E3.20 Sutton and Cheam Labour Party

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London Borough of Sutton
Under Standing Order 8.13

1) Question asked by Charlie Mansell, to Councillor Ruth Dombey, Chair of the Strategy and Resources Committee.

The Chair of the Strategy and Resources Committee will have no doubt seen the recent Sutton North Focus leaflet which says it is "News from your Local Liberal Democrat team Councillor Ruth Dombey, Councillor Marlene Heron and Councillor Steve Penneck", having possibly helped deliver it too!

This states on its second page "the CCGs preferred option of moving them to Belmont is likely to be carried forward unless opposition is mounted". In view of this public statement on a document published by her as a Councillor can she confirm whether this "opposition" to the "preferred option" is also now the formal position of Sutton Council too?

Response

Thank you for your question Mr Mansell and my apologies for the slight delay in responding. I am sure you will understand the impact that the Coronavirus emergency is having on all Council services.

At the meeting of the Strategy and Resources Committee on Monday 30 March 2020 the Council adopted its formal response to the Improving Healthcare Together consultation which was duly submitted before the close of the consultation. The report and the audio recording of the meeting can be found on the Council website. I can confirm that the formal position of Sutton Council is St Helier as our preferred site for the new acute hospital.

2. Question asked by Charlie Mansell, to Councillor Ruth Dombey, Chair of the Strategy and Resources Committee.

Therefore can the Chair of the Strategy and Resources Committee clarify what discussions the Council has had so far had with either the Improving Healthcare Team, the Epsom and St Helier Hospital Trust or their agents such as Savills Estate Agent as to use of what is currently Council land and whether that also involves any swaps of any other land the Trust or the Council own?

In doing so can the Chair of the Strategy and Resources Committee also explain whether the Council actually agrees with this somewhat bold proposed use of their land - which was supposedly for a Cancer Hub - for the purpose now proposed by the CCGs and Trust, or is the Council intending to neither lease nor sell the land back to the Trust?

Response

The land acquired by the Council for the London Cancer Hub is as set out in the Committee reports and there have been no discussions about selling or leasing it back for development

of the new acute hospital, if it takes place at this location. The whole of the land purchased for the Cancer Hub remains earmarked for that scheme. Final layout will emerge from further design work and subject to the agreement of all parties involved.

“Who in their right mind is now going to build an ICU for Pandemics on the same site as a specialist hospital full of Immune-suppressed people?”

Why this consultation is already out of date and the preferred option should be dropped

Improving Healthcare Together Consultation

Sutton and Cheam Labour Party Response

<u>Important Note to Improving Healthcare Together Team and any organisation analysing the survey.</u> Above in red is the full title for this report, which is what it should be referred to in your recording of responses to the consultation

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Introduction

In 2005 Sutton and Epsom Labour proposed new investment in St Helier Hospital when there was a previous proposal to move services to the Sutton Hospital site. In 2009 what was our proposal was the one that most resembled the policy adopted by the Government. These were plans that retained acute services at Epsom and proposed a major reconstruction of St Helier, at a cost then estimated at £219m, which the government agreed to fund, avoiding the costly Private Finance Initiative. That scheme survived one budget under the 2010 coalition but after a few years of austerity was dropped as a policy in 2013.

The latest scheme for a new acute unit at Sutton would cost more than twice as much as that plan, but provide far fewer beds, reducing both Epsom and St Helier to little more than urgent treatment centres, offering only beds with nursing home levels of care, along with residual outpatient clinics and minor day surgery.

The Consultation Document – devoid of detail – and the PCBC on which it depends, fail to make a credible case for the clinical viability of the new hospital, evade the probability if not certainty of the limited capacity at Sutton being heavily used by Royal Marsden private and NHS patients rather than the local catchment of ESTH, and fails to provide convincing arguments that the resulting 3-site option would be cheaper, more efficient or any easier to staff than the current 2-site system.

Rather than squander £500m on a small hospital offering just 386 core acute beds, an updated version of the 2009 plan to build a new St Helier Hospital and upgrade and expand Epsom (for far less than £500m) could deliver better results and better accessibility, leaving additional resources to improve and expand community health, primary care and mental health services.

The proposals regarding the removal of acute services from Epsom and / or St Helier Hospitals constitute a major risk to life – especially after the Coronavirus outbreak and proposing colocation of ICUs needed for a pandemic on the same site as a specialist hospital visited out of necessity by mainly immune-suppressed cancer patients is a future scandal in the making.

We therefore call on the government to put an immediate stop on all plans to remove acute services from Epsom and / or St Helier Hospitals. We need to retain all services in all hospitals. We need to properly invest in all services at all hospitals and we need more beds, more specialist doctors and more staff, not less

Thus, again we suggest the CCG's and Trust heed our proposals as we do have a track record of being proven right over the future of our local hospitals

Summary

We support the responses from Unison, GMB and KoSHH in totally opposing the preferred proposals to downgrade St Helier and Epsom Hospitals and replacing their acute services with a smaller unit on the Sutton Hospital site. They have put forward many important points that should be carefully heeded. We have drawn from them in this response but we are also adding further new points in this document. In summary we oppose the preferred proposal because:

1. Coronavirus has made this proposal totally out of date due to lack of bed provision and the future scandal of collocating pandemic ICU units in the middle of a specialist cancer hospital site full of immune-suppressed cancer patients
2. Prior to Coronavirus it was still clear the bed reductions proposed were unsustainable
3. The proposal is trying to dress up a massive investment in a specialist regional cancer hospital as a local hospital configuration.
4. This proposal is driven by the funding envelope for its estate strategy not clinical need. This is a "plunder of the commons" where publicly owned land is likely to be sold off to deliver this proposal. This is short-sighted and reduces public trust in the local NHS
5. The Sutton site has very poor transport links whilst both the current acute hospitals are near transport hubs and are accessible
6. Because we have total scepticism from the evidence elsewhere that the 24-hour Urgent Treatment Centres (UTCs) will stay at 24 hours and will drop to 16 hours
7. That the UTCs likely struggle is also indicative that we will see a reduction in Primary Care through less GP surgeries, so this acute services proposal impacts on them too, however that is not covered in what is being put forward.

We note that the entire emphasis of the consultation document and the 1000+ pages of supporting documents is on pressing the case for Option 4, the building of a new acute care centre on the Sutton Hospital site: it is obvious that regardless of the views expressed in the consultation that this is the only Option that will be pursued by the CCGs and the Trust, and we will concentrate our comments on this preferred option.

The proposal to centralise acute hospital services and specialist inpatient care on a new 496-bed hospital in Sutton will result in a serious loss of provision of acute beds and front-line acute services, downgrade the existing services at both Epsom and St Helier, undermine the possibility of further development of more local and accessible community services, and, by establishing a more complex 3-site service in place of the two existing sites, worsen rather than improve the efficiency of the service and the problems of recruiting and retaining staff.

We are also concerned that the preferred location of the new hospital, on the Sutton site adjacent to the Royal Marsden and a substantial new emerging “Cancer Hub” (which has been promoted and partially funded by Sutton Council) is likely to result in a considerable proportion of beds, theatre time, and the work of consultants and medical staff, nurses and other health professionals being allocated to treating surgical patients – including private patients – from the Royal Marsden.

This would mean that far from simply reproviding services currently serving the Epsom & St Helier catchment area, defined geographically and estimated at 720,000, the reduced number of acute beds in the new Sutton centre would be also covering an additional, demanding caseload that has not been incorporated into the projections or discussed in the Pre-consultation Business Case or the Consultation document itself. The new arrangement would clearly benefit the RMH – one of the foundation trusts making the largest share of its

income from private patients – at the expense of services for the people of Merton, Sutton and Surrey Downs.

The proposal from 'Improving Healthcare Together' (IHT), which would reduce trust provision from 743 front line acute beds open overnight [1](or 619 according to NHS figures from last year)[2] to just 407[3] also flies in the face of the most recent Planning Guidance from NHS England, [4] which firmly rejects any further reduction in numbers of acute hospital beds, and calls for provision to remain at the level established to cope with the winter pressures of 2019-20 (including escalation beds). This guidance was before the Coronavirus outbreak and the NHS Leadership has already indicated in press conferences bed numbers will rise in the future and have said this in front of senior government ministers with no contradiction from them.

This last winter (2019-20) the use of up to 50 escalation beds in addition to the core 743 acute beds in Epsom and St Helier University Hospitals NHS Trust (ESTH) meant that occupancy levels were consistently held to within the recommended safe maximum of 85%, [5] unlike many trusts in London and elsewhere. The "specialist emergency care hospital" at Sutton includes half of that bed provision, with just 35 "contingency" beds available. All of this indicates that on bed numbers even before Coronavirus, these proposals were unsustainable.

Our Proposal

In order to move things forward now and set the agenda, we believe the CCGs and ESTH and local Councils should fully engage local people on a new proposal with 3 options. A full rebuild would cost £750 million, a part rebuild like the 2009 proposal would cost £350 million and a more short-term refurbishment would cost £80 million. Labour's preference is for a £750 million rebuild with all the 1930's external facade protected and the hospital then made a Grade 2 listed building. If local health organisations and Council's secure strong public support for that proposal, they should demand resources from central government to fund it. The best option would be for the government to fund the rebuild and the loan made at a low rate of interest.

Our proposed solution is not "status quo", so don't you dare class this response under that measure, but instead is "stand up for your local community". We would expect as part of your options appraisal, that you publish a "if we had enough money to have enough staff to safely provide two A&Es, this would be the cost and this is the case we are making to the Government" as a full option as part of this process. That is clearly very different to the "status quo" and thus needs to be considered and covered in your response.

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[1] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/03/Winter-data-timeseries20190307.xlsx

[2] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/11/Beds-OpenOvernight-Web_File-Final-Q2-201920-l0ksh.xlsx

[3] PCBC Appendix 17, pp20-23

[4] https://www.england.nhs.uk/wp-content/uploads/2020/01/2020-21-NHS-Operational-Planning-ContractingGuidance.pdf

[5] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/03/Winter-data-timeseries20190307.xlsx

The Consultation is already out of date – the need for a new approach in a world of Pandemics

This consultation was written for a different era and its is clear is will have to be scrapped.

The Public Inquiry or Royal Commission into the handling of the Coronavirus outbreak is like to make the current consultation and preferred proposal out of date for the following reasons:

a) Bed numbers will need to rise to build capacity into the NHS for the future. This proposal is now completely inadequate
b) Building an acute hospital unit with pandemic ICU facilities on a site full of immune-suppressed patients is going to be a future scandal in the making and will be seen as unacceptable in future

Let's be absolutely clear with this warning to the CCG's, ESTH and Royal Marsden Trust – (for whom this response will also be sent). The Government's Shielded Patient List [6] says the following people need to be well away from any chance of infection:

People with specific cancers - people:

- *with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer*
- *with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment*
- *having immunotherapy or other continuing antibody treatments for cancer*
- *having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors*
- *who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs*

All of these shielded patients use the Royal Marsden. None of them will want to see a unit dealing with future pandemics located at their specialist hospital for immune suppressed people. It is clear we should separate these units from each to avoid creating a dangerous situation.

[6] https://digital.nhs.uk/coronavirus/shielded-patient-list

Beds

The preferred Option 4 proposals would downsize both Epsom and St Helier hospitals, reducing from the present 454 at Epsom and 594 at St Helier to just 273 at Epsom and 183 at St Helier – halving and reducing by two thirds respectively.

The CCGs' preferred option involves cutting up to 200+ beds. This would leave around 1 bed per 1000 population.

Only by reading the PCBC and its appendices can we find a breakdown of the misleading and apparently unchanged total of "beds" across the Trust to see that the current total of acute beds open overnight would be cut back to just 386 in the new hospital (328 Non-elective, 37 for more complex elective cases and 21 Critical care), [7] less than half the total of "core" and escalation acute beds reportedly open overnight during the winter of 2019-2018. This compares with the current total of 662.

The reduction centres on the 244 general medicine and 84 geriatric beds which are currently available for emergencies, but which would reduce to 227 "district" beds and 62 "community beds" (a total of 289) available at Epsom & St Helier with a much lower level of clinical input.

Given that the same figures show neighbouring acute hospitals in London (St George's, Croydon and Kingston) have run for most of the last winter with percentage bed occupancy rates at the high 90s, occasionally hitting 100% in Croydon, with Ashford & St Peter's in Surrey also frequently upwards of 99%, this drastic reduction in acute beds for the Epsom & St Helier catchment is extremely worrying. There are no alternative nearby beds, and the plans make no adequate provision for expansion of bed capacity elsewhere to take patients who would no longer be able to be treated locally.

It's not clear why the PCBC figures on the emergency caseload should so seriously understate the numbers of Type 1 A&E patients treated at Epsom & St Helier. While the PCBC claims that the total is just 53,000 "major acute patients per year," (PCBC 140) NHS England statistics show 154,915 of the more serious Type 1 A&E cases dealt with by the trust during 2019[8], and almost 44,000 emergency admissions in 2018/19. It seems that the people drafting the consultation material keen to misrepresent the facts to exaggerate the possibility of the trust being able to cope with less than half the current number of front-line beds

We should also note that the planned total also includes:

- 35 "contingency district" beds (which would presumably not be kept open all year round, and for which no site has been identified);
- a reduced provision of 73 maternity beds – all at Sutton: this reduction (from 94) is not discussed or explained.
- And a 20% increase to 24 private patient beds (which can currently be made available when needed for NHS patients, but which would quite likely be filled with Royal Marsden patients if the new hospital is at Sutton). Interestingly this planned figure represents a 50% increase on the 16 Private Patient beds projected in the PCBC p203. This is not explained.

[7] https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/06/Joint-clinical-senate-review-ofImproving-Healthcare-Together-2020-2030.pdf

[8] https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendancesand-emergency-admissions-2019-20/

- We also note that no details are given in PCBC or (of course) consultation document on how the 496 NHS beds in the proposed Sutton hospital would be divided between the various existing ESTH specialties. At present varying numbers from the total of 641 overnight beds plus critical care (Quarter 3 2019/20) are allocated to consultants dealing with: General Surgery, Urology, Trauma and Orthopaedics, A&E, General Medicine, Cardiology, Nephrology, Paediatrics, Geriatric Medicine, Obstetrics, Gynaecology, Haematology and Community Medicine.

However, the new hospital will have just over half as many – 386 – overnight acute beds, 21 of which are set aside for critical care. The Sutton site is expected to be the centre delivering the Trust's six core specialist services. So which consultants/services will lose out most when the reduced numbers of beds are shared out?

Following the Coronavirus outbreak, it is clear that there will need to be a review of bed numbers in the UK and we will see a likely increase to ensure we have more capacity in future. Pre-coronavirus pandemic, only around 4,000 NHS beds were for critical care. [9] The coronavirus pandemic has exposed, among other things, the serious shortage of hospital beds with the NHS having to rent 8,000 private hospital beds for £2,400,000 per day. [10] Reports suggest that around 15% of the population will become severely ill and a further 5 per cent will become critically ill… and would require around 560,000 beds and another 93,000 beds with ventilators – critical care beds. [11]

However even before that it was clear there were already not enough beds:

- According to the Kings Fund, between 1987/8 and 2016/17, the total number of NHS hospital beds fell by approximately 52.4 per cent, from 299,364 to 142,568. [12]
- Reports show that UK has fewer hospital beds per person than virtually anywhere in the western world with less than half (46.3%) of those in France and almost two thirds (35.6%) less than Germany. [13] [14]
- The British Medical Association has called for more hospital beds. [15]
- The Royal College of Nursing has called for more hospital beds. [16]
- The Royal College of Emergency Medicine has called for more hospital beds. [17]
- There are also high bed occupancy rates. In 2017, the Kings Fund warned that, in England, data on overnight hospital bed occupancy had risen from an average of

[9] www.telegraph.co.uk/global-health/science-and-disease/hospitals-could-need-75-times-number-critical-care-beds-treat/
[10] www.metro.co.uk/2020/03/16/nhs-rent-8000-private-hospital-beds-2400000-per-day-12406301/
[11] www.telegraph.co.uk/global-health/science-and-disease/hospitals-could-need-75-times-number-critical-care-beds-treat/
[12] www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers
[13] www.independent.co.uk/life-style/health-and-families/health-news/nhs-stretched-to-breaking-point-claims-international-study9263211.html
[14] www.nationalhealthexecutive.com/Health-Care-News/nhs-has-one-of-lowest-levels-of-doctors-and-nurses-in-western-world

[15] www.bma.org.uk/news/media-centre/press-releases/2018/december/new-bma-analysis-shows-nhs-needs-thousands-of-extrabeds-to-meet-pressures-this-winter
[16] www.nursingtimes.net/news/hospital/more-nurses-needed-to-meet-winter-demand-experts-warn-30-10-2019/
[17] https://www.rcem.ac.uk/RCEM/News/News_2019/NHS_in_England_needs_over_4000_extra_beds_this_winter.aspx

87.1 per cent in 2010/11 to 90.3 per cent in 2016/17….and that such levels of occupancy meant that the average hospital in England was at risk of being unable to effectively manage patient flow leaving it vulnerable to fluctuations in demand. [18]

- A 2019 study by leading NHS doctors found that almost 5500 patients had died over the previous 3 years waiting for a bed in A&E. [19]
- A & E delays are at their worst ever level. [20] [21]

It has been stated that, worst case scenario, the proposals will result in a maximum of 100 additional beds at each of Croydon and St George's Hospitals. These are phantom beds. Neither Croydon nor St George's have the capacity to absorb this and there is little space for additional beds. Croydon hospital is also currently operating at full capacity. [22]

[18] www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers

[19] www.theguardian.com/society/2019/dec/10/thousands-of-patients-die-waiting-for-beds-in-hospitals-study

[20] www.theguardian.com/society/2020/jan/09/ae-staff-despair-as-nhs-delays-are-at-their-worst-ever-level

[21] www.theguardian.com/society/2020/jan/09/patients-suffer-record-delays-because-of-pressure-at-ae-units

[22] www.insidecroydon.com/2018/12/24/mayday-hospital-is-already-operating-at-100-capacity/

Planning, Land and Buildings

The drivers for these proposals are not clinical despite what we keep hearing. The same arguments for why we need to reduce A&E have been made for close to 20 years, but we are all still hear arguing over them. So, what are the new drivers this time:

1. An NHS level driver to give the Royal Marsden an acute facility for its specialist role, not to provide an acute facility for Sutton, Merton and Epsom.
2. The way to generate capital for funding the Epsom and St Helier estate strategy

Over the last decade Council's and Health bodies have had tight revenue funding issues. It is inevitable that talented senior staff feeling frustrated over the limitations placed on them by austerity will see all the concurrent flexibility over capital spend and become institutionalised into a role more akin to being property developers.

However, it needs to be said, this is a "plunder of the commons" [23]where publicly owned land is likely to be sold off to deliver this proposal. This is short-sighted and reduces public trust in the local NHS.

Buildings

The "Buildings" argument focuses on the age of the St Helier and Epsom sites, where backlog maintenance has been left undone, accumulating a current total cost to clear of £96m (St Helier £70.2m, Epsom £26m)10. Everyone wants these repairs to be done: however this alone (or even the need to go further and replace specific blocks or add new) is not a strong argument for spending five times as much – up to £500m – on a new, third site while retaining heavily downsized versions of the two aged hospitals.

Land

The extent to which the preferred Option 4 proposals would downsize both Epsom and St Helier hospitals, reducing from the present 454 at Epsom and 594 at St Helier to just 273 at Epsom and 183 at St Helier – halving and reducing by two thirds respectively – means of course that extensive land would be freed up for sale that might otherwise be used to develop more modern and more accessible services.

With far fewer beds on both the Epsom and St Helier sites, there will be substantial land assets which the Trust will be under pressure to sell off, in line with the proposals of the Naylor Report. [2425]

The property development role of this process can be listed as follows:

- We have already seen the sale of 20% of the Epsom Hospital site
- The ESTH Trust employed Savile's estate agents to propose to Sutton Council that part of the St Helier site be reclassified for housing. This was rejected.
- The ESTH put in one of its documents that part of the St Helier site should be for "high-density housing". This was later withdrawn after it was challenged

[23] https://www.penguin.co.uk/books/308/308407/plunder-of-the-commons/9780141990620.html
[24] https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review
[25] https://www.theguardian.com/society/2018/sep/09/nhs-land-earmarked-for-sale-to-developers

- ESTH has sold a lot of the Sutton Hospital site to Sutton Council and the CCGs will no doubt be aware that the Council purchased Plots 3 and 4 at Sutton Hospital on 18 January 2018.[26] The CCGs will be aware of the siting of Plots 3 and 4 as set out on the map here: https://moderngov.sutton.gov.uk/documents/s58203/20180118%20-%20Acquisition%20of%20Additional%20Land%20for%20the%20London%20Cancer%20Hub%20-%20Appended%20Plan.pdf
- The site options maps proposed by the Improving Healthcare Together Team [27] includes their map of their "preferred option" of a new unit at the former Sutton Hospital site co-located next to the Royal Marsden which is set out in quite a bit of detail in a map here https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/01/Sutton-hospital-option-diagram.pdf
- The two maps above show that part of the proposed new building would be on plots 3 and 4 owned by the Council and it is described as "shared services" which may relate to the two hospitals on the site but could refer to other "shared services" with other organisations. We have asked Sutton Council to clarify their situation, but we would want the CCGs, ESTH and Royal Marsden to explain what is intended here as the land holdings currently do not actually enable ESTH to build their full hospital

The Role of the Royal Marsden

The proposal to locate the new hospital on the Sutton hospital site, right next to the Royal Marsden Hospital is the hidden agenda behind this proposal.

The Royal Marsden in Sutton (which would be located next to the proposed site of the new acute facility) earned £100m in revenues from private patients in 2017, representing about a third of its income and bringing it close to the 49% limit on the amount NHS hospitals can earn from private patients. [28] However, the exact link between Royal Marsden and the proposed new Sutton acute facility has not been properly detailed to the public in this consultation. (Senate Report p8).

The PCBC makes light of the new nexus that would be created as it discusses the siting of the new hospital half way through the document: “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. 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.” [29]

The PCBC goes on to drop more hints of how closely the new hospital is expected to be working with the Royal Marsden, which has no surgical capacity and is eager to expand its work with NHS and of course its numerous and lucrative private patients, a business which

[26] https://moderngov.sutton.gov.uk/ieDecisionDetails.aspx?ID=2844
[27] https://improvinghealthcaretogether.org.uk/document/site-options-maps/
[28] www.ft.com/content/befcda6c-2b91-11e9-a5ab-ff8ef2b976c7
[29] PCBC p174

rose to £121m in 2018-19 (more than one fifth of all NHS private patient income): [30] "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. … 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)." (PCBC p221)

The PCBC goes on to discuss "enhanced joint working" (PCBC 222) with a focus on the claimed "upsides" of "Sutton option identified through working with RMH", and an emphasis on "synergies" (PCBC 256 and 266). The PCBC goes on to express a desire to expand ESTH's private work, picking up work from the Royal Marsden (hence the increased provision of private beds in the new plan):

"Improved margin for private care and increased demand through access to RMH private catchment." (PCBC p258)

While the RMH is looking for acute beds and operating theatres to expand their options for treatment in South London, the London Borough of Sutton is also heavily committed to resourcing the London Cancer Hub on a site that includes Sutton Hospital: indeed much of the land now being pieced together for the Cancer Hub has been released by the Epsom & St Helier Trust.

In January 2019 [31] Sutton Council purchased a further 0.38 hectares of NHS land on the site of the London Cancer Hub for £2.2m as part of the Borough's partnership with The Institute of Cancer Research. Finalising that land deal brought the total invested by the borough to £30.3m and opened the way to seek a development partner for a £350 million life science campus, bringing forward new buildings on the site.

Sutton now owns land with the potential to accommodate up to 100,000 square metres of new space [32] on the life science campus: the aim is for private enterprises to share the site with the ICR and The Royal Marsden – intensifying collaboration with these internationally renowned organisations.

In February 2020 Sutton council and the Institute of Cancer Research, announced [33]that they have together secured £8.4 million in funding to prepare land for development and put in place the infrastructure required for the first wave of commercial life-science buildings. The funding comes from the 'Strategic Investment Pot', which is administered by the City of London on behalf of all London Boroughs to support projects that will help promote future economic growth.

But with a limited plot on the campus site apparently being left to slot in the new acute hospital, in a location far closer to the Royal Marsden than to the two District Hospitals, it seems quite clear that the ambitions for the Cancer Hub include the provision of surgery adjacent to the research work.

[30] https://www.hsj.co.uk/the-royal-marsden-nhs-foundation-trust/specialist-trust-now-providing-a-fifth-of-allnhs-private-patient-work/7025787.article
[31] https://www.icr.ac.uk/news-archive/land-deal-completes-multimillion-pound-investment-to-make-londoncancer-hub-a-reality
[32] https://www.infrapppworld.com/news/tender-for-london-cancer-hub-to-be-launched-next-year
[33] https://www.londoncancerhub.org/news/detail/major-investment-to-transform-uk-s-leading-cancer-campus

Most people support the development of a London Cancer Hub and it being located in Sutton, which has many advantages over costly and congested inner London sites. However local people would not support is a plan that would give the Cancer Hub access to acute hospital services and a body of consultants on the cheap – at the expense of access for the ESTH catchment population. Thus, we are very much opposed to a consultation which seeks to smuggle this proposal through under the guise of simply reorganising local services, and without any proper disclosure of the likely level of demand for the new hospital's services as a junior adjunct of the RMH.

A new Cancer Hub is a good thing – as long as it is properly funded with capital and revenue to function as part of the NHS and the academic sector.

We support the call by Unison on the CCGs, the ESTH Trust and the local boroughs whose views have been sought in the consultation to make clear the extent to which the "synergies" of proximity to the RMH will add to the caseload of the new hospital, and explain the steps that are being taken to expand it appropriately to enable the new hospital to cope with the combined caseload without impacting negatively on local access to hospital services for communities in the EHST catchment.

Transport

According to the PCBC the top of the list of concerns was “Access, public transport, parking and travel times and the impact for patients, relatives and visitors.” [34]

It’s also clear that for much of the existing catchment area the Sutton Hospital site is less accessible, especially by public transport. Many without access to private cars would have a choice of forking out for taxi fares or to undertake complex bus journeys with long walks to get to the hospital.

Or as the Draft Interim Impact Assessment sums up:

> *“residents requiring access to major acute services will likely experience increased journey times. While in many cases these journeys will be infrequent, and the increased journey time will be less than 30 minutes, the change in travel time may result in residents using new transport modes and routes to access acute services.”*[35]

The DIIA makes clear who would be most inconvenienced by the changes, warning they:

> *“Will likely have a greater impact on those who are older, disabled, pregnant, from an ethnic minority background, or from a deprived area.” (p87)*

The PCBC also concedes that the Sutton site is less accessible for many than the current 2 hospitals, summing up (PCBC 207): “Marginal adverse - short increases for a large proportion of the population living across the study area.” On page 229 a table shows again that the Sutton site is the option that would increase journey times the most.

To make matters worse there is currently almost no visitor parking at Sutton, [36]and the costly redevelopment of the surrounding site as a Cancer Hub and campus area is likely to heavily constrain parking in the immediate vicinity of the new hospital, exacerbating access problems, especially for those with any limitation on their mobility.

[34] PCBC page 87
[35] Draft Interim Impact Assessment (DIIA), https://improvinghealthcaretogether.org.uk/wpcontent/uploads/2020/01/IHTIIA1.pdf , p86
[36] DIIA p93.

Will the Urgent Treatment Centres really stay at 24 hours service?

We question GP capacity to staff Urgent Treatment Centres. We also believe urgent treatment centres will themselves be soon under threat with the government initially promising that the urgent treatment centres would be a 24/7 service whereas history suggests that this will end up as office hours only followed by the closure of many GP's surgeries[37] [38] [39]

The PCBC argues that the reconfiguration is aiming to follow the example of the Northumbria Healthcare Foundation Trust[40], which covers a widely scattered, smaller population of 500,000 people[41]. In 2015 the Trust opened a £95m specialist emergency unit [42]– at Cramlington, with 210 beds and 24/7 consultant cover.

As part of the reorganisation three A&E units (Hexham, North Tyneside and Wansbeck) were closed and 24/7 Urgent Treatment Centres were established to replace them (just as Epsom & St Helier are now promised 24/7 UTCs). However, pressures on staffing at Cramlington and the fall-off in demand for services overnight meant that less than a year later the UTCs were cut back to 16 hours a day.[43]

[37] www.theguardian.com/society/2015/sep/29/almost-half-seven-day-trial-gp-surgeries-cut-hours-after-lack-of-demand

[38] www.theguardian.com/society/2019/may/31/gp-surgery-closures-in-uk-hit-all-time-high-in-2018

[39] www.pharmatimes.com/news/gp_surgery_closures_hit_all-time-high_last_year_1289671

[40] PCBC 117, p154

[41] https://www.northumbria.nhs.uk/about-us/key-facts-about-us/

[42] https://www.chroniclelive.co.uk/news/health/look-cramlingtons-new-95million-hospital-9311848

[43] https://www.itv.com/news/tyne-tees/2016-11-22/temporary-overnight-hospital-closures/

Where is primary care in this?

In all the past proposals over the last 20 years acute services have been considered as part of a whole systems approach with primary care. That has not been the case as this set of proposals focuses on just acute provision

As well as fearing that the UTCs will be cynically reduced down to 16 hours if the proposal is agreed, we also fear the impact they will have on the distribution of local GP's surgeries and whether there is any rationalisation despite them being independent contractors. It would be regrettable if under the guise of developing more local services, people ended up travelling further for certain treatment they used to receive from their GP locally when instead they have to travel to a local health Centre where he or she have been relocated.

Thus, the CCGs should have set out what GP surgery coverage there would be under these proposals. In particular, areas with high levels of deprivation and poor health must have improved local access to GP services in order to assist with the achievement of local and national public health targets.

Epsom, Sutton or St Helier Hospital - The False Choice

We believe for the reasons stated above that a choice between St Helier, Epsom and any other site is a false choice. Let us assume for one moment that the principle of a single Acute Hospital is agreed. What are the implications?

a) If it is sited at St Helier:

Much of the Surrey part of the catchment area will disappear to other hospitals and the new Critical Care Centre may still face accreditation problems. If St Helier is to become the main hospital for the whole catchment population of 500,000, which is what the Trust say will happen, it is likely to become a London hospital, by off-setting its Surrey patient losses with gains from Merton residents who currently go to St George's.

b) If it is sited at Epsom:

The site is outside the Greater London boundary away from the main Trust catchment area and as a result the public transport costs are prohibitive. With Epsom in Surrey having far less public transport than St Helier in Greater London. It is likely to end up as a smaller hospital with accreditation problems and the likelihood of being swallowed up by a larger hospital trust in Surrey

c) If it is sited at Sutton:

There is no campaign for the Sutton site and residents around it have generally opposed to further development of the Royal Marsden and Sutton Hospital site. It was interesting to note that when the original Investing in Excellence proposals came out in 2000/01 and suggested a downgraded role for the Sutton site there was relatively little local opposition to this.

d) Are we really being downgraded to provide an acute regional specialism and most are really going to St Georges

Even if there is only one acute unit will it really be as comprehensive as the current Accident and Emergency services at the present hospitals. If the main aim is to provide an acute unit on the Sutton Hospital site to mainly assist the Royal Marsden Foundation Trust, then it is clear that some of the present Accident and Emergency work will go to past defined "fixed points delivering acute services" such as St George's, Kingston and Guildford and East Surrey, whilst a much smaller unit is mainly for the Regional Cancer specialism not primarily for local people.

The response to the consultation needs to address these options/issues.

Responses to the Trust's specific questions

Page 1: Our Model of Care (or new way of working)?

Answer: It is a very poor solution

Comment: The Trust's starting point, is this is the only solution, within the revenue resources it has, so want to reduce 2 A&Es to 1. From a clinical perspective having more resources is better, so securing those should be its objective, not carrying out in effect a government cut. The Trust instead of seeing itself as rooted in the community, sees itself simply as an arm of government, reducing its resources. Instead of cutting services with this proposal it should stand up for its community and work with Councils and the local community to make the case for more resources not less. After all the government tells us austerity is over. Whilst its revenue resources are currently tight it has 3 sites and thus it trying to realise resources from this proposal from a sell off of its capital. This is a "plunder of the commons" where publicly owned land is likely to be sold off to deliver this proposal. This is short-sighted and reduces public trust in the local NHS

Page 2: Location?

Sutton Hospital

Answer: It is a very poor solution

Comment: This is the wrong site as it is far from the two main populations that are most in need of an A&E. It also has poor transport links. This is an attempt to try to find a middle point, but it in the wrong place. The links with the Royal Marsden next door are not essential for any A&E and indeed the lack of serious interest by that Trust over the years, makes the linkage a bit of a red herring. The proposal is often described as an "acute unit" rather than a hospital in its own right, therefore you need to explain if this site was used would it be called the Royal Marsden A&E or would it be called Sutton Hospital even though in size you imply it is quite a small unit?

St Helier Hospital

Answer: It is a very good solution – as long as it is also a good solution with Epsom

Comment: This is an existing site and should have its A&E improved just as Epsom should too. It is in the right place for the poorest community in its area

Epsom Hospital

Answer: It is a very good solution – as long as it is a good solution with St Helier.

Comment: This is an existing site and should have its A&E improved just as St Helier should too. It is in the right place as part of an urban centre and not far from the poorest community in its area

Page 3: What would help transport and travel?

Epsom Hospital

Comment: Improved bus services would benefit the hospital for both acute and other services at the hospital

St Helier Hospital

Comment: Improved bus services would benefit the hospital for both acute and other services at the hospital. The tram is no doubt going to be stated by many, but since there is not enough money for that and since it is unlikely the money you will have if you sell off hospital land will be used to build a new unit, that is really a red herring too. If you want to improve public transport to St Helier an express X280/X44 service nearby would be a lot cheaper along with the extension of the N155 night bus from Morden Tube past the hospital to Wallington where it would link with the late running east/west 154 bus route.

Sutton Hospital

Comment: The tram is no doubt going to be stated by many, but since there is not enough money for that and since it is unlikely the money you will have if you sell off hospital land will be used to build a new unit, that is really a red herring too. This site has poor public transport links in general but especially to Epsom and Surrey. Since Surrey County Council are cutting back bus services, you really will have a problem with justifying this site in transport terms

Page 4: How would our proposals affect you and your family, and what else should we consider?

If you think any of our proposals would affect you, your family or other people you know, either positively or negatively, please tell us why you think this using the space below.

Comment: This is going to impact on the community as well as staff. In order to cut service provision under the narrative of clinical need, two communities will lose out and see their hospitals downgraded. Instead of the Trust and CCGs saying our job is to convince the community to accept a worse option, you should be joining with the local community to demand that in the post-austerity era we need more resources to meet an aging population not less

Please use the space below to tell us about anything else you think we should consider when deciding the best option for specialist emergency care for people living in the Surrey Downs, Sutton and Merton area.

Comment: You need to answer the following questions:
1. What land sales at all sites are proposed as part of this programme?
2. If the Sutton site were chosen what would happen to the land currently identified for the new acute unit at St Helier and Epsom?
3. What happens to Queen Mary's Hospital for Children in each of the 3 options?
4. If the Sutton site were chosen what would the name of the "unit" be called?
5. From past reviews 60% of ambulances go the St Helier and 40% to Epsom. What would be the percentages in each of the 3 options depending on the combination of Acute Unit and Urgent care centres
6. If Epsom and St Helier had Urgent Treatment Centres out of the proposal, in the past these have been planned to be 18 hours rather than 24 hours. Is the 24-hour option a definite commitment and is it even deliverable?
7. It is claimed 85% of services would stay at current sites, but that is a bit misleading. Can it be expressed in terms of how many of the current staff posts will be at each site in all the options? Also based on the numbers of patients for each major service, how many patients are there at present and where will these go under the options?

Do you have any other solutions that we should consider?

Comment: As we have stated twice above, the other solution is not "status quo", so don't you dare class this response under that measure, but instead "stand up for your local community". We would expect as part of your options appraisal, that you publish a "if we had enough money to have enough staff to safely provide two A&Es, this would be the cost and this is the case we are making to the Government" as a full option as part of this process. That is clearly very different to the "status quo" and thus needs to be considered

The Survey and Consultation

The Survey and Consultation questions are here:
https://improvinghealthcaretogether.org.uk/consultation/questionnaire/

We assume the organisation that conducted the survey will analyse it so we wish to address you at this point.

How the public response is presented is important. We would want to see the data which has been mainly collected by postcode to set out the public response from the various local authorities and parliamentary constituencies that comprise the area

We would also want to see this information then put side by side with the surveys conducted by local authorities such as Merton and any petitions submitted so we can see all the numbers of those who support all or any aspects of the proposals as well as the numbers against

An Alternative Plan

What follows is our broader proposal for health and social care in this local "health ecology" – a much better term than health economy.

Acute Services

1. Celebrate that St Helier Hospital is one of the safest in the country and one of the few trusts in the country that consistently delivers the four-hour A&E target and is among the best in London.

2. Support a local health strategy that includes a full Acute Hospital service with A&E and maternity at the current St Helier Hospital site. In 2009 after years of Labour campaigning the last Labour Government agreed to £219 million for a partial rebuild of a new acute unit on the Ferguson House part of the hospital. This money was taken away from local people by the Tory/Lib Dem coalition in 2013.

3. We opposed the Epsom and St Helier Trust's inadequate engagement exercise which seems mainly aimed at convincing their own staff and Epsom consultants to accept a small and inadequate acute unit on the Sutton Hospital site. We also strongly oppose the Trust's secret agenda, which Labour is exposing, for the sale of parts of the St Helier site for housing purposes. We support the idea of a local Council referendum to ask residents to vote to keep the current full NHS health use of the St Helier site. This would create a "Residents' Lock" on the site in future so its status can only be changed by another residents' referendum.

4. In order to move things forward now and set the agenda, the CCG's ESTH and Local councils should fully engage local people on the three real options for St Helier hospital's future. A full rebuild would cost £750 million, a part rebuild like the 2009 proposal would cost £350 million and a more short-term refurbishment would cost £80 million. Labour's preference is for a £750 million rebuild with all the 1930's external facade protected and the hospital then made a Grade 2 listed building. If they secure strong public support for that proposal, they should demand resources from central government to fund it. The best option would be for the government to fund the rebuild and the loan made at a low rate of interest.

5. Continue to support the provision of Children's Hospital Services at Queen Mary's Hospital for Children on the St Helier site. Labour, health campaigners and trade unions locally fought hard to keep a local Children's hospital We will continue to fight for that service to stay where it is now.

6. We support the continuation of two acute Hospitals on the St Helier and Epsom Hospital sites. We believe they can be sustained through:

a) Combined workforce and service re-design which will enable available trainee and career grade doctors and consultant medical staff to be used more effectively;

b) Effective protocols and joint working;

c) Effective diagnostics through "Telemedicine" technology.

7. Adopt a key policy to minimise the need for residents to have to travel for acute services, so residents from Epsom do not have to travel to St Helier and Sutton residents do not have to travel to Epsom.

8. This consultation is based on a treatment approach to health provision and does not take account of the emerging preventative health agenda. An emerging preventative health agenda for Acute Trust area could for example see the development of a joint NHS and local Council St Helier Healthy Living Village comprising:

- St Helier Hospital
- Sutton Arena Sports Centre (opposite the current St Helier Hospital)
- Sutton Junior Tennis Centre
- A Healthy Living Centre/Gym
- A healthy living supermarket

9. A facility like this would have much greater flexibility to respond to future changes in health care. We would also support a similar facility for the Centre of Epsom.

10. In addition, a network of Healthy Living Centres, health centres and GP surgeries could provide additional local care. The aim would be to develop these in areas with the greatest need of preventative health advice. Some of them should even be located in schools. It is vital that these centres are closely located to communities with the greatest health need so they can most influence their lives as well as provide local care.

11. Any reorganisation of GP services to ensure good access across the entire area covered by the Review with proper consultation of local communities affected. In particular, areas with high levels of deprivation and poor health must have improved local access to GP services in order to assist with the achievement of local and national public health targets.

12. Continue to recognise the importance of Epsom Hospital which is used by around 10% of Sutton residents. We want to see it retain its acute services too.

13. In order to defend our local hospital, there should be a big community campaign to support it. This should include banners on Council dustcarts and at the Civic Offices as Labour Merton has done. Council's, if necessary, should use all their scrutiny powers to slow down the process & support a judicial review to protect local services.

14. Press the hospital trusts to abolish parking charges to reduce the impact on local residents in surrounding roads.

<u>Regional Specialisms - Cancer Care</u>

15. Support Specialist Cancer services at the Royal Marsden site. We want to see a "Cancer Hub" in Belmont not a replacement acute facility. The Mayor of London also supports that Cancer Hub. We will demand all the land used at the Sutton Hospital site is used for NHS service purposes and to assist this the Council would aim to offer Council owned land to provide a site there for a public research body or a publicly owned pharmaceutical organization.

<u>Primary Care</u>

16. Support a comprehensive network of GP surgeries, Health Centres, Clinics and Community Health services. GP services should be retained across the borough and we would oppose all services being concentrated in just 5 or 6 GP hubs. We will examine ways in which co-operative business can be developed in this area; eg a co-operative consortium

of most (or all) local GPs could provide out-of-hours services, similarly a co-operative out-of-hours dental service could be set up.

17. Invest more in mental health and, in particular, use our wider social policy plans to build relationships and tackle issues such as loneliness and isolation seeking to implement the Jo Cox Foundation report on these issues.

18. Support our local pharmacies and work with them to protect this vital service.

19. Demand that any locally developed “health apps” supplement the work of trained health staff and do not replace them.

Social Care

20. Provide modern Day Services for older people and disabled people and an in-house intensive Home Care Service. We would adopt the Ethical Care Charter which would mean an end to 15-minute home visits. We want to see accessible services and early intervention rather than a service led by eligibility criteria, and local provision which would include care co-operatives for children and vulnerable adults. We want to see a full replacement for the loss of services after the closure of SCILL (Sutton Centre for Independent Living).

21. Support the provision of Extra-Care Housing, but this should not be allowed to force elderly residents from their existing homes. We will examine ways in which co-operative business can be developed in this area. We will examine the creation of a “handyperson” service to help the elderly stay in their homes.

22. Support a reduction in “Meals on Wheels” charges after reviewing resources.

23. Expand the Occupational Therapy service: speeding up assessments, ensuring enough staff for ongoing provision; expanding the choice of physical disability services.

24. Enhance the existing Community Transport (CT) Scheme with the voluntary and co-operative sector. CT schemes could cover bus routes, taxi services, transport for High Need (SEN) students, Dial a Ride, etc. We also wish to expand the Blue Badge scheme to improve mobility.

Integration of services

25. Prior to future legislation, seek to develop whole person care locally through integrated health, mental health & social care services. We support CCG/HWBs using Section 31 agreements covering older people, mental health, physical & learning disabled.

26. In the longer-term develop a Sutton Care Service and consult as to how it can be integrated into the NHS with an all through budget for them. A move to NHS standards will increase the recognition of social care staff as part of the new wider NHS family.

Public Health and Well-being

27. Develop a Sutton well-being strategy which recognizes the need to tackle the root causes of Londoners' ill-health, e.g. poverty, the housing crisis and poor air-quality. In the long run we would like to develop a pilot for what we would hope would be a future National Wellbeing Service, running alongside the NHS and a National Care Service, that integrated

public health, mental health and advice services to empower people and prevent poor life episodes.

28. Develop the Council's public health role & review all existing projects & contracts to address key health & social inequality targets. For example, we will see if public health monies could be spent on "social prescribing" such as providing free local gym membership & free swimming for those who are unwaged. We want to see our local public health service developing innovative behaviour change policies & contributing to community resilience.

Accountability

29. Strengthen the local Health and Wellbeing Board (HWB) with more elected representatives. We will subject local CCGs to intensive scrutiny, including scrutiny of where GP surgeries are placed, who is funding them & GP financial interests. A key focus for Health Scrutiny, will be to hold Sustainability and Transformation Plans (STP) to account. We will also fully review the Epsom & St Helier Trust's current proposals as well as considering evidence from those presenting alternative proposals.

30. Get the Council to hold an Annual Health Conference bringing together patients, public, local health campaigners, NHS practitioners, management & governance, along with Councillors to discuss in detail all current proposals in order to hold them better to account.

STPs and ACOs

31. Oppose the direction of the South West London Clinical Commissioning Groups' Sustainability and Transformation Plan (STP*) and its 'Five Year Forward View ('FYFV). We oppose the projected financial cuts in the SW London Five Year Health Plan of some £828 million.

32. Oppose the local development of any US-style Accountable Care Organisations (ACOs*) which are planned to replace NHS hospitals with down-skilled community units. We support a democratically accountable NHS and an integrated National Care Service.

Health Principles

33. Support a properly integrated and accountable, publicly owned, publicly provided and adequately funded NHS.

34. Support a future Labour Government in ensuring the NHS is free from all "marketisation", both internally & externally.

35. Oppose "reconfigurations" of London's services without proper local consultation and full local consent by local people and their elected representatives.

36. Welcome Labour's national commitment to repeal the Health & Social Care Act 2012, restoring the Health Secretary's duty to provide an NHS. A Labour Council will also campaign against Clause 119 which was supported by local Lib Dem MPs in 2012.

37. Support an end to hospital closures & will argue for increasing funding to the European average and increasing beds per thousand residents to the European average.

38. Campaign for a publicly owned and publicly provided Social Care system with some scope for worker owned co-operatives integrated within the NHS.

39. Support the idea of a publicly-owned pharmaceutical manufacturing corporation which would supply a range of generic medicines for the NHS and work with universities to research new drug treatments.

40. Support the bringing back into NHS employment, with NHS pay, terms and conditions, all medical, clinical, admin, clerical and ancillary staff, currently employed by private contractors.

Appendix 1 - Past Proposals

Local residents have had to deal with a succession of proposals for radical change to the provision of healthcare in South West London going back to at least the 1990s when the Epsom and St Helier trusts were merged**.** [44]

Each of these plans has presented differing rationales – and most have not involved the creation of a new hospital at Sutton as the solution.

At the end of 2000 the "Investing in Excellence" plan proposed downgrading services in Epsom to centralise at St Helier.

In the autumn of 2003 a Clinical Services Review Team proposed closing Epsom's A&E and temporary centralisation at St Helier pending the building of a new "Critical Care Centre": the plan was abruptly dropped, but not before Epsom MP Chris Grayling had retaliated by proposing the expansion of Epsom and downgrade of St Helier – opposed by his Conservative colleagues in Carshalton and Sutton[45].

This was followed by the consultation on 'Better Healthcare Closer to Home' (BHCH 2003), which involved the closure of both Epsom and St Helier hospitals to be replaced by a new single site 500 bed 'Critical Care Hospital' – at St Helier, Sutton or Priest Hill – and a group of ten 'local care centres' (effectively community hospitals) which, it was claimed, would facilitate a reduction in acute activity of up to 50%. These proposals were rejected at the end of 2005 following strong local opposition: soon afterwards plans for a single-site critical care hospital on the Sutton Hospital site collapsed, and the project director resigned.

In 2009, with the future of services secured at Epsom Hospital after Surrey PCT dropped proposals to divert patients elsewhere, plans were approved for the complete refurbishment of St Helier hospital at a cost of £219m, and it was agreed that this would be government funded, and not paid for through the Private Finance Initiative[46].

Plans were published, and widely approved. Local campaigners were delighted[47].

However, this, too, came to nothing. After the election of the coalition government in 2010, yet another reconfiguration proposal, 'Better Services, Better Value' (BSBV), was introduced in May 2011, and in effect killed off the refurbishment plans.

BSBV was put forward as a clinical initiative 'led by local GPs and hospital clinicians', and included some of the original proponents of BHCH. Ostensibly its aim was to improve the quality of services in South West London and to contribute to the need to ensure financial sustainability in the wake of the financial crash and the Government's austerity policies. However, common to both BHCH and BSBV seems to have been an antagonism to the continuation of services on the St Helier site.

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[44] This historical summary is drawn from reports and analysis in the ESTH UNISON Branch's In Touch newspaper from 1998-2019, and from UNISON's detailed 2004 response to "Better Healthcare Closer to Home" (Gambling with Our Lives).

[45] http://epsom-sthelierunison.com/images/stories/InTouch/14_autumn_2003.pdf?LMCL=lOvOyR

[46] http://epsomsthelierunison.com/Web%20Work/Unison%20website/unison%20test/in%20touch/Spring%202009.pdf?LMCL =lOvOyR

[47] http://epsom-sthelierunison.com/images/stories/InTouch/27_autumn_2009.pdf

Then came proposals to break up the ESTH, with St Helier to be merged with St George's, and Epsom to be merged with Ashford and St Peter's in Surrey[48]. Both of these proposed mergers collapsed in 2012 because of unresolved financial problems on all sides[495051]

Eventually in 2014, and after much controversy, BSBV plans were also dropped, after failure to present a compelling a business case or to secure agreement across stakeholders in SW London and in Surrey.

Just 3 months later yet another 5-year "strategy" document was published by the South West London CCGs, now working together as "South West London Collaborative Commissioning," and apparently cutting the links with Surrey Downs CCG. The Strategy proposed "vacating and disposing of" the Sutton Hospital site, but also ominously called for "service changes … across the provider landscape which will deliver financial savings while also making it easier to deliver the improved services Commissioners want to achieve for their patients."

It proposed to expand Kingston Hospital and increase bed numbers at St George's – not least to offer "greater provision for private patients." But by 2016, much of the "strategy" had apparently been quite sensibly forgotten or discarded: instead the new Epsom St Helier chief executive began promoting plans for a new 800-bed single site hospital – to replace the 1,162 beds provided in the Epsom and St Helier. [52] The most recent IHT proposals, formulated in the later months of 2019, have sought to overcome past problems by narrowing the scope of proposals to three CCG areas, rather than attempt a pan SW London solution.

The main argument now being wheeled out to justify this new plan is that staff cannot be recruited to support two A&E departments at St Helier and Epsom.

They have also managed to secure pre-approval in principle from the Secretary of State for up to £500m of capital … dependent upon the development of a robust business case. This once again will be the fatal flaw in yet another plan, not least because the objectives are far from clear, and the capacity of the new hospital and the Trust as a whole could well be seen by NHS England, the Department of Health and Social Care or even by ministers to be inadequate to deal with a growing population and rising demand for emergency and specialist care and the greater need for more capacity in the wake of the Coronavirus crisis.

Even the PCBC has to admit that none of the Options it discusses scored as much as 5 out of 10 in voting by stakeholders on 'meeting population health needs'[53]. Centralising on the St Helier site scored best on 'clinical quality' and 'patient experience' and there was little difference between the St Helier and Sutton options on Safety. Whether ministers and NHS Improvement will be more readily convinced remains to be seen, but we in the Labour Party, local unions and health campaigners are not convinced the proposals give a sound footing for a Business Case.

[48] http://epsom-sthelierunison.com/images/stories/InTouch/30_summer_2011.pdf
[49] http://epsom-sthelierunison.com/images/stories/InTouch/32_spring_2012.pdf?LMCL=S_ZSoQ
[50] http://epsom-sthelierunison.com/images/stories/InTouch/st_helier_summer_2012_final.pdf
[51] http://epsom-sthelierunison.com/images/stories/InTouch/St_Helier_autumn_2012_web.pdf

[52] UNISON In Touch Summer 2016 64 PCBC 243-246
[53] PCBC 243-246