Sarah Blow/Matthew Tait

Accountable Officers

NHS South West London/Surrey Heartlands CCGs

Dear Sarah and Matthew

Improving Healthcare Together Committees in Common 3 July 2020

Providing the best possible health and care system for the residents of Merton is something that we all wish to achieve.

As you will be aware, Merton Council does not agree with the proposals for how this should be achieved, due to be put to a resolution at the Committees in Common (CIC) meeting on 3 July. Our view remains that the proposals to downgrade services at St Helier Hospital would have a disproportionate impact on the deprived communities that rely on the hospital and would likely widen existing health inequalities.

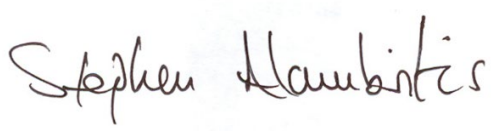
Irrespective of our view on the preferred option, however, the Council believes that it is quite inappropriate to be making such a decision whilst the impact of COVID-19 is still not fully understood, and that the decision should be postponed. We know that the pandemic has exposed and exacerbated existing health inequalities, and we believe further work to understand the impact of the pandemic on the options is necessary before a decision can be taken.

I also note that the Mayor of London in his response to the consultation has highlighted the need for further detail about how you plan to reduce health inequalities in the Decision Making Business Case, and that he specifically asked for a focus on East Merton. I note that this work is intended to be undertaken following the decision being made. The Council believes that it is imperative this work is undertaken prior to the decision, in tandem with the work looking at the impact of the pandemic.

Please find enclosed a short written submission for the CIC meeting explaining why, and an Appendix with more detail.

I look forward to continuing to work with you towards a good outcome.

Yours sincerely



Leader of the Council

Improving Healthcare Together
LB Merton written submission to the Committees in Common 3 July meeting

Summary

The Council believes that the degree of uncertainty about how COVID-19 will affect society in general and the health and care system in particular means that taking a decision today about the future configuration of major acute services in South West London and Surrey would be reckless.

Further detail of how the Council has reached this conclusion is detailed below.

Explanation of the Council's position

The Council has reached the position summarised above having considered the following questions

1. What are the expected negative consequences, if any, of delaying the decision?
2. What are the possible benefits of delay, if any?
3. What additional information could be provided to the Committees in Common, which would enable a later decision to be a better one?

The Council realises that opinions will vary on the correct answers, and would like to hear the views of Committee members. Below is a summary of the Council's view.

<u>What are the expected negative consequences, if any, of delaying the decision?</u>

Possible negative consequence	Why LBM believes this is unlikely
The opening of the new facilities will be postponed and patient outcomes will be affected.	The planned opening is not until 2025 as there are a number of stages to follow the agreement of the DMBC. A short delay whilst more information is collated for the CIC can easily be made up at the planning or commissioning stage. Many of the better outcomes expected from the new clinical model can begin before 2025 anyway.
The reputation of the NHS to get things done will be impaired.	The NHS has clearly demonstrated its ability to build and open new acute facilities quickly when required.
The opportunity for £500m investment in SWL/Surrey will be lost.	The new Government has firmly committed to wide ranging capital investments in this electoral cycle.

What are the possible benefits of delay?

Potential benefit	Why LBM believes these are likely and substantial
Greater understanding of the consequences of COVID-19 on the health and social care system.	Understanding of the long term impact of COVID-19 is still immature. Many more research projects are due to report over the next few months.
Clarity about the bed capacity required in a post-COVID-19 NHS.	As noted in the IHT "Review of the impact of COVID-19 on the clinical model - Emerging Findings" dated 10 June 2020, c. 20% additional capacity may be needed on all 3 sites.
A smoother path to HM Treasury approval.	A single revised proposal can be submitted rather than the 2 stages which otherwise are likely to be required.

What additional information could be provided to the Committees in Common, which would enable a later decision to be a better one

Some of the information which could be provided is as follows:

Type of information	Rationale for a better decision
Revised JSNAs for affected populations.	Confirmation that the decision is based on correct understanding of underlying health needs post-COVID-19.
Revised capacity planning assumptions from NHSE for a post-COVID NHS.	See above – will confirm whether current capital funding is sufficient.
Revised Integrated Impact Assessment.	IIA data collection and analysis was pre-COVID-19.
Further detail about how the plan will reduce health inequalities, including analysis of how the different options would impact the diverse populations across the combined geographies, with a specific focus on East Merton.	As recommended by the Mayor of London, and because COVID-19 is widely recognised to have exacerbated health inequalities
Employment market statistics.	Staffing shortages are a big driver for IHT. Labour market may be quite different in London post-COVID-19.

Postscript

The Council has raised a number of important questions about the completeness of the analysis and the underlying assumptions that a 3-site model for ESHT is better than the current 2-site configuration. These were summarised in the Council's response to the formal consultation and so are not repeated here.

Improving Healthcare Together
LB Merton comments on "Review of the impact of COVID-19 on the clinical model - Emerging Findings" dated 10 June 2020

Summary

The Joint Health Overview and Scrutiny Committee (JHOSC) held on 4 June 2020 requested further information about how the unprecedented COVID pandemic affected the case for reconfiguration of major acute services. The Chair of the JHOSC was supplied with a copy of the above document on 10 June 2020.

The Council does not agree with the assertion in its covering letter that "the JHOSC has received sufficient information on our proposals to make its comments"

The table below provides more detail on why the Council believes the paper is an insufficient basis for scrutiny, and for the decision itself.

Detail

Statement in the 10 June paper	Council comments
The interim assessment paper is one of the additional pieces of evidence that CCG Governing Bodies will consider (page 1).	When will the final assessment be made? Would the Governing Bodies not require sight of that before making their decision?
This model was developed and detailed through 2018–19, including refinements in response to feedback from patients, clinicians and regulators.	It is unclear whether the model has been refined to include the interface with adult social care and with specialist mental health services, as per feedback.
Context: COVID-19 Bullet list of issues.	The widening of inequalities exposed by COVID-19 has not been included. This matters because the Integrated Impact Assessment showed differential impact on deprived groups. The Mayor of London has also requested more detail about the impact on diverse communities across the combined geographies
The estate cannot adapt to meet the challenges of a pandemic.	An assumption appears to have been made that the only way to address deficiencies in the estate is to create a 3rd site. The case for developing the two existing sites has not been examined. The funding available may be enough to make all necessary modifications to the existing estate

ESTH's people are stretched and under pressure, leaving limited capacity to respond to a crisis.	Spreading staff over 3 sites will not in itself reduce stretch and increase capacity. Some of the £500m available could be used to support staff directly e.g. mental health support.
The model of care can be different – with less time in acute hospitals.	This positive consequence of COVID-19 is equally applicable to the current as to the proposed configuration.
We are currently exploring scenarios where c. 20% additional capacity is required	Rather than a simple +20% across the board increase, the whole capacity model should be recalibrated based on refreshed JSNAs for the affected communities.
COVID-19 has given us lots of insights into how hospital buildings need to be designed.	It is not just for the structural design of the buildings that COVID-19 provides new insights. There will also be insights for the clinical process. These have not been articulated.
Digital needs to be embedded in the hospital.	Digital needs to be embedded across the whole of the health and care system. The current paper does not address this.