Merton Council

South West London and Surrey Joint Health Overview and Scrutiny Committee Agenda

Date: **Tuesday 26 June 2018**

Time: **7.00 pm**

Venue: **Room 6.2 and 6.3, 120 The Broadway, Wimbledon SW19 1RH**

This is a public meeting and attendance by the public is encouraged and welcomed.
For more information about the agenda please contact   or telephone .

All Press contacts: press@merton.gov.uk, 020 8545 3181

South West London and Surrey Joint Health Overview and Scrutiny Committee Agenda

26 June 2018

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Note on declarations of interest

Members are advised to declare any Disclosable Pecuniary Interest in any matter to be considered at the meeting. If a pecuniary interest is declared they should withdraw from the meeting room during the whole of the consideration of that mater and must not participate in any vote on that matter. If members consider they should not participate because of a non-pecuniary interest which may give rise to a perception of bias, they should declare this, .withdraw and not participate in consideration of the item. For further advice please speak with the Assistant Director of Corporate Governance.

Committee: South West London and Surrey Joint Health Overview and Scrutiny Committee

Date: 26 June 2018

Subject: Terms of Reference and Rules of Procedure

Contact officer: Stella Akintan, stella.akintan@merton.gov.uk; 020 8545 3390

Recommendations:

A. Agree the Terms of Reference – Attached at Appendix two

B. Agree the Rules of Procedure. – Attached at Appendix three

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report includes the Terms of Reference and Rules of Procedure which will govern the operation of the South West London and Surrey Joint Health Overview and Scrutiny Committee and the establishment of any sub-committees. These documents were also agreed at the Full Council meeting at each of the constituent local authorities during May 2018.

2 DETAILS

2.1. Both documents will provide for the flexible operation across South West London and Surrey of joint scrutiny activity to meet the statutory duties as required in the s.245 of the NHS Act 2006 and the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The Rules of Procedure provide for a governance structure which will respond quickly to any reconfiguration proposals on which joint scrutiny activity is required.

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Establishment of a Joint Health Overview and Scrutiny Committee for South West London and Surrey County Council.

Background

Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, local authorities may establish a joint health overview and scrutiny committee to undertake health scrutiny functions on their behalf, and must establish a joint health overview and scrutiny committee to respond to consultation on proposals for substantial variation in health services affecting more than one local authority area.

Discussions between officers responsible for health scrutiny across South West London and Surrey County Council has concluded that the best way forward is the continuation of a Standing Joint Health Overview and Scrutiny Committee, with responsibility for responding to consultations on substantial service change affecting multiple boroughs across the area. This has proved to be a useful way to obviate the need to go through a separate decision-making process each time a consultation requiring the establishment of a Joint Health Overview and Scrutiny Committee is initiated, enabling local authorities to respond more rapidly and saving officer and member time. The draft terms of reference and rules of procedure are attached as Appendices 2 and 3. Points to note are:

- There will be two members of the Committee for each local authority represented, appointed in accordance with local procedures. Local authorities are also encouraged to nominate substitutes to attend when their primary representatives are unable to.
- The Committee will have the power to establish sub-committees, and much of the work in relation to specific consultation will be undertaken in these sub-committees. The members of a sub-committee may be members of the main committee, but constituent local authorities may also nominate another representative to serve on a specific sub-committee.
- Where a consultation affects some, but not all, of the constituent areas voting membership of the relevant sub-committee will be restricted to the authorities directly affected. Thus, for example, the sub-committee responding to consultation on the Mental Health Trust's estates strategy would not include Croydon as a voting member.
- There is no minimum frequency of meetings of the Committee, and when there are no current consultations there will be no need for the committee to meet.
- The life of the Committee will be for a maximum of four years. Constituent areas will nominate members annually, and there will be an annual election for the Chair and Vice-Chair of the Committee.

Appendix Two

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
SOUTH WEST LONDON AND SURREY.

TERMS OF REFERENCE

1.1 The South West London and Surrey Joint Health Overview and Scrutiny Committee is established by the Local Authorities of **London Borough of Croydon, London Borough of Merton, London Borough of Richmond upon Thames, Surrey County Council, London Borough of Sutton, London Borough of Wandsworth,** and the **Royal Borough of Kingston upon Thames (constituent areas)** in accordance with s.245 of the NHS Act 2006 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

1.2 It will be a standing Joint Overview and Scrutiny Committee or a sub-committee thereof which will undertake scrutiny activity in response to a particular reconfiguration proposal or strategic issue affecting some, or all of the constituent areas.

1.3 The length of time a specific matter / proposal will be scrutinised for will be determined by the Joint Committee or Sub Committee.

1.4 The purpose of the Standing Joint Committee is to act as a full committee or commission sub-committees to consider the following matters and carry out detailed scrutiny work as below:

(a) To engage with Providers and Commissioners on strategic sector wide *proposals* in respect of the *configuration* of health services affecting some or all of the area of Croydon, Merton, Richmond upon Thames, Surrey County Council, Sutton, Wandsworth, and the Royal Borough of Kingston upon Thames (constituent area).

(b) Scrutinise and respond to the consultation process (including stakeholder engagement) and final decision in respect of any reconfiguration proposals affecting some, or all of the constituent areas.

(c) Scrutinise in particular, the adequacy of any consultation process in respect of any reconfiguration proposals (including content or time allowed) and provide reasons for any view reached.

(d) Consider whether the proposal is in the best interests of the health service across the affected area.

(e) Consider as part of its scrutiny work, the potential impact of proposed options on residents of the reconfiguration area, whether proposals will deliver sustainable service change and the impact on any existing or potential health inequalities.

(f) Assess the degree to which any proposals scrutinised will deliver sustainable service improvement and deliver improved patient outcomes.

(g) Agree whether to use the joint powers of the local authorities to refer either the consultation or final decision in respect of any proposal for reconfiguration to the Secretary of State for Health.

(h) As appropriate, review the formal response of the NHS to the Committees consultation response."

1.5. The Joint Committee will consist of 2 Councillors nominated by each of the constituent areas and appointed in accordance with local procedure rules. Each Council can appoint named substitutes in line with their local practices.

1.6 Appointments to the Joint Committee will be made annually by each constituent area with in-year changes in membership confirmed by the relevant authority as soon as they know.

1. 7 A Chairman and Vice Chairman of the Joint Committee will be elected by the Committee at its first meeting for a period of one year and annually thereafter.

1.8 The life of the Joint Committee will be for a maximum of four years from its formation in May 2018.

1.9 For each specific piece of scrutiny work undertaken relating to consultations on reconfiguration or substantial variation proposals affecting all or some of the constituent areas, the Joint Committee will either choose to act as a full Committee or can agree to commission a sub-committee to undertake the detailed work and define its terms of reference and timescales. This will provide for flexibility and best use of resource by the Joint Committee.

1.10 In determining how a matter will be scrutinised, the Joint Committee can choose to retain decision making power or delegate it to a sub-committee.

1.11 The overall size of each sub-committee will be determined by the main Committee and must include a minimum of 1 representative per affected constituent area

1.12 Where a proposal for reconfiguration or substantial variation covers some but not all of the constituent areas, in establishing a sub-committee, formal membership will only include those affected constituent areas. Non affected constituent areas will be able to nominate members who can act as 'observers' but will be non-voting.

1.13 The Committee and any sub-Committees will form and hold public meetings, unless the public is excluded by resolution under section 100a (4) Local Government Act 1972 / 2000, in accordance with a timetable agreed upon by all constituent areas and subject to the statutory public meeting notice period.

Appendix three

SOUTH WEST LONDON AND SURREY JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC)

RULES OF PROCEDURE

1. Membership of Committee and Sub-Committees

1.1 The London Boroughs of Croydon, Merton, Richmond upon Thames, Sutton, Wandsworth and the Royal Borough of Kingston upon Thames and Surrey County Council will each nominate, 2 members to the JHOSC, appointed in accordance with local procedure rules.

1.2 Appointments will reconfirmed annually by each relevant authority.

1.3 Individual authorities may change appointees in accordance with the rules for the original nomination.

1.4 Individual authorities will be strongly encouraged to nominate substitutes in accordance with local practice.

1.5 In commissioning Sub-Committees, membership will be confirmed by the JHOSC and can be drawn from the main Committee or to enable use of local expertise and skill, from non-Executive members of an affected constituent area.

1.6 The membership of a sub-committee will include at least one member from each affected constituent areas. An affected constituent area is a council area where the proposals will impact on residents. Non affected areas can appoint 'observer' members to sub-committees but they will be non-voting.

1.7 The JHOSC, may as appropriate review its membership to include authorities outside the South West London area whom are equally affected by a proposal for reconfiguration or substantial variation who can be appointed to serve as members of relevant sub-committees.

2. Chairman

2.1 The JHOSC will elect the Chairman and Vice Chairman at the first formal meeting. A vote will be taken (by show of hands) and the results will be collated by the supporting Officer.

2.2 The appointments of Chairman and Vice Chairman will be reconfirmed annually.

2.3 If the JHOSC wishes to, or is required to change the appointed Chairman or Vice Chairman, an agenda item should be requested supported by four of the seven constituent areas following which the appointments will be put to a vote.

2.4 Where a sub-committee is commissioned, at its first meeting a Chairman and Vice-Chairman will be appointed for the life of the sub-committee.

3. Substitutions

3.1 Named substitutes may attend Committee meetings and sub-committee meetings in lieu of nominated members. Continuity of attendance is strongly encouraged.

3.2 It will be the responsibility of individual committee members and their local authorities to arrange substitutions and to ensure the supporting officer is informed of any changes prior to the meeting.

3.3 Where a named substitute is attending the meeting, it will be the responsibility of the nominated member to brief them in advance of the meeting.

4. **Quorum**

4.1 The quorum of a meeting of the JHOSC will be the presence of one member from any five of the seven participating constituent areas.

4.2 The quorum of a meeting of a Sub Committee of the JHOSC will be three quarters of the total membership of the sub-committee to include a minimum of two members.

5. Voting

5.1 Members of the JHOSC and its sub Committees should endeavour to reach a consensus of views and produce a single final report, agreed by consensus and reflecting the views of all the local authority committees involved.

5.2 In the event that a vote is required, each member present will have one vote. In the event of there being an equality of votes the Chairman of the JHOSC or its sub-committee will have the casting vote.

6. JHOSC Role, Powers and Function

6.1 The JHOSC will have the same statutory scrutiny powers as an individual health overview and scrutiny committee that is:

- accessing information requested
- requiring members, officers or partners to attend and answer questions
- Referral to the Secretary of State for Health if the Committee is of the opinion that the consultation has been inadequate or the proposals are not ‘in the interests’ of the NHS

6.2 The JHOSC can choose to retain the powers of referral to the Secretary of State for Health for a particular scrutiny matter or delegate them to an established sub-committee.

7. Support

7.1 The lead governance and administrative support for the JHOSC will be provided by constituent areas on an annual rotating basis.

7.2 The lead scrutiny support for sub-committees will be provided by constituent areas on a per issue basis to be agreed by the sub-committee.

7.3 Meetings of the JHOSC and its sub-committees will be rotated between participating areas.

7.4 The host constituent area for each meeting of the JHOSC will be responsible for arranging appropriate meeting rooms and ensuring that refreshments are available.

7.5 Each constituent area will identify a key point of contact for all arrangements and Statutory Scrutiny Officers will be kept abreast of arrangements for the JHOSC.

Appendix three

8. Meetings

8.1 Meetings of the JHOSC and its sub-committees will be held in public unless the public is excluded by resolution under section 100a (4) Local Government Act 1972 / 2000 and will take place at venues in one of the seven constituent areas.

8.2 Meetings will not last longer than 3 hours from commencement, unless agreed by majority vote at the meeting.

9. Agenda

9.1 The agenda will be drafted by the officers supporting the JHOSC or its sub-committees and agreed by the appropriate Chairman. The officer will send, by email, the agenda to all members of the JHOSC, the Statutory Scrutiny Officers and their support officers.

9.2 It will then be the responsibility of each borough to:

- publish official notice of the meeting
- put the agenda on public deposit
- make the agenda available on their Council website; and
- make copies of the agenda papers available locally to other Members and officers of that Authority and stakeholder groups as they feel appropriate.

10. Local Overview and Scrutiny Committees

10.1 The JHOSC or its sub-committees will invite participating constituent areas health overview and scrutiny committees and other partners to make known their views on the review being conducted.

10.2 The JHOSC or its sub-committees will consider those views in making its conclusions and comments on the proposals outlined or reviews.

10.3 Individual Overview and Scrutiny Committees will make representations to any NHS Body where a consensus at the JHOSC cannot be reached”.

11. Representations

11.1 The JHOSC or its sub-committees will identify and invite witnesses to address the committee and may wish to undertake consultation with a range of stakeholders.

11.2 As far as practically possible the committee or sub-committee will consider any written representations from individual members of the public and interest groups that represent geographical areas in South West London and Surrey that are contained within one of the participating local authority areas.

11.3 The main Committee and any established sub-committees will consider up to 3 verbal representations per agenda item from individual members of the public and interest groups that represent geographical areas in South West London and Surrey that are contained within one of the participating local authority areas. Individuals must register to speak before 12pm on the day before the meeting takes place and will be given three minutes to make their representations to the committee.

11.4 The Chairman or any committee or sub-committee will have the discretion to accept more or late speakers where s/he feels it is appropriate.

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BRIEFING PAPER FOR SOUTH WEST LONDON AND SURREY JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE: RECOMMENDED OVERVIEW AND SCRUTINY ARRANGEMENTS

Introduction

1. Improving Healthcare Together 2020-2030 is a commissioner-led programme formed of three CCGs which cover the areas of Surrey Downs, Sutton and Merton. There are approximately 720,000 residents in our combined geographies and we have been working closely together to better integrate care and to address the challenges to major acute services delivered in the area.

2. Programme representatives met with scrutiny officers from the London Boroughs of Merton and Sutton and Surrey County Council on 18 May 2018 to discuss potential scrutiny arrangements. An outline agenda has been agreed for a meeting of the South West London and Surrey Joint Health Overview and Scrutiny Committee, scheduled to take place on 26 June 2018.

3. The programme is committed to fulfilling its obligations under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 should there be a 'substantial variation or development' necessitating public consultation.

4. This paper recommends that local authority oversight and scrutiny of the programme would be best carried out by a subcommittee of the South West London and Surrey Joint Health Overview and Scrutiny Committee, comprised of members from Surrey County Council and the London Boroughs of Merton and Sutton.

Improving Healthcare Together 2020-2030

5. In 2017 Epsom and St Helier University Hospitals NHS Trust assessed their acute services against the South West London Clinical Senate's agreed standards. They were the only provider trust in south west London to declare that their services were not sustainable in their current form. The Trust published a Strategic Outline Case proposing solutions to these issues.

6. Improving Healthcare Together 2020-2030 is a commissioner-led programme looking at the challenges identified in delivering major acute services from Epsom and St Helier, against a wider agenda of integrating primary and community services.

7. On the 21st June 2018, the Improving Healthcare Together 2020-2030, Committees in Common will meet. The Committees in Common comprises membership from Surrey Downs CCG, Merton CCG and Sutton CCG and Healthwatch Surrey, Merton and Sutton. The Committees in Common will be asked to approve the following draft documents: Improving Healthcare Together 2020-2030: Issues paper, Improving Healthcare Together 2020-2030: Issues paper technical annex: Case for change, Clinical model and Development of potential solutions and the Improving Healthcare Together 2020-2030: early engagement plan.

8. A copy of the *Improving Healthcare Together 2020-2030: Issues paper* is included as a separate attachment for reference. This is a public facing document. It summarises the key challenges faced by the local health community and explains why change is necessary. Specifically, it summarises the case for change, the provisional clinical model, development of potential solutions and supporting engagement plan.

9. Andrew Demetriades, Programme Director for Improving Healthcare Together 2020-2030 will provide an update to the JHOSC on the outcome of the Committees in Common meeting.

Epsom and St Helier activity commissioned across Clinical Commissioning Groups

10. Epsom and St Helier provides major acute services predominantly to patients who fall under the three Clinical Commissioning Groups – Surrey Downs, Sutton and Merton – across three hospital sites; Epsom Hospital, St Helier Hospital and Sutton Hospital.

11. Over 85% of Epsom and St Helier University Hospitals NHS Trust's total patient care in 2017/18 was provided by Surrey Downs CCG (c. 32%), Sutton CCG (c. 30%), Merton CCG (c. 10%), and NHS England (c. 14%) (who commission specialist services), through contracts with them. Appendix 1 on page 3 provides the full breakdown of commissioning activity for Epsom and St Helier.

12. Over ten further Clinical Commissioning Groups commission services delivered by Epsom and St Helier, however the commissioning flow from these CCGs is small.

Recommended overview and scrutiny arrangements

1. Commissioners are of the view that, where possible, local authority scrutiny should mirror the predominant commissioning flow.

2. With regard to the breakdown of commissioner activity, it is apparent that the activity with commissioners other than Merton, Sutton and Surrey Downs is not significant. Therefore, in terms of the statutory duty to consult with local authorities, it would be reasonable to focus on the 3 local authorities: Sutton, Merton and Surrey where activity is substantial.

3. It is therefore suggested that a subcommittee of the South West London and Surrey Joint Health Overview and Scrutiny Committee, comprising representatives of Surrey County Council and the London Boroughs of Sutton and Merton, is set up to carry out the overview and scrutiny function.

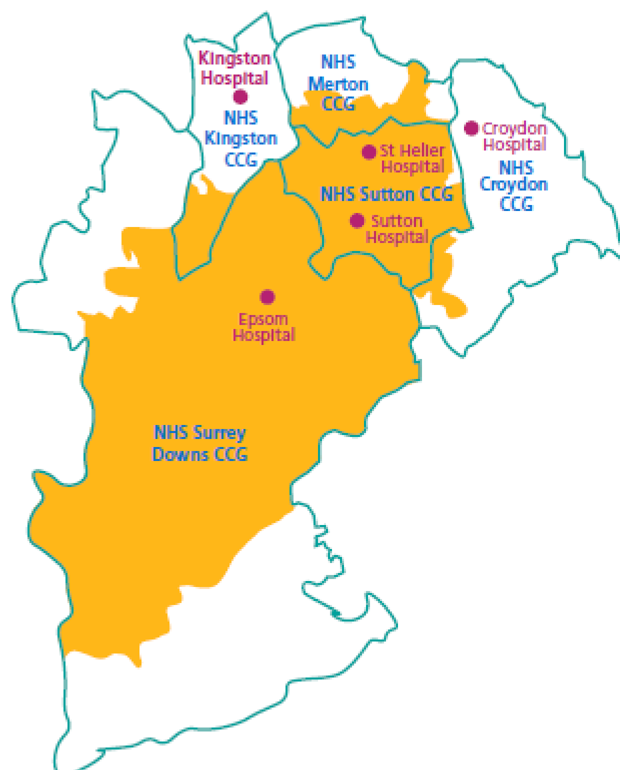
4. This would be the most effective and efficient way to scrutinise the Improving Healthcare Together 2020-2030 programme given the coterminous boundaries shared between the two London CCGs and London Boroughs, as well as the essential inclusion of Surrey County Council.

5. The programme understands that representatives from neighbouring local authorities may wish to sit in attendance at any meeting of the subcommittee should they wish to do so.

Appendix 1: Commissioning activity at Epsom and St Helier[1]

Commissioner	% of activity and income by main commissioner
NHS Surrey Downs CCG	33%
NHS Sutton CCG	32%
NHS England (specialised commissioning)	14%
NHS Merton CCG	11%
NHS Croydon CCG	4%
NHS Kingston CCG	2%
NHS East Surrey CCG	1%
NHS North West Surrey CCG	1%
NHS Richmond CCG	1%
NHS Wandsworth CCG	1%

Figure 1 below illustrates the Trust catchment across CCG footprints



For further information please contact:
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[1] Activity and income data for 2017/18, Epsom and St Helier University Hospitals NHS Trust

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Improving Healthcare
Together 2020-2030
NHS Surrey Downs, Sutton and Merton CCGs

NHS

Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups

Issues Paper

NHS
Surrey Downs
Clinical Commissioning Groups

NHS
Sutton
Clinical Commissioning Groups

NHS
Merton
Clinical Commissioning Groups

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Foreword

We, the clinical leaders for NHS Surrey Downs, Sutton and Merton clinical commissioning groups (CCGs), are a body of experienced local GPs who lead the organisations responsible for planning care for our patients and communities. We want to ensure the very best quality of care is available to our patients and communities, and that it is sustainable into the future from buildings which are fit for purpose.

To do this, we have come together to resolve the long-standing healthcare challenges with our ***Improving Healthcare Together 2020-2030*** programme. We believe there is a compelling set of reasons why change has to happen now and we want to share these with you.

We have been working with our clinical colleagues across local healthcare organisations to develop our view of how healthcare needs to be delivered in the 2020s and beyond. We need to plan for the future and we want to share this early thinking with you.

At the heart of our vision is wanting to keep you well, and for as much care to be delivered as close to your home as possible. We want to do this in a joined-up way with GPs and clinicians from hospitals, community and mental health organisations, working together alongside social care practitioners and the voluntary sector.

We also need to ensure that when you are seriously unwell or at risk of becoming seriously unwell, you have access to the highest quality care, available at any time of day or night and on any day of the week.

We are committed to keeping hospital services within the combined geographies of the three clinical commissioning groups and so we are not proposing any solutions which will result in hospital-based services being moved from our area.

We have looked at all the different ways we could deliver this vision and address our challenges and we have come to a provisional view that there are three ways we could do this. It is important to state that we have made no decisions on which solution is best.

What we are certain of is that if we do not resolve these issues now, we will not be able to maintain all the services we currently provide locally and which our population need.

In this document, and the information we have published on our website, we want to share how we have got to these three potential solutions. This is the start of our conversation with you about this, and we are looking forward to hearing your views. Following your feedback, we are aiming to have a public consultation in early 2019 when we have a view on our preferred solution. We want to involve you throughout this process and for everyone to have the opportunity to have their say.

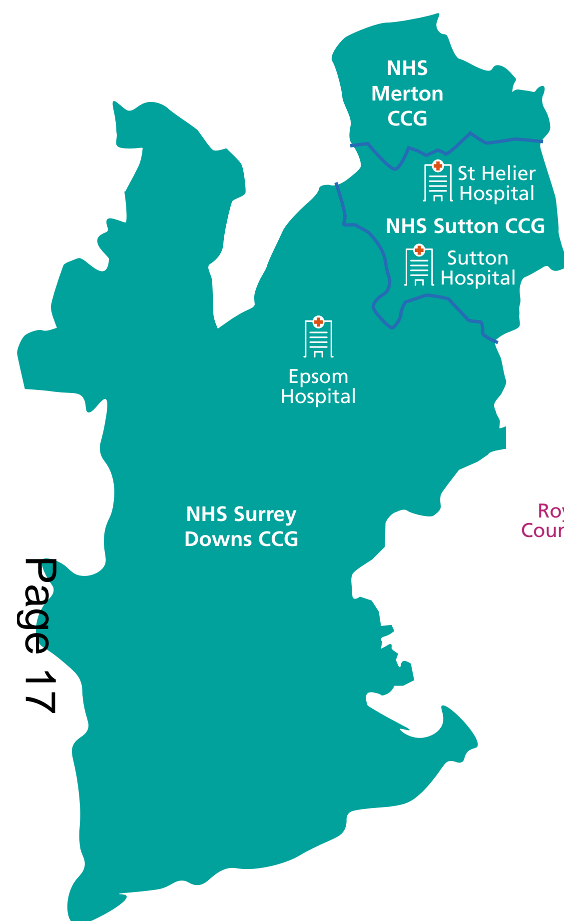
We look forward to hearing from you.

Yours faithfully,

[subject to CiC approval]	[subject to CiC approval]	[subject to CiC approval]
Dr Russell Hills Clinical chair of NHS Surrey Downs CCG	**Dr Jeffrey Croucher Clinical chair of NHS Sutton CCG**	**Dr Andrew Murray Clinical chair of NHS Merton CCG**

A compelling case for change

Geography of CCGs



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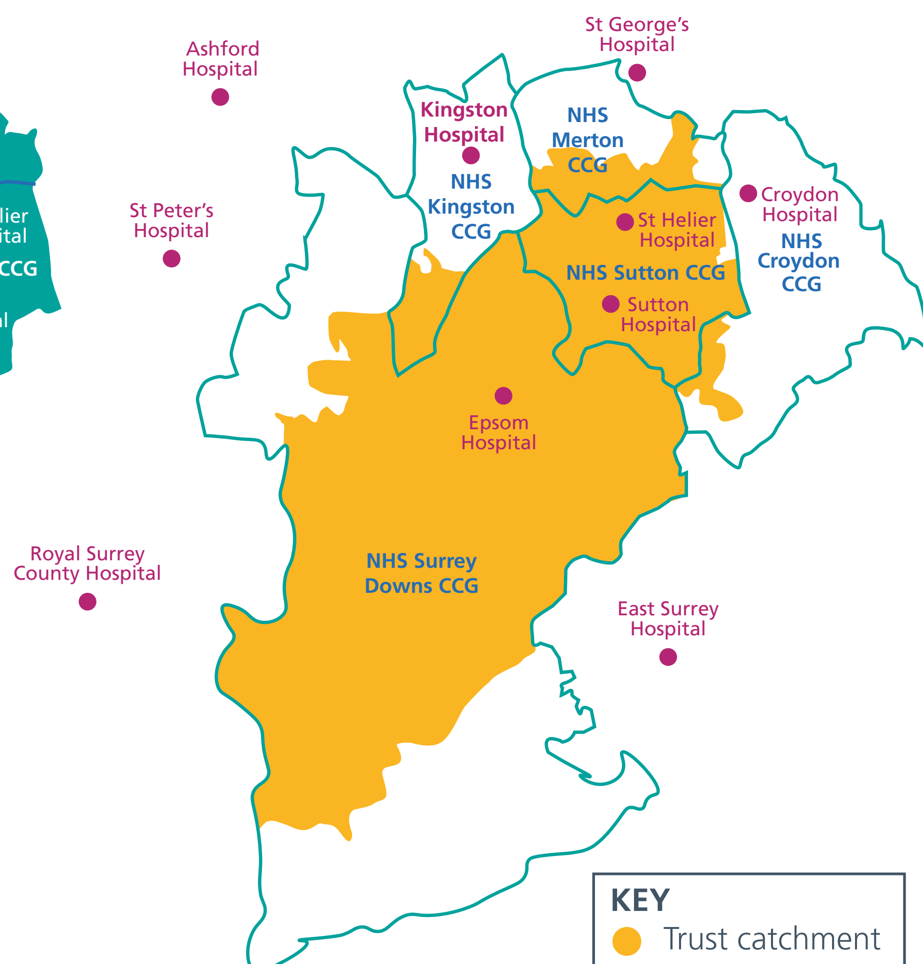
Catchment area for Epsom and St Helier University Hospitals NHS Trust



Our three CCGs cover the catchment area of Surrey Downs, Sutton and Merton, known as the 'combined geographies', shown on this map. There are approximately 720,000 residents in our combined geographies and a number of healthcare providers are based here.

For some time, we have been exploring ways to address long-term issues of sustainability in our combined geographies. As many people will be aware, this has often focused on Epsom and St Helier University Hospitals NHS Trust so this map shows the catchment area it serves.

Last year, Epsom and St Helier engaged with its patients and communities on what its next steps should be in providing care sustainably into the future and asked us, as commissioners, for our view. We reviewed the work of Epsom and St Helier and we agree that we are facing three big challenges which mean a growing need for change. Collectively, we need to address these three main issues, which are:

Improving clinical quality
Our role as commissioners is to set clinical standards for care, assess objectively how these standards can best be met and then hold providers to account to deliver the standards. In line with national best practice, in 2017 we as commissioners defined clear clinical standards for six acute services. These standards set out expected senior staffing levels. We asked all our providers of patient care whether they believe they can meet these quality standards and all except Epsom and St Helier said they could. Therefore the Trust is a key focus of this discussion.

Based on the standards agreed in South West London, there is a shortage of consultants in emergency departments, acute medicine and intensive care. The Trust is not meeting the Royal College of Emergency Medicine guidance for consultant cover and this is something recently identified by the Care Quality Commission (CQC) the regulator of services, when it inspected acute services. Additionally, there is also a shortage of middle grade doctors and nursing staff.

The work which has been done across all of our CCG geographies to date indicates that there is not a need to look more broadly at changes to acute hospital services in our local area, other than those at Epsom and St Helier.

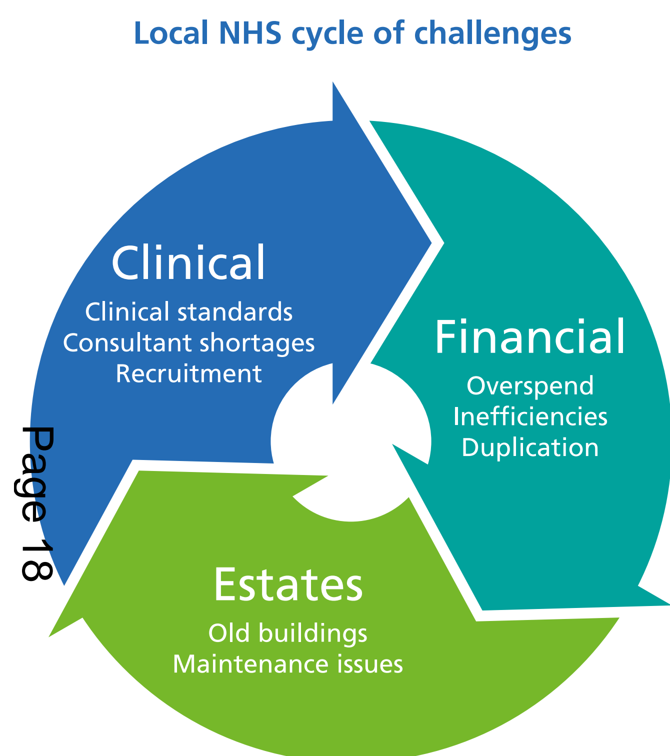
Providing healthcare from modern buildings
The buildings of Epsom and St Helier, in particular, were built before the NHS was founded and are ageing. They are not designed for modern healthcare, an issue repeatedly highlighted by the CQC, including in its latest report (May 2018). Epsom and St Helier has a very significant and critical backlog of maintenance and the deterioration of the estate is affecting the day-to-day running of clinical services and patients' experience.

Achieving financial sustainability
The Trust has an underlying financial deficit which is getting worse each year. In 2013/14 it was around £7million and in 2017/18 it has increased to around £37m. This growing deficit is driven by unavoidable increases in costs for clinical workforce including temporary staff, increasing costs for estates maintenance and decreasing opportunities for changing the way we work. The financial position will continue to worsen unless changes are made.

Conclusion

These three challenges faced in our local healthcare system will not only affect the experience of our patients and the quality of patient care, but also have the potential to affect the outcomes for patients. Moreover, these challenges each impact each other, as shown in the diagram below. If we do not solve each of these problems we will not be able to provide high quality healthcare into the future.

Local NHS cycle of challenges



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We would like you to consider the following question:

In addition to solving the clinical quality, financial deficit and poor quality buildings in our local NHS, are there any other challenges you think we may need to solve?

Our clinical vision for care: prevention, integration and acute services

As a group of local GPs, we have considered from a clinical perspective how to address the challenges our local healthcare system faces. We want to resolve these challenges and believe that the best way to do this is by looking at how to deliver care in the future. We are doing this with our clinical partners from other healthcare providers in the area.

We aim to prevent as much ill health as possible and ensure services are appropriate, joined up, high quality and meet the necessary quality standards when healthcare is needed.

Looking at the long-term healthcare needs of our population, we have identified local aims for the future of healthcare.

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These aims are:
- Delivering care as close to patients' homes as possible
- Ensuring high standards of healthcare across all our providers
- Maintaining the provision of major acute services within our combined geographies
- Improving the health of our populations

This will be achieved through:
- Greater prevention of disease
- Improved integration of care
- The delivery of enhanced standards in major acute services

The NHS's direction of travel was set out in its 2014 *Five Year Forward View*. This focus is consistent with our aims and is the basis of the priorities established by our sustainability and transformation partnerships. These are:

We need to avoid people becoming ill wherever possible, either by preventing diseases in the first place or preventing existing conditions deteriorating.

Integration is key to ensuring continuity of care and delivery of care closer to patients' homes.

Making progress with integrating care in each of our three areas.

Integrating care, which means 'joining up' health and care services so they work effectively together, requires a completely different approach and there are examples of where we are doing this. All three CCGs have plans to integrate services and provide care which is more proactive rather than reactive. The boxes below show some examples of this.

Sutton Health and Care

Sutton Health and Care (SHC) delivers integrated health and social care services for patients with long-term, complex needs in two ways. Firstly, preventative and proactive care to support people staying well in the community. Secondly, reactive care, to avoid admissions and accelerate discharge for the frail, older population. It is a joint venture between the London Borough of Sutton, the hospital trust, the mental health provider and Sutton GP Services (a federation of GP practices in Sutton). SHC has ambitious plans to extend integrated services to cover all ages and patient groups which would benefit from organisations working closer together to deliver their care, as close to home as possible.

Sutton CCG also pioneered the 'red bag scheme'. This sees residents from nursing homes bring a specially packed red bag to hospital, which means patients arrive with a discharge plan already in place, as well as clothes to go home in, meaning quicker and easier discharge.

Epsom Health and Care

Epsom Health and Care @home has been established to provide extra support and care within a patient's home to support those who have two or more long-term conditions to live as independently as they can and to prevent them from needing a hospital admission.

It also works to sees patients over the age of 65 discharged earlier from hospital and, where possible, cared for at home rather than in hospital. This is a joint venture between acute services, GPs and Surrey County Council. The @home service has seen a reduction in patients needing to stay the night and excellent feedback from patients and carers.

Merton Health and Care Together

The Merton strategy for integrated community and primary care focuses on local teams working together to take action to prevent patients who are frail or have complex conditions from becoming unwell in the first place. It also sees a rapid response for vulnerable patients who become unwell, with measures in place to ensure patients are discharged from hospital at the right time.

East Merton has seen GP practices work in teams to give patients better access to care, undertake 'social prescribing' and initiatives to look after the wellbeing of residents.

Merton has also been working closely with local A&E departments to help them determine which patients may have urgent rather than emergency care needs, and provide the right care.

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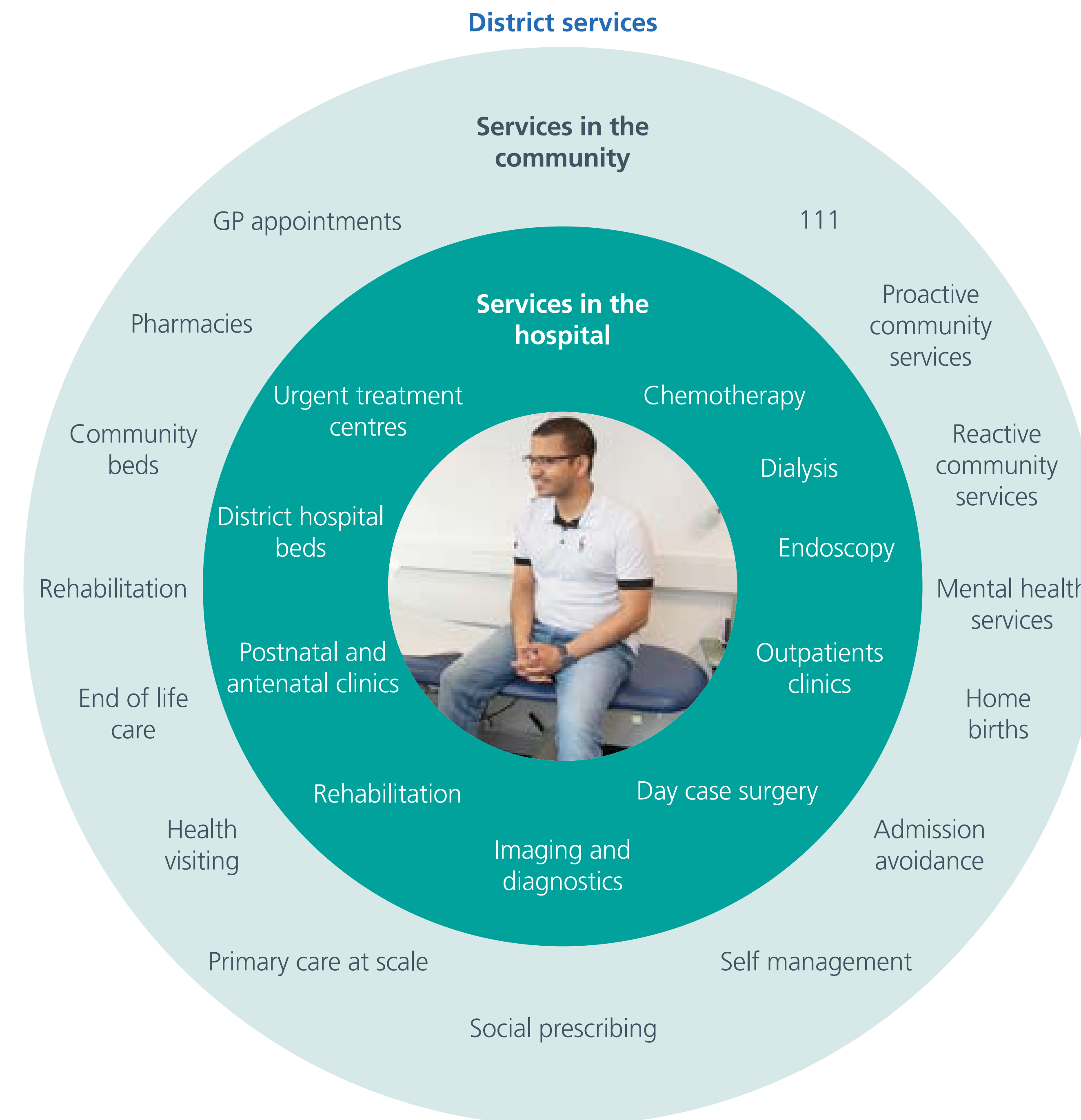
Our emerging clinical model focuses on two types of services: district services and major acute. This builds on the work we have been doing on integrated care and all the services where we can provide high-quality care for you.

Most health services in the local area will not change. The majority of services, including those for patients who do not need lifesaving, emergency, or unplanned care, will be unaffected by any potential changes.

District services are services which are provided locally. These are services which patients are likely to require more frequently, and in each area there is a local strategy which is working to ensure they are co-ordinated and integrated with community, primary, social and voluntary care. Where there is not a case for change for these services, they would continue to develop in line with current plans.

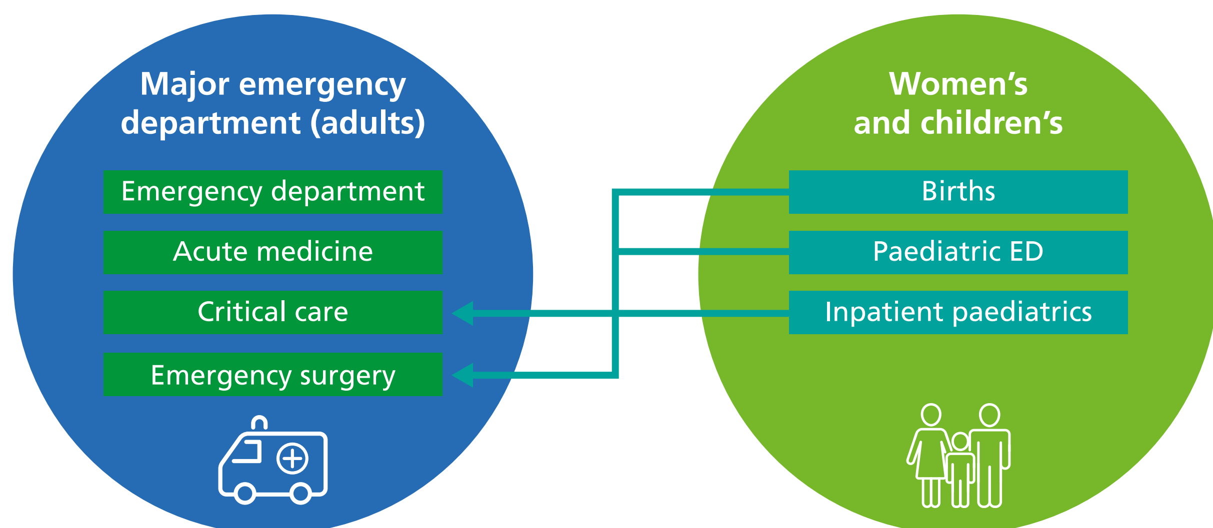
District services include urgent treatment centres, outpatients, day case surgery, low-risk antenatal and postnatal care, imaging and diagnostics, and district beds. District services and how they relate to other services are shown in the diagram opposite:



Major acute services are often needed if you are very unwell. These major acute services include emergency departments, acute medicine, critical care, emergency surgery, obstetrician-led births, paediatric emergency departments and paediatric inpatients. These services all depend on the use of intensive care services and specialist input for patients who are the highest risk and sickest. There are other 'co-dependencies' between services (meaning that they have to be located together) which are shown on the diagram on the following page.

We believe these six major acute services may need to change so that people who are very unwell, or at risk of becoming very unwell, get the right support straight away from senior specialist staff.

Co-dependent major acute services



Clinical evidence shows that, for some conditions, bringing services and the most experienced doctors (consultants) together means better care for patients and those with life-threatening conditions such as major trauma or stroke. It also means we can deliver the clinical standards, which means better survival rates and improved outcomes for our patients.

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This table shows the number of senior specialist doctors currently needed by our services.

Service	Total requirement consultant (two sites)	Current consultant staffing	Gap (two sites)
Emergency department	24	14	10
Obstetrics	22	26	-
Emergency general surgery	10	10	-
Paediatrics	24	26	-
Acute medicine	24	11	13
Intensive care	9	7	2

The Trust has already moved its emergency surgery and critical care to St Helier Hospital, which has improved care for patients. Emergency fractured neck of femur (broken hip) services have been brought together at St Helier Hospital and now see significantly better outcomes for elderly patients than the national average. This means that less people die as a result of breaking their hip. These improvements have been possible because, by having a single team on one site, the Trust has been able to ensure that patients have access to the right specialist. This is why we think change may be needed – because we believe it will improve clinical standards and care for patients.

We would like you to consider the following question:

Do you think our vision for healthcare services is the right vision for this area?

Developing potential solutions

To find potential solutions to our challenges, we have looked at how our case for change can be addressed. We have explored how our clinical vision for care can be delivered and how our hospitals can be maintained into the future. We have focused on this process in two different ways:

Firstly, we have focused on major acute services only, as there is a need for significant changes in these services. District services, which comprise the majority of healthcare provided on our hospital sites, do not face the same issues and can continue to be developed through local strategies, which includes looking at delivering care in a more integrated way.

As highlighted below, we are also doing work as part of this programme to analyse the different needs of communities across the Trust catchment, and in particular how relative levels of deprivation affect those needs and the ability to access services.

Secondly, we have focused only on changes within our combined geographies. Our focus has been on major acute services, so we have been looking at how many hospital sites can deliver care in line with the quality standards for major acute services. However, if these changes impact on other providers including other hospitals, this would be considered as part of a detailed analysis of ways services can be delivered.

Based on this, we have then made further considerations. We have looked at how potential solutions might develop into a long list of ideas for solving our health and care challenges. This is intended to capture a wide range of potential solutions so we can then consider whether they meet the needs of local people and address the problems we are facing.

We have considered how many major acute hospitals we have in our geographies, which major acute services these hospitals provide, whether workforce from outside the area could be used to supplement rotas, and which sites could be used to deliver major acute services.

All the combinations of these factors leads to 73 potential solutions. This forms our provisional long list of ideas for solving our challenges.

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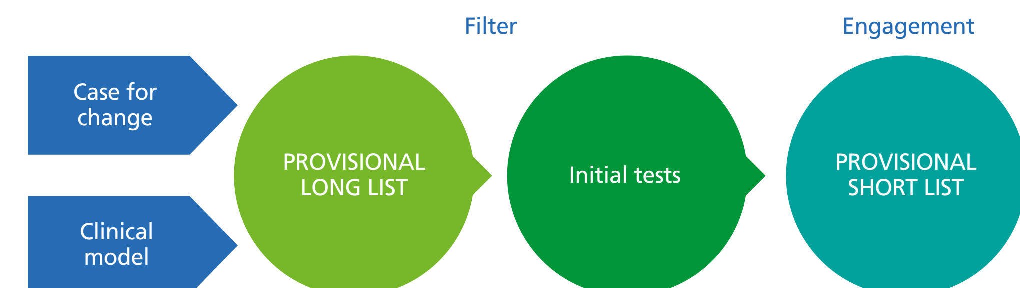
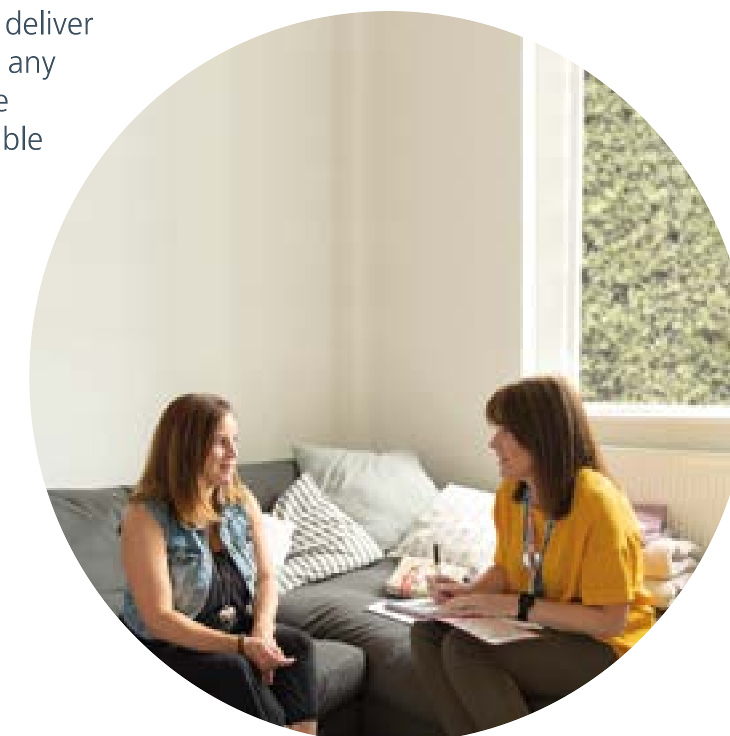
Our long list is refined by testing these potential solutions against three initial tests, which are in line with our case for change and include whether services are maintained in our combined geographies. This is shown in this diagram.



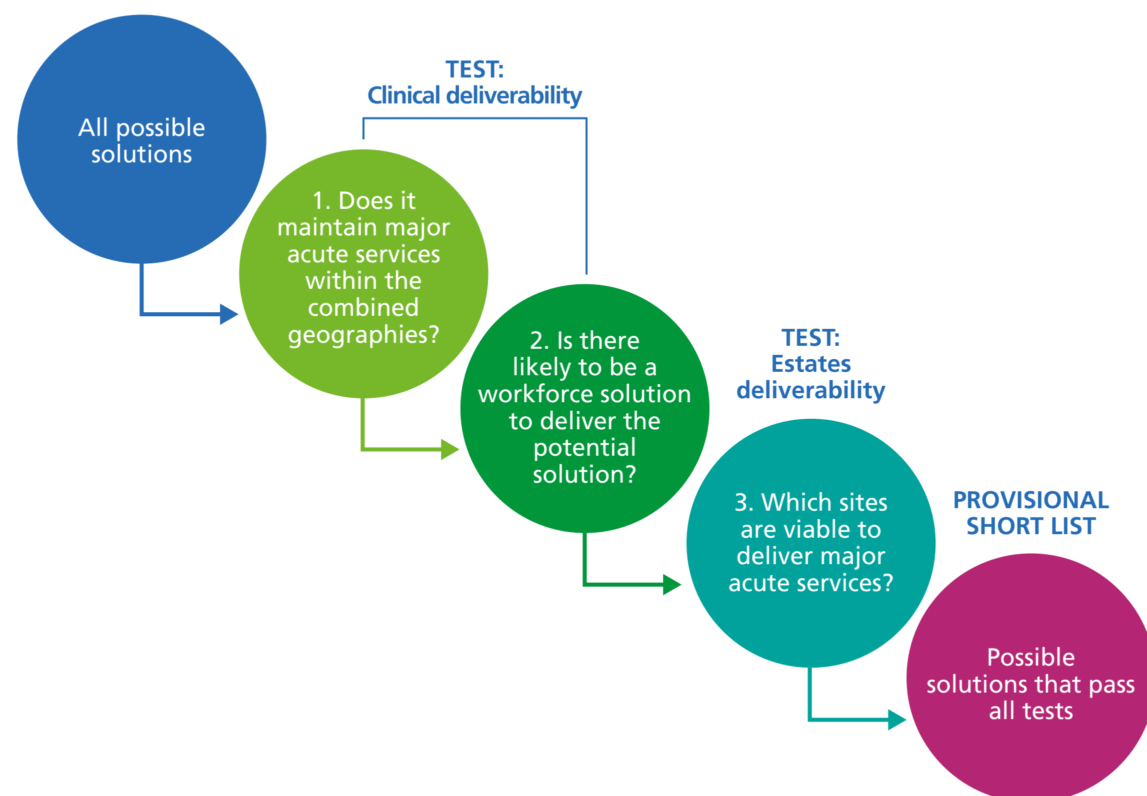
We have applied three initial tests to this long list to reach a provisional shorter list we can consider in detail. The most important of these tests is whether a solution fits in with our collective commitment to maintaining services within our combined geographies. Our other two tests are about whether we can deliver the solution based on the available workforce and the quality of the estate.

The initial tests we have applied are:

1. Does the potential solution **maintain major acute services within the combined geographies**? This is a key commitment for us and any potential solution must maintain all major acute services within our combined geographies.
2. Is there likely to be a **workforce solution** to deliver the potential solution? This includes ensuring any potential solution meets our standards for the quality of major acute services with the available workforce.
3. From which **sites** is it possible to deliver major acute services? This considers whether different sites are feasible for the delivery of major acute services.



Applying these tests, shown in this diagram, sequentially reduces the long list:



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- After the first test, **any potential solution that does not offer all major acute services within the combined geographies is eliminated** (e.g. no major acute hospitals or only providing major adult emergency department services within the combined geographies). This provisionally results in 50 potential solutions.
- After the second test, workforce limitations and the six acute services which need to be located together mean that **any potential solution with more than one major acute site and any potential solution relying on external workforce is eliminated**. This provisionally results in four potential solutions – a single major acute site from one of four sites, including the possibility of a new site. Detail on this analysis is included in the technical annexe which we have published.
- After the third test, where we looked at other locations in our geographies, **only existing sites appear feasible**. This provisionally results in three potential solutions.

We will compare these solutions with the concept of continuing as we are.

There are therefore three potential solutions in our provisional short list.

This provisional short list includes:
- 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.

This table shows the number of senior specialist doctors which are needed by a service when they are brought together in one place, compared with two.

Service	Current consultant staffing	Total requirement (two sites)	Total requirement (one site)	Gap
Emergency department	14	24	12-16	0
Obstetrics	26	22	12-16	0
Emergency general surgery	10	10	10	0
Paediatrics	26	24	12-16	0
Acute medicine	11	24	12	1
Intensive care	7	9	9	2

To build on the engagement work already done by Epsom and St Helier with patients and our communities, further public engagement is taking place on our provisional short list of three potential solutions, which we have described in this document. Any views on this provisional short list will be taken into account in the next phase of work, which will be informed by the views gained through this engagement.

The case for change makes clear that we need to consider our plans for the future and explore the ways in which the issues we face can be addressed. We are clear that any potential solutions must address the three main issues of clinical quality, estates and financial sustainability, while supporting our broader plans for healthcare locally. Further work is required, and we will continue to explore:
- How the clinical model can change to address our challenge of clinical quality and ensure that care is integrated and standards for major acute services are met
- The potential solutions which deliver this clinical model to our populations while addressing our challenges of workforce, estates and financial sustainability

Other important things to consider

As part of this work, there are a number of other important considerations for our patients and their families and carers. We will consider pieces of work as we progress further. These include:

- **Travel and access**
  What kind of journey would patients have, and what kind of distance would they need to travel, in order to access care? What public and patient transport would be available or needed?
- **Impact on deprived communities**
  We will consider how potential changes might affect communities within our local area which are affected by deprivation, such as poverty, poor education or housing, all of which can affect health and wellbeing.
- **An equality impact analysis**
  This will consider the impact of any change on our communities, including people with protected characteristics.

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We have already started looking into these important elements of how care is accessed, using experts to analyse work which has already taken place.

We would like you to consider the following question:

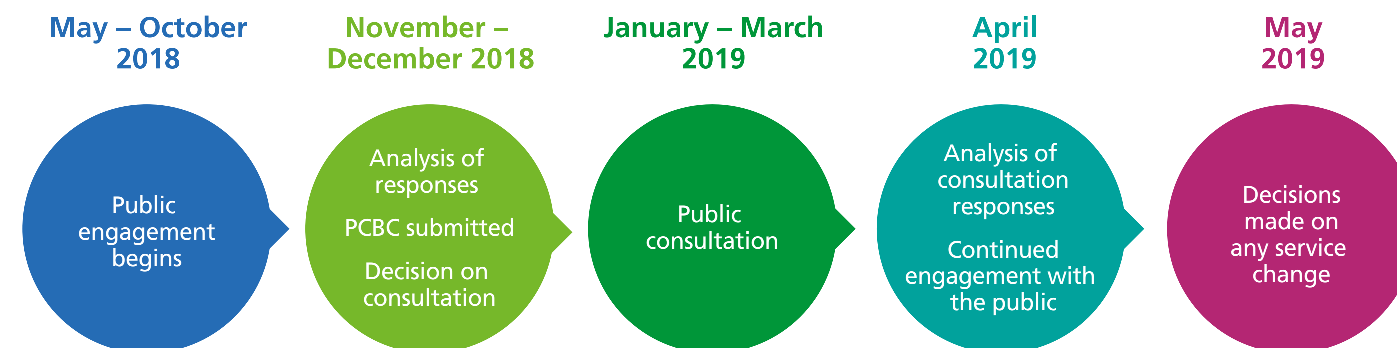
Do you think we should consider any other initial tests – apart from those described in this document – as we develop the long list of ideas into a short list?

Next steps

There is lots of work to be done on our challenges in healthcare, and a number of key issues which need to be considered. During this phase of engagement, we intend to listen to and talk with our communities through a number of engagement activities. This document is the start of the engagement process.

We also have a stakeholder reference group for local patient, community and other organisations which will be sharing thoughts and ideas. Additionally, we are undertaking a number of activities to make sure people know about this programme and can tell us their thoughts.

Potential timeline



During this engagement period, we will publish the equality impact and deprivation analyses referred to above. We will also be seeking stakeholder input to the issues set out in this document. In the future, we will also be seeking your views on any potential evaluation criteria we might use to evaluate any shortlisted solutions. However, we will as CCGs consider all feedback from stakeholders, patients, staff and the wider public before proceeding with any future review of potential solutions.

After that phase, the next phase of the programme will be to take all this information into account as we create a series of options for how we might change the way deliver care. We will continue to involve our local communities and other important stakeholders to ensure we receive feedback to inform our thinking.

If significant change is proposed, then we would draft a document which asks for the funding needed to undertake this work called a pre-consultation business case (PCBC) for approval by NHS England and if approved we would consider proceeding to consultation.

We would like you to consider the following questions:

Do you have any questions about the process we are proposing to follow or any suggestions for improving it?

Can you think of any other ways of tackling the challenges described in this document, within what the document describes as possible?

What are the best ways for involving our patients and community in developing ideas to address the challenges described in this document?

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How to get involved

It is vital that this programme talks with local communities who may be affected by changes to services in the area. As lead clinicians working to improve healthcare into the future, we and our colleagues want to hear from local patients, their families and carers to establish their thoughts, feelings and ideas about local healthcare and how it can be improved.

We will be publishing details of upcoming engagement activities. We would also like to ask you some questions in response to this document. Most of these questions appear throughout this ***Issues Paper*** – we have collated them here for you to consider.

Please send us your answers to these questions, or any other thoughts, questions or comments, using the contact details on the back cover of this document.

1. In addition to solving the clinical quality, financial deficit and poor quality buildings in our local NHS, are there any other challenges you think we may need to solve?
2. Do you think our vision for healthcare services is the right vision for this area?
3. Do you think we should consider any other tests – apart from those described in this document – as we develop the long list of ideas into a short list?
4. Do you have any questions about the process we are proposing to follow or any suggestions for improving it?
5. Can you think of any other ways of tackling the challenges described in this document, within what the document describes as possible?
6. What are the best ways for involving our patients and community in developing ideas to address the challenges described in this document?
7. Would you like to receive the regular electronic update newsletter we propose to publish? If so, please let us know. Our contact details are on the next page.

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Improving Healthcare
Together 2020-2030
NHS Surrey Downs, Sutton and Merton CCGs

NHS

Please send us your thoughts, questions or comments.
Contact details below.

Online:
[To follow after CiC approval]

By email:
[To follow after CiC approval]

In writing:
[To follow after CiC approval]

[To follow after CiC approval]

[To follow after CiC approval]

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SOUTH WEST LONDON AND SURREY JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

DATE: **26 June 2018**

SUBJECT: **Establishment of a Sub-Committee to consider the Improving Healthcare Together 2020-2030 Programme**

SUMMARY

1. To agree to establish a sub-committee to carry out the scrutiny of the Improving Healthcare Together 2020-2030 Programme.

DETAILS

2. The Procedure Rules governing the Joint Committee indicate that where a proposal requiring Joint Scrutiny Activity is required within South West London, a Sub-Committee can be established to carry out this detailed work. This flexible arrangement means that the Standing Committee can respond to multiple requests for joint scrutiny running concurrently and use the time and expertise of members effectively.

An established Sub-Committee would include representatives from each of the affected Boroughs (1 proposed). Non affected Boroughs can appoint members with observer status.

A sub-committee will be established relating to a particular reconfiguration with appropriate timescales applying for the conclusion of its scrutiny work.

The main Committee can choose to delegate final decision making to the sub-committee or retain it. Where it is retained, the sub-committee will provide a report and recommendations to the main Committee for consideration. Members from non-affected boroughs would, in considering the relevant item revert to observer status.

Each sub-committee will elect its own Chairman and Vice-Chairman and agree its own programme of work.

RECOMMENDATION

3. **The Committee be recommended to:**

(a) Agree to the establishment of a sub-committee to carry out the detailed scrutiny on the Improving Healthcare Together 2020-2030 Programme.
(b) Agree that the membership of the sub-committee include one member from the boroughs of Merton, Surrey and Sutton
(c) Consider whether final decision making power should be delegated to the sub-committee or retained by the main Committee.

CONTACT:

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