NHS Surrey Heartlands and NHS South West London Commissioning Groups (CCGs)
Improving Healthcare Together 2020 to 2030 (IHT)
Committees in Common
Minutes

3rd July 2020, from 11:00 – 14:00
Online and live streamed meeting via Microsoft Teams

Minutes approved by NHS Surrey Heartlands and NHS South West London CCGs Governing Bodies

Convenor: Jonathan Perkins, Deputy Chair and Lay Member for NHS Surrey Heartlands CCG

Name	Initials	Role
Jonathan Perkins	JP	Convenor
Andrew Demetriades	AD	IHT Programme Director
Surrey Heartlands CCG		
Voting members:		
Dr Charlotte Canniff	CC	Clinical Chair, Surrey Heartlands CCG
Julia Dutchman-Bailey	JD	Board Nurse Governing Body Member, Surrey Heartlands CCG
Dr Russell Hills	RH	GP Governing Body Member for Surrey Downs, Surrey Heartlands CCG
Matthew Tait	MT	CCG Accountable Officer, Surrey Heartlands CCG
Jacqui Burke	JB	Lay Governing Body Member – Audit, Surrey Heartlands CCG
In attendance:		
Colin Thomson	CT	Surrey Downs ICP Director, Surrey Heartlands CCG
Kate Scribbins	KS	Chief Executive, Healthwatch Surrey
South West London CCG		
Voting:		
Dr Andrew Murray	AM	Clinical Chair, South West London CCG
Dr Jeffrey Croucher	JC	GP Borough Lead for Sutton Governing Body Member, South West London CCG
Dr Vasa Gnanapragasam	VG	GP Borough Lead for Merton Governing Body Member, South West London CCG
Sarah Blow	SB	Accountable Officer, South West London CCG
Susan Gibbin	SG	Patient and Public Involvement Lay Governing Body Member, South West London CCG
In attendance:		
James Blythe	JB	Locality Executive Director, Merton and Wandsworth, South West London CCG
Lucie Waters	LW	Locality Executive Director, Sutton, South West London CCG
Pippa Barber	PB	Registered Nurse Governing Body Member, South West London CCG
Paul Gallagher	PG	Audit Chair Lay Governing Body Member, South West London CCG
Pete Flavell	PF	Chief Officer, Healthwatch Sutton
Dave Curtis	DC	Chief Officer, Healthwatch Merton

Technical witnesses:

Name	Initials	Role
James Murray	JM	Chief Finance Officer for South West London CCG

Daniel Elkeles	DE	Chief Executive Officer, Epsom and St Helier University Hospitals NHS Trust
Dr James Marsh	JM	Deputy Chief Executive and Joint Medical Director and Consultant Renal Physician, Epsom and St Helier University Hospitals NHS Trust
Dr Ruth Charlton	RC	Deputy Chief Executive and Joint Medical Director and Consultant Paediatrician, Epsom and St Helier University Hospitals NHS Trust
Dr Amir Hassan	AH	Clinical Director of Emergency Medicine and Consultant in Emergency Medicine, Epsom and St Helier University Hospitals NHS Trust
Arlene Wellman	AW	Chief Nurse and Director of Infection Prevention and Control, Epsom and St Helier University Hospitals NHS Trust
Charlie Wilson	CW	Opinion Research Services
Kester Holmes	KH	Opinion Research Services
Brian Niven	BN	Mott MacDonald
Christian Norris	CN	IHT Programme Team

Please note that these minutes are not verbatim but a summary of the statements and conversations that occurred during the meeting.

No.	Agenda Item	Who
1.	**Welcome and introductions**	
	The Convenor welcomed all members and confirmed that no apologies were noted. The Convenor noted: • This Committees in Common (CiC) meeting is held in public; due to Covid-19 social distancing restrictions the meeting is taking place online and is also live streamed to the public and external stakeholders. • The CiC is responsible for ensuring that key decisions are taken in relation to the IHT programme. • The Terms of Reference permits the Committees to call additional individuals or technical witnesses to attend meetings to inform discussions as appropriate.	
2.	**Declarations of interests**	
	The Convenor advised that all panel members' declarations of interests are publically available on the Surrey Heartlands and South West London CCGs' websites as these were declared for the two CCGs' Governing Bodies. No new changes were noted to the register of declared interests.	
3.	**Minutes of the previous Committees in Common on 6th January 2020**	
	The draft notes of the previous Commitees in Common meeting held on 6th January 2020 were approved as accurate. The Convenor also noted the revised Terms of Reference for the Committeees in Common which were updated following the creation of: • Surrey Heartlands CCG as a new organisation, comprising of Surrey Downs CCG and three other CCGs in Surrey; and	

	• South West London CCG, comprising of Sutton and Merton CCGs and four other CCGs in South West London.	
4.	**Decision-Making Business Case**	
	a) The process so far AD noted the IHT Programme was established in January 2018 to address the long standing challenges facing Epsom and St Helier Hospitals by developing solutions with clinicians in partnerships with the CCGs. AD outlined the local challenges facing Epsom and St Helier Hospitals which include: 1. Clinical quality standards: with a focus on the difficulty of running two A&E departments across two hospitals and the current shortage of nurses and clinical staff. The two hospitals cannot meet key clinical standards of care that patients deserve and expect. 2. Old buildings: many of the buildings are older than the NHS; the structure and condition of buildings are inadequate for modern day healthcare with the third highest backlog maintenance in England; and 3. The increasing financial pressures directly linked to issues 1 and 2: the growing financial deficit that Epsom and St Helier University Hospitals NHS Trust ('Trust') faces will continue to worsen if the CCGs do not solve these challenges as set out in the case for change. AD advised that the CCGs have been through a process to develop proposals to solve the long-standing challenges at Epsom and St Helier hospitals and test them with the patients, staff and the public. This process included five stages: **a. Development of a pre-consultation business case:** • The IHT programme has worked closely with clinicians at the Trust and the CCGs to define a clinical model for the future. • Extensive engagement was undertaken with the public and stakeholders on the case for change, emerging clinical model and short list of options as set out in the Issues Paper (June 2018). • The programme has developed evidence which supported the establishment of a preferred option. **b. Public consultation:** • The CCGs asked local populations and wider stakeholders for views on the options via public consultation which ran from 8th January to 1st April 2020. • The Consultation Institute has awarded a 'best practice' rating for the IHT consultation. **c. Consultation analysis:** • An independent report was developed by Opinion Research Service to analyse and understand the views from consultation. • The two CCGs' Governing Bodies have considered all feedback from consultation and developed responses to address the impacts of the proposals. • All consultation documents were published on the IHT website. **d. Further evidence development** – this included: • The independent consultation analysis report, by Opinion Research Services. • The final Integrated Impact Assessment report, by Mott MacDonald.	

- The decision-making business case (DMBC), which sets out the additional evidence developed and considered following the closure of the consultation, and the CCGs' proposals and recommendations for implementation.

e. **Committees in Common decision-making meeting** – the purpose of this meeting is for the CCGs' to consider all the evidence to date and make a decision about the best solution that addresses the case for change and delivers the proposed clinical model.

The proposed clinical model and shortlist of options

AM noted that the development of the clinical model was overseen by the IHT Clinical Advisory Group (CAG) and included input from primary care, clinicians at Epsom and St Helier University Hospitals NHS Trust and various specialist working groups.

AM outlined the two key elements of the clinical model:

a. **Epsom and St Helier hospitals will continue to provide district services:**
   - District hospital services include the majority of hospital services which do not rely on critical care such as: day case surgery, outpatients, ante/post-natal clinics, chemotherapy, dialysis, endoscopy and imaging and diagnostics.
   - 85% of services will stay at Epsom and St Helier hospitals. These will be further integrated with other services people use to meet the needs of local communities.
   - There will be 500 beds across the two hospital sites. These will include district beds for medically stable patients - for those 'stepping down' from major acute services into rehabilitation settings, and those 'stepping up' from the community and directly admitted into specialist beds.
   - Both hospitals will have urgent treatment centres (UTCs) which will be open 24 hours a day, 365 days a year. AM explained that roughly two-thirds of current A&E patients can be dealt with more effectively and quicker via an UTC.

b. **Bring together six core services for the most unwell patients and those who need more specialist care into one specialist emergency care hospital (SECH) located at either Epsom, St Helier or Sutton Hospital:**
   - The six core services for the most unwell patients include: major emergency department, acute medicine, critical care, emergency surgery, births and inpatient paediatrics (children's beds).

AM advised that the CCGs have continued to evaluate the three viable options against the evidence available and their potential impacts for local people. The three options include:

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

AM advised that prior to the public consultation earlier this year, the Committees in Common have identified Sutton as the preferred option for the location of the SECH as it provides the most benefits for the local populations, patients and staff. This option would:

- Allow the provision of high-quality services for everyone living in the area and improve care for Epsom and St Helier cancer patients through the co-location with Royal Marsden.

- Allow the provision of a third urgent treatment centre alongside the emergency department.
- Have less of an overall effect on travel for older people and deprived communities than the other options.
- Be quickest and easiest to build.
- Be best value for the taxpayer.

b) The public consultation

CW advised:

- Consultation is not a vote or referendum. The consultation provides an opportunity for the public and stakeholders to give feedback on the proposals to be conscientiously taken into account by decision-making bodies alongside all the other evidence.
- The IHT public consultation unfolded over a 12 week period, from 8th January – 1st April 2020, during which members of the public and stakeholders were able to provide feedback on the proposals through a wide range of channels (i.e. consultation questionnaire, events, meetings, social media etc.).
- Substantial efforts were made to engage widely with the public and stakeholders, to promote the consultation and to disseminate information. These included:
  - The production of accessible materials
  - Large scale distribution of materials to households and in public locations (i.e. GP practices, libraries etc.); and
  - Promotional activity in community settings as well as via social media, traditional media and the IHT website.
- Specific work was undertaken to engage with protected characteristics, deprived communities and hard-to-reach groups, including those who may be disproportionally affected by the proposals.
- Consultation strands included:
  - Activities undertaken by independent organisations such as Opinion Research Services, YouGov and Ipsos MORI.
  - Event and meetings undertaken by the IHT programme, the two CCGs and the three local lead Councils for Voluntary Services.
  - The receipt of a large number of written submissions from the public and stakeholders; and
  - The receipt of several petitions and locally organised surveys.
- All consultation activities resulted in an extensive range of responses which were into the consultation analysis.

CW thanked the three local Healthwatch organisations in Merton, Sutton and Surrey for promoting the consultation and encouraging public engagement on the proposals.

CW explained the key findings related to:

- The case for change – many consultees recognised the challenges faced by both NHS nationally and Epsom and St Helier University Hospitals NHS Trust.
- The clinical model – the model gained broad support across different consultation respondent types and geographical areas. The level of support varied however by geography with more residents living in Merton in particular stating that the model of care is a poor or a very poor solution.
- Feedback on the potential sites for a new SECH:
  - On balance, the Sutton option received broader support.
  - There was localised support for both Epsom and St Helier and objection to any centralisation of major acute services.

CW noted that a large number of written submissions were received via email, freepost and the messaging function. These included for example responses from seven Local Authorities:

- *Merton Council* – opposes the proposed model of care and rejects the business case.
- *Sutton Council* - endorses the proposed model of care and prefers a new SECH to be located at St Helier.
- *Surrey County Council* - supports the overall ambition of the IHT Programme, and welcomes investment.
- *Epsom and Ewell Borough Council* - supports the model of care and believes that Epsom should be the site of the new SECH.
- *Royal Borough of Kingston Upon Thames* – seeks further assurance with regards to the IHT programme.
- *Reigate and Banstead Council* - supports a SECH at either Epsom or Sutton, subject to retention of local services in Epsom, including 24-hour urgent care facility.
- *Wandsworth Council* - supports plans to build the new hospital in Sutton to strengthen existing specialist cancer care and enhance local services.

AD explained there were a number of cross-cutting themes arising from the consultation which have been considered in detail throughout the DMBC development process. For each theme the CCGs' Governing Bodies have looked at the consultation feedback, developed further evidence, and considered whether this impacts on the ranking of options.

AD outlined the 7 consultation themes and how the CCGs have used the feedback to improve the proposals:

- **Travel and access**
  - The most common concerns shared by respondents related to access to services, the impacts of the proposed changes on local communities and travel and transport to the SECH.
  - In response, the programme board has:
    - Refreshed the travel times analysis – this showed no material changes in terms of journey times to the SECH by either car or public transport.
    - Committed to extend the H1 shuttle bus between Surrey and Merton.
    - Set out the requirements for the Trust to address wider public transport issues. These include undertaking further detailed travel and access assessment and the production of a travel and access plan in partnership with transport providers, Local Authorities and the voluntary sector.
    - Recognised that having sufficient car parking capacity in all options and across all sites is vital in the future. The Trust confirmed sufficient space is available in each of the options to accommodate predicted numbers of staff, patients and the public.
    - The CAG has also further reviewed district services and their link with out of hospital services.

- **Clinical model**
  - Common concerns raised in the consultation included for example:
    - *Greater clarity with regards to accessing district hospitals and the SECH*
      - The programme has discussed with CAG the need to develop a comprehensive engagement and communications plan to ensure patient education and signposting in terms of access to the district sites and the SECH.
    - *The impact of proposals on other local providers as a result of potential changes in the patient flow*

- Local providers have confirmed that all options are deliverable.
- The Trust will continue to work with providers post-decision to refine assumptions around patient activity and if needed the planned investment.
- The wider financial model includes the cost of the capital required to mitigate impacts on other providers for each of the three options.

- **Workforce**
  - The most common workforce related concerns shared by respondents referred to *alternative solutions to workforce challenges*, *availability of required skills* and *training*.
  - The programme has:
    - Reviewed the workforce challenge as set out in the case for change with CAG and the Trust who confirmed that there are no other viable solutions to address this challenge.
    - Set out in the DMBC requirements for the Trust to develop a detailed workforce implementation plan, including recruitment and retention plans, continuing to work in partnership with Health Education England, the Royal Colleges, local clinicians and stakeholders.

- **Population and bed modelling**
  - *Having sufficient beds to meet demands considering the aging population* was a key element highlighted during consultation.
  - The programme has looked again at the bed modelling undertaken in the development of the pre-consultation business case following requests from the public and stakeholders to extend the timeframe for the model from 2020/2025 to 2029/2030. Additionally, the programme also looked at housing developments linked to each of the three sites locations. This led to an increase of the number of beds by 14 from the previous modelling and an overall total increase of 18 beds from the existing 1048 beds at the Trust.
  - The Trust confirmed that there is flexibility across all three sites to provide an additional increase in capacity should this be needed to meet any future demands.
  - The Mayor of London also applied this test for hospital capacity and asked for further detail which has been addressed.

- **Deprivation and health inequalities**
  - This is an important theme considered both in the run–up to consultation, through the deprivation assessment study and the first two phases of the Integrated Impact Assessment (IIA), as well as during and post-consultation through the completion of the final IIA report.
  - Additional deprivation analysis was undertaken as part of the IIA to assess the impact on health inequalities.
  - The final IIA report highlights the importance of district and out of hospital services as key elements that can reduce the impact on deprived communities.
  - All the evidence shows that services working together – primary and community, health and social care, statutory and voluntary sector – improves life chances for individuals and reduces health inequalities.

- **Multi-site working**
  - The consultation highlighted concerns in relation to:
    - *Potential different levels of care provision with local district hospitals providing only basic services compared to care delivered at the SECH*

        - The CAG has looked at how the sites and all services could work effectively together as well as the data around the level of patient transfers between sites. There will need to be appropriate differentiation between patients to ensure they get to the right sites as effectively as possible and that patients are stepped-down in between the SECH and the district sites.
    - *Hospital design needs to take into account environmental considerations*
        - There are number of recommendations detailed in the impact assessment in relation to environmental considerations that the Trust will need to address as part of its implementation plans.
    - *Ensure state of the art facilities and technologies*
        - Having an Electronic Patient Record is key in enabling the sites to work together effectively, make the exchange of patient information accessible to clinicians and allow clinicians to talk to each other. This will be delivered in advance of opening the SECH.
    - *Funding may not be available for the delivery of the IHT proposals*
        - The Government has confirmed that the IHT programme remains one of the Health Infrastructure Plan wave 1 priorities with an allocation of £500 million.

- **Other**
    - AD advised that other consultation feedback themes included:
        - *The consolidation of renal service currently delivered by St George's and Epsom and St Helier hospitals*
            - This proposal was discussed with CAG who saw its potential merit and agreed that this should be considered separately from the IHT process following decision-making.
        - *The impact of Covid-19 on the proposed clinical model*
            - The programme, with input from the Trust, has undertaken an interim assessment of the impact of Covid-19 on the clinical model. This clearly emphasized the importance of the IHT proposed changes.
        - *Merton and Sutton Council proposed that potential additional services (i.e. child development services, primary scare services etc.) should be considered for the St Helier Hospital site if it is not the SECH to ensure it remains at the heart of the community*
            - The CCGs supported that further work should be undertaken in partnership with the local authorities, other relevant providers and the Trust on whether these services should be included in the new model on these sites.

AD explained that following the closure of the public consultation the interim IIA report has also been further updated as part of the evidence consideration process. The final impact assessment incorporates:

- A review of the consultation responses.
- A refreshed impacts analysis based on new data sources which include new indices of deprivation and new data for travel times for both private car and public transport.
- An additional analysis on deprivation; and
- Sustainability statements in relation to Covid-19.

AD thanked the IIA Steering Group and the Independent Chair, Professor Andrew George, for their input in and oversight of the IIA programme of work.

AD further explained that the IHT Programme Board and the CCGs' Governing Bodies have been through a comprehensive deliberation process of all the available evidence which has

been integral to the CCGs' governance and decision-making process. This process included:

- The analysis of all feedback and evidence from consultation into an independent consultation analysis report.
- The review and deliberation of consultation findings.
- The consideration of the final IIA including positive and potential adverse impacts of each of the options and suggested enhancements to mitigate these.
- The development of further analysis.
- The consideration of and compliance with all legal duties throughout the programme; and
- The incorporation of all evidence into the DMBC with clear recommendations linked to the consultation key themes and feedback received.

Impact of Covid-19 on the proposed plans

CC explained:

- Covid-19 has tested both the current clinical infrastructure at the Trust and the IHT proposals by highlighting significant challenges of tackling a pandemic in old facilities.
- The interim analysis of the impact of Covid-19 on the proposals highlighted even more the need for change and has strengthened the proposed clinical model in terms of the need to consolidate the major acute services in a modern fit for purpose SECH.
- The analysis also highlighted the need to review and alter as required the design of both the SECH and the district hospitals to reflect the learning from Covid-19.
- The emerging learning to date has emphasised for example the need of more single rooms, flexible places to allow opportunities to close off or open up areas as needed, more hand washing facilities close to patients' beds, and partnership working to allow care closer to patients' homes. The Public Health England report has also clearly highlighted the need to ensure that the needs of local protected characteristic groups, including BAME, deprived communities and vulnerable groups are met and reduce health inequalities.

c) Developing the Decision-Making Business Case

MT advised that the DMBC describes the work undertaken to determine the best solution to address the challenges that Epsom and St Helier hospitals are facing and provided a summary of each of the chapters in the business case.

Recommendations of the decision-making business case for implementation

SB advised that as part of implementation of any preferred option, considering all the feedback from consultation and the evidence developed, commissioners have determined 24 recommendations for the Trust to deliver as part of its implementation planning. These include the mitigation and enhancements actions outlined in the final IIA.

SB further provided a brief overview of the recommendations set out in full in chapter 11 of the DMBC and some of which have already been discussed throughout the meeting:

- **Preferred option** – The Trust should implement the preferred option as decided by commissioners.
- **Assurance and implementation** – The CCGs will ensure through reporting and the establishment of the Strategic Executive Group and a Strategic Overnight Group that recommendations are implemented appropriately.
- **Travel and access** – recommendations include for example:

- The development and publication of the travel and access plan including additional access roads, public transport routes, review of any subsidised travel and parking and access to services for protected characteristics and vulnerable groups (i.e. new transport links, the good neighbour car schemes, Dial-a-ride etc.)
- The development of plans/proposals for car parking at the SECH and district sites ensuring appropriate parking capacity and site accessibility
- The design work within the OBC and the implementation of the clinical model should ensure appropriate access to district services and out of hospital services in conjunction with CCGs and other stakeholder plans

- **Workforce:**
  - The Trust will develop a detailed workforce implementation plan, including recruitment and retention plans, continuing to work in partnership with Health Education England, Royal Colleges, local clinicians and stakeholders.
  - The Trust should ensure staff are involved in the design and implementation of the SECH and district services.
- **Multi-site working**
- **Clinical model:**
  - The clinical model should continue to be developed and should be based on the latest evidence available and any new information received. The Trust will report regularly on the implementation of the benefits realisation and evaluation plan.
  - The Trust should continue to work with providers to test and review patient flow assumption and support providers in their capital requirements.
- **Population and future bed requirements** – the Trust should reflect the bed requirements to 29/30 (1066 beds) and continue to review and refine beds requirements as needed.
- **Deprivation and health inequalities**:
  - South West London CCG will work with local partners to undertake a further focused deprivation review specific to East Merton and North Sutton residents to determine whether any additional services should be made available locally.
  - It is a key requirement that the Trust, working with other partners ensures the implementation of district services, enhanced local services and the targeted local strategies developed by CCGs to reduce health inequalities.
- **Digital** - Digital technology should be fully incorporated into the design of the hospitals and enable connectivity with wider healthcare providers.
- **Environmental** - The Trust should work towards implementation of a carbon net zero building and address sustainable green travel alternatives as part of the travel and access plan.
- **Funding** - The Trust should develop an Outline Business Case (OBC) keeping within the funding envelope as confirmed by Department of Health / NHS England and Improvement.
- **Covid-19**:
  - The Trust should incorporate a flexibility within the build to be able to respond to any future potential impacts including future viruses or pandemics.
  - The local health and care partners should monitor the latest guidance on implementing the response to Covid-19, including any further requirements for protected characteristics (e.g. BAME), deprived communities and vulnerable groups.
- **Renal** - The Trust should undertake a further appraisal of the options for renal services separate from the IHT process.
- **Primary and community services** - Commissioners should undertake further work in partnership with local authorities and the Trust to appraise the additional services (including community beds, primary care, CAMHS, mental health, and a children's hub) that could be located on district site(s) or other local settings.

	• **Social care** - Working in partnership with Local Authorities, any potential financial or non-financial impact on social care and community services should be taken into account in implementation planning. MT advised: • To secure funding for the preferred option, The Trust will need to develop an OBC and a full business case. • The Trust would need to implement all recommendations in order to gain support from commissioners for any future business cases related to IHT. • Commissioners would have oversight of the implementation of the recommendations set out within the DMBC and the implementation of the OBC through the Strategic Oversight Group.	
5.	**Written submissions received from stakeholders**	
	The Convenor advised: • Each CCG wrote to selected representatives such as local politicians, Local Authority representatives and Keep Our St Helier Hospital campaign group providing them with an opportunity to submit a written submission to give any additional information which has not been included in the representatives' original consultation response. The deadline for these submissions was Wednesday 1st July (12 noon) • The CCGs received 10 written statements from various stakeholders including: o Surrey Adults and Health Select Committee o Chris Grayling MP o Siobhain McDonagh MP o Cllr Elizabeth Daly, District Councillor for Bookham South (on behalf of Mole Valley District Council) o Cllr Paul Kennedy, District Councillor for Fetcham West o Merton Council o Merton Conservatives Group o Sheldon Vestey, Chair of New Mill Quarter Residents Association o Keep Our St Helier Hospital campaign group; and o A letter from a group of 4 MPs: Elliot Colburn MP, Crispin Blunt MP, Stephen Hammond MP, Paul Scully MP • All submissions were shared with Committee Members and published on the IHT website in advance of the meeting. The Convenor checked with Clinical Chairs if these submissions have been noted by the two committees. The Clinical Chairs confirmed that Committee members have received and considered the written statements.	
6.	**Pre-submitted questions received from the public**	
	The Convenor explained that members of the public were provided with the opportunity to submit CIC agenda items related questions in advance of the meeting. The deadline for these submissions was Wednesday 1st July (12 noon). The Convenor further advised that 20 members of the public have submitted questions which pick up on the key consultation themes. Questions received have been shared with Committees in Common members and published on the IHT website in advance of the meeting. In order to protect personal data we have not published the names, addresses or other personal information of those members of the public who have submitted questions.	

The Convenor explained that process for selecting the questions to be addressed at the CIC has been outlined on the IHT website. This process involved:

- All questions received were clustered by theme.
- The Convenor has reviewed all questions and has selected a question from each cluster that is most representative of the issues.
- As some members of the public submitted multiple questions, only one question from any individual or on behalf of any organisation should be selected to allow the consideration of as many questions as possible within the time allocated.

The Convener read each question selected by theme and invited different Committee members to respond as relevant.

Theme 1 – The clinical model:

1. Will there be enough beds between the new proposed hospital and St. Helier and Epsom Hospitals for patients leaving the new hospital and others recovering from every day operations and treatments?

JC explained that following feedback from consultation, the Mayor's Office and the Clinical Senates, the CCGs have extended the bed modelling until 2029/2030. The bed modelling takes into account that over the next few years there will be further advances in technology and treatment as well as the joint working with community services to provide quality care closer to people's homes. We expect to need 1,066 beds for the population in 25/26 for each of the short listed options. This includes an increase of 18 beds from 1,048 currently available at the Trust. These beds at both the SECH and the district hospitals include emergency beds, i.e. beds for those who are receiving unplanned care, and routine (or planned) beds, with around 500 beds at the SECH and 500 across the district hospital sites. Therefore those leaving the SECH and being treated at the district hospitals for rehabilitation will have the appropriate number of beds available alongside those who are receiving planned treatments.

2. In the event of another epidemic, what advantages for public health, patients and medical staff will result from locating what would be the only Intensive Care and Ventilator beds available in the Epsom area in the heart of a major Cancer Hospital which cares for immune suppressed patients, under the proposal you are considering?

RH explained that if the SECH is located at Sutton, the Trust and Royal Marsden Hospital (RMH) clinical areas are expected to be separate, in separate buildings with separate entrances. This would mean that RMH patients who are immune suppressed would be completely separated from patients attending the SECH.

JM advised that this will be implemented as part of the design of the building. JM explained that, for example, when exploring options for joint services to improve the patient care, any future infection control issues will be taken into account at the site design stage. One example is the SWLEOC model which take place in a standalone building. JM highlighted that under the proposals, the SECH would allow an increase of the number of ITU and HDU beds from 22 now to 30.

RH recognised the need to ensure that facilities and workforce are resilient to future surges in demand to deliver care and improved outcomes for patients. Bringing the 6 major acute services together on a single and new hospital site, which can effectively separate patients for infection control purposes, will deliver this for patients and improve resilience in staffing.

This will also allow opportunities for more ITU beds and more single rooms to care for patients who may need to be isolated.

Theme 2 - Other providers:

3. Has there been any modelling done to look at the external pressures of other surround A&E departments if St Helier and Epsom were to close, and replaced by one A&E unit at the Marsden hospital?

MT explained that the programme has carried out extensive work with other local providers in the area to assess what the impact would be of consolidating the services at Epsom, St Helier or Sutton. This modelling has started early on in the process and an important part of this work was constituted by the A&E modelling. All providers have stated that all options would be deliverable with the right level of investment (capital and revenue) and mitigations which have been factored in both the pre-consultation business case and the DMBC. MT highlighted that importantly as part of the proposed clinical model, each option would provide an UTC to support local access to urgent care. Providers will need to continue to be closely involved in the implementation of any preferred option to ensure it remains deliverable.

Theme 3 - Deprivation and health inequalities:

The Convenor noted that, notwithstanding his selection criteria, as this is such an important topic, he has chosen to include two questions from this theme to be taken together.

4. A) The recent Public Health England report revealed the disproportionate impact that coronavirus is having on BAME communities. In light of this, and given that 64 of the 66 areas across the catchment with the highest proportion of BAME residents are nearest to St Helier Hospital, why does the programme still propose moving acute services away from St Helier, why has just 5 pages of analysis been completed to assess the impact of coronavirus on this programme, and why does this analysis not once mention the impact on BAME communities?

   B) Please rethink and reconsider your decision to shut St. Helier Hospital when Black Lives Matter is critical and something we should all be supporting, you choose to move hospitals like this from a deprived to an affluent area. Does this make sense to you, do you think this is fair especially given the impact that COVID-19 has had on black and ethnic minorities?"

AM explained that he has been involved in the response to Covid-19 in South West London and has closely looked at how the pandemic has affected the populations in the area. The data, in line with Public Health England's report, showed that older people, people from deprived and BAME communities have had an increased rate in hospitals admissions and deaths during Covid-19. The data also shows a clear association between these outcomes and long-term conditions (e.g. diabetes). The work undertaken to date with a focus on health inequalities, prevention, early detection and management of long-terms conditions is critical to prepare people for pandemics like Covid-19 and to ensure best health outcomes. The district hospitals will provide support (through clinical specialists, teams and diagnostic tests) for general practice and community services to do this more effectively. Covid-19 has also showed that bringing core services together onto one site saves lives when people are critically ill. The SECH will allow building a facility at the highest level of infection control which will allow a better management of future pandemics like Covid-19.

VG highlighted that the impacts on deprived communities and protected characteristics groups, including BAME communities, is critical to this programme, which is why there have

been multiple deprivation studies, a focus in the Integrated Impact Assessment and within the consultation report. VG explained that as a clinician he has learnt three lessons from this pandemic:

1. Local residents have stepped up to support the response to the pandemic in various ways – this spirit and force need to be channelled towards delivering this much needed clinical model.
2. The people who survived Covid-19 need support both in the short and long term. This requires fit for purpose buildings.
3. The importance of prevention, early detection and management of existing conditions so that, in any future pandemic, people are in better shape. To achieve that services need to work together – primary and community, health and social care, statutory and voluntary sector. This improves life chances for individuals and reduces health inequalities. The district services model will enable this to take place.

AH explained that the Trust, various departments and staff have pulled together and managed this crisis generally well. However this was done in the best way it could have been done considering the existent facilities. For example, this meant placing patients in cohort areas rather than into side rooms which are better in terms of isolation. AH highlighted the need of having an emergency department joined with an acute floor to better manage infection control and patient pathways. This could be achieved at Sutton – as at St Helier and Epsom hospitals there are many other services and the facilities are poor.

Theme 4 - Travel and access:

5. A) It is good to hear that the original NHS bus service from Epsom Hospital to St. Helier Hospital will be extended to Leatherhead. Can it please also be extended to Fetcham and Bookham which is in the area of the Epsom & St. Helier NHS Hospital Trust?

   B) Can there be better travel arrangements to the new proposed hospital in Sutton if not by the NHS bus service?

SB advised that the CCGs are committed to extend the H1 hospital shuttle bus route between Surrey and Merton to provide an improved service for patients, visitors and staff. We will also look at the feasibility of including areas such as Fetcham and Bookham. We have recommended that the Trust should establish a Travel and Transport Working Group which should include representation from Local Authorities and local transport providers and that will look at travel arrangements going forward. This will ensure the development of a detailed travel and transport plan.

Theme 5 - Covid-19:

6. How would the region served currently by E&SH hospital cope in the event of a future Virus (of the kind currently existing: C19)? Channel Four News focussed closely on the E&SH ICU managed during the worst of the crisis in March\April, the coverage was overwhelmingly positive about the life saving service being provided. See Inside an ICU, Channel Four. In the plans ahead, the ICU would cease to exist and the hospitals be radically downsized and more like 'cottage' hospitals, so would this not put the local population at greater risk?

AM explained that the new SECH will provide better specialist care by bringing specialists together into a single team and having the right workforce to deliver the clinical standards. The SECH will allow better infection control through single beds rooms and new ICU beds. AM further advised that having the three sites provides more flexibility for protecting patients.

	DE explained that the NHS has had to go to extraordinary lengths to cope with the increase of sick patients. Additionally, in comparison with other organisations, the Trust has also had to handle to other factors: having a spread-out workforce and the quality of the buildings which created massive issues in managing the response to the pandemic. A new fit for purpose SECH that has the right facilities and staff will enable the Trust to respond to pandemics like Covid-19 much better in the future.	
7.	**Committee discussion**	
	The Convenor provided a recap of the information considered by the IHT Programme Board and CCGs' Governing Bodies in the run-up to the decision-making, and explained that Committee members have been thoroughly involved in the analysis and deliberation of consultation outcomes and the available additional evidence to date. The Convenor reminded Committee members that the purpose of the meeting is for the Committee to consider all the information available to date and, based on this, to determine the best solution that addresses the case for change and delivered the clinical model for Epsom and St Helier hospitals. The Convenor asked members if they have any other further questions that will help the Committee to make a decision. Questions from Committee members included: • SB highlighted that clinicians at St George's and the Epsom and St Helier Trust have written a letter around consolidating renal services. What does this mean for the IHT proposals and how will it impact the clinical model? SG advised that the clinicians were supportive of the case for change and the consolidation of major acute services onto a single site. Their proposal to consolidate renal services was considered by CAG which recognised the potential merit in the proposals but agreed that this should be considered separately from the IHT process following decision making. This is supportive of the model of care and does not affect any of the benefits bringing services on to one site. In fact there may be further benefits for another group of patients. It is recommended this is considered fully at OBC stage and taken through the appropriate process. • JB asked if there have been any changes made to the financial model and, if not, if the Committee is assured that the financial modelling is still correct. Does the model include the financial investments and commitments of the providers? Also, as the financial model will be refreshed as part of implementation planning, would this include change in cost in construction because of Covid-19? JM confirmed that no significant changes have been made to the financial model since the PCBC when the model was assured by regulators. The model will be refreshed as part of the development of the OBC and will take account of any issues and disruptions (such as those experienced during the Covid-19 pandemic) that may arise and the capital investments agreed with providers, while keeping within the financial envelope. JM explained that he has chaired the financial process during the development of the development of the PCBC and will remain involved in the next stage of the model.	

- PB asked if primary and community services are sufficiently integrated with the IHT proposals, particularly in relation to the district services, to provide better continuity of care for patients.

LW advised that the PCBC incorporated our plans for out of hospital care, including significant investment in primary and community care. There are a large number of schemes in place, and these are becoming more developed. The new evidence we have developed in the DMBC supports our plans for out of hospital care and reflects early delivery of these and how they support the bed base and integrated care. Plans to further develop integrated services, around the needs of individuals and close to home, will be progressed through the OBC to deliver holistic, proactive care to our older and our deprived communities from the district hospital sites. Using the district hospital sites as hubs, the OBC will outline how we will engage new stakeholders in the evolution of the model of care; extending services (8-8, seven days a week for community nursing and therapy services), offering 'one stop' outreach services in the community, in people's home and from the district hospital sites.

- KS, on behalf of local Healthwatch in Surrey, Sutton and Merton, recognised that, during the CCGs' led pre-consultation engagement and consultation, a lot of resource has been invested in building positive relationships and connections with the community, voluntary sectors groups and any individuals involved in this process. KS highlighted the importance of these relationships to continue to be maintained to allow genuine community involvement following the CCG's decision-making meeting. KS requested further clarification in relation to how engagement across the geography would be carried forward as plans are developed and which organisations will be responsible for continued patient and public involvement following the decision-making.

MT acknowledged the support of the local Healthwatch organisations in designing and delivering the various engagement process. The feedback from engagement and consultation has been embedded in the programme of work and clinical model. MT highlighted the importance of the Strategic Oversight Group to ensure the incorporation of effective public engagement in the implementation planning and the Trust develops its OBC.

DE explained that as part of implementation, the Trust is committed to establishing dedicated governance stakeholder groups, including Healthwatch and patient groups, to participate in the design of the SECH and the refurbishment of the Epsom and St Helier hospitals.

- JD asked if the Committee is assured that through the clinical model there will be good local access to hospital services, and, in particular given the consultation feedback, if there will be a continuity of care for maternity?

JC explained that CAG has confirmed that continuity of care for maternity would be an essential part of the clinical model and the Trust should deliver this. Throughout the development of the clinical model maintaining good local access to maternity services has been essential. For example, antenatal appointments will continue to take place with midwives in community clinics or the at the district hospitals. Women who are deemed to have low risk births, they will still have a choice of having their baby at home fully supported by healthcare professionals. Women, who don't have complications and who will typically be able to go home shortly after a hospital birth, will continue to be visited by midwives. Those who need an obstetrician or a consultant bed birth, will be cared for on the site of the SECH.

- CC asked for further clarification with regards to how the Trust will work with partners to ensure CCGs' recommendations are implemented.

	DE recognised that the programme has gone so far in the process due to working together across the local NHS and has committed that next stage in the programme will continue in the same manner. The Trust has established a draft programme structure that will work with all the appropriate partners across our geography. SB highlighted that commissioners and regulators will continue to provide strategic oversight of future plans to ensure that recommendations are implemented. The Convenor asked the Clinical Chairs of the two CCGs if they areassured that there is governance in place to ensure CCGs continue to have oversight and scrutiny of implementation. CC confirmed that the Strategic Oversight Group and the Strategic Executive Group will be the forum to report progress and monitor the delivery of the recommendations. AM explained that the Trust will need to secure commissioner support for its OBC and full business case. This support will be contingent upon meeting the recommendations. The Clinical Chairs confirmed that they are confident the governance in place will ensure that CCGs will continue to have oversight and scrutiny of implementation.	
8.	**Decisions**	
	The Convenor asked the Clinical Chairs to reflect and check with their Committee members whether on the basis of having heard all of the discussion: • The feedback from consultation and additional evidence have not materially impacted on the relative ranking of the options; and whether • The options continue to be ranked as: a. Sutton as the top ranked and, on this basis, the preferred option b. St Helier as the second ranked option; and c. Epsom as the lowest ranked option. The Convenor further asked Committee members to consider a number of resolutions: a. To agree and adopt the clinical model for the delivery of district hospital services and the specialist emergency care hospital (SECH). b. To agree that the preferred option for the location of the SECH is Sutton, with continued provision of district hospital services at Epsom Hospital and St Helier Hospital. c. To agree and adopt the recommendations for implementation (set out in the Decision Making Business Case and Appendix 1 of the Cover Sheet to the DMBC circulated to CiC members for this meeting); and d. To establish a Strategic Executive Group and Strategic Oversight Group to monitor the delivery of the recommendations throughout implementation. The Clinical Chairs asked each one of their Committee members to reflect on whether the evidence considered to date and discussed at the meeting has changed their views in relation to the ranking of options and if they are fully supportive of the resolutions proposed. Committee members approved the four resolutions as set out in the DMBC (and above) which will see a brand new, state of the art specialised emergency care hospital built in Sutton to treat the sickest patients with most services staying put in modernised buildings at Epsom and St Helier hospitals.	

	Clinical Chairs thanked Committee members and the programme team for their input and continued support throughout the programme.	
9.	**Any other business**	
	No AOB was raised at the meeting.	
	The Convenor closed the meeting.	