have included LA financing as part of an example mixed financing scenario, to demonstrate that a PPP solution is likely to be affordable, this is not our preferred route.
- Some sources will only provide limited financing potential:** Whilst providing helpful contributions, energy efficiency schemes, land receipts, charitable donations and NHS Digital sources are likely to be more constrained in terms of available capital. In particular, energy efficiency financing is restricted to schemes which are directly linked to improvements in energy usage. In addition, ESTH has recently completed a c. 3 year programme optimising its estate, including selling surplus land in line with the principles of the Naylor review, whilst maintaining current services.

14.1.2 Financing scenarios

Based on the investigations undertaken, a number of scenarios were developed to reflect different potential options to finance the capital requirement.

The scenarios include a range of financing sources across:

- PDC;
- LA investment;
- LIFT and PPP;
- Energy efficiency programmes;
- Charitable donations; and
- Land sales.

The following table sets out the refined indicative short list of funding scenarios and their availability.

Table 124: Initial availability of funding scenarios

	Source of finance	Indicative availability
1	LIFT	Not at this stage
2	Other PPP	Not at this stage
3	Public Dividend Capital	Potentially available – currently our preferred route
4	Local Authority, including Prudential Borrowing	Potentially c. £150m, but not preferred
5	Energy Efficiency financing	Potentially c. £50m
6	Land Receipts & Internal Financing	< £50m
7	Charitable Donations	c. £30m

14.2 Emerging financial proposition

Based on considering the availability of different sources, and their advantages and disadvantages, we developed a preferred financing route, based on financing the full capital amount through PDC. This was based on a number of advantages:

- **Simplicity** – there is only one transaction – between DHSC and ESTH – compared to other mixed arrangements which involve complex contracting arrangements between multiple parties;
- **Affordability** – the financing costs (a fixed 3.5% dividend) are lower than most other forms of financing; and
- **Availability** – while the availability of PDC for this particular scheme is currently uncertain, it is appropriate for funding large capital schemes such as this – as compared to other financing routes which are restricted to specific purposes such as energy efficiency financing.

As an alternative, should public financing routes be unavailable, we have also considered a mixed financing approach – drawing on a number of sources, including leveraging LA financing. Further information on the example mixed financing approach has been shared separately with regulators. We note the uncertainty around this particular scenario, given the ongoing central review in to PPP.

Initial analysis suggests that all financing scenarios can help to drive a positive income and expenditure for the options.

Further ways of considering financing solutions will take place as this process moves forward, such as analysis of value for money and risk transfer.

DRAFT

15 OUTPUTS OF THE OPTIONS APPRAISAL

We went through a process of options consideration to identify how the challenges set out in our case for change may be met and how we can best deliver our clinical model to meet our 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.

This process of options consideration led to:

- the development of a **long list of options** that can deliver our clinical model;
- the **development of initial tests** which were applied to the long list to reach a manageable short list for further analysis;
- a **non-financial evaluation** through a series of workshops which resulted in a weighted average score for the short list of options against a list of criteria developed with local stakeholders; and
- a **financial evaluation** of the short list and an assessment of their affordability.

Having undertaken an options consideration process, a summary of the non-financial and financial metrics for each of the shortlisted options and the no service change counterfactual can be found in Section 12 and 13.

Table 125: Summary of key non-financial and financial metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Non-financial	Non-financial average weighted score	4.79	5.89	6.21	6.65
Financial	System net present value (50 years) (£m)	50	354	487	584

These non-financial scores and financial metrics are two of the sources of evidence that will support the CCGs' decision-making process.

The outputs of this pre-consultation business case are draft. Any new options, new evidence and information can be considered by CCG Governing Bodies up to the point of the decision after consultation.

15.1 Non-financial analysis

A non-financial consideration of options was carried out in November 2018 through the development of a weighted short list of criteria and a scored short list of options. This process is further described in Section 3.5. The scoring workshop resulted in a mean average score for options against the criteria, against which the weightings were applied.

For the non-financial score it is important to note that the scores for each of the options against criteria were anonymous with no rationale requested from participants. It was therefore not possible to

provide a specific overall rationale for any average score and associated weighted score. **This applies to all options.**

Table 126: Summary of non-financial metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Non-financial	Non-financial average weighted score	4.79	5.89	6.21	6.65

The initial evidence outlined in the scoring workshop was further developed as a result of further analysis. This has been described in Section 12.5.2.1, 12.8.1 and 10.6, and the overall impact on the non-financial analysis is described below.

15.1.1 Evidence review: Non-financial analysis

Since the non-financial scoring in November 2018, there have been some updates to the analysis as well as the generation of additional evidence. This is focused across three main areas:

1. **Clinical Senate:** The joint Clinical Senate has reviewed the draft PCBC and provided 94 recommendations, all of which have now been addressed through the Clinical Advisory Group and its working groups. The Clinical Advisory Group does not view there to be any particular impact on the options within the non-financial domains as a result of this review.
2. **Interim integrated impact assessment:** The integrated impact assessment steering group has completed its deliberations for the purpose of the interim IIA. There are small differential impacts across each of the options, however these are not expected to change the options to the extent that there is an impact on ranking in the non-financial scoring.
3. **Other local providers:** Other providers have indicated that all options are deliverable with the appropriate mitigations. As set out in the initial non-financial scoring, the option with the highest impact remains Epsom.

These factors were taken into account as part of the decision-making process.

15.1.2 Non-financial scores for the options

As a result of the process undertaken, all the options scored more highly than no service change (4.79). The Sutton option (6.65) scored more highly than Epsom (5.89) or St Helier (6.21) options.

For each of the options, the overall scores are summarised below:

- **The no service change comparator:** As a result of the non-financial scoring process, the no service change counterfactual scored a weighted mean average of 4.79, which is lower than the scores for the Epsom, St Helier and Sutton options.
 - The no service change counterfactual scored higher than the other options on the access criterion.
 - For all other non-financial criteria the no service change counterfactual scored lower.
- **Major acute services at Epsom:** As a result of the non-financial options consideration process, the major acute services at Epsom option scored a weighted mean average of 5.89, which is higher than the no service change counterfactual, but lower than the St Helier and Sutton options.
 - The Epsom option scored higher than the other options on the older people criterion.
 - For all other criteria, the Epsom option was considered to be less favourable by the participants of the workshop than at least one of the other options.
- **Major acute services at St Helier:** As a result of the non-financial options consideration process, the major acute services at St Helier option scored a weighted mean average of

6.21, which is higher than the no service change counterfactual and Epsom option, but lower than the Sutton option.

- The St Helier option scored higher than the other options on staff availability, clinical quality and patient experience criteria.
- For all other criteria, the St Helier option was considered to be less favourable by the participants of the workshop than at least one of the other options.
- Major acute services at Sutton: As a result of the non-financial options consideration process, the major acute services at Sutton option scored a weighted mean average of 6.65, which is higher than the no service change counterfactual and Epsom and St Helier options.
 - The Sutton option scored higher than the other options on 11 criteria, including availability of beds, delivering urgent and emergency care, workforce safety, recruitment and retention, alignment with wider health plans, integration of care, complexity of build, impact on other providers, time to build, deprivation, health inequalities and safety. This drives a relatively higher total average score than other options.
 - For access, staff availability, clinical quality, patient experience and older people the Sutton option was considered to be less favourable by the participants of the workshop than at least one of the other options.

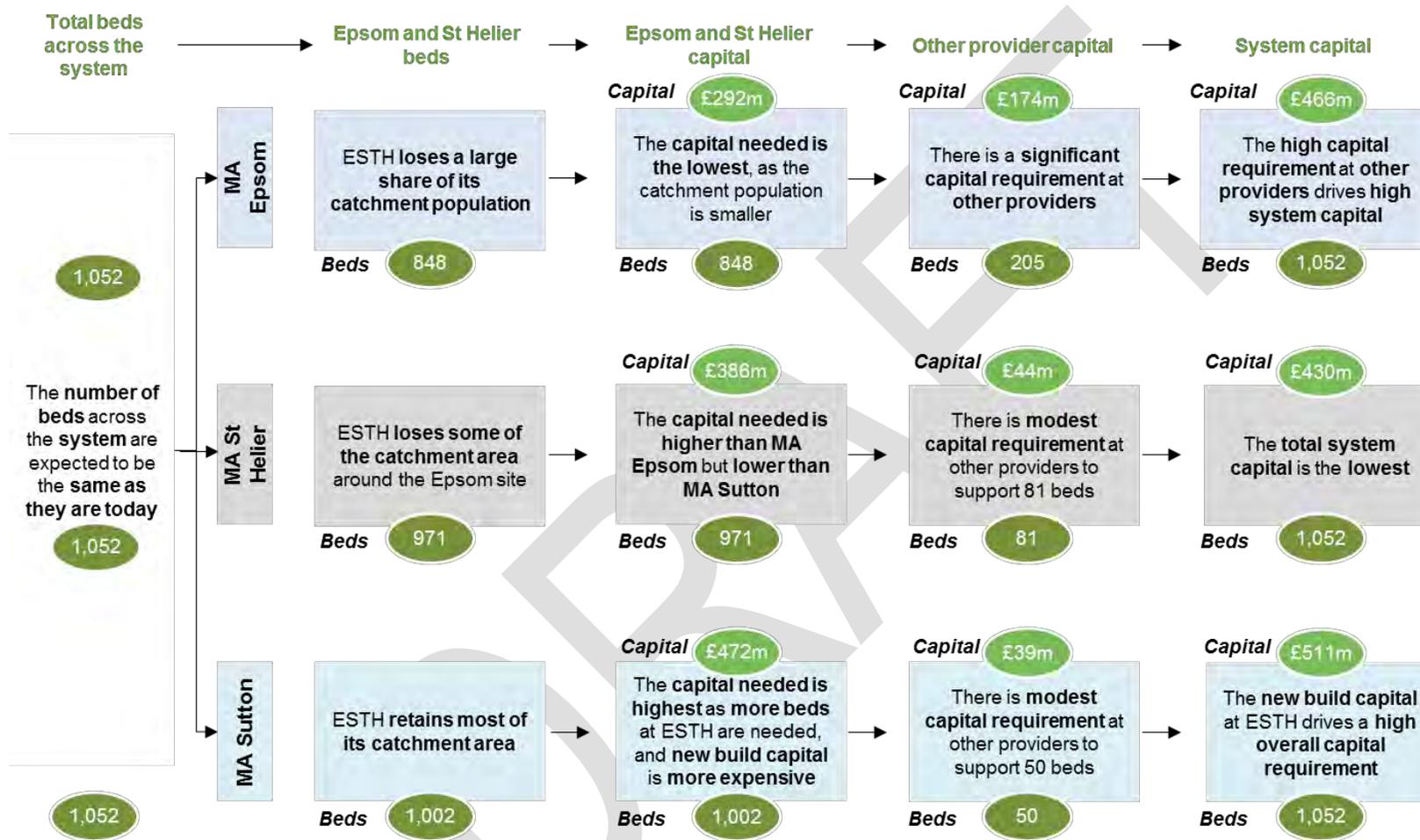
15.2 Financial analysis

The financial analysis of the options resulted in outputs for a range of financial metrics.

15.2.1 Capital requirement

While the total number of beds in the system are expected to be the same across all options, the providers where these beds are needed is different by option. This drives variation in the capital investment between options.

Figure 66: Beds and capital requirement by option



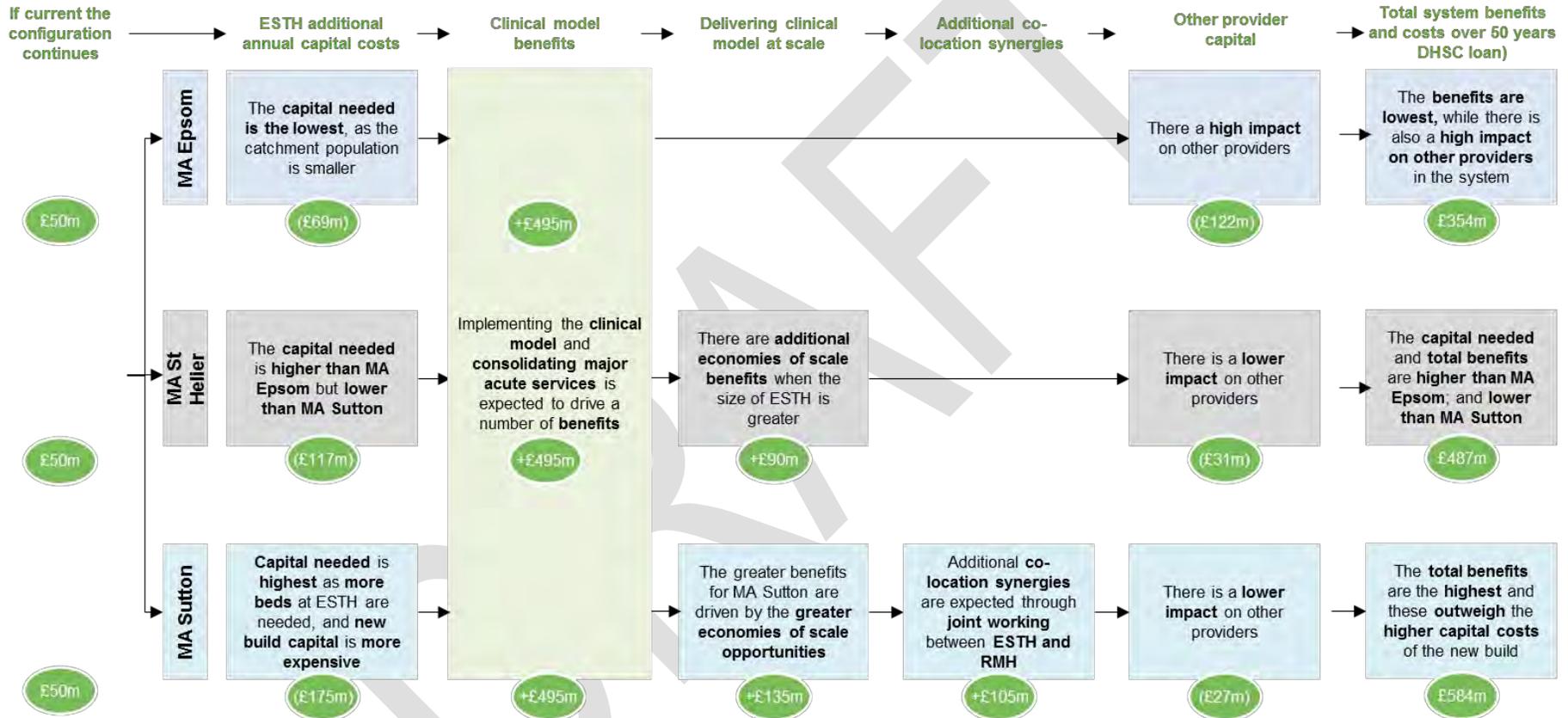
15.2.2 Income and expenditure

The total ESTH income and expenditure position by 25/26 is greatest for major acute services at Sutton. This is driven by the additional benefits (including co-locating with RMH) outweighing the higher annual capital costs needed to pay for the new build facility.

15.2.3 Net present value

The greater benefits for the Sutton option are also reflected in the total system benefits and costs over a 50 year period (the net present value):

Figure 67: Net present value by option



15.2.4 Financial scores for the options

The NPV for each of the options has been summarised below. Overall the options have a higher NPV than no service change (£50m). The Sutton option has a higher NPV (£584m) than Epsom (£354m) or St Helier (£487m) options.

- **No service change comparator:** The system NPV for the no service change counterfactual at £50m is lower than for any of the other options. This is driven by:
 - A higher expenditure than income for ESTH
 - The current clinical model will not deliver the financial benefits associated with consolidation.
- **Major acute services at Epsom:** While a lower net capital investment is required for the Epsom option than St Helier or Sutton, the system NPV for the Epsom option at £354m is higher than the no service change counterfactual, but lower than the system NPV for St Helier and for Sutton. This is due to the Epsom option delivering many services at a reduced scale as a result of catchment size. This is further driven by a higher impact on other providers.
- **Major acute services at St Helier:** The system NPV for the St Helier option at £487m is higher than the no service change counterfactual and Epsom option, but lower than the system NPV for Sutton. This is due to a St Helier having a larger catchment than Epsom resulting in services running at a greater scale. There is also a lower impact on other providers.
- **Major acute services at Sutton:** The system NPV for the Sutton option at £584m is higher than other options. This is driven by Sutton having the largest catchment and therefore greatest scale of services. There are also a number of additional financial benefits as a result of co-location with RMH.

15.3 Summary of options

The strengths, weaknesses, risks and opportunities associated with each of the options have been summarised in the tables below.

Table 127: Summary of strengths, weaknesses and risks for the Epsom option

Strengths	Weaknesses
<ul style="list-style-type: none"> • Delivers the clinical model and associated benefits 	<ul style="list-style-type: none"> • Greatest increase in median travel time (3 – 6 minutes depending on transport method) • Medium complex build, medium decanting and temporary accommodation cost • Significant impact on other providers (capital requirement of £174m) • Second shortest time to build (6 years) • Greatest impact on deprived communities due to increased travel costs and time (as determined by IIA) • Lowest NPV of the options (£299m) • Lowest ROI for the system (5.3%) • Second highest total capital requirement for the options (£466m)
Opportunities	Risks
	<ul style="list-style-type: none"> • Staffing and maintaining a L2 neonatal unit • Significant capacity required from other providers • Intersite transfers required

Table 128: Summary of strengths, weaknesses and risks for the St Helier option

Strengths	Weaknesses
<ul style="list-style-type: none"> • Some impact on other providers (Capital requirement of £44m) • Delivers the clinical model and associated benefits • Highest ROI for the system (7.4%) • Lowest total capital requirement for the options (£430m) 	<ul style="list-style-type: none"> • Second greatest increase in median travel time (2 – 4 minutes depending on transport method) • Most complex build, highest decanting and temporary accommodation cost • Longest time to build (7 years) • Greatest impact on older people due to increased travel time • Second highest NPV of the options (£487m)
Opportunities	Risks
	<ul style="list-style-type: none"> • Intersite transfers required

Table 129: Summary of strengths, weaknesses and risks for the Sutton option

Strengths	Weaknesses
<ul style="list-style-type: none"> • Lowest increase in median travel time (1 – 3 minutes depending on transport method) • Delivers an additional UTC • Least complex build, lowest decanting and temporary accommodation cost • Some impact on other providers (Capital requirement of £39m) • Shortest build time (4 years) • Delivers the clinical model and associated benefits • Highest NPV of the options (£583m) • Second highest ROI for the system (7.3%) 	<ul style="list-style-type: none"> • Highest total capital requirement of the options (£511m)
Opportunities	Risks
<ul style="list-style-type: none"> • Joint working with RMH to improve cancer care 	<ul style="list-style-type: none"> • Potentially greater number of intersite transfers required

The outputs of the options appraisal and the summary of strengths, weaknesses, opportunities and risks were incorporated into the decision-making process. An overall summary table is shown on the following page.

Table 130: Overall summary of options

Category	No service change	Sutton	St Helier	Epsom
Non-financial score	4.79	6.65	6.21	5.89
System NPV (£m)	50	584	487	354
Advantages		<ul style="list-style-type: none"> • Delivers the clinical model and associated benefits • Joint working with RMH • Delivers an additional UTC • Lowest increase in median travel time • Lower impact on older people (vs. St Helier) and deprivation (vs. Epsom) • Some impact on providers • Least complex build – new build • Shortest build time • Highest NPV of the options 	<ul style="list-style-type: none"> • Delivers the clinical model and associated benefits • Some impact on other providers • Lower impact on deprived communities (vs. Epsom) • Lowest total capital requirement for the options 	<ul style="list-style-type: none"> • Delivers the clinical model and associated benefits • Lower impact on older people (vs. St Helier)
Disadvantages	Undeliverable – for comparative purposes only	<ul style="list-style-type: none"> • Highest total capital requirement of the options 	<ul style="list-style-type: none"> • Second greatest increase in median travel time and • Greatest impact on older people • Most complex build – refurb with multiple decants/phases • Longest time to build • Second highest NPV 	<ul style="list-style-type: none"> • Greatest increase in median travel time • High impact on providers • Greatest impact on deprived communities • Medium complex build – extensive refurb • Second shortest time to build • Lowest NPV of the options • Second highest total capital requirement
Risks		<ul style="list-style-type: none"> • Potential further benefits from London Cancer Hub – including potential shared surgical centre • Risk of additional provider impacts from further development • Greater number of intersite transfers 	<ul style="list-style-type: none"> • Intersite transfers required 	<ul style="list-style-type: none"> • Staffing and maintaining a L2 neonatal unit • Significant capacity required from other providers • Intersite transfers required

16 DECISION-MAKING

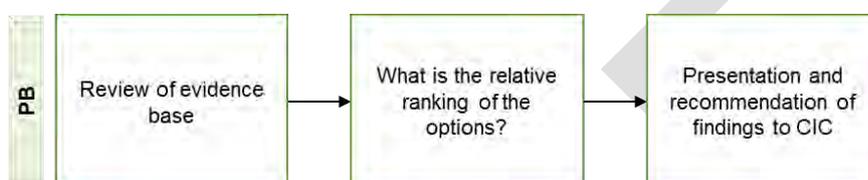
Following the non-financial and financial analysis of options and further evidence development, we continued to follow the decision-making process.

This Section sets out how the Programme Board and Committees in Common used the evidence developed by the programme to determine a relative ranking of options, and how the Committees in Common will use this to determine preferred option(s) for consultation.

16.1 Determining the relative ranking of options

As part of the decision-making process, Programme Board considered the evidence to determine the relative ranking of options.

Figure 68: Decision-making process for PB



Key questions the Programme Board considered included:

- Is the evidence sufficient at this stage?
- Does the non-financial evidence change the ranking of options?
- Does the financial analysis suggest a ranking of options?
- Is there an overall ranking of options taking into account non-financial and financial ranking?

Programme Board reached a shared position on the meaning of the current evidence base for the relative merits of the different options. This is described below.

16.1.1 Outcome of the decision-making process for the relative ranking of options

Programme Board agreed:

- The evidence was sufficient at this stage
- There was a non-financial ranking:
 1. Sutton
 2. St Helier
 3. Epsom
- There was a financial ranking:
 1. Sutton
 2. St Helier
 3. Epsom
- There was an overall ranking – supported by a broader narrative including advantages, disadvantages and risks of the options
 1. Sutton
 2. St Helier
 3. Epsom

Table 131: Summary of relative option ranking

Category	No service change	Sutton	St Helier	Epsom
Non-financial	-	1	2	3
Financial	-	1	2	3
Overall ranking	-	1	2	3

16.2 Determining a preferred option for consultation

16.2.1 National assurance outputs

As part of the Health Infrastructure Plan published on the 30th of September, the Government announced funding for six new large hospital builds, which included allocated investment in Epsom and St Helier University Hospitals.

At the NHS England and Improvement Oversight Group for Service Change and Reconfiguration on the 8th of October, the programme was given approval to proceed to the next stage and seek final assurance sign off from the Delivery, Quality and Performance Committees in Common (DQPCiC).

16.2.2 Programme Board recommendations

As part of the next stage of the decision-making process, based on the work to date, the Programme Board considered all the evidence set out within this pre-consultation business case and concluded that:

- The three options are viable and should be included in any public consultation.
- The options continue to be ranked as:
 - Sutton as the top ranked, and on this basis, subject to CiC review and approval, the preferred option.
 - St Helier as the second ranked option and,
 - Epsom as the lowest ranked option

This formed the basis of its recommendations to the Committees in Common.

16.2.3 Committees in Common decision-making

The evidence set out within this PCBC is one of the factors the Committees in Common will consider as part of their decision-making process.

Any new options or evidence can be considered at any stage in the process. No decisions will be made on any option until after any public consultation.

17 PLANNING FOR CONSULTATION

The options to be considered during the consultation will set out the potential solutions for delivering high quality major acute services that are sustainable into the future, for the people of Sutton, Merton and Surrey Downs.

We will aim to obtain a broad range of views from our local communities, services users and their representatives and partners on our proposals. The feedback gathered during consultation and any further evidence will help the CCGs to make their decision. No decisions about any changes to services will be made until after a full public consultation has taken place and all of the information, including the feedback from the consultation, has been considered by the Surrey Downs, Sutton and Merton CCGs in line with Gunning principle 4.

The consultation will seek to:

- Ensure people in the affected CCG areas are aware of and understand the case for change and the proposed options for change, by providing information in clear and simple language in a variety of formats
- Hear people's views on the proposed changes to major acute services in Surrey Downs, Sutton and Merton
- Ensure the CCGs as decision-makers receive detailed outputs and feedback from the consultation, to ensure they are as well informed as possible for making decisions.
- Hear ideas for alternative solutions via the consultation questionnaire. While we have carried out a robust options development and consideration process, we are still open to other new ideas and suggestions for different ways we could solve the challenges set out in this consultation.

The information collected in a consultation is an important factor in health service decision-making. The consideration of all feedback and additional evidence gathered during consultation will help the CCGs to make an informed decision on progressing the future shape of hospital services - ensuring that these are high quality, safe, sustainable and affordable and result in the best possible outcome and experience for patients, as well as on which services should be provided in the community, closer to where people live.

We will commission an independent company to analyse all of the consultation responses and outputs from all engagement methods. On conclusion of the analysis the independent company will produce a final written report which will be publicly available and shared with the Joint Health and Overview Scrutiny Committee. The report will be used to support deliberation and decision making by the three Clinical Commissioning Groups and inform the Decision-Making Business Case, on which the Committee in Common of the three local Clinical Commissioning Groups final decision will be based.

17.1 Delivering a consultation

Subject to approval of this pre-consultation business case, we are committed to undertaking a full public consultation to test our ideas and any preferred option(s). Our consultation plan outlines our approach on how we intend to listen to and gather views from our local communities and partners. Our plan has been co-developed with our Consultation Oversight Group, Stakeholder Reference Group and Joint Health and Overview Scrutiny Committee.

Under Section 14Z2 of the NHS Act 2006, the NHS has a duty to ensure that people who use NHS services are involved in the development and consideration of proposals for change in the way services are provided.

We will also be complying with our duty to consult the local authority under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 (“the 2013 Regulations”) made under section 244 NHS Act 2006.

The proposed consultation dates are the 8th of January 2020 up until the 1st of April 2020.

We will deliver a best practice consultation (advised and assessed by the Consultation Institute), which is founded on the commitment to inform and listen. The Consultation Institute (tCI) is undertaking a quality assurance role and has reviewed and provided feedback on our draft plan for consultation.

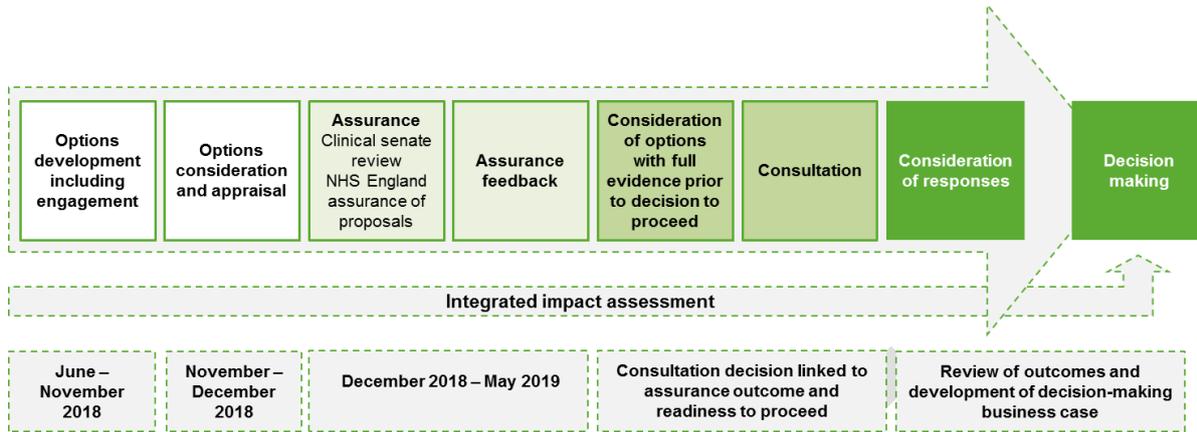
We will continue to develop our consultation plan both prior and during the formal consultation by working closely with tCI and our partners to ensure that all our statutory duties are met.

The consultation will also be underpinned by the four over-arching NHS England tests, and the Government’s bed test:

- Clarity around the clinical evidence base – the case for change must be widely understood and there should be clear, clinical evidence of the benefits of the proposals being consulted on.
- Support from GP commissioners must be clear and unequivocal and there should be involvement and ‘ambassadorship’ of the programme by them throughout.
- Promotion of genuine patient choice – we should be able to demonstrate that patients, residents and other stakeholders have understood how and why the proposals will benefit them and offer a better way forward for their healthcare needs.
- Genuine engagement with the public, patients and local authorities – we will strive at all times to reach as many people as possible, put the proposals forward in a clear and comprehensible way and listen and respond to people throughout the process.
- Where appropriate, service change which proposes plans significantly to reduce hospital bed numbers should meet NHS England’s test for proposed bed closures and commissioners should be able to evidence that they can meet one of the following three conditions:
 - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and the new workforce will be there to deliver it; and/or
 - Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
 - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting It Right First Time programme).²⁷¹

²⁷¹ NHS England, *Planning, assuring and delivering service change for patients*, 2018

Figure 69: Timeline to consultation



17.2 Consultation approach

The CCGs need to understand the views of the local populations in Surrey Downs, Sutton and Merton and neighbouring impacted areas about the way in which urgent care, emergency care, maternity and paediatric care as well as planned care are provided in the future. The CCGs have set out their case for change with a proposed service changes to deliver safe, sustainable services that deliver improved outcomes for patients.

A formal decision on any proposed service changes will take into account all of the evidence received following consultation by the three CCGs.

All elements of the consultation plan for a consultation will seek to:

- Ensure that the methods and approaches are developed to provide a range of opportunities for stakeholders to respond to the consultation Identify the best ways of reaching and engaging key interest groups
- Provide an easy read version of documents and offer translated versions relevant to the community as required (upon request)
- Make sure there is equality monitoring of participants to ensure the views received reflect the whole of the local population
- Use different methods or specifically target communities where there is any under-representation
- Target activity so it covers all the local geographical areas that make up the three CCGs
- Arrange any events and meetings in accessible venues and offer interpreters, translators and hearing loops where required
- Purchase or hire resources for delivering consultation activity from the local community whenever it is possible
- Inform partners of the consultation activity and share the plans for engagement.

The public consultation will be guided by the principles for all stakeholder engagement set out in Section 17.3 below.

17.3 Consultation principles

We commit to the following key principles during public consultation:

Table 132: Consultation principles

Principles	Proposed approach
1. Providing local communities with a range of opportunities to be involved regardless of who they are and where they live. This includes coverage of activity across all three CCG geographical areas.	<ul style="list-style-type: none"> • We will map out all our local communities and map interest groups and stakeholders so we know who to engage with and how. • We will provide a range of methods of engagement. • We will work closely with a wide variety of local individuals and organisations to make the most of all opportunities to reach out to people. • We will endeavour to go out to where people are, using creative and innovative methods of engagement.
2. Providing accessible information in clear and simple language and in a variety of formats	<ul style="list-style-type: none"> • We will test our materials on patients, interest groups and the public through the Consultation Oversight Group. • We will stick to plain English standards and where possible gain kite mark status for key documents. • We will provide an easy read version of our consultation document and questionnaire as well as other key documents as required. • We will provide materials in other formats should they be requested. This includes translation of written materials into other formats, including Braille or other languages.
3. The process will be open and transparent.	<ul style="list-style-type: none"> • We will publish our evidence, public and stakeholder and interest group feedback, the consultation process and our decision making timeline on our website. • We will be easily accessible for local people to ask questions and raise concerns. • We will update our website with responses to frequently asked questions. • We will work with our local communities to co-design our consultation plan.
4. Careful management of resources to deliver good value for money.	<ul style="list-style-type: none"> • We will endeavour to use evidenced based methods of engagement to make sure we deliver good value for money.
5. Sharing updates on the consultation activity during and after consultation	<ul style="list-style-type: none"> • We will share updates regarding feedback during consultation. • We will commission an independent analysis of consultation feedback which will be published after consultation has finished.
6. Using the feedback received during consultation to inform our decision-making.	<ul style="list-style-type: none"> • We will share our governance structures and timelines so the public and our partners can understand our decision-making process.
7. Running an evidenced-based, best practice consultation.	<ul style="list-style-type: none"> • We will work with our partners to design our consultation activities. • We will work with the Consultation Institute to ensure we are following best practice guidance.

17.4 Consultation oversight group

As the programme moves towards potential public consultation a practical, task-oriented Consultation Oversight Group has been set up to ensure seldom heard and marginalised communities are supported to participate in the consultation process. This group will offer practical advice, suggestions, views, expertise and local knowledge as an independent voice.

The Consultation Oversight Group consists of Healthwatch, Councils of Voluntary Services (e.g. Voluntary Action Mid-Surrey and Community Action Sutton) and volunteers from seldom groups such as alcohol, drug abuse and mental health service users and the Gypsy, Roma and Traveller community.

The inaugural meeting of the Consultation Oversight Group which took place on 31st May 2019 generated a wealth of feedback on our planned consultation activity and how to engage young people. Future areas of work will include reviewing the consultation document, proposed communications activity and stakeholder mapping to ensure capture local groups.

17.5 Co-designing the consultation plan

All methods for consultation will be developed in line with best practice and co-produced with our stakeholders as well as input and oversight from the Consultation Institute.

In developing this draft plan we have considered feedback from all our early engagement and pre-consultation activities. The table below outlines feedback received in relation to consultation planning. The information included in this table will be constantly updated up until a decision to proceed to consultation.

Group	Aims	Date	Feedback
Pre engagement audiences	To share and receive feedback on the case for change, proposed options, and any other evidence to date (such as the Integrated Impact Assessment).	July - October 2018	<ul style="list-style-type: none"> • Be transparent around the decision-making process • Open and honest communication about the potential solutions and more detailed information • Make the process inclusive and use a range of communication and engagement channels to meet the needs of different audiences • Promote involvement at hospital sites, GP practices and other public places to reach patients • Hold evening meetings and meetings in venues to reach seldom heard communities; • Consider opportunities for a door to door mail drop as part of the commitment to reach out to the widest sections of the communities served; • Work with community organisations to review and create 'easy read' documents; • Ensure independent facilitation for events; • Ensure that all key documents contain executive summaries.
Ongoing pre-consultation engagement with community forums	To continue to raise awareness of the proposed options, explain the case for change, provide an update on the work of the programme, gather feedback, strengthen partnerships and source wider opportunities for consultation with local service user, resident, patient and carer groups	October – current	<ul style="list-style-type: none"> • The feedback obtained mirrors the findings from our programme of early engagement undertaken during July – October 2018

Group	Aims	Date	Feedback
Communications and engagement steering group	To ensure that messages and activities are aligned with other CCG and Trust communications and engagement objectives.	Workshop in October 2018	<ul style="list-style-type: none"> • Make sure the case for change is very clear • Involve the public and stakeholders in designing the consultation plan so we get rich ideas about how to make consultation really successful • Publish all evidence and more Q&As • More online and social media advertising
Stakeholder Reference Group (SRG)	Set up to reach out to community members and partners from the combined geographies, who have scrutinised and provided input into the programme and key evidence.	Meetings on: 15 th August 2018 17 th October 2018 7 th March 2019 22 nd May 2019 12 th September 2019	<ul style="list-style-type: none"> • Easy Read version of the consultation survey • Consultation fatigue on this issue so encourage people to complete the survey by offering a voucher (M&S vouchers worked for residents in Surrey) • Engage with resident associations, deprived and elderly communities • Make sure we are getting responses from each demographic area and weight them - same geographically • Need a response handling team so people can get responses during the consultation in case they want to follow up again • Aim for 1% response rate which is national average (The Consultation Institute) • Publish all the evidence in simple formats so people can understand everything, include infographics and other images • Materials need to be precise and short • Engage with the Royal College of Emergency Medicine • Website translation plug-ins • Hold public events • Ensure the press coverage of the consultation

Group	Aims	Date	Feedback
Consultation Oversight Group	Set up to ensure seldom heard and marginalised communities are supported to participate in the consultation process. This group offers practical advice, suggestions, views, expertise and local knowledge as an independent voice and critical friend. The COG consists of Healthwatch, Councils of Voluntary Services (e.g. Central Surrey Voluntary Action and Community Action Sutton) and volunteers from seldom groups such as alcohol, drug abuse and mental health service users and the Gypsy, Roma and Traveller community.	Meetings on: 31 st May 2019 11 th July 2019 12 th September 2019 21 st October 2019	<ul style="list-style-type: none"> • Provided feedback on local community organisations, networks and partners following a stakeholder mapping exercise eg to reach young people work through secondary schools – use peer-to-peer methods – work through colleges; neighbourhood watch groups; parochial church groups. • Provided early thinking on draft consultation activities – good menu of proposed activities to reach population – wide variety of methods – not just events • To ensure the programme works with the voluntary and community sector as a deliver partner for consultation activities with the provision that enough lead in time is given to prepare and deliver this work • Target and empower community networks to facilitate conversations for you – provide supporting materials • Equality groups are important – how do they fit into the consultation? • Be clever – capture captive audience attending existing events e.g. to promote flu jabs – look at what is going on locally to catch large numbers • Work with local councils to reach the working well – largest employers • Use annual public health reports • Focus consultation on reaching affected service users who are more likely to use the service • Develop social media activity as a specific workstream • Engage with locally via media and press • Ensure engagement with service users – i.e. include leaflets in regular prescriptions • How will you work with resident’s associations to have meaningful participation? • Consider how we incentivise attendance at meetings and events to ensure we have the right people in the room • Look at what other consultations have done • Develop a media plan to advertise the consultation (i.e. newspapers, local radio) • Ensure consistent levels of engagement with the general public as in the case of the planned engagement with targeted equality and seldom-heard groups • Consider holding ‘pop-up’ events nearby GP surgeries as another way of engaging with patients • Ensure documents state any facts based on the work undertaken to date • Clearly explain why postcodes will be collected as part of the consultation questionnaire and highlight that the provision of this information is voluntary • Test the questions for consultation, ensure they are in plain English and accessible

Group	Aims	Date	Feedback
Integrated Impact Assessment (IIA) Steering Group	Set up to review and agree the IIA scope and membership for the Travel and Access Working Group. This group offers practical advice and suggestions to ensure representative engagement with community members from protected characteristic groups. The group will review and agree the interim and final IIA reports.	Meetings on: 23 rd January 13 th May 2019	<ul style="list-style-type: none"> ● To work with community representatives to reach out to equalities groups (for example, the Lesbian, Gay, Bisexual and Transgender and the Gypsy Roma Traveller Communities) ● To undertake further engagement with Trust staff ● To ensure the engagement plan incorporates people with both learning and physical disabilities ● Consultation fatigue was raised as an issue by members of the IIA Steering Group
Travel and Access Working Group	Set up to provide review and agree methodology for travel and access work, provide advice to the Programme around local travel and access plans and to review and agree all related data analysis. This group reviewed and agreed the travel and access chapter for the interim draft IIA report.	Meeting on: 14 th March	<ul style="list-style-type: none"> ● Committed to continue to engage with staff at the Trust
IHT Joint Health and Overview Scrutiny Sub-Committee		Meetings on: 16 th October 2018 30 th April 2019 26 th September 2019	<ul style="list-style-type: none"> ● The sub-committee will undertake its statutory responsibilities to consider whether the consultation is adequate and whether the proposals being put forward are in the interest of the local population ● Clarity around timeline and the consultation plan ● Ensure a sufficient time period to allow people to be made aware of the consultation ● Provide further clarity on what information CCGs require to make an effective consultation ● Provide further detail on the engagement approach to potentially impacted communities

17.6 Audiences

The consultation aims to engage as effectively as possible with the following groups across Sutton, Merton and Surrey Downs and neighbouring CCG areas:

- Patients, carers and the public – Groups of patients and the public who are specifically affected by any proposed changes including young people, carers and the wider community including those not always actively engaged with health services.
- Voluntary and community sector: Healthwatch, residents' associations, patient representative groups.
- Traditionally under-represented or seldom heard groups – people with protected characteristics, people with learning disabilities, those with long term conditions, those leaving in deprived areas, carers (including young carers), refugee and undocumented communities, the 'working well' and people who are homeless or in unsecure housing. Our engagement strategy for engaging with these groups will be informed by the findings of the equalities impact assessment undertaken during both phases 1 and 2 of the Integrated Impact Assessment work.
- Clinicians and staff – clinicians and those working in secondary care, primary care, social care, mental health and other parts of the health and social care service, and their trade unions.
- Partners and providers – all local partners and providers of services, community and mental health providers and voluntary organisations.
- Political stakeholders – Joint Health Overview and Scrutiny Committee, individual Health Overview and Scrutiny Committees, Health and Wellbeing Boards, Members of Parliament, local councillors and Cabinet members.
- Media – local, regional, national and trade media, and social media commentators including bloggers and vloggers.
- Local and national government and regulators – local councils, Joint Clinical Senate (London and the South East), NHS Improvement, NHS England and professional bodies.
- Information will also be shared with statutory health and care organisations and key stakeholders and interest groups in neighbouring boroughs.

Information will also be shared with statutory health and care organisations and key stakeholders in neighbouring boroughs.

This list of stakeholders is not exhaustive and we will work through the evidence we receive during consultation to make sure we are constantly updating our stakeholder list and targeting groups effectively.

17.7 Consultation methods and materials

We will use a range of materials and methods to enable local people to take part in the consultation and talk to us about our proposals. Consultation methodology generally falls into two main categories - giving information and getting information.

Our consultation document will clearly lay out the basis on which we are consulting, the background to the consultation, a summary upon which options have been developed and what the proposals/options are, and signposting for more detailed technical information if needed.

Our consultation methods will highlight the different ways in which various stakeholder groups and audiences might choose to participate, allowing for differing levels of engagement or interest. By using a range of different methods, we will be able to facilitate a wide range and breadth of feedback.

We will seek to engage with patients, carers, their families, healthcare staff at the Trust and in the community, local people and their representatives through a range of engagement activities and events as outlined below.

Engagement activity	Description
Listening events	<p>Open-invite listening events in each of the three CCG areas (nine in total) will be held in order to capture feedback from local residents.</p> <p>Residents will also be encouraged to complete the consultation questionnaire.</p> <p>All public listening events will include British sign language interpreters and will be recorded.</p>
Mobile engagement events	<p>Awareness raising roadshows</p> <p>The aim of the roadshows is to:</p> <ul style="list-style-type: none"> • Raise awareness of the consultation • Engage people who otherwise might not actively engaged with the process or be aware of developments so far • Encourage people to fill in the consultation questionnaire • These events will take place in local community venues across the areas covered by the three CCGs <p>Pop-up events</p> <p>These events will be held at the three hospitals and local healthcare centres in the combined geographies. The purpose of these events is to provide easy access and opportunity for staff, clinicians and patients to find out more, ask questions and take part in the consultation.</p>
Focus groups	<ul style="list-style-type: none"> • To support our efforts to consult local people who may be most impacted by our proposals, including any equality, seldom-heard and protected characteristics groups across the three CCG and neighbouring impacted areas, we will run targeted focus groups with these cohorts. These groups will be by invite only. • Additional focus groups with young people will also be undertaken to hear the views of this group. • These events will be recruited to from a representative sample of people from equality, seldom-heard and protected characteristic groups • The focus groups will be informed by the equalities impact assessments undertaken to date.
Deliberative events	<ul style="list-style-type: none"> • We will run independently facilitated and invite based deliberative events to hear the views of local residents on the questions for consultation based on informed, two-way debate and dialogue. • These events will be recruited to from a representative sample of our CCGs populations. These events will be invite based.
Telephone survey	<ul style="list-style-type: none"> • We will undertake a telephone survey with a representative sample of the three CCGs populations and neighbouring impacted areas.
Voluntary and community sector support	<ul style="list-style-type: none"> • We want to ensure that local communities are supported to share their views on our proposals for change and participate in the consultation. • To complement our other engagement activities, we will set up a Small Groups Grant Scheme to incentivise each Community Voluntary Sector lead organisation in Surrey Downs, Sutton and Merton to independently capture consultation feedback on behalf of the programme either a via large scale meeting or by offering small community groups funding to facilitate and capture feedback from the communities they serve at their own events and/or focus groups. • This approach will ensure that views are gathered from protected characteristic, seldom heard and carer groups.

Engagement activity	Description
Engagement with elected representatives	<ul style="list-style-type: none"> • Face to face meetings and regular written briefings will ensure these key stakeholders are informed and involved. • In addition, the IHT Joint Health Overview and Scrutiny Committee will be formally consulted on the engagement and consultation plans in line with the Health and Social Care Act 2012.
CCG and Trust staff engagement	<ul style="list-style-type: none"> • This work will focus on building on existing platforms in organisations and utilise websites, internal communication channels, staff briefings and local intranets. • Meetings at each hospital site will target groups of staff around the services specifically affected to raise awareness of the consultation and encourage staff to complete the consultation survey. • Attendance at locality forums with GPs, practice managers and nurses to engage them in the consultation questions and gather feedback. We will work with the Communications leads at the three CCGs and Trust to ensure attendance at these meetings.

We have commissioned external, independent experts to deliver some of the engagement activities. A range of consultation materials to support the consultation process will be developed, including:

Engagement activity	Description
Full consultation document	<p>The full document will be available online and in paper format. The online version of the document will be published on the programme's website and the paper version - disseminated to partner organisations.</p> <p>The document will include:</p> <ul style="list-style-type: none"> • Description of the proposals in a clear and transparent way • Case for change, including the implications of no change • What the consultation is about in a clear and simple way • How the options have been developed and considered • What is the likely impact of the proposals on stakeholders and the general public • Ways of responding as well as finding out more about the consultation and deadline for submitting responses • Information about how the feedback from consultation will be used • Timescales and when and how a decision will be made.
A summary consultation document	<p>The summary will be available electronically and in hard copy and available at all public events and distributed in bulk, for example, to libraries, GP practices and pharmacies.</p>
Consultation questionnaire	<p>The questionnaire aims to gather views and feedback on issues, concerns, and areas of support in relation to our proposals these can be understood and taken account of.</p> <p>An online and hard copy consultation questionnaire will be available.</p> <p>The questionnaire will be printed for use at events and circulated widely to interest groups and stakeholders.</p> <p>The questionnaire will be available as an easy read document and translated into other languages. Other formats will also be available where required and upon request.</p>
Videos	<p>Two types of videos:</p> <ul style="list-style-type: none"> • Hearing from local clinicians on why change needs to happen and their support for the proposals • An animation video highlighting the case for change, clinical model and aims and objectives of the consultation

Engagement activity	Description
Clinical model materials and resources	<p>These materials will include:</p> <ul style="list-style-type: none"> • Clinical model factsheets • Patient stories • Other resources (i.e. presentations) <p>The purpose of these materials is to strengthen understanding of the proposed clinical model.</p>
Poster, leaflet, banners	<p>These publicity materials will be distributed in bulk and/or available at events to engage with patients, the public and partners.</p> <p>The consultation leaflet will be delivered to every household in the combined geographies and neighbouring areas and will include:</p> <ul style="list-style-type: none"> • A summary of the case for change • A description of the proposal • Listening event dates and venues
Displays	<p>Displays in key locations will promote the opportunity to respond to the consultation. This will include displays at the Epsom and St Helier hospital sites, GP surgeries and in other public areas.</p>
Briefings	<p>Briefings will be arranged and promoted to update on the consultation process. Briefing materials will be tailored for each stakeholder group.</p>
Consultation closing procedure	<p>This document will detail how each element of consultation feedback will be recorded.</p>

17.8 Handling responses

It is vital that patients, the public, staff and other stakeholders feel that their feedback is valued and that they can give feedback easily and directly. The mechanisms for response will include:

- freepost address for return of the consultation questionnaire and other written correspondence
- generic 'info@' email address
- web form/online survey
- a freephone telephone number

17.9 Raising awareness of the consultation

We will aim to raise awareness of the consultation process, questions and timelines throughout the consultation period. We will achieve this through a dedicated marketing and communications strategy.

Our strategy will include a number of elements, for example:

- Regular media releases, and ongoing initiatives with local media outlets and social commentators/influencers
- News stories and case studies for community newsletters
- Social media plans with dedicated content and engagement activity
- Strategic advertising (we will explore newspapers, outdoor and online advertising)
- The use of TV screens in hospitals, GP practices and local authorities wherever possible
- A regular electronic newsletter, published throughout the consultation period, to update members of the public and key stakeholders on the latest consultation activities and evidence
- A dedicated consultation website with online survey

- Outdoor banners and boards advertising the consultation

17.10 Consultation analysis and decision making

Consultations can be sensitive and controversial and it is recommended that the analysis of findings is independent to allow for continued transparency. The format for responses may also be varied and analysis may be required on data collected from a number of sources, including but not limited to:

- Hard copy and online consultation survey returns
- Telephone surveys
- Qualitative feedback from consultation engagement activities and events
- Transcripts, recordings and minutes of meetings
- Letters
- Petitions
- Handling petitions

Once the formal consultation data input has taken place and the data analysed, all the feedback will be captured in one report, produced by an independent, organisation specialising in consultation analysis.

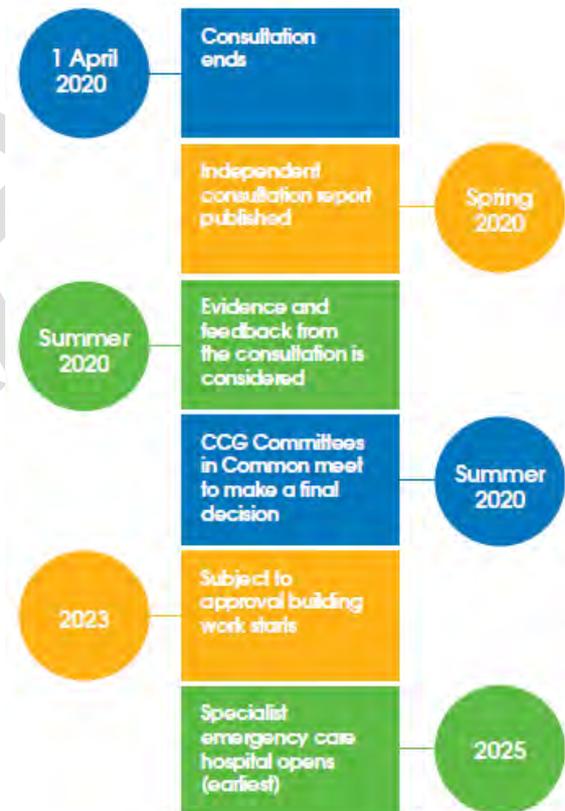
The report will capture all responses highlighting the following:

- Relevant to and/or having particular implications for the model of care and/or one or more of the options
- Well-evidenced submissions that point to evidence that supports their perspective
- Representatives of the general population or specific localities who may be potentially impacted in the combined geographies
- Views from under-represented people or equality groups in the combined geographies

A simple summary and easy read version of this report will also be produced. This report will provide a view from staff, public, patients, carers and key stakeholders on the proposals.

To give additional assurance the Consultation Institute will provide an independent evaluation of the consultation.

After the consultation has finished and phase 3 of the Integrated Impact Assessment is completed, due consideration will be given by Surrey Downs, Sutton and Merton CCGs to all the evidence in order to make a decision on the proposals.



18 IMPLEMENTATION PLAN

The implementation plan describes, subject to assurance, public consultation and decision-making by the Committees in Common, the provisional high-level steps to implement the options.

The building of new sites or refurbishment will differ in terms of time and complexity by option. An overview of phasing and timeline is set out within this chapter.

Implementation by ESTH is dependent on the outcomes of public consultation and any decisions taken as part of the DMBC.

Following any decision on which option to take forward, a more detailed implementation plan will be developed. This will include a clear benefits realisation timetable with key milestones against which progress can be monitored.

The implementation plan describes, the provisional high-level steps to implement the options. Further work will take place during consultation in the lead up to any decision-making.

18.1 Timeline to decision-making

Any decision-making by the Committees in Common will be preceded and informed by:

- The outputs of early engagement;
- The options consideration process;
- Assurance by NHS England and Improvement of this pre-consultation business case;
- Assurance by the Clinical Senate of the clinical model;
- Outputs of the integrated impact assessment; and
- Public consultation.

Following assurance and consultation, a decision-making business case (DMBC) will be developed to review the outcomes and set out any decisions.

As set out in the NHS planning and assurance guidance for delivering service change, a DMBC should ensure that:

- The final proposal is clinically, economically and financially sustainable;
- The proposal can be delivered within the planned for capital spend; and
- A full account is given of how views were captured during consultation.

Where there are any major changes, or for more complex schemes it may be assured by NHS England before any decision making.

18.2 ESTH implementation process

Implementation by the Trust is dependent on the outcomes of public consultation and any decisions taken as part of the DMBC.

For major spending proposals (cases over £15 million), there are three key stages in the development of a project business case, which correspond to the key stages in the spending approval process for NHS Improvement²⁷².

The Trust will therefore need to:

²⁷² NHSI Capital scheme business case checklist

- Carry out a refresh of its SOC (published November 2017). Expectations of this would include:
 - Strategic rationale and benefits of the investment
 - Alignment of the scheme to clinical strategy and commissioning intentions
 - Confirmation that a deliverable and affordable option exists before development of an outline business case
- Develop an outline business case
 - The overall impact, financial and non-financial (including full quality impact assessments), has been assessed and evaluated.
 - A clear statement of affordability and funding sources is provided for capital and revenue.
- Develop a full business case
 - Financial figures are confirmed and final.
 - There is a clear statement of affordability and funding sources are provided for capital and revenue

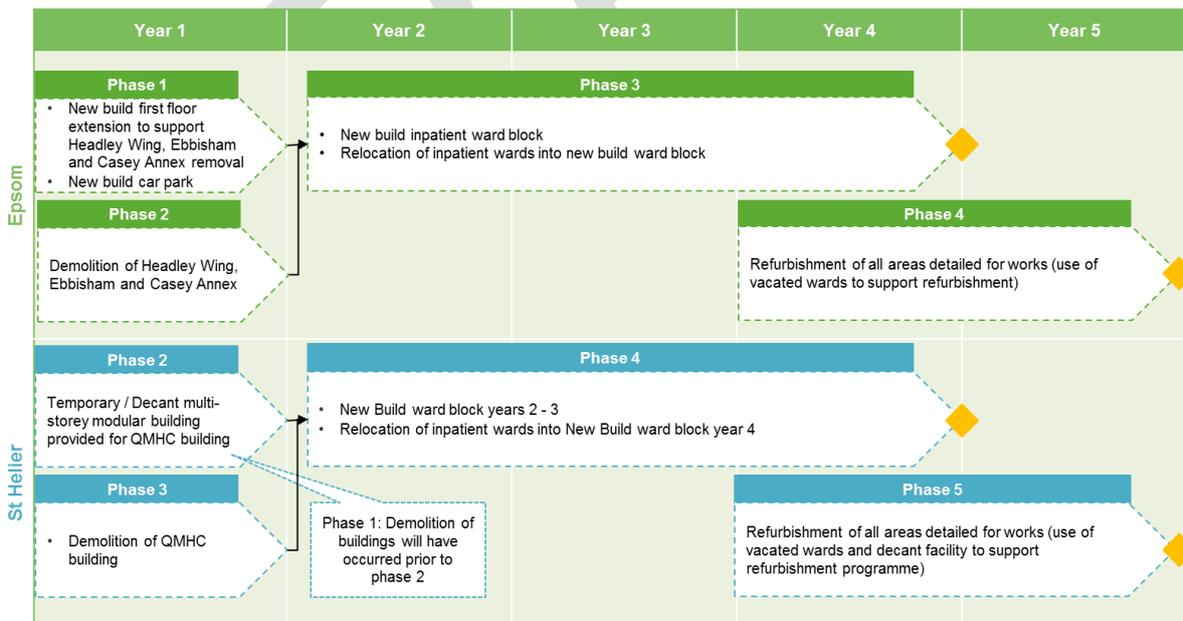
18.3 Implementation of decision

The building of new sites or refurbishment will differ in terms of time and complexity by option. An overview of phasing and timeline is set out by option below.

18.3.1 No service change implementation

The no service change implementation involves refurbishment of existing buildings, with a temporary decant building required at St Helier. Due to space constraints, refurbishment will be undertaken over a number of phases. The redevelopment would take a total of five years.

Figure 70: No service change phasing summary

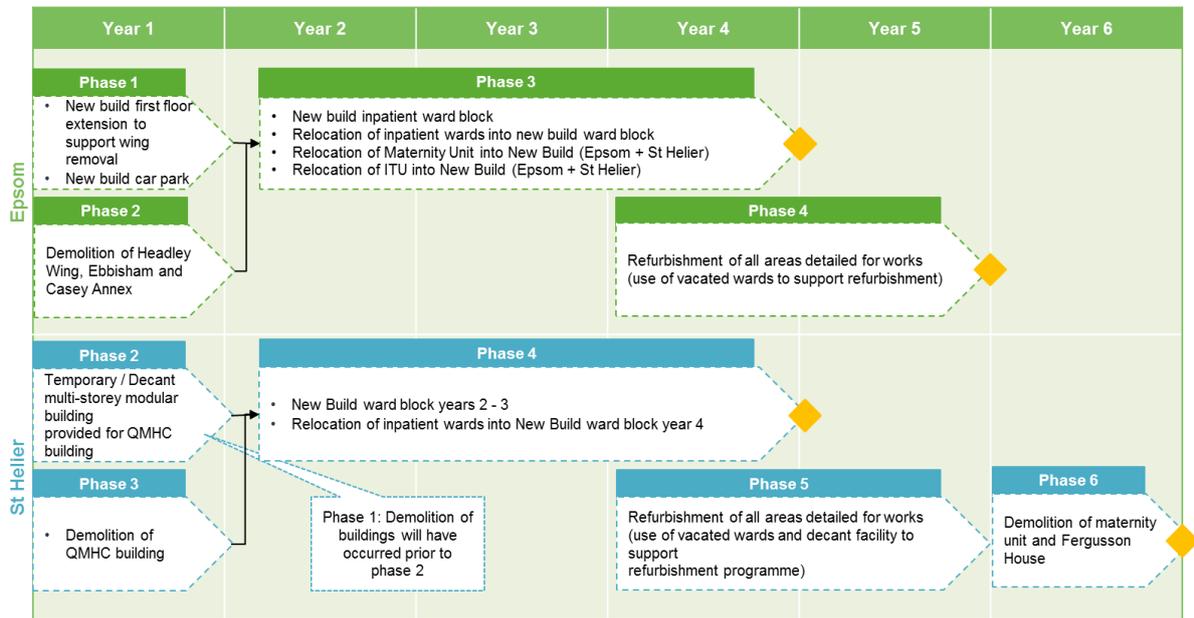


18.3.2 Epsom option implementation

The implementation of the Epsom option requires a new ward block, with decanting of services required from buildings prior to construction. Refurbishment can take place once the new building is

open, with some decant required. Demolition of buildings may mean that access points to the site would need to be changed. The redevelopment would take a total of 6 years.

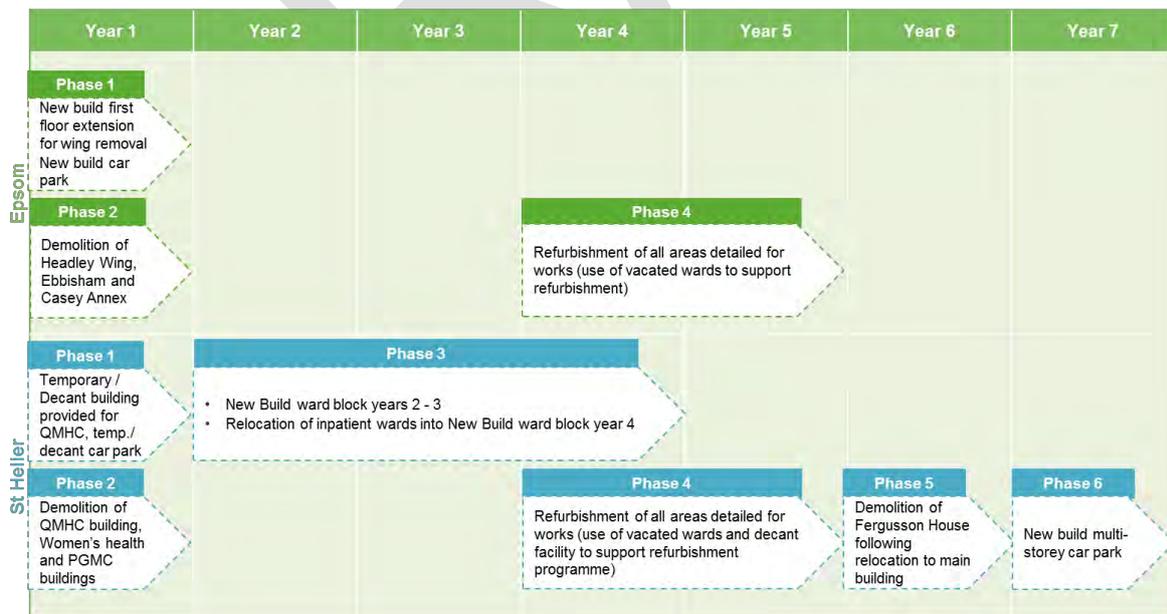
Figure 71: Epsom option phasing summary



18.3.3 St Helier option implementation

The implementation of the St Helier option would require a large decant facility to be built. This may need to be located in the main car park, meaning staff would need to park elsewhere. Refurbishment can take place when the new building is open, with some decant required. The overall time required would be 7 years.

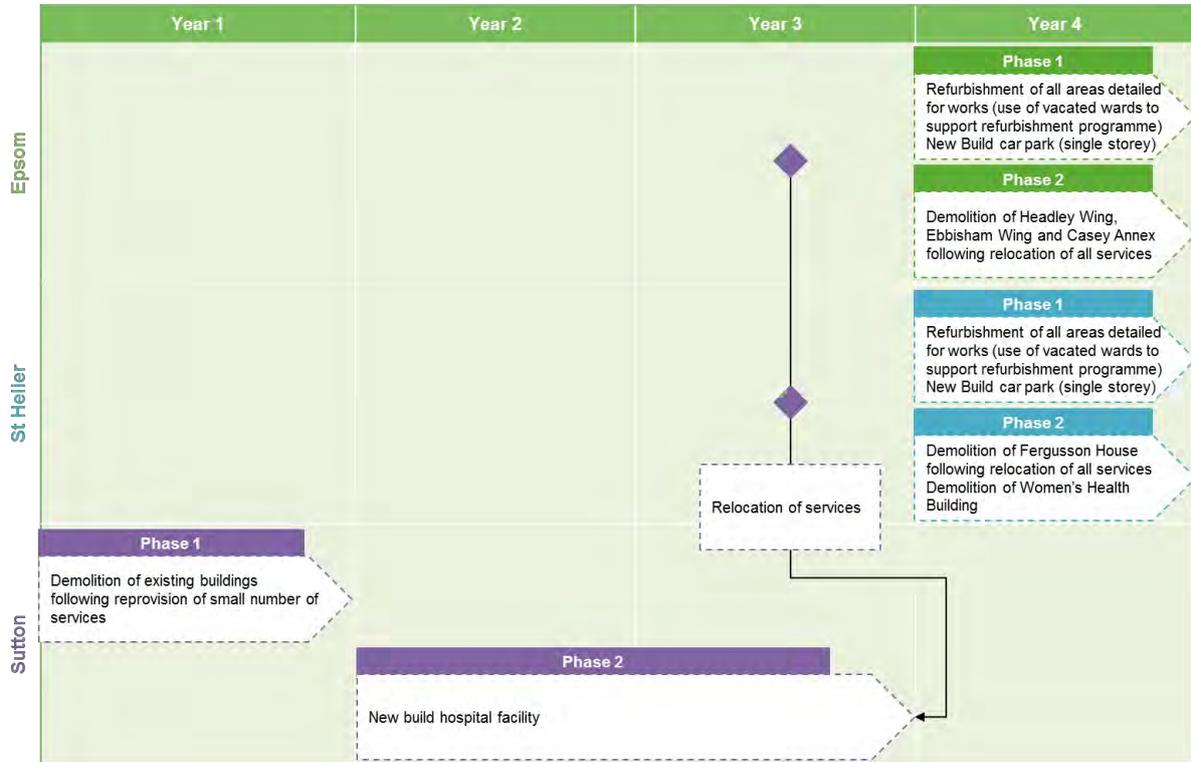
Figure 72: St Helier option phasing summary



18.3.4 Sutton option implementation

The implementation of the Sutton option requires less phasing, as there is mostly clear land with only a small amount of demolition required. Refurbishment of Epsom and St Helier can take place when new building open with some decant required. This would take around four years.

Figure 73: Sutton option phasing summary



18.3.5 Hospital transition planning

Once any new facility has been built a transition will need to take place between any old site to any new site. This requires careful planning, and involves four main phases:

- Preparing the new facility for relocation, e.g. equipment / technology installation
- Department planning and design, e.g. setting out service locations within any new facility
- Staff preparation, e.g. educating staff with new equipment / technology / processes
- Physical patient and staff transition. This requires detailed plans for all services, and sometimes specific patients, to provide a schedule for the move.

These plans will be set out in more detail while any decision-making business case is prepared.

18.4 Next steps

Following any decision on which option to take forward, a more detailed implementation plan will be developed. This will include a clear benefits realisation timetable with key milestones against which progress can be monitored.

19 APPROVAL PROCESS

This pre-consultation business case and the work set out within it was assured by a range of organisations. This includes:

- NHS England and Improvement: Any proposal for service change must satisfy the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks and be affordable in capital and revenue terms. This also includes ensuring each option submitted for public consultation is sustainable in service and revenue and capital affordability terms.
- The Joint Clinical Senate for London and the South East: This organisation scrutinised the clinical model and provided recommendations to address, which have been incorporated within this PCBC.
- The joint health authority oversight and scrutiny committee reviews the PCBC as it relates to the planning, provision and operation of health services in their local area.

A further assessment of the possible impact of the options and any changes were captured as part of the detailed interim integrated impact assessment. This identified positive and negative impacts of any proposals and recommend mitigations.

19.1 Governance and decision-making

19.1.1 Improving Healthcare Together 2020 – 2030

In line with the programme governance set out in Section 3.1.1, the approval process for this PCBC was:

- CAG and FAE submitted recommendations within this PCBC to the Programme Board.
- Programme Board reviewed the PCBC and submitted it to NHS England and Improvement for assurance (see Section 19.1.2).
- The Joint Health Overview and Scrutiny Committee also assured the consultation plan (see Section 19.4).
- After assurance, a decision whether to proceed to consultation was made by a public Committees in Common.

19.1.2 Assurance by NHS England and Improvement

NHS England and Improvement assures CCGs against their statutory duties and other responsibilities under the CCG Assurance Framework. It has a role to both support and assure the development of proposals by commissioners. Assurance is applied proportionately to the scale of the change being proposed, with the level of assurance tailored to the service change.

NHS England and Improvement supports commissioners and local partners to produce evidence-based proposals for service change, and to undertake assurance to ensure they can progress, with due consideration for the government's four tests of service change and its test for proposed bed closures²⁷³.

Prior to public consultation, both NHS England and Improvement considered the financial proposal in terms of both capital and revenue and its sustainability. This ensured each option submitted for public consultation is:

- Sustainable in service and revenue and capital affordability terms;

²⁷³ NHS England, *Planning, assuring and delivering service change for patients*, 2018

- Proportionate in terms of scheme size;
- Capable of meeting applicable value for money and return on investment criteria.²⁷⁴

NHS England will operate a two stage assurance process prior to public consultation:

- a strategic sense check; and
- an assurance checkpoint.

Most assurance of service change proposals is undertaken at a regional level, however due to the size of this proposal assurance and decision making was undertaken by the Delivery, Quality and Performance Committee in Common (DQPCIC). The oversight of the national work programme for service change takes place through the Oversight Group for Service Change and Reconfiguration (OGSCR) as a sub-committee of the DQPCIC. The roles of these bodies are described below:

- **Delivery, Quality and Performance Committee in Common (DQPCIC):** This body provides assurance on service reconfiguration. Membership includes the Chief Financial Officer, Chief Operating Officer and National Director for Operations and Information.
- **Oversight Group for Service Change and Reconfiguration:** This body supports the DQPCIC to oversee the implementation and continued working of the assurance process. Membership includes Regional Directors, Medical Director (Acute), Director of Strategic Finance, and Director of Operations and Information.

As part of the Health Infrastructure Plan published on the 30th of September, the Government announced funding for six new large hospital builds, which included allocated investment in Epsom and St Helier University Hospitals.

At the NHS England and Improvement Oversight Group for Service Change and Reconfiguration on the 8th of October, the programme was given approval to proceed to the next stage and seek final assurance sign off from the Delivery, Quality and Performance Committees in Common (DQPCiC).

19.2 Regulatory tests

Any proposal for service change must satisfy the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks and be affordable in capital and revenue terms. These tests are:

1. Strong public and patient engagement.
2. Consistency with current and prospective need for patient choice.
3. A clear, clinical evidence base.
4. Support for proposals from clinical commissioners.
5. Where appropriate, service change which proposes plans significantly to reduce hospital bed numbers should meet NHS England's test for proposed bed closures and commissioners should be able to evidence that they can meet one of the following three conditions:
 - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and the new workforce will be there to deliver it; and/or
 - Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
 - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting It Right First Time programme).²⁷⁵

²⁷⁴ NHS England, *Planning, assuring and delivering service change for patients*, 2018

²⁷⁵ NHS England, *Planning, assuring and delivering service change for patients*, 2018

How our proposals have met these tests is set out below.

19.2.1 Strong public and patient engagement

As set out in Section 4 we undertook a significant amount of patient and public engagement during our programme of early engagement. This ensured patients, carers and residents were fully involved in the development of the case for change, clinical model and potential solutions.

All the feedback gathered through our various engagement activities was independently analysed by The Campaign Company and the findings captured in their engagement report (see Appendix □).

Our overarching aims in undertaking this engagement activity were as follows:

- To seek feedback on the emerging clinical model
- To seek feedback on the case for change – our vision and challenges
- To seek feedback on the potential solutions developed by the programme
- To seek feedback on how the short list of potential solutions may affect different groups

In addition, unlike many other programmes, the public have been actively involved in our options consideration process. Following TCI best practice, the programme adopted its recommended process for working collaboratively with local people to evaluate the proposed options.

This options consideration process ensured patients, carers and the public played a full part in agreeing criteria, weighting criteria and scoring the final options based on a 60:40 attendee ratio of local people and professionals. This is set out in Section 3.4.

19.2.2 Consistency with current and prospective need for patient choice

All major acute and district services will continue to be offered by Epsom and St Helier NHS Trust, regardless of the shortlisted option. All options where major acute services are provided out of area fail our first test (see Section 9.2).

The NHS Choice Framework²⁷⁶ sets out statutory requirements for choice, of which the most relevant are outlined below:

Choosing where to go for your first appointment as an outpatient

What choices do I have?

If you need to be referred as an outpatient to see a consultant or specialist you may choose the organisation that provides your NHS care and treatment (an outpatient appointment means you will not be admitted to a ward). You may choose whenever you are referred for the first time for an appointment for a physical or mental health condition.

You may choose any organisation that provides clinically appropriate care for your condition that has been appointed by the NHS to provide that service. You may also choose which clinical team will be in charge of your treatment within your chosen organisation.

Choosing maternity services

What choices do I have?

You can expect a range of choices in maternity services, informed by what is best for you and your baby.

When you find out that you are pregnant you should expect to be able to choose which midwifery service you attend from a range of options. To access this service you can:

- go directly to your chosen midwifery service: you can use NHS Choices to find out more about the different services that are available and then self-refer
- go to your GP and ask to be referred to your chosen midwifery service: your GP should provide you with information about the different services that are available

While you are pregnant you should be able to choose to receive antenatal care from:

- a midwife
- a team of maternity health care professionals, including midwives and obstetricians. This will be the safer option for some women and their babies

When you give birth you should be able to choose to do so:

- at home, with the support of a midwife
- in a midwife-led facility (for example, a local midwife-led unit in a hospital or birth centre), with the support of a midwife
- in hospital with the support of a maternity team. This type of care will be the safest option for some women and their babies

After going home you should be able to receive postnatal care:

- at home
- in a community setting, such as a Sure Start Children's Centre

The choice of any service at Epsom and St Helier Trust remains open regardless of the location of the major acute site.

- All services will continue to be provided within the combined geographies. ESTH will continue to provide clinically appropriate care for outpatients across the services currently provided.

²⁷⁶ <https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs>

- Women requiring maternity services will continue to be able to choose to give birth at home, in a midwife-led facility or an obstetrician-led facility. This is set out in detail in Section 5.5.6.

19.2.3 A clear, clinical evidence base

This PCBC was produced on the basis of clear, clinical evidence. This includes:

- Our case for change, which is based on local and national clinical evidence (Section 2).
 - We used local and national data to define the health needs of our population, with an analysis of demographics, disease prevalence and variation in health outcomes. This involved research of a wide range of sources, including local joint strategic needs assessments, the national quality and outcomes framework and NHS RightCare focus packs.
- We developed our clinical model based on clinical standards for acute services and best practice (Section 5).
 - The importance of consistent, consultant-delivered acute care as a component of clinical quality has led to the local and national clinical standards for acute services. This includes national standards for the delivery of seven-day acute hospital services, minimum staffing level recommendations from royal colleges (such as the RCEM), and the clinical standards for acute services provided in South West London or operated by a South West London Trust.
 - These sources are nationally and locally recognised as a clear clinical evidence base.
- We developed a robust, evidence-based process for developing and appraising options for change, working with stakeholders, senior local clinicians and patients and the public (Section 3.4).
 - This process was recommended by the Consultation Institute and involved the provision of local, national and programme analysis (as set out above), and was presented to those who attended the workshops by clinicians.

19.2.4 Support for proposals from clinical commissioners

Clinical commissioners led this programme. From its outset, the programme established governance groups to ensure any decision-making process is underpinned by recommendations set out by workstreams (see below), and is supported by key stakeholders across our combined geographies.

This included:

- The clinical advisory group, which was established by the CCGs of Surrey Downs, Sutton and Merton. The membership of the clinical advisory group included the CCG chairs and local GPs from across the area.
- The finance, activity and estates group, which included representatives from across the CCGs and was chaired by the CFO for the South West London Alliance of CCGs.

All decision-making takes place through a committees in common (CiC) of CCGs, formed by Surrey Downs, Sutton and Merton CCGs.

Letters of support from the accountable officers for South West London and Surrey Heartlands can be found in Appendix □.

19.2.5 Bed capacity

As discussed in Section 12.3.1, across all the options the programme is planning that the appropriate number of beds will be offered across the system provided either by ESTH or by other providers.

We expect to need 1,052 – 1,082 beds for the population in 25/26. Currently there are 1,048 at ESTH. All options will provide 1,052 beds in the future other than the no service change option is expected to be less efficient than the other options and mean a requirement for 30 additional beds (1,082).

The number of beds in the future are distributed differently for each option:

- **Epsom as the major acute site:** There would be 293 district beds and 342 major acute beds at Epsom Hospital, 213 district beds at St Helier Hospital and 205 beds moving to other providers as a result of changed travel times impacting on the ESTH catchment.
- **St Helier as the major acute site:** There would be 225 district beds and 469 major acute beds at St Helier Hospital, 277 district beds at Epsom Hospital and 81 beds moving to other providers.
- **Sutton as the major acute site:** There would be 496 major acute beds at Sutton Hospital, 285 district beds at Epsom Hospital; 221 district beds at St Helier Hospital, and 50 beds moving to other providers.

These totals are shown below.

Table 133: Number of beds by option

Major acute site	Epsom	St Helier	Sutton	Other providers	Total beds needed for the population 25/26
No service change	470	612	0	0	1,082 ²⁷⁷
Epsom	634	213	0	205	1,052
St Helier	277	694	0	81	1,052
Sutton	285	221	496	50	1,052

There is therefore an increase in the number of beds across the system. This coupled with the out of hospital initiatives described in Section 5.4.1 means there is a strong foundation across the system to ensure there is sufficient bed capacity.

19.3 Financial metrics

A range of financial metrics have been used to determine the feasibility of delivering the options and their overall affordability. As set out in Section 13, alongside the non-financial options consideration process, the finance workstream reported a series of financial criteria for each option, including I&E, cashflow, net capital expenditure, NPV and ROI.

Below we have reported further financial metrics required by NHS England and Improvement for assurance purposes.

19.3.1 CDEL

As discussed in Section 14.1.1 our preferred financing route is PDC. In this instance, the full capital amount would draw on CDEL. As an alternative, a number of mixed financing scenarios have also been explored.

19.3.2 Cash position

For each option, other than the no service change counterfactual, ESTH generates a cash surplus by 25/26 (first recurrent year of operation) of over £10m p.a. which can be used to pay back the principal.

19.3.3 ESTH I&E

The options have an improved I&E position relative to the no service change counterfactual, as described in Section 2.5.1.1. While there are additional financing costs compared to the no service change comparator due to the capital investment required, this improvement is driven by the benefits from consolidating major acute services.

²⁷⁷ The no service change counterfactual requires more beds as it is expected to be less efficient.

Table 134: Outputs for finance metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Finance	ESTH 25/26 in year I&E (£m)	(22.6)	10.9	11.3	17.0

19.3.4 Capital availability

As set out in Section 13.3, in order to deliver the significant benefits expected, a large capital investment in the hospital sites is required across all options.

To understand how this capital requirement may be financed, we also undertook an initial appraisal of potential financing sources, and considered their advantages and disadvantages as well as tested the affordability of a short list of potential financing scenarios.

The main financing scenario we have explored is drawing on PDC to secure the financing – this is our preferred financing route. As an alternative, should public financing routes be unavailable, we have also considered a mixed financing approach – drawing on a number of sources, including leveraging LA financing.

Initial analysis suggests that all financing scenarios can help to drive a positive income and expenditure for the options.

19.3.5 Capital to income test

As part of the financial analysis the ratio of capital to income test – which is often applied as a rule of thumb – was considered. This refers to assessing the ESTH net capital investment (£m) as a percentage of total 19/20 income included in contracts – where a ratio of greater than unity could indicate affordability challenges.

Table 135: Capital to income test

Metric	Baseline	MA Epsom	MA St Helier	MA Sutton
ESTH net capital investment (£m) as % of total 19/20 income	46%	60%	79%	96%

19.4 Joint Health Oversight and Scrutiny Committee

The local Joint Health Authority Oversight and Scrutiny Committee reviewed our work as it relates to the planning, provision and operation of health services in their local area. This is set out in legislation in that commissioners must consult the local authority when considering any proposal for a substantial change in health provision. As part of this process, the JHOSC will engage interested parties and take into account relevant information available, including that from local Healthwatch. This therefore enhances public involvement in the commissioning process²⁷⁸.

The programme engaged with the JHOSC while work and evidence development progressed. The table below provides an overview of the meetings and items for discussion.

²⁷⁸ NHS England, *Planning, assuring and delivering service change for patients*, 2018

Table 136: JHOSC meetings

	Meeting date	Items for discussion
1	16 October 2018	<ul style="list-style-type: none"> • Scrutiny issues: the approach of the Improving Healthcare Together subcommittee • Improving Healthcare Together 2020 -2030 progress update • Q&A / discussion of progress update • Dates for future meetings of sub-committee
2	28 November 2018	<ul style="list-style-type: none"> • Overall briefing report and verbal update on engagement • Deprivation Impact Analysis • Provider Impact Analysis • Independent review by the Campaign Company into Improving Healthcare Together Engagement
3	7 February 2019	<ul style="list-style-type: none"> • Programme update • A Report on the Options Consideration Process by Traverse • Response from Epsom & St Helier NHS Trust to the report on the Options Consideration Process by Traverse • Reports from local Healthwatch on focus groups with protected characteristic groups • Programme Equalities responses to Healthwatch reports
4	30 April 2019	<ul style="list-style-type: none"> • Programme update • Consultation plan update • Stakeholder Reference Group update • Integrated Impact Assessment emerging findings
5	4 July 2019	<ul style="list-style-type: none"> • Programme update • Provider impact update • Draft interim Integrated Impact • Clinical Senates report
6	30 July 2019	<ul style="list-style-type: none"> • Programme update • Consultation plan update
7	26 September 2019	<ul style="list-style-type: none"> • Programme update • Consultation plan update

19.5 Clinical senate review

For substantial service change, it is best practice to seek the clinical senate's advice on proposals. Senate advice is impartial and is informed by the best available evidence and where evidence is limited clinical senates seek to build and reflect consensus.

As part of the assurance of the clinical model, the Senate carried out a review in two phases:

- Phase one: Review of the emerging clinical model set out in the Technical Annex.
- Phase two: Review of the clinical model as described in the draft PCBC.

19.5.1 Phase one clinical senate review

We received initial feedback on the case for change and clinical model a set out in the Technical Annex as part of the stage one Senate desktop review. This was responded to and an updated clinical model was sent for assurance as part of the phase two review.

19.5.2 Phase two clinical senate review

Phase two involved a more detailed review of the clinical model. An initial presentation and discussion was held with the Clinical Senate focusing on key elements of the model. This was then followed by a full Clinical Senate report on the clinical model including a set of recommendations to address. These recommendations of the Clinical Senate can be categorised across seven main areas:

1. Finance, activity and estates – The Senate asked for several activity and bed modelling assumptions and breakdowns to be revisited. This included further examination of demand and capacity in community care and provision of more detailed demographic forecasts. These recommendations were addressed through FAE.
2. Risk and benefit analysis – The Senate recommended across several areas that the risks and benefits of the options and services were revisited. This included evaluating the potential risks and benefits of a standalone district site in comparison to a district site co-located with the major acute site; standalone UTCs and critical care capacity. A specific risk and benefits group was set up to address these points. This included clinicians from across the area as well as externally for additional check and challenge.
3. Transfers and ambulance impacts – The Senate made several recommendations around transfers and ambulance impacts. This included continuity of care during handovers and managing the (emergency) demand on ambulances. These recommendations were considered through a specific intra- and intersite group, with further impacts on ambulances considered through FAE.
4. Workforce – The Senate made numerous recommendations around workforce. This included examining training requirements, considering the benefits of centralising specialists and understanding the workforce requirements for the district site. This was examined through CAG and the risk and benefits group.
5. District hospital and urgent treatment centres – The Senate queried a number of aspects of the model relating to the district hospital model as well as UTCs. This crossed over with several other themes, including risks, transfers and workforce. These recommendations were considered through various working groups, including CAG, the intra- and intersite group and the risk and benefits group.
6. Patient pathways – The Senate emphasised the importance of effective patient pathways between major acute and district services, discharge pathways and pathways with other services including mental health and social services. These were considered as part of CAG's further refinement of the clinical model.
7. General clarifications – A number of strategic recommendations were made around managing population health, understanding why major acute services needed to be maintained across the geography and alignment with digital strategies.

The clinical model was refined to reflect these comments, and a detailed action plan was developed by the CAG detailing the responses to each of the recommendations.

20 CONCLUSION AND NEXT STEPS

Within this document, we have:

1. Described the health needs of our combined geographies and set out the case for change: Sections 1 and 2.
2. Described the process we have followed: Section 3.
3. Described how key stakeholders and the public have been engaged and involved: Section 4.
4. Described the clinical model and potential benefits thereof: Sections 5 and 6.
5. Set out our options consideration process: Sections 7, 8, 9 and 12.
6. Carried out an analysis of financial impact and affordability: Sections 13 and 14.
7. Set out how we will assure and potentially implement our plans if a decision is made to move forward: Sections 17, 18 and 19.

Subject to approval of this document by the Committees in Common, based on this work, we have considered all the evidence and established a preferred option.

Figure 74: Summary of non-financial evidence, financial evidence and overall preferred option

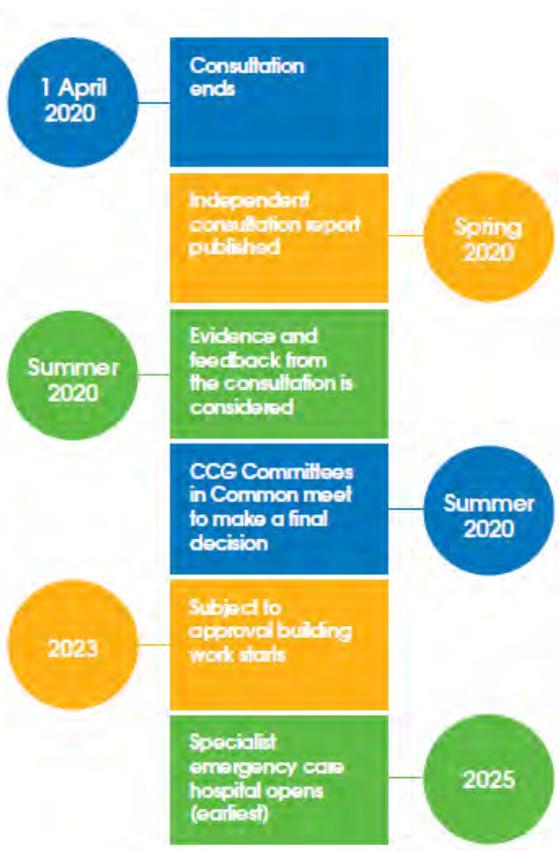
Criteria	Sutton	St Helier	Epsom
 Quality of care Would it improve safety and quality of clinical care, improve patient experience, deliver the required beds and resolve the workforce, recruitment and retention issues?	The proposed changes would deliver improved quality of care in all options. In all options how care is delivered would be the same, there would be the same number of beds (a slight increase on what is available now) and the workforce issues would be resolved.		
 Long term clinical sustainability Does it improve access to urgent and emergency care and are there other clinical benefits for patients?	Three urgent treatment centres that would be open 24 hours a day, every day of the year Located with Royal Marsden it would improve care for Epsom and St Helier cancer patients	Two urgent treatment centres that would be open 24 hours a day, every day of the year	Two urgent treatment centres that would be open 24 hours a day, every day of the year
 Meeting the health needs of local people What would the impact be on older people and people from deprived communities?	Least overall impact on travel for older people and people from deprived communities	Greatest impact on travel for older people and least impact on travel for people from deprived communities	Least impact on travel for older people and greatest impact on travel for people from deprived communities
 Fit with NHS Long Term Plan Would it fit with the NHS Long Term Plan and support bringing health and care services together?	All options would deliver a similar fit with how the NHS Long Term Plan sees healthcare delivered in the future		
 Access including travel What would the impact be on travel and accessibility?	Smallest increase in average travel time. Fewer local people would have to travel further as Sutton is the most central to where people live in the areas of Surrey Downs, Sutton and Merton	Second greatest increase in average travel time. More local people would have to travel further with more complicated journeys	Greatest increase in average travel time. A larger number of local people would have to travel further with more complicated journeys
 How easy it is to deliver? Complexity and length of time to build and impact on neighbouring hospitals	Easiest to build Would take four years to build Least impact on neighbouring hospitals – 50 beds move to other local providers	More complicated to build Would take seven years to build Bigger impact on neighbouring hospitals – 81 beds move to other local providers	More complicated to build Would take six years to build Greatest impact on neighbouring hospitals – 205 beds move to other local providers
 Finance What is the capital cost to build and long term financial benefit to the NHS over 50 years, which is the planned lifetime of hospital buildings?	Most cost to build: \$511 million. It has the most new buildings but because it keeps the most patients in the area and there are extra benefits of being located with the Royal Marsden it is the best value for the tax payer	Least cost to build: \$430 million as it has the most amount of refurbished buildings and keeps the majority of patients in the area making it medium value for the tax payer	Medium cost of build: \$466 million as the build size is smaller as it keeps the least number of patients in the area. It also has the largest investment needed at other providers and therefore it is the least value for the tax payer

The Programme Board considered all the evidence set out within this pre-consultation business case and concluded that:

- The three options are viable and should be included in any public consultation.
- The options continue to be ranked as:

- Sutton as the top ranked, and on this basis, subject to CiC review and approval, the preferred option.
- St Helier as the second ranked option and,
- Epsom as the lowest ranked option

This formed the basis of its recommendations to the Committees in Common.



No decision will be made until after consultation (subject to approval by the Committees in Common). The programme would then proceed following the timeline to the left.

A decision-making business case will be produced which brings together all the information required by the CCGs' Governing bodies to make their decision on how services may be improved moving forward to any implementation phase.

None of the six services would be brought together until the new specialist emergency care hospital is built which, under the preferred option, would be 2025 at the earliest.

The three CCGs' Committees in Common will meet to make any decisions will be held in public and will consider all of the evidence and the consultation report.

21 APPENDIX

The documents below have been published on the Improving Healthcare Together website (<https://improvinghealthcaretogether.org.uk/>), and are available for reference in support of this pre-consultation business case.

- Joint Clinical Senate review of the Improving Healthcare Together 2020 – 2030 pre-consultation business case for Surrey Downs, Sutton and Merton CCGs
- Traverse independent report: Options consideration process
- Traverse independent report: July / August 2018 Discussion events
- Independent analysis of feedback from public engagement (The Campaign Company)
- Draft interim integrated impact assessment
- Initial equalities analysis of major acute services
- Baseline Travel analysis June 2018
- Technical note on travel analysis methodology
- Deprivation impact analysis report
- Issues Paper
- Issues Paper Technical Annex
- Improving Healthcare Together Stakeholder briefing document