Improving Healthcare Together 2020-2030

NHS Surrey Downs, Sutton and Merton CCGs

NHS

# Improving Healthcare Together 2020–2030

## Committees in Common

## Decision-making meeting

3 July 2020

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# Improving Healthcare Together 2020–2030

## Committees in Common

## **Presentation of the Decision-Making Business Case**

3 July 2020

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# Process undertaken to date

Andrew Demetriades, IHT
Programme Director

# The IHT Programme was established in January 2018 to address the long standing challenges facing Epsom and St Helier Hospitals

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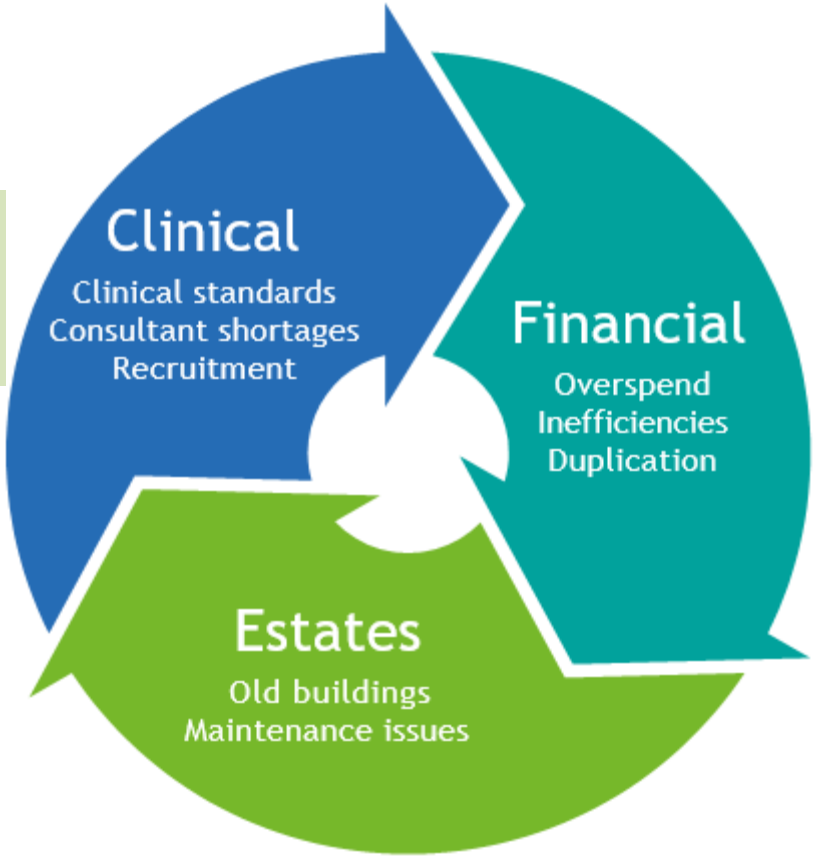
**1** **ESTH cannot meet key quality standards for consultant-led care**




**3** **ESTH is not financially sustainable**

**2** **Over half the ESTH estate is not suitable, with the third highest backlog maintenance in England**

# We have been through a process to develop our proposals and test them with the patients, staff and the public

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**1 Development of the pre-consultation business case**

With the PCBC, we:
- Determined our challenges
- Defined the clinical model
- Carried out pre-consultation engagement
- Used evidence to establish a preferred option

**2 Consultation**

The consultation:
- Asked our local population and wider stakeholders for views on the options

**3 Consultation analysis**

- An independent report was developed to understand the views from consultation

**4 Further evidence development**

- Consultation feedback and reports
- Phase 3 IIA
- Further evidence has been developed as part of the DMBC

**5 Today**

- We will consider all the evidence that has been developed and make a decision about the best solution that address our case for change and delivers our clinical model

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# The proposed clinical model and short list of options

Dr Andrew Murray, Clinical Chair
South West London CCG

# The clinical model: Building on our locally delivered district hospital services at Epsom Hospital and St Helier Hospital

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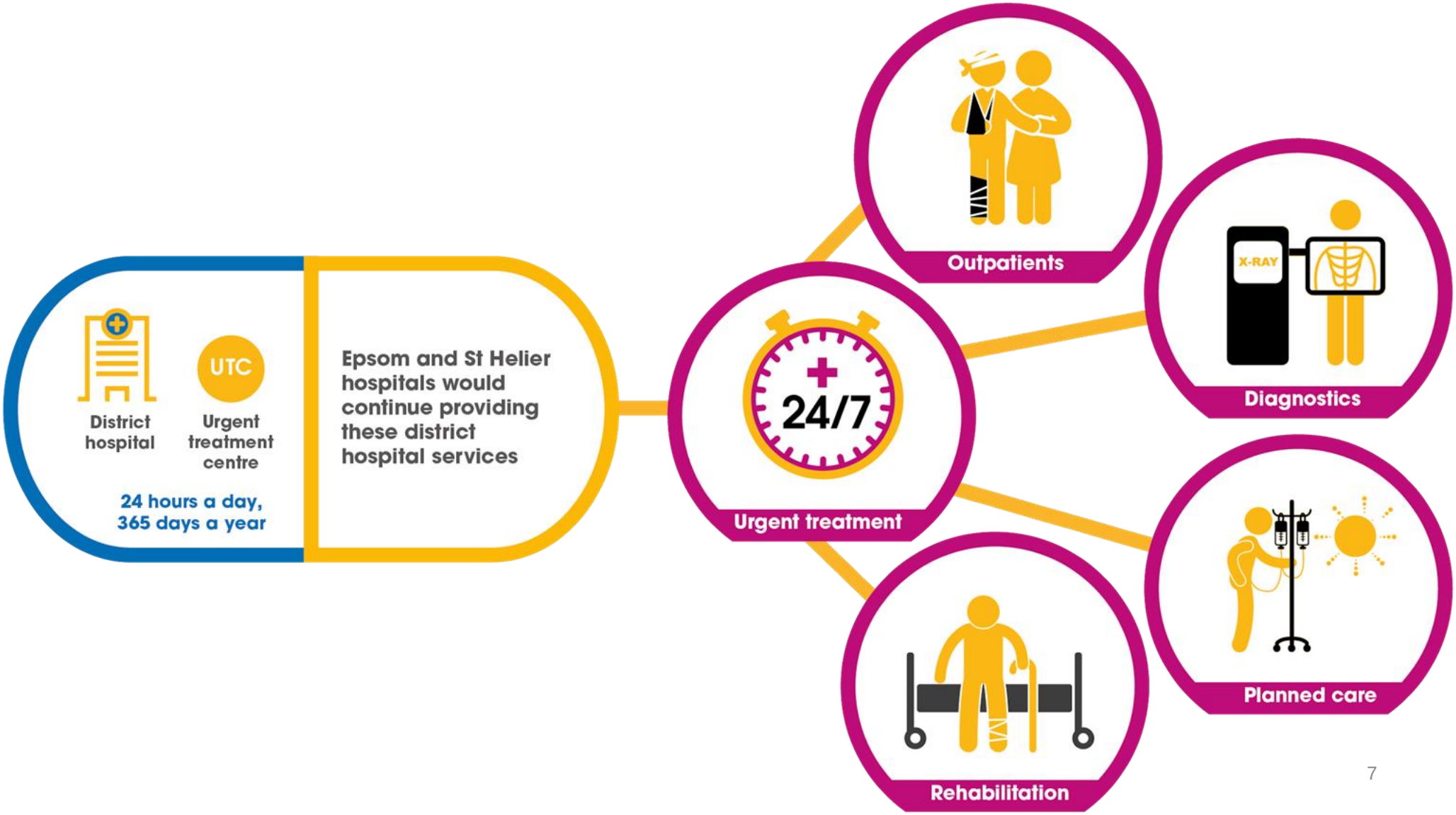

# The clinical model: Investing in a new Specialist Emergency Care Hospital for our population

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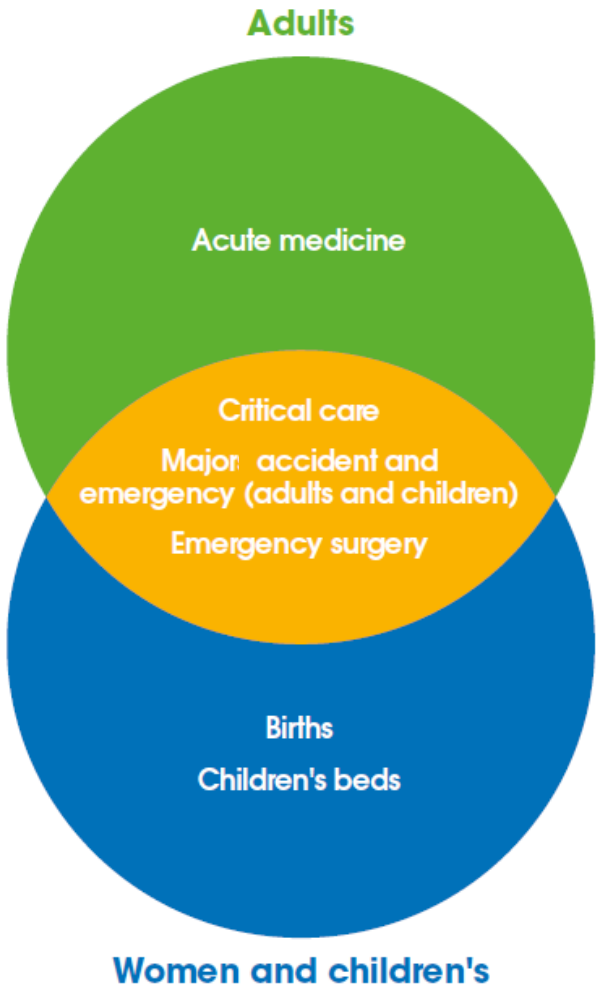
## Specialist emergency care hospital

We want to bring **together six core services** for the most unwell patients and those who need more specialist care onto **one site** at **Epsom, St Helier or Sutton Hospital**:

1. **Major emergency department** for the sickest patients with life threatening conditions, including a specialist children's A&E
2. **Acute medicine** for patients with the most urgent medical needs for example severe pneumonia
3. **Critical care** for the specialist care of patients whose conditions are life threatening and require constant monitoring – usually in an Intensive Care Unit
4. **Emergency surgery** for patients requiring emergency surgical assessment, treatment and operations for conditions like severe appendicitis
5. **Births** – bring together in one place both a midwife-led unit and a consultant-delivered unit for more complex births, and also supporting as many women who choose to, to give birth at home
6. **In-patient paediatrics or children's beds** - for children who need to stay overnight in hospital for treatment or observation



We have **three viable options** that we have been **evaluating** and reviewing the evidence on their **potential impacts** for local people

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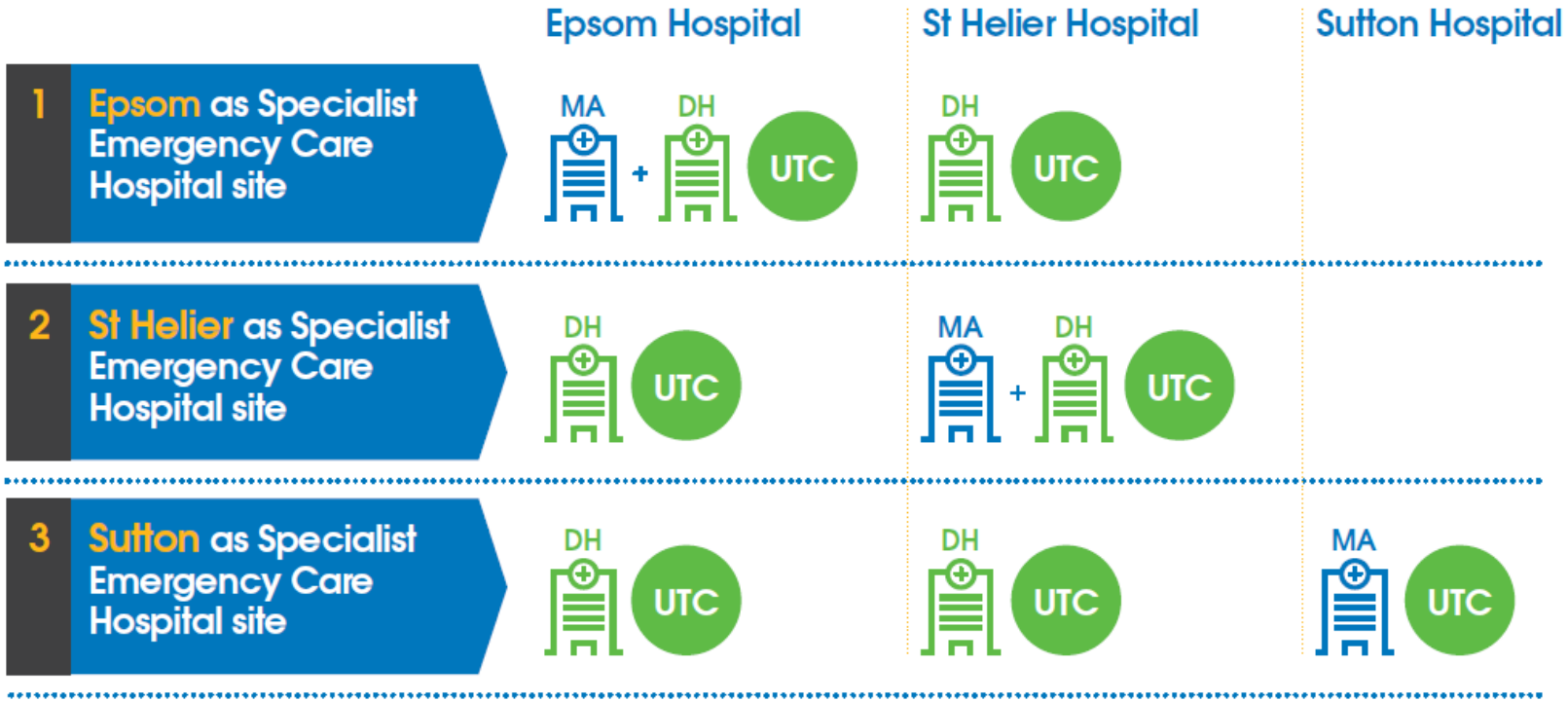

# The Sutton option was selected as the preferred option for the location of the SECH, as it provides the most benefits for our population

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Prior to consultation, and as set out in our pre-consultation business case**, the Committees in Common identified Sutton as the site we prefer for the specialist emergency care hospital to be built.**

- We believe this option would provide the most benefits for people living in our combined area, patients and staff. This option would:
  - allow us to **provide high-quality services for everyone** living in our area
  - make sure most people can use core services, as the new **specialist emergency care hospital would be built at a central location**
  - allow us to offer a **third urgent treatment centre** alongside the emergency department, and
  - have **less of an overall effect on travel for older people and deprived communities** than the other options.
- Therefore, the options were ranked as:
  - Sutton as the **top ranked**, and on this basis, the preferred option.
  - St Helier as the second ranked options and,
  - Epsom as the lowest ranked option

We have consulted on the three options for locating a new specialist emergency care hospital considering their relative benefits.

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# The Public Consultation

Charlie Wilson and Kester Holmes

Opinion Research Services

# The consultation was launched following the publication of the PCBC in January 2020 for 12 weeks

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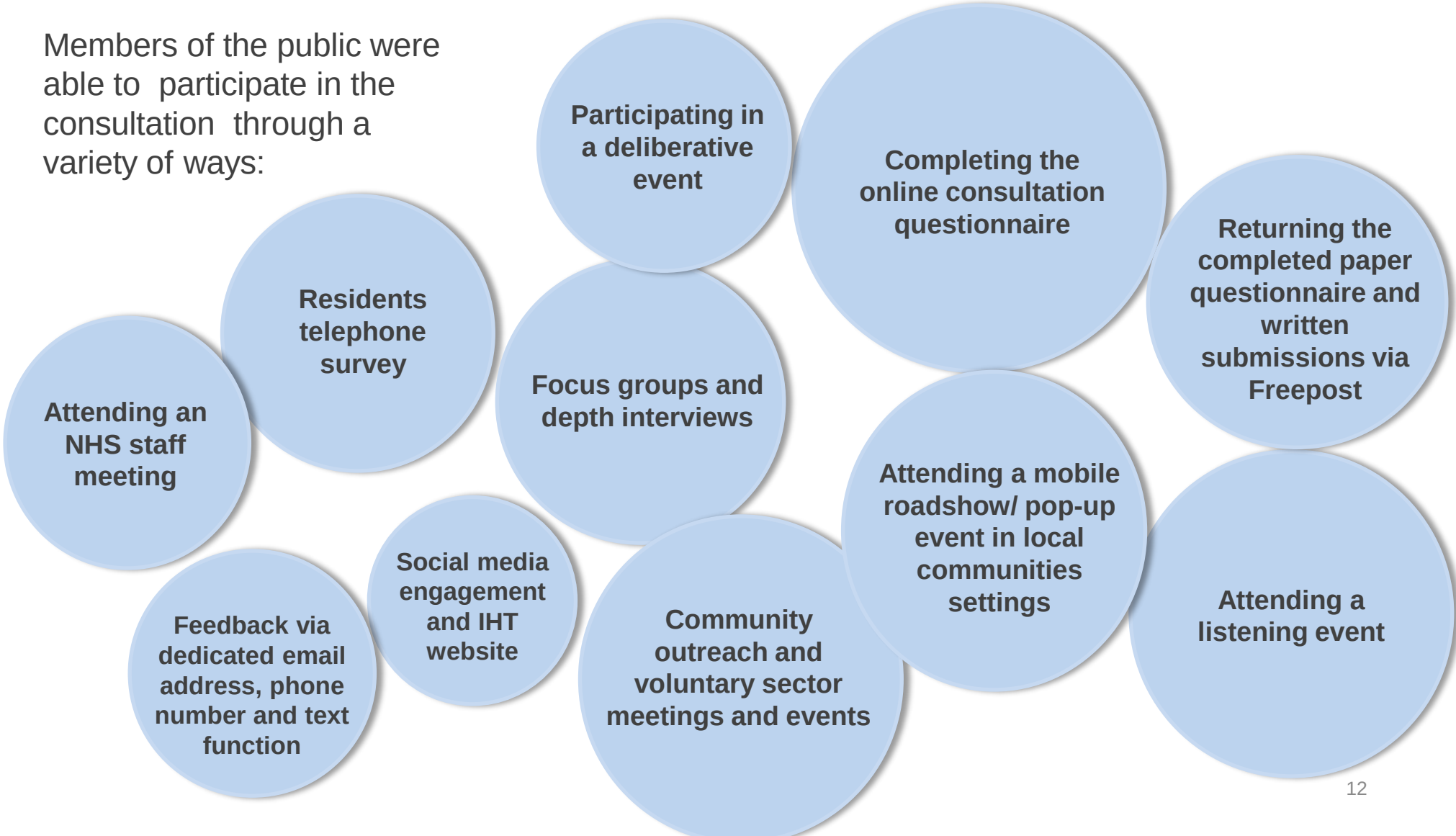
Members of the public were able to participate in the consultation through a variety of ways:



# A wide range of promotional activities were undertaken to promote the consultation and disseminate information

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- **Made materials accessible to all** - we have translated the consultation questionnaire and consultation summary into three other languages (Tamil, Urdu and Polish); we have also produced Easy Read versions of the consultation summary and questionnaire.

- **Distributed 579,023 leaflets** to households in Surrey Downs, Sutton and Merton, and a number of impacted neighbouring areas.
- At least **4,434 standard questionnaires, 930 easy read questionnaires, 5,292 summary consultation documents, 107,183 consultation leaflets and 5,000 'Talk to us' postcards were distributed** to a variety of local community locations (i.e. GP practices, libraries, councils etc.) stakeholders and partners.

- **Promoted the consultation in community settings** via 17 mobile roadshows (in areas of high footfall) and 13 clinical pop-up events (in GP practices and health centres).
- Organised extensive **communications and promotional activity of the consultation questionnaire to all staff** working at the ESTH via staff meetings, CEO weekly messaging from the, social media and website.

- **Advertised the consultation on Facebook and Twitter**
- Issued **11 media releases** to raise awareness and disseminate information in print media
- IHT **consultation stories were covered 25 times in local and pan-London newspapers**, eight times on radio, nine times on online-only news websites and four times in trade media
- Promoted the consultation through the **IHT website**

# All of these activities resulted in an extensive range of responses feeding into the consultation analysis

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## Consultation questionnaire

**4,172 responses**

including:

**724 NHS staff**

**26 from organisations**

**54 easy read versions**

## Residents Survey (Ipsos MORI)

**751 interviews**

655 across the three CCGs

96 in nearby areas

## Focus Groups residents' workshops, depth interview (YouGov)

**11 focus groups** targeted to specific demographics with **88 participants**

**3 forums** with **108 participants**

**6 depth interviews** with 'seldom heard' groups

## IHT Listening Events and CCG outreach meetings

**8 public listening events** with **1,000+** attendees

More than **100 events** and meetings, engaging with c. **5,000 participants**

## Meetings organised by local CVS organisations

**48** engagement activities

organised by **33 groups**

involving **426 participants**

## Feedback received

**434 'written' submissions**

**1,160** social media posts resulting in **1,730+ engagements**

## Petitions and third party surveys

**2 petitions** with a total of **9,486 signatures**

**2 substantial third-party surveys** involving **3,339 respondents**

**7 comments** received via **Healthwatch Sutton's** website

# The key findings include support for the case for change and the clinical model

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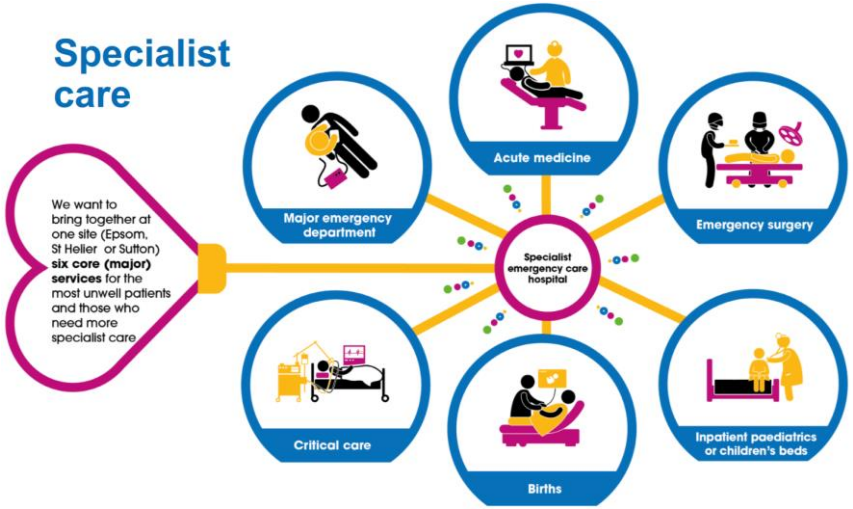
## The case for change

Many consultees recognised the challenges facing the NHS nationally, and Epsom St Helier University Hospitals Trust (ESTH) hospitals in particular, and welcomed the proposed investment into local hospitals.


## The model of care

There is widespread support for the clinical model from respondents, and particularly from clinical stakeholders and NHS staff, on the basis that it addresses the case for change.

However, levels of support varied by geography, with more individuals living in Merton CCG stating that the model of care is a poor or very poor solution.

# Views on the preferred site to deliver a new SECH

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- With regard to potential sites for a new SECH, looking across different consultation strands and the whole geography of the Trust area, Sutton as a site received broader support than either Epsom or St Helier, but there was variation among members of the public and some stakeholders based on geography.
- The majority of NHS staff felt Sutton would be a good location for a SECH (78% saying good or very good in the consultation questionnaire); professional and clinical groups also supported the Sutton site.
- Among the nearly 3,000 individual non-NHS staff members who responded to the three questions in the questionnaire, Sutton was the only site that received a positive balance of opinion overall (48% good vs 40% poor). And in the residents' telephone survey, all three potential sites were viewed as good or very good solutions by a majority of those participants living in the Trust catchment area who expressed a view (51% - 59%).
- There was also local support for other hospitals; political organisations and elected representatives typically voiced support for their members' and constituents' closest ***existing*** hospital (Epsom or St Helier), as did residents' survey participants.
- Petition signatories and some written submissions from members of the public opposed centralisation of care and lobbied for all services to remain at existing hospitals.
- There was vocal opposition to a new SECH at large IHT public meetings, and demands for all services to remain 'local', although there was also some support for the model of care and the preferred location.
- In smaller public meetings, and targeted workshops and focus groups, participants typically viewed locating a new SECH at Sutton as a good option, although there was also some support for existing hospital sites.

# Key stakeholders providing submissions (written, email and via questionnaire)

| NHS TRUSTS, CCGs AND PROFESSIONAL GROUPS (8) | |
|---|---|
| Consultant physicians, Epsom and St Helier University Hospitals NHS Trust (letter signed by 273 clinicians) | Royal Marsden NHS Trust |
| Croydon University Hospitals NHS Foundation Trust | South West London and St George's Mental Health NHS Trust |
| Epsom and St Helier University Hospitals NHS Trust Leadership Team | South West London Renal Community (signed by 7 senior clinicians of St George's University Hospital NHS Trust and St Helier and Epsom University Hospitals NHS Trust) |
| Outer SW London Royal College of Nursing Branch, supported by the Local British Orthoptic Society | St George's University Hospitals NHS Foundation Trust |
| **LOCAL AUTHORITIES (7)** | |
| Merton Council | Reigate and Banstead Borough Council |
| Sutton Council | Epsom and Ewell Borough Council |
| Surrey County Council | Royal Borough of Kingston Upon Thames |
| | Wandsworth Council |
| **MPs, COUNCILLORS AND POLITICAL GROUPS (47)** | |
| 15 MPs (incl Dr Rosena Allin-Khan, Elliot Colburn, Paul Scully, Crispin Blunt, Stephen Hammond, Chris Grayling, Siobhain McDonagh, Crispin Blunt, Steve Reed, Bell Ribeiro-Addy) | Merton Conservatives |
| 28 Councillors | Merton Liberal Democrat Group |
| | Wandsworth Council: Labour Councillors Group |
| | Sutton and Cheam Labour Party |
| **TRADES UNIONS/COUNCILS (4)** | |
| GMB | UNISON Epsom and St Helier University NHS Trust branch (2) |
| Merton & Sutton Trades Council | |
| **CHARITIES AND SPECIAL INTEREST/COMMUNITY GROUPS (9)** | |
| Ewell Village Residents' Association | Love Me Love my Mind |
| Healthwatch Croydon | Merton Mental Health Forum |
| Keep our St Helier Hospital (KOSHH) and Keep our Epsom Hospital (KOEH) | Sutton Seniors Forum |
| | Tadworth & Walton Residents' Association |
| Leatherhead Hospital Group | One organisation that did not provide it's name |
| **INDIVIDUAL RESIDENTS (359)** | |

# Local Authority Submissions

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| Merton Council | Sutton Council | Surrey County Council |
|---|---|---|
| Commissioned independent advice on the IHT proposals.<br>States that objectives being pursued are *"unrealistic and restrictive"*<br>Opposes proposed model of care and rejects business case:<br>- Interests of clinicians put above those of patients<br>- All options = deterioration compared to status quo<br>- Longer/more complex journeys for patients, especially by public transport<br>- Particularly difficult for disadvantaged groups<br>Council's own questionnaire → strong support for acute services at **St Helier**<br>Claims 'flawed' IHT consultation process | Endorses the proposed model of care and prefers a new SECH to be located at **St Helier** because:<br>- Health services should be "*in the heart of our community*" and St Helier Hospital serves populations in areas of multiple deprivation<br>- Is most accessible site for most Sutton residents<br>- Has good existing transport links<br>- New hospital would bring investment & jobs to deprived areas<br>Locating hospital at Sutton would widen inequalities and present extra transport barriers/costs for those least able to afford it<br>Sutton site = inaccessible by public transport (particular difficulties for elderly, disabled and pregnant women) | Support the overall ambition of the IHT Programme, and welcomes investment<br>Stress the importance (and complexity) of health and social care working closely together, and the need for a fit-for-purpose 'discharge to assess model'<br>Encourage active engagement to mitigate impact of maternity proposals<br>Highlight travel times, transport costs, parking & other access issues – esp. older people, those with major life challenge, mobility issues or with low income<br>If Sutton selected as site of SECH, public transport issues MUST be fully considered.<br>Ready to work with CCGs and TfL to collectively improve public transport and make this an exemplar green initiative |

# Local Authority Submissions

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## Epsom and Ewell Borough Council

Supports model of care and believes that **Epsom** should be the site of the new SECH because:

- Travel times too long from the south
- Sutton and Merton residents have other hospitals in close proximity
- Building on Sutton site is most expensive
- Concerns re: accessibility of Sutton for those living in deprived parts of Epsom and Ewell
- Area to see population growth and ageing population = more need for acute care

Highlights a disproportionate number of health conditions within its communities

Suggests that an SECH in Epsom may offer opportunity to create a centre of excellence

Seeks improvements to transport and infrastructure, including subsidised travel

## Royal Borough of Kingston Upon Thames

Seeks assurance that the IHT programme will:

- Commit to limiting impacts, particularly on those with long-term acute health conditions, in more deprived areas and in Surrey Downs (esp. over 65s)
- Commit to ongoing stakeholder engagement, with special emphasis on travel time concerns, inc. accessible transport between the 3 hospital sites
- With the exception of births, ensure midwifery, postnatal and antenatal care remain long-term at Epsom and St Helier hospitals;
- Ensure South West London Elective Orthopaedic Centre remains long-term at Epsom; preserve its Centre of Excellence status

## Reigate and Banstead Borough Council

Supports a SECH at either **Epsom** or **Sutton**, subject to retention of local services in Epsom, inc. 24-hour urgent care facility.

Sufficient funding must be available for both a new SECH *and* upgrades at existing sites

Urges close cooperation between partners re: public transport, sustainable travel and minimisation of local congestion

## Wandsworth Council

Supports plans to build new hospital in **Sutton**, to strengthen existing specialist cancer care and enhance local services

The council calls upon politicians of all parties in SW London to support the CCGs' preferred option

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# Themes from consultation and responses

Andrew Demetriades, IHT
Programme Director

# There are some cross-cutting themes arising from the consultation which we have considered in detail throughout the DMBC development process

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*For each cross-cutting theme we have looked at the consultation feedback and developed further evidence, and considered whether this impacts on the ranking of options*

# 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 Specialist Emergency Care Hospital (SECH)*

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| You said | There needs to be good access to services, including the SECH | There needs to be sufficient parking at the hospitals for patients, visitors and staff | There needs to be good access to services for protected characteristics, deprived communities and vulnerable groups | There needs to be good local access to district services |
|---|---|---|---|---|
| **We did** | Refreshed the travel data analysis<br><br>Committed to extend the H1 hospital shuttle bus route between Surrey and Merton to provide an improved service for patients, visitors and staff<br><br>Set the requirements for a detailed travel and access plan | A review of the parking capacity for each of the options and confirmed sufficient space is available to accommodate predicted numbers of staff, patients and the public | Refreshed the travel analysis and reviewed the impacts on the options as part of IIA phase 3<br><br>Carried out an additional deprivation analysis as part of the IIA phase 3 | Clinical Advisory Group further reviewed district services and their link with out of hospital services.<br>Confirmed the benefits of current models, e.g. Surrey Downs Health and Care, Sutton Health and Care and Merton Health and Care Together |

# Clinical model

*There is widespread support for the clinical model from respondents, and particularly from clinical stakeholders and NHS staff, on the basis that it addresses the case for change. However, levels of support varied by geography, with more individuals living in Merton CCG stating that the model of care is a poor or very poor solution.*

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| You said | There needs to be clarity on access for the SECH and district sites | Other local providers need to be supported if there are any impacts on the running of their service | Continuity of carer model is key to the maternity and paediatrics model | Implementing the district hospital model |
|---|---|---|---|---|
| We did | Clarified with the Clinical Advisory Group that there will need to be a comprehensive communications and engagement plan to ensure patient education and signposting regarding access to district and specialist emergency care services. | Reviewed the provider responses during consultation which confirmed previous analysis that all options are deliverable<br><br>We will continue to work with providers to deliver the changes in line with the planned investment in the financial modelling | The Clinical Advisory Group has confirmed that continuity of carer would be essential part of the clinical model and the Trust should deliver this. | Further reviewed the district hospital model and its interdependency with the SECH model<br><br>Ensured the district hospital services would be implemented prior to SECH being completed |

# Workforce

*The most common concerns shared by respondents related to alternative solutions to workforce challenges, availability of required skills and training*

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| | | |
|---|---|---|
| **You said** | **There is public support for the case for change, however some stakeholders felt that workforce challenges should not be a driver of change.** | **The workforce model needs to be sustainable and deliver sufficient training** |
| **We did** | Reviewed our workforce challenge with the Clinical Advisory Group and the Trust with no other solutions available to address this challenge as set out in our case for change.<br><br>No other viable solutions are available to address the challenges as set out in the case for change. | Reviewed the workforce and training requirements at Clinical Advisory Group and confirmed that these are deliverable.<br><br>In addition to the work already undertaken, the Trust will develop a detailed workforce implementation plan, including recruitment and retention plans, continuing to work in partnership with HEE, Royal Colleges, local clinicians and stakeholders. |

## Population and bed modelling

*Across all consultation strands, one of the main concerns raised was that the proposals do not provide sufficient hospital bed numbers across Epsom Hospital, St Helier Hospital and a new Specialist Emergency Care Hospital, particularly in light of the anticipated growing and ageing population.*

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**You said**

**Bed modelling should forecast to 2029/30 and account for housing growth**

**We did**

- We extended the bed modelling to 2029/30 and considered the impact of housing developments on population and activity growth.
- This increased the number of beds needed by 14 from the previous modelling, meaning there is now a total of 1,066 beds required for the population, a total increase of 18 beds from the current 1,048.
- The Mayor of London has also applied this test for hospital capacity, and asked for further detail on assumptions which we have provided, including length of stay and quality, innovation, productivity and prevention (QIPP) initiatives.
- We have also looked at how we could increase capacity should this be required on all sites.

## Deprivation and health inequalities

*Concern was expressed around health inequality and the potential for adverse impacts arising from the proposed changes on people living in socio-economically deprived areas, compared to those living in more affluent areas, largely due to the greater challenges around travel and access*

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**You said**

**There needs to be sufficient account taken on the impact of the option on deprivation and health inequalities**

**We did**

- Carried out additional deprivation analysis as part of the IIA and assessed the impact on health inequalities.
- Updated the phase 3 IIA which highlights the importance of district and out of hospital initiatives and their impacts earlier in the pathway on care provision to improve health outcomes for patients.
- Plans to further develop integrated services, around the needs of individuals and close to home, will be progressed through the Trust's implementation plans to deliver holistic, proactive care to our older and our deprived communities from the District Hospital sites.
- 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.

## Multisite working & other themes

*There were concerns that multi-site working could result in two levels of care provision with local district hospitals providing only basic services compared to care delivered at the SECH and a divergence in care quality could develop over time. Some commented that there could be increased transfers between two or three sites, requiring excellent communication and clear protocols to be established between the sites.*

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| You said | Care delivered across different sites need to meet patient needs, with a consideration of transfers | Ensure state of the art facilities and technology throughout all three hospitals | Hospital design needs to take into account environmental considerations | We are concerned funding may not be available for the delivery of the IHT proposals |
|---|---|---|---|---|
| **We did** | Reviewed the clinical model and the needs of the different patient cohorts for district services and SECH services. | Ensured Electronic Patient Record is incorporated as part of implementation with the necessary investment and that it will be delivered in advance of the SECH opening | Ensured that environmental considerations are will be addressed as part of the Trust's implementation plans | Confirmed that ESTH remains one of the HIP1 schemes with an allocation of £500m |

# Other

*Other themes and responses that we have received include considerations around COVID-19, delivery of renal services and additional district services that could be delivered from other sites.*

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| | | | |
|---|---|---|---|
| **You said** | **There needs to be a consideration of how changes related to Covid-19 may impact on the clinical model** | **Consolidation of renal services currently delivered by St George's and ESTH could result in improved outcomes for patients.** | **Specific services should be considered for St Helier Hospital if it is not the SECH to ensure it remains at the heart of the community.** |
| **We did** | A interim review of the impacts and concluded that:<br>• The need for change is even more important to do now.<br>• Further analysis will be undertaken as more information is available.<br>• We are requiring the Trust to demonstrate how the design of the hospital meets the learning from Covid-19 | Considered the feedback with the Clinical Advisory Group which recognised the potential merit in the proposals and agreed that this should be considered separately from the IHT process following decision making. | Considered Merton and Sutton's proposals for potential additional services on the St Helier site (e.g. primary care). 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. |

# The Integrated Impact Assessment is now complete; it incorporates a review of the consultation responses and an updated impacts analysis

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- The final Integrated Impact Assessment report was agreed by the IIA Steering Group and the Independent Chair for this Steering Group following a meeting on the 1st June 2020.
- The final IIA report builds on the interim report and incorporates evidence gathered through:
  - **A refreshed analysis with new data sources**:
    - Indices of deprivation.
    - New data is also now available on travel times for both public and private transport.
  - **An additional analysis on deprivation**
  - **A review of the consultation responses**
  - **Covid-19:** Relevant sections of the report have been updated with available evidence at the time of publication
- This additional work enabled the final IIA to incorporate any additional impacts or mitigating actions which had not already been identified as part of the interim report.

## In summary, we have scrutinised all evidence through comprehensive deliberation, and this has been integral to the CCGs' governance and decision-making process

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The process has brought together all the available evidence and feedback involved in several stages:

- We have **collated the feedback and evidence from consultation** into an independent consultation analysis report;
- **Reviewed and deliberated on the consultation findings**;
- The final updated **integrated impact assessment** has been concluded and considers the positive and potential adverse **impacts of each of the options and the suggested enhancements** to mitigate these;
- Developed **further analysis and an evidence review and incorporated the findings into the Decision-Making Business Case** with clear recommendations linked to the key themes and responses received.
- We have complied with all **relevant legal duties** as part of our processes

# We have scrutinised the evidence through our governance and decision-making framework; we have fully considered our legal duties as CCGs

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| Relevant legal duty | Evidence of CCGs' compliance |
|---|---|
| **Duty of public involvement** (s.14Z2 of the NHS Act 2012) | PCBC chapters 3, 4 and 12<br>Analysis of feedback from engagement report, by The Campaign Company<br>Consultation plan<br>Consultation questionnaire and document<br>Consultation analysis report, by Opinion Research Services (ORS)<br>Final Integrated Impact Assessment (IIA) report, by Mott MacDonald<br>DMBC chapter 7 |
| **Duty to secure improvement of services** (s.14R of the NHS Act) | Final IIA report, by Mott MacDonald<br>The Clinical Senate report<br>DMBC Chapter 3 and Chapter 9 |
| **Duty to promote integration** (s.14Z1 of the NHS Act) | PCBC chapters 5, 6 and 11<br>DMBC chapter 3 |
| **Duty as to patient choice** (s. 14V of the NHS Act) | Final IIA report, by Mott MacDonald<br>NHSE assurance, as per PCBC chapter 17 |
| **Duty to promote NHS Constitution** (s. 14P of the NHS Act) | DMBC and associated evidence |
| **Duty to exercise functions effectively, efficiently and economically** (s. 14O of the NHS Act) | DMBC chapters 2 and 3<br>PCBC chapter 13 (financial appraisal) |
| **Duty to have regard to commissioning guidance published by NHS England** (S. 14Z8 of the NHS Act) | PCBC chapter 4<br>Consultation plan<br>Consultation questionnaire and document |
| **Public sector equality duty** (s.149 Equality Act 2010) | PCBC chapter 12<br>Final IIA report, by Mott MacDonald<br>Consultation analysis report, by ORS<br>DMBC chapter 10 |

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# Decision-making business case – COVID-19

Dr Charlotte Canniff, Clinical Chair, NHS Surrey Heartlands CCG

# We have developed an interim assessment of the impact of COVID-19 on our proposals and our population

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There were significant challenges at ESTH in order to manage COVID-19:

- **Limited critical care capacity** at St Helier Hospital requiring Level 3 critical care to move to Epsom Hospital.
- **Insufficient single rooms** meaning potentially infected patients could not be isolated. Less than 20% of the beds at Epsom and St Helier are in single rooms.
- **Difficulties separating patients in emergency spaces, limiting infection control.**
- **Planned care cannot be effectively separated** from emergency care.
- To manage **staffing pressures already in existence, and additional sickness and absence pressures,** ESTH had to retrain and redeploy hundreds of staff (including doctors in ITU and acute medicine, as well as nurses) and rely significantly on the goodwill of its people to manage the demand.

Our analysis of the impact of Covid-19 on the proposals in the programme has two conclusions:

- The need to consolidate acute services in a modern fit for purpose SECH is **even more important to do now**.
- We may need to **alter the design** of both the SECH and the district hospitals to reflect the learning from Covid-19, **including improved infection control management and patient experience**.

We are also clear from **the Public Health England report that we need to ensure that the needs of our protected characteristic groups, including BAME**, deprived communities and vulnerable groups are met and reduce health inequalities.

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# Decision-making business case overview

Matthew Tait, Accountable Officer, NHS Surrey Heartlands CCG

# The decision-making business case describes the work we have undertaken to determine the best solution to address our challenges (1/2)

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| Chapter | Summary |
|---|---|
| 1: Introduction | Describes the background to the IHT programme, and our vision for future healthcare. |
| 2: Case for change | Describes the barriers to delivering our vision for future healthcare |
| 3: Clinical model | Describes how we will deliver district hospital services and major acute services to provide excellent care in the future, integrated with and supported by out of hospital services. |
| 4: Options to deliver the clinical model | Determines the potential solutions to address our case for change and deliver the clinical model, having followed a standard approach for options consideration. |
| 5: Previous assurance undertaken | Describes how our proposals have been assured by a range of organisations pre-consultation, including the Joint Clinical Senate and NHSE/I |
| 6: Decision-making for consultation | Sets out how we arrived at a decision to proceed to consultation with a preferred option |
| 7: Consultation and engagement process | Describes the detailed programme and activities to listen to the views of the local population |

# The decision-making business case describes the work we have undertaken to determine the best solution to address our challenges (2/2)

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| Chapter | Summary |
|---|---|
| 8: Feedback from consultation | Describes the key feedback from consultation and identifies consistent cross-cutting themes |
| 9: Addressing themes from consultation | • Sets out for each theme how we have listened to the consultation feedback as set out in Chapter 8;<br>• How we have developed and assessed any new evidence or alternative options and its materiality as a result of this feedback; and<br>• How we have listened to this feedback and incorporated this into our decision-making. |
| 10: Further assurance of proposals | Describes the further assurance that has taken place after consultation, including the final Integrated Impact Assessment, the Mayor's assurances and the JHOSC |
| 11: Decision-making | Identifies whether there have been any changes to the option ranking as a result of the consultation feedback and further evidence development, and describes a set of resolutions and recommendations for implementation. |
| 12: Implementation | Describes how the IHT proposals would be implemented in terms of governance and the role of commissioners in scrutinising this. |
| 13: Conclusion and next steps | Concludes on the overall process and describes the next steps for future business cases |

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# Recommendations of the decision-making business case for implementation

Sarah Blow, Accountable Officer,
NHS South West London CCG

# We have determined a set of recommendations for implementation, aligned to the enhancements in the final IIA (1/7)

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| Recommendation | Relevant IIA enhancement |
|---|---|
| The Trust should implement the preferred option as decided by commissioners. | |
| The Trust will report on the delivery of the recommendations and implementation of the OBC and FBC to commissioners. This includes reporting through the establishment of a Strategic Executive Group and Strategic Oversight Group. | |
| A full travel and access strategy should be carried out, including additional access roads and public transport routes, and review of any subsidised travel and parking | Effective communication of transport options and travel plan to staff, patients and visitors (IIA Action 5) |
| The Trust should establish a Travel and Transport Working Group and Travel and Transport Reference Group to ensure local communities inform these plans | Build site specific transport offerings (IIA Action 8) |
| The Trust and the CCGs will publish the travel action plan. | Explore the possibility of ensuring more personalised support to patients in promoting clarity around transport options (IIA Action 9) |
| The Trust will develop plans/proposals for car parking at the SECH and district sites, and ensure appropriate parking capacity and site accessibility is available for our local population, including staff, patients and visitors. | Ensure appropriate parking capacity on the site chosen to host acute services (IIA Action 6) |

# We have determined a set of recommendations for implementation, aligned to the enhancements in the final IIA (2/7)

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| Recommendation | Relevant IIA enhancement |
|---|---|
| Access to services for protected characteristics and vulnerable groups should be specifically addressed within the travel and access strategy to meet the needs of these groups including older people.<br><br>The Travel and Transport Working Group should:<br><br>• Explore and make recommendations to improve existing transport opportunities to/from the hospital sites.<br><br>• Explore new transport links in particular new bus routes connecting Surrey (i.e. Leatherhead, Banstead, Epsom) to the SECH.<br><br>• The Travel and Transport Reference Group should review and recommend potential alternative travel solutions for vulnerable groups for example (and not limited to): the good neighbour car scheme (operating in Surrey), Dial-a-ride, and services provided by the Merton and Sutton Community Transport. | Support development and capacity building of community transport options and make the community aware of the options available to them (IIA Action 7)<br><br>Work with local councils and transport providers (IIA Action 10)<br><br>Ensuring accessibility to hospital site (IIA Action 22) |
| 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 CCG and other stakeholder plans<br><br>There should be representation from system partners in the further design of pathways, including primary care, community care and patients. | Continuous review of service model (IIA Action 11)<br><br>Ensure district services are joined up with local strategies (IIA Action 21) |

# We have determined a set of recommendations for implementation, aligned to the enhancements in the final IIA (3/7)

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| Recommendation | Relevant IIA enhancement |
|---|---|
| In addition to the work already undertaken, the Trust will develop a detailed workforce implementation plan, including recruitment and retention plans, continuing to work in partnership with HEE, Royal Colleges, local clinicians and stakeholders. | Ensure workforce requirements are met (IIA Action 1)<br>Develop a clear workforce plan (IIA Action 15)<br>Understand clinical training and supervision needs at district sites (IIA Action 17)<br>Detailed workforce analysis on staff groups affected by change, understanding their demographics and the impact on travel (IIA Action 18) |
| The Trust carries out further staff (including clinical) engagement to develop the design and implementation of the SECH and district hospital clinical models. | Ensure staff are involved in the design of consolidated services (IIA Action 19) |
| Transfer protocols are developed for implementation, working with ambulance providers and the voluntary sector. | Introduce appropriate transfer protocols and action to reduce transfers (IIA Action 3) |
| The clinical model should continue to be developed based on the latest evidence. The Trust should report regularly on implementation of the benefits realisation and evaluation plan. | Continuous review of service model (IIA Action 11)<br>Develop an evaluation plan (IIA Action 4) |

# We have determined a set of recommendations for implementation, aligned to the enhancements in the final IIA (4/7)

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| Recommendation | Relevant IIA enhancement |
|---|---|
| A communications and engagement plan will be developed to ensure clarity for the public on when to attend a SECH or District Hospital. | Provide clear communication about patient pathways and undertake an awareness raising campaign (IIA Action 2)<br><br>Support patient clarity on accessing district services (IIA Action 16) |
| The Trust should implement the continuity of care model for maternity through a team approach, to ensure each woman has a named midwife and continuity of carer from the first prenatal appointment to the last antenatal appointment. | N/A |
| The Trust should establish joint arrangements with local providers as part of the OBC to ensure patient flow assumptions are tested and reviewed as implementation plans are developed, including supporting them in their capital requirements. | Continued work with neighbouring providers (IIA Action 24) |
| The Trust should ensure district services are fully implemented and in place to support patient flow and the operation of the SECH. | Ensure district service enhancements and sufficient lead in time (IIA Action 14)<br><br>Ensure district services are joined up with local strategies (IIA Action 21) |

# We have determined a set of recommendations for implementation, aligned to the enhancements in the final IIA (5/7)

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| Recommendation | Relevant IIA enhancement |
|---|---|
| The Trust should provide the 1,066 beds to reflect the bed requirements to 29/30. This should continue to be reviewed and refined as further population growth forecasts, housing growth forecasts, and demand management initiatives are developed and delivered. | N/A |
| 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 through increased access to local primary or community care are realised, with a focus on prevention, as well as targeted initiatives to manage patients with risk factors around diabetes or high blood pressure and supporting behaviour change.<br><br>See also recommendation 23. | Review district service provision against local health inequalities (IIA Action 12)<br><br>Re-assess accessibility issues for deprivation groups for preferred option (IIA Action 13)<br><br>Continuously review needs of equality groups (IIA Action 23) |
| NHS 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. | N/A |
| The Trust should continue to develop plans to implement EPR in advance of SECH implementation. Digital technology should be fully incorporated into the design of the hospitals and enable connectivity with wider healthcare providers. | N/A |

# We have determined a set of recommendations for implementation, aligned to the enhancements in the final IIA (6/7)

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| Recommendation | Relevant IIA enhancement |
|---|---|
| The Trust should work towards implementation of a carbon net zero building.<br><br>The Trust should address sustainable green travel alternatives as part of the travel and access plan. | Introduce and encourage more sustainable/green travel (IIA Action 25<br><br>Seek to implement carbon offsetting strategies across the Trust (IIA Action 26)<br><br>Further air quality and carbon assessment following selection of preferred option (IIA Action 27) |
| The Trust should develop an Outline Business Case keeping within the funding envelope as confirmed by Department of Health / NHSE/I | N/A |
| The Trust should ensure there is future capacity within the hospital design to incorporate flexibility to respond to future surges in demand across inpatient beds and ITU.<br><br>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. | Ensure flexibility and adaptability in the design for the new major acute hospital (IIA Action 20) |
| The Trust should undertake a further appraisal of the options for renal services. Should significant service change be proposed, this will require further consideration by commissioners. | N/A |

# We have determined a set of recommendations for implementation, aligned to the enhancements in the final IIA (7/7)

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| Recommendation | Relevant IIA enhancement |
|---|---|
| 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 to best serve local community health needs. | N/A |
| 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, both system wide and for the district hospital site(s). | N/A |

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# CCG oversight of the delivery of the recommendations

Matthew Tait, Accountable Officer, NHS Surrey Heartlands CCG

# As part of the next stage, the Trust would need to implement these recommendations in order to gain support from commissioners

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- Commissioners would have oversight of the implementation of the recommendations set out within this DMBC and the implementation of the OBC.
- This would be in the form of a **Strategic Oversight Group, consisting of the two CCGs and regulators**. This group would meet on a bi-monthly basis as a forum to report progress.
- On the intervening months, the Strategic Executive Group would meet, consisting of the two CCG accountable officers and the Trust Chief Executive.
- To secure funding for the preferred option, ESTH will need to:
  - Develop an outline business case; and
  - Develop a full business case.
- As part of this process, **ESTH will need to secure commissioner support for its outline business case and full business case.** This support will be contingent upon meeting the recommendations described previously.

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NHS

# Improving Healthcare Together 2020–2030

## Committees in Common

## **Written submissions – for noting**

3 July 2020

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NHS

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## Committees in Common

## **Pre-submitted questions from the public – for discussion**

3 July 2020

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NHS

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## Committees in Common

## **Committee Discussion**

3 July 2020

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NHS

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## Committees in Common

## **Decisions**

3 July 2020

# Following on from the consideration of the evidence and consultation feedback, the CiC is asked to consider a number of resolutions

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- It is the Programme Board's recommendation to the Committees in Common that the following resolutions should be considered for agreement and approval, taking into account all the evidence that has been made available, on the basis that **they represent the best solution to address the case for change**:
  - To **agree and adopt the clinical model** for the delivery of district hospital services and the SECH;
  - 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.
  - To **agree and adopt the recommendations for implementation**; and
  - To **establish a Strategic Executive Group and Strategic Oversight Group** to monitor the delivery of the recommendations throughout implementation.