ACUTE DANGER

A detailed response to proposals for a single emergency care centre in **Sutton** covering **Merton, Sutton** and **Surrey Downs**

Merton & Sutton Trades Council

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Introduction and Summary

This is the detailed response from Merton & Sutton Trades Council (MSTUC) to the consultation by Surrey Downs, Sutton and Merton Clinical Commissioning Groups on the proposed reconfiguration of hospital services for an area covering 720,000 people in London and Surrey.

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.

In any case the three alternative options discussed in the PCBC are clearly unacceptable to MSTUC and to many local campaigners and politicians, who have correctly argued over the years that the geography and the scale of the 720,000 population of the area require more than one acute hospital.

Prior to this consultation, however, nobody had previously suggested that the way forward would be to move from two hospital sites to *three*.

Our concerns

MSTUC is profoundly concerned that 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.

MSTUC is also concerned that the immediate and eager support for the proposals from Sutton Council and from the Royal Marsden and its medical staff is based on this, unstated, future prospect rather than on a balanced and critical assessment of the proposals and the impact on local people.

We note that despite the recommendations of the South East and London Clinical Senates, there is no serious analysis of the impact of the proposals on the London and Surrey ambulance services, which, in addition to existing emergency calls, would be required to make vehicles and crew available to ferry "step up" patients from Urgent Treatment Centres and so-called "District Hospital" beds at Epsom and St Helier, and "step down" patients from the Sutton centre who still need hospital treatment but who are deemed stable enough to complete their treatment in "District Hospital" beds.

Indeed it's clear from the Consultation and Pre-Consultation Business Case (PCBC) that despite the claims to have developed a "detailed action plan" to address "each of the 94 recommendations made by the Senate,"[1] many of their recommendations have clearly been ignored, and many of the direct questions raised have not been answered.

The proposal from 'Improving Healthcare Together' (IHT), which would reduce trust provision from 743 front line acute beds open overnight[2] (or 619 according to NHS figures from last year)[3] to just 407[4] also flies in the face of the most recent Planning Guidance from NHS England[5], 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 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%[2], 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.

This is not the first time we have had to challenge what we have seen as badly framed and potentially damaging proposals from commissioners and providers in our area seeking to reconfigure hospital services. Since the 1990s there have been a succession of plans put forward, each with equal enthusiasm from the management of the day, insisting that theirs was the only way forward –

[1] Pre Consultation Business Case (PCBC) p73

[2] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/03/Winter-data-timeseries-20190307.xlsx

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

[4] PCBC Appendix 17, pp20-23

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

only for their plans to be later abandoned as impractical, unaffordable, or both. Previously discarded unworkable plans have proposed the building of a new single site hospital on various sites including St Helier, the sale of the Sutton site, and building a completely new smaller acute hospital supported by ten community hospitals across the area.

MSTUC over the past two decades and more has been, and remains, willing to support plans which are properly funded, and which maintain or improve levels of provision of acute services for the full catchment area. Sadly the latest plan, boldly branded 'Improving Healthcare Together', does not fit these basic criteria.

In 2009, MSTUC was happy to support 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 bit the dust when David Cameron's coalition government took office and with Lib Dem support instigated the 10-year austerity squeeze on NHS funding that continues to constrain local options today. **The latest scheme for a new centre 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.**

This response will explain why we cannot support the proposals, and indeed why in our view it is quite possible that NHS England could reject the plan as inadequate and suspend the release of the promised £500m announced last year. In the following 12 sections we will work through our objections and show the evidence on which we base our concerns.

1.) What is the plan aiming to achieve?

The Consultation document identifies three reasons for proposing major changes in the way hospital services are organised in South West London and Surrey Downs. None of them appears consistent or convincing: alternative solutions to the problems identified appear to have been dismissed without adequate consideration, while the proposals that are set out in the consultation ignore the advice of professional bodies and evidence.

In addition it is clear to MSTUC that one of the underlying objectives – to relocate the main centre of emergency and specialist services from the current hospitals to a site adjacent to the Royal Marsden Hospital – has been omitted from the opening list of three main concerns. This omission leads to an inadequate discussion of the implications of choosing this location for the new centre.

The stated objectives of the proposals are to address three problems:

> **1. Quality: "**There are not enough specialist doctors, nurses and clinical staff for some of the most important emergency services. This is an issue facing many hospitals and especially those providing the same services on more than one site where they are located close together."
> **2. Buildings: "**Many of the hospital buildings are older than the NHS, and over half of the hospital space has been assessed as not suitable for treating patients to modern healthcare standards."

3. Finances: "Not having enough staff and having to maintain old buildings contribute to a worsening financial position"

The question that arises from these is which of them, if any, is the real driver of change proposals?

The "Quality" argument should really be labelled as "workforce", since it centres on levels of staffing in the two existing hospitals. However there is a leap of logic required to see the answer to problems of staffing services spread across two sites as reorganising at great expense … to spread services over THREE sites instead.

Since the focus is on staffing "some of the most important emergency services," it's useful to take note of the Royal College of Emergency Medicine (RCEM) guidance on Reconfiguring Emergency Medicine Services[6], published in April 2017. This is current RCEM advice. The summary states (emphasis added):

> "Reconfiguration of emergency medicine services should always have patient care at its heart. **Perceived cost efficiencies may be illusory.**
>
> Basing reconfiguration decisions around planned reductions in demand for urgent and emergency care, or around hoped-for effects of redirection strategies, is not recommended.
>
> **Workforce shortages are a poor justification for service reconfiguration.** The solution for this is investment in the workforce.
>
> …
>
> Most EDs are already crowded. Actively deciding to increase attendances into crowded EDs will harm patients. **This will be made worse if bed closures are also planned in the same systems.**
>
> Whilst there are strong arguments for centralising some specialised capability, **local EDs must retain basic capability to treat time critical problems and manage common injury and illness.**
>
> Emergency Departments can become too big to work effectively.
>
> The consequences of closing or reconfiguring EDs on other co-dependant hospital and community services should be modelled carefully. Resources should be allocated to track progress."

It appears that the IHT proposals have been drawn up without regard to this expert guidance. The proposals are clearly motivated in part by the quest for financial savings which the RCEM argue "may be illusory."

Even further from the RCEM approach are suggestions in the consultation and pre-consultation business case (PCBC) that the staffing in Epsom and St Helier would be downgraded along with the downgrade of the hospitals to "District Hospitals," with the wards staffed by "interface physicians"[7] – a category so vague that the Clinical Senate report sought further clarification, and warned that GPs would not have adequate training for the work:

> "The PCBC outlines the requirements for staffing the district hospital beds (section 5.3.3.4). The nature and required skills and training of the proposed 'interface clinician' is not clear enough here (nor when comparing tables 22 and 23 in the PCBC, where table 22 shows consultant numbers required, but table 23 does not specify that). It states that the role

[6] RCEM. Reconfiguring Emergency Medicine Services. 2017
[7] PCBC p 130 and elsewhere

should be undertaken by a 'senior medical clinician at consultant/GP level'. These two professions are not interchangeable. If a GP, this would mean that hospitalised patients may be under the direct care of a clinician without post-graduate qualifications in the medical care of hospital inpatients. Whilst this might be sufficient for patients just needing intermediate care, the criteria for DH bed admission are much broader than that. Patients would have a wide range of acute medical conditions (even if not of an acuity or complexity requiring an acute hospital bed), many of which might not be fully diagnosed at the time of admission, and specific skills and training must be able to meet the needs of these patients."[8]

It's also clear that the nurse staffing would be downgraded in the District Hospital beds, with 40:60 nurses to health care assistants in place of the current 60:40[9].

Any cash savings arising from this downgrade of services and reduction in numbers of front line acute beds would come at a possible cost of declining quality of patient care: but the Consultation also takes no account of the complexity and potential costs of running a services across three sites rather than the current two, or the challenge of two of the sites delivering a new and untried mix of services and level of care, while the new site carries the full pressure of delivering all of the emergency and more complex acute services from a reduced bed provision.

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]. MSTUC obviously 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.

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[11] 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.

Indeed various "do minimum" permutations would allow refurbished and new facilities to be put in place on the existing two sites for much less capital expenditure, and in the process even freeing up some land that might be sold to help cover the costs, while developing services that would clearly be dedicated to the Trust's existing 720,000 catchment population rather than drawing in potential additional clientele from the Royal Marsden Hospital.

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[8] South East Clinical Senate & London Clinical Senate (2019) Joint Clinical Senate Review of the Improving Healthcare Together 2020-2030 Pre- Consultation Business Case, p41 https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/06/Joint-clinical-senate-review-of-Improving-Healthcare-Together-2020-2030.pdf

[9] PCBC p130

[10] https://files.digital.nhs.uk/63/ADBFFF/ERIC%20-%20201819%20-%20SiteData%20v4.csv

[11] PCBC p232

No such options have been considered by the CCGs, although there is no clear explanation of why this has not been done. It seems clear that the aim of the Consultation Document has been from the outset to convince people that there is no viable option but to massively downsize St Helier in particular – despite the fact that just ten years ago the agreed plan was for a major new hospital on that site.

Extravagant claims are now made of the benefits that would flow from a new hospital, including the theory, based on a theoretical 2011 US study[12], that a new building – if suitably designed – could "reduce direct length of stay by up to 10% through enhanced recovery, including larger windows, improved natural light, noise-reducing measures and a healing environment;" reduce patient transfers by up to 60% through larger "acuity-adaptable" [single occupancy] private rooms; and reduce adverse drug events by up to 20% through acuity-adaptable rooms, medication task area lighting, noise reduction measures and e-ICU[13]. MSTUC is of course not opposed to hospitals being built with bigger windows, more space, and individual occupancy where that is appropriate. But it is far from clear how larger rooms might reduce adverse drug events, and we would point out that the actual plan being discussed is NOT to establish "acuity adaptable rooms", but a new specialist hospital, which will take only "the sickest patients," and transfer them when they have lesser needs to St Helier or to Epsom.

The fact that the quoted US study is based on an *imaginary* project, which includes proposals to expand private rooms by "one hundred square feet" (10x10) [what would the implications of this be for the cost of the 496-bed proposed hospital at Sutton?], or that the 3-site proposal would mean *more* transfers of patients – by ambulance – rather than less, appear not to have registered with the authors of the PCBC, who are fixated on arguing for a new hospital.

The Finances argument makes huge and unproven assumptions on the potential for substantial savings from the proposed new model of care, again ignoring the warnings of the RCEM, and paying little attention to the costs and complexity of running on ***three sites*** – while claiming that savings will accrue. It almost depicts the new building as possessing magical powers, as if it is the building and not systems of working or the recuperation time of the older human body that is responsible for errors and even for patients taking longer to recover:

> "Improvements in building design result in financial benefits, **particularly through the avoidance of adverse events.**
> "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.**
> "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 through the avoidance of the increased cost of meeting clinical standards that a single consolidated acute site allows.

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12 https://www.thehastingscenter.org/uploadedFiles/Landing_Page/SadleretalFableHospitalBusinessCase_HastingsJan11%281%29.pdf

13 PCBC 162-3

…

"The changes in WTE nurse staffing will reduce nursing workforce costs, particularly through changes in skill mix ratios applied across the Trust."[14]

As noted above, PCBC and Consultation offer no serious "do minimum" option, for upgrading and expanding the existing two hospitals as necessary to continue to deliver services across the existing catchment population, so retaining the Surrey patients that could be lost to a Sutton site, but also avoiding the dangers of the new centre's resources being increasingly used by RMH patients.

It's clear that for much less than £500m significant positive changes could be made, especially on the St Helier site, and that the benefit for the population of the three CCGs would be even greater.

2.) What are the proposals?

The Consultation document proposes that Epsom and St Helier should become "District Hospitals":

> "Under our proposals, both Epsom and St Helier hospitals would continue to provide district hospital services, with GPs, community health, public health, social care and mental health services coming together with hospital clinicians to support people in their communities.
>
> "Both hospitals would have urgent treatment centres (UTCs) which would be open 24 hours a day, 365 days a year. The UTCs would be staffed by doctors and specialist nurses."[15]

Only by reading the Pre-Consultation Business case do we discover that these two hospitals would also be drastically reduced in size, as noted above.

Alongside this reduced and downgraded service, the CCGs propose the building of a single emergency centre, on the Sutton Hospital site:

> "We believe that six core services should be brought together in a new specialist emergency care hospital so that the most unwell patients, those who need more specialist care, and women giving birth in hospital get the right support straight away from senior specialist staff."[16]

Again 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[17]), less than half the total of "core" and escalation acute beds reportedly open overnight during the winter of 2019-20[18].

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

[14] PCBC p257

[15] Consultation Document p14

[16] Consultation Document p18

[17] https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/06/Joint-clinical-senate-review-of-Improving-Healthcare-Together-2020-2030.pdf … see p55

[18] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/03/Winter-SitRep-Acute-Time-series-2-December-2019-1-March-2020.xlsx

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.

The PCBC argues that the reconfiguration is aiming to follow the example of the Northumbria Healthcare Foundation Trust[19], which covers a widely scattered, smaller population of 500,000 people[20]. In 2015 the Trust opened a £95m specialist emergency unit[21] – 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.[22]

While MSTUC fears that the swift scaling down of the promised UTCs could also be echoed in Epsom & St Helier, it's not clear that the new Sutton hospital would be able to deliver the level and quality of care achieved at Cramlington, which is purely an emergency unit, while the Trust still retains hundreds more acute beds in its other three hospitals. It's worth noting that the Clinical Senate requested clarification from the PCBC on the "direct relevance of the quoted Northumbria model": there is no sign that this recommendation has been responded to in the published PCBC.

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[23], and almost 44,000 emergency admissions in 2018/19. It seems that the people drafting the consultation material are desperate to distort the facts to exaggerate the possibility of the trust being able to cope with less than half the current number of front line beds.

Urgent Treatment centres

The substitution of much more limited Urgent Treatment centre services for the existing A&Es at Epsom and St Helier is not addressed in much detail by the PCBC and of course even less in the Consultation document. MSTUC has concerns because the existing A&Es can call on a much larger pool of beds for the more serious cases, while a standalone UTC would have to call an ambulance to transfer any patient who mistakenly arrives with a condition requiring inpatient care**. The fact that these can function well alongside a full A&E and co-located on a general hospital site with back-up and expertise available is not a guarantee that they can deliver as successfully if separated from this support.**

[19] PCBC 117, p154

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

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

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

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

The Clinical Senates' review raised concerns over the assumptions being made on the extent to which UTCs could divert caseload from the Emergency Department:

> "The urgent treatment centres (UTCs) are expected to reduce demand on the planned single consolidated emergency department (ED). This impact is not currently quantified, and needs to be, with a clearer outline of the types of cases that would be diverted and credible methodology provided for such quantification." (p9)

The Senates returned to this with a series of recommendations (p30 ff):

> **"R41. The full implications of having a UTC on a different site from the acute hospital, and how any risks will be mitigated, should be described.**
>
> All four of the proposed options have two urgent treatment centres (UTCs): in option 1 each is co-located with an acute hospital, in options 2 and 3 one will be on the acute hospital site and one on the district hospital site, and in option 4 both would be at the DH sites and neither co-located with the acute hospital.
>
> There is a long history of minor injuries units/level 3 A&Es as standalone units, but urgent treatment centres (UTCs) that will see a wider range and higher acuity of patient are more recent conceptions, and there are no national specifications for their configuration and function. Many service re-designs are considering having these co-located with an acute hospital, though this is not mandated in the national guidance:
>
> *'There are advantages if they can be co-located alongside hospital A&E departments to allow the most efficient flow of patients to the service that best serves their need but this will be determined by geographic distribution of urgent care sites and patient flows.'*
>
> Therefore care must be taken in ensuring the quality and safety of patient pathways for patients assessed at a standalone UTC who do not have a clear diagnosis and who may be unstable or at risk of rapid deterioration (which may be unforeseen when first assessed).
>
> The stand-alone UTCs may need clearly defined criteria for which acutely ill patients they accept via GPs, paramedics or 111 referral, and which they direct to the acute site for primary assessment."

It should be noted that proposals in various parts of the country for reconfiguration of hospitals including downgrades of A&E services to UTCs or Urgent Care Centres have in general been reluctant to spell out the list of excluded conditions for which patients should go or be referred/transported directly to an Emergency Department. The emphasis is always on how much of the ED's work can be done in a UCC/UTC.

However the exclusions are substantial: for example in North West London the *Shaping a Healthier Future* Decision Making Business Case[24] in 2013 contained a summary list of exclusions which appeared far fewer than the conditions that could be treated in an Urgent Care Centre:

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24 https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/SaHF%20DMBC%20Volu

Figure 8.23: UCC clinical exclusion criteria

Conditions suitable for UCC	Clinical exclusions (adults)	Clinical exclusions (children)

• The scope of the UCC will include both Minor Illnesses and Minor Injuries:
  ○ cuts and grazes
  ○ minor scalds and burns
  ○ strains and sprains
  ○ bites and stings
  ○ minor head injuries
  ○ ear and throat infections
  ○ minor skin infections / rashes
  ○ minor eye conditions / infections
  ○ stomach pains
  ○ suspected fractures
• The interpretation of X-rays and other diagnostics/ investigations will be in scope
• The treatment of Minor Fractures will be in scope.
• Interventions considered in-scope include:
  ○ the manipulation of uncomplicated fractures
  ○ non-complex regional anaesthesia for wound closure
  ○ incision and drainage of abscesses not requiring general anaesthesia
  ○ minor ENT/ophthalmic procedures
• There will be no lower or upper age limit for UCC patients
	• Markedly abnormal baseline signs
	• Chest Pain (likely cardiac)
	• Complex fractures (e.g. open fractures, long bone fracture of legs, spinal injury)
	• Patients receiving oncological therapy
	• Sickle cell crisis
	• Acute Shortness Of Breath (inc. severe shortness of breath compared to normal, cyanosis, increased peripheral oedama)
	• Signs of severe or life threatening asthma
	• Airway compromise
	• Acute exacerbation of heart failure
	• Burns (> 5%; facial/eye; inhalation, chemical/electrical)•New CVA
	• Significant DVT
	• Temporarily unable to walk
	• Haematemesis/ Haemoptysis
	• Overdose / Intoxicated and not able to mobilise
	• Acute psychosis / neurosis
	• Significant head injuries
		In addition to the adult exclusion criteria:
		• Acutely ill children (defined using PEWS)
		• Paediatric head injury
		• Procedure requiring sedation
		• Multiple pathologies deemed to be complex
		• Repeat attendances: 3 attendances in 3 months
		• Fever with non-blanching rash
		• Fitting
		• History of decreased or varying consciousness
		• Combination of headache, vomiting and fever
		• History of lethargy or floppiness

But the same Business Case also contained a much more substantial and detailed list of excluded conditions that was clearly much larger – and went on for **five pages.**[25] MSTUC is concerned that the necessary steps to ensure the public are fully informed of the limitations of UTCs could be eclipsed by efforts to persuade people it is safe, and result in people with more serious problems wrongly attending a UTC and delaying their access to appropriate care.

We note further recommendations from the Clinical Senates:

> **Recommendation 42** notes the possibility of "increased use of the UTC co-located with the acute hospital;"
>
> **Recommendation 43**, indicating Clinical Senate concerns that the promised 24/7 operation of UTCs will be short-lived, also calls for "Clear operational guidance" for patients needing UTC assessment near closing times: "Diversion or transfer to A&E or the acute medical unit

me%201%20Edition%201.1.pdf, accessed 9 March 2020. Shaping a Healthier Future was axed a year ago by Health Secretary Matt Hancock having never completed a full business case.

[25] Numbered pages 152-156 (pdf pages 182-186 out of 456).

> at the acute hospital might be required, and this needs to be carefully managed to ensure the patient comes to the right place first time whenever possible at these watershed times."

In addition to these concerns MSTUC notes the proposal for the UTCs to be staffed by GPs[26]: we seek evidence from the CCGs that there are sufficient numbers of suitably qualified and experienced GPs in the area to sustain both primary care services and these additional UTCs.

Ambulatory care

A step up from UTC treatment is the provision of swift emergency care that avoids the need for an overnight hospital stay, as discussed in NHS England's Long Term Plan. The Clinical Senates however warn (Recommendation 45**)** that there is insufficient clarity in the PCBC (and of course even less in the Consultation document) about the extent to which ambulatory care service should be provided on each site.

> "The PCBC states that 'ambulatory care' will be available at the district hospital sites. It is not clear what the term refers to here and what specific types of care would be provided. In more common use is the term 'ambulatory emergency care' (AEC, referring to emergency care delivered without an overnight stay), which the new NHS Long Term Plan (LTP) proposes is re-named as 'same day emergency care' (SDEC). The LTP states that: 'Under this Long Term Plan, every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care'." (p32)

MSTUC shares these concerns: we note that with such restricted bed base and the likelihood that the Sutton hospital would be running under heavy pressure most of the time, it may well be difficult to coordinate the various diagnostic and other services needed to ensure same day emergency care.

Bed numbers

Indeed the PCBC and Consultation document are profoundly evasive and inconsistent in reporting the current levels of bed numbers, and there is little consistency to be found in official published figures. As noted above the numbers of beds reported as "core" acute beds during the winter of 2019-20 vary around the 738-743 level, with varying numbers of as many as 50 additional escalation beds. NHS England's Quarter 3 figures for 2019/20 give a Trust total of 754 'general and acute' beds open overnight,[27] plus 94 maternity beds. The same statistics show a further 163 general and acute beds open days only. This gives a combined total of 1,011 – a figure that does not correspond with any of the totals given in the PCBC or Consultation document.

The same NHS England statistics give a breakdown of the specialty beds open overnight in ESTH as just 641. A snapshot figure compiled by UNISON on March 4 2020 found 419 acute beds at St Helier and 350 in Epsom – a total of 769.

So it's almost impossible to get a consistent baseline figure from which the IHT plan wants to make changes, especially since the Appendices to the PCBC are not available on the IHT website. Helpfully, however, the Clinical Senates report (p55), with access to the Appendices, compiled a breakdown of

[26] PCBC 130

[27] https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/

the figures of that the new plan would produce: we can compare these numbers with the latest official numbers from NHS England and the Trust[28]:

Bed category	Current provision	Plan: Epsom	Plan: St Helier	Plan: Sutton	Plan: TOTAL
Non elective overnight	290			328	**328**
Elective overnight				37	**37**
Critical care	21			21	**21**
NEL day	163			34	**34**
EL day		39	53	97	**97**
District beds		112	115		**227**
General medicine	244				
Geriatric	84				
Community beds	23	47	15		**62**
Contingency District beds					**35**
SWLEOC	75	75			**75**
Private patients	20[28]			24	**24**
Maternity	94			73	**73**
TOTAL	**1014**	**273**	**183**	**521**	**1012**

Although the totals may appear similar, the breakdown shows that the new Sutton site would only have **386 acute and critical care beds available overnight**, compared 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.

None of these details are clear from the ball park total figures of undifferentiated bed numbers given by the PCBC at page 193, or the Consultation Document, which gives very few details at all.

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**);

[28] https://www.epsom-sthelier.nhs.uk/download.cfm?ver=24181

- 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.**

- 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? Have they been told?**

  How does this help with improving the recruitment and retention of clinical staff?

Reducing caseload?

Despite this reduction in frontline bed capacity, the PCBC (page 115) makes clear there is no intention to expand or invest any further money in community services, which are assumed to be already delivering a reduction in demand for acute hospital care. **Yet the CCGs expect there to be a reduction in hospital activity over next 7 years[29]. How this can be achieved without expanding the resources elsewhere is not explained adequately.**

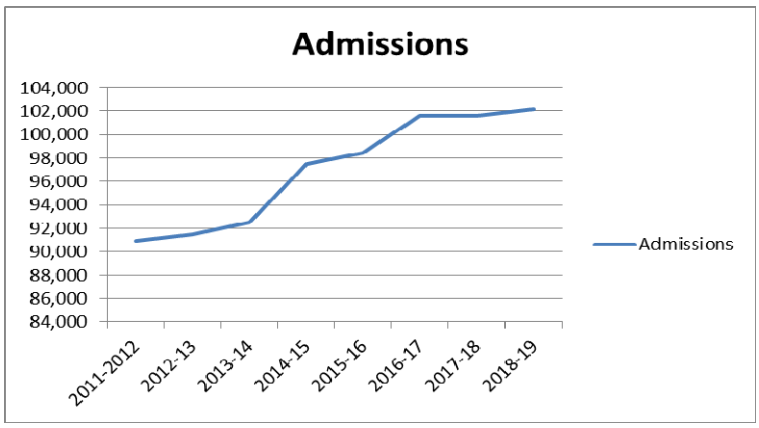
The PCBC (p116) makes clear that there are high hopes for reduction in acute caseload:

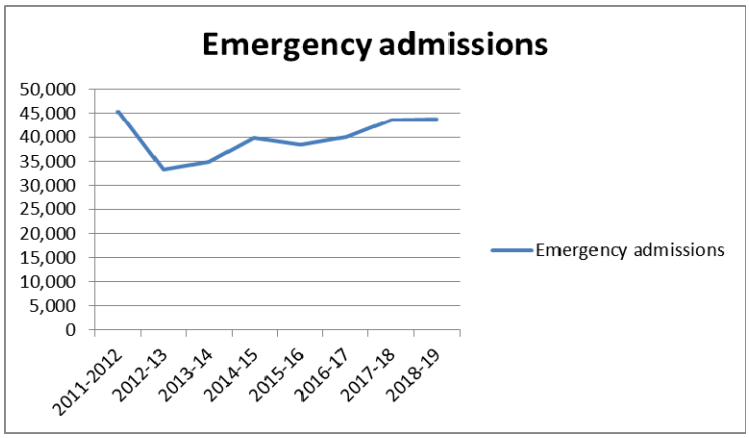
> "In estimating the capacity required for the hospital sites in future, we have considered CCGs current delivery of out of hospital schemes (including demand management), benchmarking (including RightCare) and other PCBCs.
>
> "Based on this, we have estimated within the PCBC **an average of c. 3% annual 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."

However NHS England's figures show no significant reduction in admissions over recent years (see graph below), and while the PCBC boasts of a reduction of emergency admissions at Epsom, it also admits that at the same time numbers at St Helier went UP! (PCBC 118).

[29] PCBC 194

Overall emergency admissions have fallen only marginally in recent years (see graph below), partially due, no doubt to the fact that trauma cases and some more serious emergencies now go directly to St George's rather than to Epsom or St Helier.





Source for both graphs: Hospital Episode Statistics (2011/12 onwards) *https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity*

CCGs proposing to centralise A&E services onto a single site in Sutton should also take note of the research findings from a Sheffield University study of the after effects of closing a major (Type 1) A&E – such as St Helier, which noted an increase in emergency calls, no evidence of any reduction in attendances at A&E and a small increase in the risk of death in the areas affected by the closure of A&E services.

> "… the overall findings were as follows:
>
> - there is evidence of an increase, on average, in the total number of incidents attended by an ambulance following 999 calls, and those categorised as potentially serious emergency incidents;
> - there is no statistically reliable evidence of changes in the number of attendances at emergency or urgent care services or emergency hospital admissions;
> - there is no statistically reliable evidence of any change in the number of deaths from a set of emergency conditions following the ED closure in any site, although, on average, there was a small increase in an indicator of the 'risk of death' in the closure areas compared with the control areas."[30]

[30] https://www.sheffield.ac.uk/polopoly_fs/1.799009!/file/ClosedPublishedReport.pdf

It would be sensible for **Merton and Surrey Downs CCGs** to consider whether this is a price they consider worth paying for their local population, and then explain this to local people.

2.) Acute beds and caseload

Projected activity for 2025/6 as estimated in the PCBC appears to vary slightly according to the Options, with No Change argued to require more beds, as shown in table 50 compared with table 53 (pp197-198):

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

By contrast the preferred option 4 appears to show some reduction in caseload , most notably the projected 14% reduction in non-elective admissions: whether or not such a substantial reduction proves possible, it is nowhere near as dramatic as the proposed reduction in acute beds handling emergencies.

This means that if we just take account of emergency admissions, and assume all of the Sutton beds are available for all of its emergency admissions, the assumed throughput of patients per bed per year is expected to increase from 68.5 in 2018/19 to an astonishing 111.7 in 2025/6 – a rise of 83%!

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

In practice the Sutton Hospital is also projected to handle the more complex elective cases: an estimated 5,900 by 2025/6. This gives a combined inpatient caseload of 49,000 complex patients to be treated each year in 386 front-line beds, equivalent to 127 patients per bed per year.

This would mean all staff at Sutton working flat out all the time 24/7 – questioning whether it would be an attractive place to work for medical or nursing staff. (While the 2018/19 admissions for the Trust added up to 102,000, averaging 159 per overnight bed, this is a much more varied caseload,

half of whom spend just 1 day in hospital: the Sutton caseload would by definition exclude any of these less demanding cases, and be composed entirely of patients with more serious clinical needs).

At the same time the segregation of patients would bring a reduction in acuity of patients using the remaining "District" beds in Epsom & St Helier, and would make the work there much less stimulating and rewarding for professional staff, while the proposed dilution of skill mix among nursing staff to deal with these less complex cases would potentially increase pressure on RGNs.

The argument for fewer beds hinges on the assertion that new models of care are reducing caseload:

> "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**" (PCBC p108)

However MSTUC notes that the even more extravagant claims for the results achieved by each of the CCGs (Merton, Sutton and Surrey Downs) in reducing non-elective, elective and A&E caseload (PCBC pp p113-114) are not reflected in the actual numbers of patients requiring emergency admission and waiting list treatment as reported by the Trust to NHS England. In fact the 3 CCGs have seen a ***substantial increase*** in emergency admissions to trusts including Epsom & St Helier (up 27% from almost 58,000 to over 73,000) and an increase in admissions overall (up 13% from almost 166,000 to 188,000)[31].

As far as Epsom St Helier is concerned, the actual numbers of emergency admissions in 2018/19 are almost back to 2011-12 levels and rising, while the total of admissions has risen over the same period by almost 10%.

It seems that the demographic pressures driving these increases are set to continue, with a growing population and an increased proportion of older patients in all 3 CCGs:

> "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." (PCBCp27)

And while there has been a welcome reduction in numbers of "super-stranded" patients left in hospital for weeks on end, the PCBC's claim to have eliminated the use of escalation beds (PCBC p114) is disproved by the Winter 2019/20 sitrep reports[32] which show varying numbers of up to 50 escalation beds in use day by day to keep occupancy levels below the recommended 85% maximum.

[31] https://files.digital.nhs.uk/publicationimport/pub16xxx/pub16719/hosp-epis-stat-admi-ccg-resp-2013-14-tab.xlsx and https://files.digital.nhs.uk/98/A6DC4C/hosp-epis-stat-admi-ccg-resp-2018-19-tab.xlsx

[32] https://www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps/winter-daily-sitrep-2019-20-data/

4.) What services would be provided by "District Hospitals" at Epsom & St Helier

The proposal to downgrade Epsom & St Helier hospitals to "District Hospitals" with reduced levels of service creates a new category of hospital that is not to be found anywhere else. There is no reference to such a model in NHS England's Five Year Forward View (2014), or in last year's Long Term Plan: and there is nothing similar proposed in Sir Bruce Keogh's 2013 review Transforming urgent and emergency care services in England.[33]

While it is fashionable in advocating NHS plans to go on at length about "innovation," it's not clear that the unfamiliar profile of services proposed for the District Hospitals will prove attractive for the medical and nursing staff they will need to attract to maintain services.

The proposal appears to have confused the Clinical Senates, which made 18 recommendations[34] seeking to clarify exactly what is meant and how it is supposed to work with both District Hospitals functioning remotely from the main body of consultant expertise, up the road in Sutton.

MSTUC shares the Clinical Senates' concerns on this, and is not reassured by the bland and evasive wording of the PCBC published in January and the total lack of detail throughout the Consultation document.

In particular the Senates' report notes (p9):

> "… great care will be required in triaging those patients needing admission, and the criteria for acute or DH admission in particular should undergo further review by the trust's clinicians. This will need to take account of the staffing and services that will be in place in the DHs.
>
> "This is particularly important for the DH that is not co-located with the acute hospital, where they will not have on site access to the more extensive range of services and workforce associated with the acute hospital. This asymmetry between the DHs within the model should be more fully articulated, and any associated clinical risks mitigated."

The Senates also express concern to ensure there is adequate medical expertise running the District Hospital beds:

> "The interface clinician in particular must be sufficiently trained in the care of hospital inpatients. It is not clear at present that this role could be fulfilled by general practitioners, as proposed in the PCBC.
>
> "It is recommended that at implementation of the DH model, there is a level of over-skilling and over-staffing, and potentially a limitation in the acuity of patients admitted, to gain confidence in the quality and safety of the care that can be provided in this new way of working before expanding the remit of the DH to that described." (p9)

[33] https://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

[34] Recommendations 53-71.

We note there is no commitment from the CCGs to this call for initial over-provision of clinical staff. We also note with alarm a clear contradiction between on the one hand the insistence in the PCBC (page 156) that:

> "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."

and on the other clear statements that recognise the DH beds **WILL** be a step down to very different, lesser levels of care:

> "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)." (PCBC p122-3)**
>
> **… "**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 ." (p162)
>
> … "Given the design of the clinical model, **transfers would be needed for patients stepping down from the major acute to district care**." (p245

Indeed the definitions of patients appropriate to District Hospital wards suggests similarities with nursing home provision more than hospital, leaving confusion on the levels of care and expertise of staff that are required:

> "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." (p124)

Once again the term "step down" is used to describe the level of care in Fig 35 on p125 (see below).

MSTUC also notes that a Nuffield Trust document cited by the PCBC (p163 and elsewhere) on care in "smaller hospitals" argues:

> "**Each step in a patient's care pathway should add value.** Movement along the pathway should be determined by need, rather than artificial time constraints. Many current models duplicate work (for example, by clerking a patient in more than one unit) and have unnecessary delays in obtaining a diagnosis. Small hospitals need a model that removes all

duplication and, where possible, ensures that critical tests are done rapidly to allow patients to be put on the most suitable pathway."[35]

Figure 35: Patient criteria

Major acute care	District services
• 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	• 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**

So the question is what "added value" can be shown for patients who are to be shipped by ambulance from one site to another? [36]

MSTUC is also concerned at the lack of any detail on how the necessary ambulance crews and vehicles would be put in place to facilitate the new 3-site system of working. We note the lack of any accompanying paper or comment from the London Ambulance or South East Coastal Ambulance Trusts to demonstrate their confidence that the necessary funding and arrangements will be put in place. The same question is raised by the Clinical senates (Recommendations 50-52).

The PCBC itself notes the need for "robust protocols" for transfers of patients between the 3 sites[37], and goes on to make clear that **transfers between the three hospitals will become more common** after the plan is in place:

> "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." (p156)

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[35] https://www.nuffieldtrust.org.uk/files/2018-10/nuffield-trust-rethinking-acute-medical-care-in-smaller-hospitals-web-new.pdf (p8)

[36] We also note that the Nuffield Trust study's definition of **smaller hospital** seems to exclude both Epsom and St Helier:

> "We mainly focus on hospitals serving 140,000 to 300,000 people – in particular those that are geographically isolated. These hospitals typically have an average of 30 to 40 emergency admissions of adult medical cases a day."

This is very different from ESTH – so why does IHT keep referring to it?

[37] PCBC p128-9, 132

It is not reassuring to see the PCBC citing the example of the Luton and Dunstable FT as a model for streaming ambulatory patients and feverish children under five between the UTC and ED (p 133) – when unlike the proposed system here, Luton has the UTC and the ED on same site[38].

MSTUC awaits with interest the considered response of the two ambulance services, while also pointing to the continuing series of contract failures by private sector providers of Patient Transport Services throughout England's NHS, and we urge the CCGs and the Trust to ensure that any PTS services in future are included in the ambulance contract and delivered by NHS ambulance trusts.

Combating inequalities?

Trying to make the case for their novel, and not very clear model, the CCGs even argue that District Hospital beds could combat inequalities:

> "… the planned changes to district services may reduce health inequalities. District hospital services ***could reduce health inequalities*** for deprived communities by, for example, focusing on wellbeing and preventing people becoming very ill." – (Consultation p36) "The planned changes to district services ***may lead to improved health outcomes*** for people from deprived areas and bring about changes which would help to reduce health inequalities." (Consultation p37)

Of course it's very possible the changes that are being proposed may deliver ***none*** of these hoped-for outcomes, but instead lumber some of the less mobile and more socially deprived in the catchment population with more complicated and expensive journeys to hospital for treatment for themselves, their family members, or to visit friends and family if they are admitted to the Sutton hospital.

5.) Workforce

We noted in the Introduction and Section 1 above that one of the most frequently cited arguments to justify the proposed change centralisation of emergency and specialist services is to address shortages of consultant, nursing and other professional staff.

We also noted that this answer to staffing problems fails to take note of the Royal College of Emergency Medicine (RCEM) guidance on Reconfiguring Emergency Medicine Services[39], published in April 2017.

The PCBC itself also notes that there is little prospect of solving ESTH's problems either by recruitment or by borrowing key staff from other local trusts:

> "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.
> … **Available evidence suggests that other providers do not have consultants available who could contribute to rotas.**
> …

[38] https://www.ldh.nhs.uk/our-services/emergency-department?highlight=urgent%20treatment%20centre

[39] RCEM. Reconfiguring Emergency Medicine Services. 2017

> 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." (p186)

MSTUC reminds the CCGs that staff shortages apply to Trusts which are already centralised as well as to ESTH with its current 2-site system: moving to 3 sites can only be seen as a way forward if it is a way of effectively reducing the level of clinical care in the two District Hospital sites 9and thus reducing the need for staff).

MSTUC also notes that the projections show a net reduction of 33 consultants as a result of the plan, with NONE of the 307 consultants working on the two District Hospital sites.[40]

However the PCBC (p234) also reveals the same total requirement for consultant staffing whether or not the new Sutton Hospital is added in to the mix.

So the 3-site model appears to offer no clear advantages for staffing, while adding complexity to the system – and the risk of creating a new, highly stressful and over-stretched acute specialist hospital that would be even less attractive to senior medics than the 2-site system.

We also note a misleading promise of "Consolidation savings" through "reduction in number of porters and bed managers required to provide care to the sickest patients across two acute sites:[41] but in fact **all three options** show the same savings, so the reduction in sites is not decisive.

MSTUC remains concerned that the IHT proposal would bring the complexity and inefficiencies of 3-site working alongside a downgrading of the clinical care in both Epsom and St Helier, a dilution of skill mix among medical, nursing and other professional staff, and a reduction in non-clinical support staff which in turn is likely to rebound as pressure on clinical staff throughout the Trust.

6.) The elephant in the planning room

As we have argued in earlier sections of this response, MSTUC is convinced that 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 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

[40] PCBC p261

[41] PCBC p257

for a major hospital at Sutton. This potential hospital site is described as 'Sutton Hospital' in this document."[42]

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 rose to £121m in 2018-19 (more than one fifth of all NHS private patient income)[43]:

> "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[44] 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[45] 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.

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[42] PCBC p174

[43] https://www.hsj.co.uk/the-royal-marsden-nhs-foundation-trust/specialist-trust-now-providing-a-fifth-of-all-nhs-private-patient-work/7025787.article

[44] https://www.icr.ac.uk/news-archive/land-deal-completes-multimillion-pound-investment-to-make-london-cancer-hub-a-reality

[45] https://www.infrapppworld.com/news/tender-for-london-cancer-hub-to-be-launched-next-year

In February 2020 Sutton council and the Institute of Cancer Research, announced[46] 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.

MSTUC is in no way opposed to the development of a London Cancer Hub, and has no problem with the hub being located in Sutton, which has many advantages over costly and congested inner London sites.

But what we are not willing to endorse 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. And 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 call 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.

7.) Access and travel issues

Between July and October 2017 ESTH engaged with local communities "around their challenges and potential scenarios for addressing these challenges." 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." [47]

MSTUC is not convinced by the vague assurance that

> "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." (PCBC p206)

This in our view exaggerates the scope of the residual services at the two District Hospitals, and understates the scale on which local people will need to access emergency care.

[46] https://www.londoncancerhub.org/news/detail/major-investment-to-transform-uk-s-leading-cancer-campus

[47] PCBC page 87

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."[48]

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[49], 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.

8.) Cost and financing

If the plan goes ahead along the lines of the PCBC and Consultation document, MSTUC fears for the financial viability of the Trust after its inpatient services have been both downsized and extensively downgraded.

MSTUC notes that the expected outflow of patients from the ESTH catchment to other hospitals is higher for Sutton (119 beds) than for the St Helier option (81 beds).[50]

However if our fears over the impact of links with the Royal Marsden are borne out, it's likely that there could be a significantly larger outflow of local patients, as capacity from within the 386 inpatient beds at Sutton is exhausted.

While NHS England has been seeking ways around the existing legislation (Health and Social Care Act 2012), and in particular seeking ways of replacing the 'payment by results' system brought in by New Labour in the mid 2000s with new forms of block contracts, it's clear that reduced bed numbers and reduced numbers of admissions are likely to mean a reduction in income for ESTH – while there are

[48] Draft Interim Impact Assessment (DIIA), https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/01/IHTIIA1.pdf, p86

[49] DIIA p93.

[50] PCBC 202

doubts over the extent to which the scaled down services at ESTH would be replaced by expanded services in other nearby trusts – many of which are clearly already working to capacity.

It's also worrying that the architects of the Improving Healthcare Together strategy seem intent on spending the whole of the potential government allocation of £500m capital on a new hospital, leaving little or nothing for expansion and improvement of community health and primary care.

Capital costs of the Sutton site redevelopment are estimated at £472m,[51] but it's not clear when this estimate was made. MSTUC notes the extremely rapid inflation in estimated costs for some recent projects, notably the proposed new William Harvey Hospital in Ashford, Kent, which appears to have more than doubled in cost in just 18 months, from £160m to £350m, while estimates for a new hospital in Canterbury have also risen from £250m to £363m[52].

While it is to be welcomed that PFI has recently been relegated from the "only game in town" for financing new hospitals to a non-starter, and that the current government is committed to public funding of infrastructure projects, it seems likely Trusts will receive the funding as Public Dividend Capital, which carries a perpetual annual interest charge – at current rates equivalent to over £16m per year. This additional annual cost is likely to run alongside a reduction in income from specialist treatment: these factors do not appear to have been taken properly into account by the Consultation or PCBC.

9.) Knock-on effects if Sutton site can't cope

The PCBC estimates 50 extra beds would be needed in neighbouring hospitals (PCBC p 308) as a result of this plan: and £39m of capital is to be set aside to help cover this[53], although it's not at all clear which of the local trusts would be most able and least unwilling to take on additional caseload, since St George's, Kingston and Ashford St Peter's are running pretty much full to capacity, and Croydon has the additional problems of poor CQC ratings alongside plummeting performance[54].

10.) How is the new IHT plan different from previous plans?

MSTUC has 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[55].

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

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[51] PCBC 255

[52] https://www.hsj.co.uk/finance-and-efficiency/cost-of-hospital-building-project-doubles-in-18-months/7026896.article

[53] PCBC p282

[54] SEE PCBC p 52

[55] 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*).

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[56].

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[57].

Plans were published, and widely approved. MSTUC and local campaigners were delighted[58].

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.

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[59]. Both of these proposed mergers collapsed in 2012 because of unresolved financial problems on all sides[60,61,62.]

[56] http://epsom-sthelierunison.com/images/stories/InTouch/14_autumn_2003.pdf?LMCL=lOvOyR
[57] http://epsom-sthelierunison.com/Web%20Work/Unison%20website/unison%20test/in%20touch/Spring%202009.pdf?LMCL=lOvOyR
[58] http://epsom-sthelierunison.com/images/stories/InTouch/27_autumn_2009.pdf
[59] http://epsom-sthelierunison.com/images/stories/InTouch/30_summer_2011.pdf
[60] http://epsom-sthelierunison.com/images/stories/InTouch/32_spring_2012.pdf?LMCL=S_ZSoQ
[61] http://epsom-sthelierunison.com/images/stories/InTouch/st_helier_summer_2012_final.pdf
[62] http://epsom-sthelierunison.com/images/stories/InTouch/St_Helier_autumn_2012_web.pdf

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[63]. 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. MSTUC fears 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.

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'[64]. 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 MSTUC is not convinced the proposals give a sound footing for a Business Case.

11.) Land for sale at Epsom and St Helier

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[65,66].

[63] UNISON *In Touch* Summer 2016

[64] PCBC 243-246

[65] https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review

[66] https://www.theguardian.com/society/2018/sep/09/nhs-land-earmarked-for-sale-to-developers

While MSTUC has no objection in principle to selling off unused NHS assets to facilitate investment in new buildings and facilities, we note the long succession of flawed and failed plans in this area over the past 20 years, and urge against any rapid sale that may well prove irreversible if plans misfire and more NHS capacity is needed.

There's no way back if the land is sold off prematurely: when it's gone, it's gone.

12.) Deeply flawed documents

It would be easier to take the Consultation document and the 300+ pages of the PCBC seriously if there were not so many examples of misleading, irrelevant and completely outdated information that reinforce the impression that the three CCGs are trying to avoid rather than engage with the real issues.

The PCBC for example begins with a lengthy, but completely irrelevant discussion of prevention[67] and public health issues – for which there are no concrete proposals in the plan, and which are outside of the scope of the Epsom & St Helier Trust. Further on (p46), in the midst of a section on long term conditions, applying primarily to older people, there is a random and unexplained reference to teenage pregnancies:

> "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."

Nor can we assume that the document citing of what might appear to be evidence can be relied upon to be relevant, appropriate or current. For example a "selection of studies"[68] are listed, with the claim that they support the approach of the Consultation proposals. They turn out to be a list of ancient 'articles' (several over 20 years old, none in last 5 years) with no proper referencing to allow their relevance to be checked. Two relate to Australia, one Canada, one the US: there is no explanation on why or how these studies are relevant to Merton, Sutton and Surrey Downs. They appear to be included only to give the semblance of academic weight to the PCBC – clearly assuming nobody will check, read them or question the usefulness of their content.

Similarly the PCBC on Page 162 gives a partial reference to a 2011 publication by the "Hastings Centre", without revealing that this is a "Hastings Center" in the USA, or that the report itself discusses potential benefits of an imagined ("Fable") hospital[69].

There are numerous examples of extremely old data being wheeled out and presented as if it is current. On page 54 of the PCB the authors cite ancient figures for ambulance handovers, when much more up to date figures are easily available. PCBC page 58, giving no date or source, quotes a vacancy rate that is double the current level: no effort has been made to update the figures. Similarly the PCBC refers to 4-year old figures on A&E staffing:

[67] PCBC p 28 – 38

[68] Table 29, PCBC pages 126-7

[69] https://www.thehastingscenter.org/uploadedFiles/Landing_Page/SadleretalFableHospitalBusinessCase_HastingsJan11%281%29.pdf

> **"In March 2016, emergency department and acute medicine have the highest vacancy rates of all specialties"** (p59).

The PCBC (pages 58-9) argues that

> **"**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 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 audits."

Yet despite the impression given by this paragraph, ESTH's performance on the most serious A&E Type 1 cases in December 2019 (80% seen an treated within 4 hours) was ***better*** than neighbouring trusts Croydon (48.2%), St George's (77.5%) and Kingston (78.7%).

Table 20 on PCBC p 62 claims that ESTH has the "third worst bill for backlog maintenance in the NHS": they do not however cite any year or source for this. While MSTUC is keen to see the chronic backlog maintenance issues resolved in the Trust, it appears this wilful exaggeration is used simply to argue for downsizing St Helier. In fact the latest ERIC[70] figures show a different picture: ESTH is ***fifteenth***, not third.

Trust	Combined backlog deficit (£million)
Imperial College Healthcare	691.1
London North West Healthcare	216.5
Barts Health	199.6
Oxford University Hospitals FT	140.5
Nottingham University Hospitals FT	130.7
Sheffield Teaching Hospitals FT	127.6
Pennine Acute Hospitals	124.5
University Hospitals Birmingham FT	118.0
Newcastle upon Tyne Hospitals FT	114.8
Leeds Teaching Hospitals	109.1
Hillingdon Hospitals FT	107.4
Cambridge University Hospitals FT	103.9
St Georges University Hospitals FT	99.2
East Sussex Healthcare	96.9
Epsom & St Helier University Hospitals	96.1

The PCBC's selective use of very old data can sometimes result in it contradicting itself. On page 63, a relatively up to date picture is given which shows the trust is under-funded and running deficits (although these are not large in comparison with many other trusts):

> "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…"

By contrast three pages further on, as the CCGs dredge through past figures in an effort to exaggerate the financial problem as part of their "case for change", they unwittingly reveal that the

[70] https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/england-2018-19

Trust has already performed better than expected, since it has apparently escaped from the feared consequences without making the changes proposed:

> "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.**" (p66)

This shows that the CCGs can't even get things right with the benefit of hindsight. If the figures they used on page 63 are correct, then the argument that the "trend" from 2013 to 2018 meant that "the financial position will worsen" is clearly misleading and inaccurate.

MSTUC would argue that if the CCGs' argument was sound, they would be able to produce honest arguments and sound evidence for it, rather than delving around for figures, references, and outdated information to buttress up their case.

Conclusion

In **MSTUC's** view the Consultation Document – almost entirely devoid of detail – and the PCBC on which it depends, which seems mainly devoted to diverting attention from the substantial downsizing and downgrading of services that are being proposed, 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.

Drafted by Dr John Lister for
Merton & Sutton TUC, 20 March 2020