Merton Council
Healthier Communities and Older People Overview and Scrutiny Panel

Date: 21 July 2020
Time: 7.15 pm
Venue: This Meeting will take place online via ZOOM.

AGENDA

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Healthier Communities and Older People Overview and Scrutiny Panel membership

Councillors:
Peter McCabe (Chair)
Thomas Barlow (Vice-Chair)
Nigel Benbow
Pauline Cowper
Mary Curtin
Jenifer Gould
Rebecca Lanning
Dave Ward

Substitute Members:
Andrew Howard
Joan Henry
Hina Bokhari
David Chung
Oonagh Moulton

Co-opted Representatives
Diane Griffin (Co-opted member, non-voting)
Saleem Sheikh (Co-opted member, non-voting)

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What is Overview and Scrutiny?

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Scrutiny's work falls into four broad areas:

⇒ **Call-in**: If three (non-executive) councillors feel that a decision made by the Cabinet is inappropriate they can 'call the decision in' after it has been made to prevent the decision taking immediate effect. They can then interview the Cabinet Member or Council Officers and make recommendations to the decision-maker suggesting improvements.
⇒ **Policy Reviews**: The panels carry out detailed, evidence-based assessments of Council services or issues that affect the lives of local people. At the end of the review the panels issue a report setting out their findings and recommendations for improvement and present it to Cabinet and other partner agencies. During the reviews, panels will gather information, evidence and opinions from Council officers, external bodies and organisations and members of the public to help them understand the key issues relating to the review topic.
⇒ **One-Off Reviews**: Panels often want to have a quick, one-off review of a topic and will ask Council officers to come and speak to them about a particular service or issue before making recommendations to the Cabinet.
⇒ **Scrutiny of Council Documents**: Panels also examine key Council documents, such as the budget, the Business Plan and the Best Value Performance Plan.

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HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL
10 MARCH 2020

(7.15 pm - 8.55 pm)

PRESENT: Councillors Councillor Peter McCabe (in the Chair), Councillor Thomas Barlow, Councillor Rebecca Lanning, Councillor Dave Ward, Councillor Nigel Benbow and Councillor Pauline Cowper, Councillor Hina Bokhari

ALSO PRESENT: Barry Causer (Public Health Commissioning Manager) Dr Catherine Heffernan, (Principal Advisor for Commissioning Early Years, Immunisations and Vaccination Services, NHS England) Bernadette Johnson , (Immunisation Commissioning Manager NHS England) Katie Bugler, (Director for Transforming Primary Care – Merton and Wandsworth CCGs). Dr Karen Worthington (Clinical Director for Transforming Primary Care – Merton CCG) Hannah Pearson, (Primary Care Transformation Manager – Merton and Wandsworth CCGs), Dr Josephine Ruwende, (Consultant Public Health - Cancer Screening NHS England) Stella Akintan (Scrutiny Officer)

Councillor Tobin Byers, Cabinet Member for Adult Social Care, Health and the Environment.

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies for absence were received from Councillor Mary Curtin and co-opted members Diane Griffin and Saleem Sheikh.

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

There were no declarations of pecuniary interests

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

The minutes of the previous meeting were agreed.

4 IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES AND PRIMARY MENTAL HEALTH CARE SERVICE DEVELOPMENTS 2019-2020 (Agenda Item 4)

The Director of Commissioning gave an overview of the report. Merton has a well-developed service providing psychological support, across a range of symptoms. This item was last reported to scrutiny in February 2019 and there were some concerns about the capacity to meet need. It was reported that the service is now

performing well. The most updated figures show that in January there were 468 cases so the service continues to meet its targets.

A Panel member asked how they will increase access amongst under-represented groups. The Director of Commissioning said they will look at where it is appropriate to introduce different ways to access the service. In 25% of cases ethnicity is not recorded, they will aim to increase this.
In response to questions it was reported there is no access criteria for the wellbeing service and support to those with long term conditions.

A panel member said as the link to poverty and long term conditions are more prevalent in black and ethnic minority communities therefore it be expected that they have more need for the IAPT service. The Director of Commissioning said they take on that challenge to ensure that all groups get appropriate access.

RESOLVED

The Chair thanked officers for their report.

5 CANCER SCREENING IN MERTON (Agenda Item 5)

The Consultant in Public Health gave an overview of the report including trends in uptake and coverage in London. It was reported that main issues include; shortage of practice nurses, radiology and radiographers. The success in bowel screening programmes has led to pressures. Coverage in Merton is lower than south west London neighbours. Breast screening coverage has been declining.

A Panel member asked that given that Merton uptake is low, if resources are allocated according to need. It was reported that NHS England look at the interventions that can be implemented across the region but within the partnership approach.

A Panel member asked for more details of the social media campaign. It was reported that they will identify groups with low uptake and have appropriate messages for those groups, using faith and community leaders to tailor messages for various sections of the community.

The Public Health Commissioning Manager added that the local public health team have used social media to support bowl screening programmes.

RESOLVED
The Chair thanked officers for their report.

6 ADULT IMMUNISATIONS PROGRAMME FOR MERTON. (Agenda Item 6)

The Principal Advisor gave an overview of the report and highlighted that the Flu season was relatively mild and there were no new strains. Uptake amongst over 65s has improved, although uptake was lower for 2-3 year olds. School vaccines are

improving, and access to GP appointments are very important for improving vaccination uptake.

A panel member asked if increases in school age children doing well is because they are a captive audience. The Principal Advisor said as they directly commission schools it has an impact. Overall Providers has a big impact on increasing uptake through processes such as calling people back.

RESOLVED
The Chair thanked officers for their report.

7 MERTON CLINICAL COMMISSIONING GROUP PRIMARY CARE STRATEGY (Agenda Item 7)

The Director for Transforming Primary Care gave an overview of the report highlighting the improvements in primary care including further development of primary care networks, GP access hubs increased from two to six. Also an increase in access to digital medical appointments.

A Panel member asked how the CCG is addressing wellbeing amongst GPs as the workforce still struggling, there are less staff with an increased workload. The Director for Transforming Primary Care reported they are talking to GPs to listen to their concerns. CCG colleagues are visiting to practices to provide support and receive feedback. A Healthy Workplace session has also been planned which will look at what more can be put in place locally. Merton are average on the ratio of GPs to patients.

A Panel member asked about progress with planning for GP retirement. The Clinical Director for Transforming Primary Care said this is a national issue and there are currently an increased number of doctors in training. In primary care it is important to make being a GP attractive. Training and support will help to attract new GPs to the borough.

A panel member asked about the success rate and reliability of digital consultation as doctors cannot do physical checks of symptoms. It was reported that If a patient is having a video consultation the doctor will decide if the consultation was appropriate and will convert to face to face if needed.

RESOLVED
The Chair thanked officers for their report.

8 WORK PROGRAMME REPORT 2020-21 (Agenda Item 8)

The substance misuse videos were seen as useful in helping to contextualise the issues and was welcomed by the Panel.
Panel members said they would like the work programme to include the following issues:

Social care

New CCG and south west London CCG
Update on the process in Merton becoming an Integrated Care System
Mental health
Community Pharmacy
Air quality with a focus on the health impacts and the health in all policies approach.

Healthier Communities and Older People Overview and Scrutiny Panel

Date: 21 July 2020

Agenda item:

Subject: Improving Health Care Together – Proposals for St Helier Hospital

Lead officer: Hannah Doody, Director of Communities and Housing

Lead member: Councillor Peter McCabe Chair of the Healthier Communities and Older People overview and scrutiny panel.

Contact officer: Louise Round, Managing Director, South London Legal Partnership

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Recommendations:

A. To agree to exercise the Committee's powers to refer the decision of the Committees in Common of the South West London and Surrey Heartlands NHS Clinical Commissioning Group made on 3 July 2020 to the Secretary of State for Health and Social Care, pursuant to Regulation 23(9) (a) and (c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013; and

B. To approve the terms of the proposed reference set out in the letter attached as Appendix A and to delegate authority to the Director of Communities and Housing, in consultation with the Chair of this Committee, to make such minor drafting changes as they consider prudent before submission.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This Committee has previously considered reports relating to the proposal of the South West London and Surrey Heartlands NHS Clinical Groups to make changes to the clinical model of care in the acute sector covering their areas. In essence, the proposal is to amalgamate all the acute and emergency services currently provided at St Helier and Epsom Hospitals on to one site and for that site to be a new build hospital in Belmont, Sutton.

1.2. Following a consultation exercise with relevant stakeholders which the Council responded to, a draft business case was produced and considered by a joint Committees in Common ("CIC") established by the two CCGs at a meeting on 3 July. The CIC agreed to proceed with the proposal on the basis of a decision making business case. Acting through its scrutiny function, the Council has the right under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the Health Scrutiny Regulations") to refer that decision to the Secretary of State for Health and Social Care and to ask him to seek a reconsideration of the decision by an independent reconfiguration panel. This report seeks the Committee's agreement to make that reference. The draft letter of reference is attached as appendix A.

2 DETAILS

2.1. There is a long history to the proposals to reconfigure hospital provision in this part of London. The proposals currently under consideration were first formulated in 17/18 and the formal consultation period closed on 7 April this year. The Leader of the Council submitted a detailed response on behalf of the Council which is attached as appendix B. It includes a report prepared by the Council's instructed expert, Roger Steer.

2.2. In summary, that response called into significant doubt the clinical model proposed in the consultation business case prepared by the CCGs which would see emergency and other acute services concentrated in a new build hospital in Belmont, Sutton and a downgrading of the services currently on offer to Merton residents on the St Helier site. That site would be rebadged a "district hospital". However, the proposal does not include the range of services which would usually be delivered at a "district hospital". For example, there will be no A & E service, no consultant-led maternity service or access to emergency surgery, intensive care and other back up provision. Further, there are no coherent proposals to develop new or improve existing community services considered necessary to support the reconfiguration of services at the hospital. The advent of the Covid-19 pandemic has given further cause for concern about proceeding with the proposals at this point, before the full impact is known, not only in the acute sector, but also in the wider social care economy.

2.3. Under the Health Scrutiny Regulations, because the proposals cover more than one local authority area, the Council was required to participate in an Improving HealthCare Together Joint Health Scrutiny Committee (JHSC) with the London Boroughs of Sutton, Wandsworth, Croydon, Kingston and Surrey County Council. The JHSC met on 4 June and heard from the CCGs and from Roger Steer. Councillor Peter McCabe is Merton's member of that committee. Given the divergence of views held by its constituent councils, the JHSC was not able to make any formal recommendations but did submit a number of comments to the CCGs. A copy of those comments is attached as appendix C.

2.4. Although those comments are supported by the Council, they do not go the heart of the Council's objection to the proposal which, as stated above, is that the proposed clinical model is fundamentally flawed and if it were to proceed, which the Council contends it should not, the most appropriate site for the consolidation of acute services is the current St Helier site. Despite the existence of the JHSC, the Health Scrutiny Regulations allow the Council to exercise the right contained in regulation 23(9) to refer the proposed decision to the Secretary of State for Health and Social Care.

2.5. If a referral is made, the Secretary of State may ask for advice from the Independent Reconfiguration Panel (IRP), an advisory non-departmental public body. The IRP will undertake an initial assessment of any referral to the Secretary of State where its advice is requested**.** It may then be asked to carry out a full review. Not all referrals to the Secretary of State will automatically be reviewed in full by the IRP – this is at the Secretary of State's discretion. Depending on the outcome of any review by the IRP, the

Secretary of State may then make the final decision on the proposed reconfiguration which may differ from that made by the CCGs. Alternatively he can give directions to the health bodies themselves.

2.6. There are a number of grounds on which a referral to the Secretary of State can be made and the ones upon which the Council would propose to rely are those set out in regulation 23(9)(a) and (c) namely that:

(a) the authority is not satisfied that consultation on any proposal has been adequate in relation to content or time allowed; and

(c) the authority considers that the proposal would not be in the interests of the health service in its area.

2.7. The Secretary of State has issued guidance on the Health Scrutiny Regulations and this has been taken into account in drafting the attached letter of referral (Appendix A). The letter cross refers to a number of other stakeholder submissions and sets out in some detail the reasons why the Council considers the grounds in regulation 29(3)(a) and (c) are met.

2.8. The Committee is asked to agree to exercise its power to make a referral to the Secretary of State and to approve the letter attached at Appendix A. In the event that it may subsequently become necessary to make any minor drafting amendments following the meeting of the Committee, authority is sought for the Director of Housing and Communities to make such changes in consultation with the Chair of this Committee.

3 ALTERNATIVE OPTIONS

3.1. The alternative course of action to making this referral is to do nothing and simply to accept that the decision of the CIC on 3 July will proceed to implementation. For all the reasons set out in this report and the draft referral letter, that would not be interests of the health service and residents of Merton.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The reconfiguration proposals have been the subject of consultation with a number of bodies and in order to inform the response submitted by the Leader on behalf of the Council, the Council carried out its own consultation exercise.

5 TIMETABLE

5.1. If the recommendations in this report are agreed, then subject to any final changes to the letter of referral, it is proposed that it be sent forthwith. There do not appear to be any timescales either in the guidance or the Health

Scrutiny Regulations within which the Secretary of State is required to respond.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. At this stage, there are no direct financial implications in making the proposed referral to the Secretary of State.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. As stated above, the process of referral is governed by the Health Scrutiny Regulations. Full Council agreed at its meeting on 21 November 2018 to reserve the right to make that referral notwithstanding its participation in the JHSC.

7.2. The Council will argue that any approach which fails to give proper regard to health inequalities breaches the CCGs' duties under section 14T of the National Health Service Act 2006 ("the NHS Act"). Endorsing such an approach would breach the Secretary of State's duties under section 1C of the NHS Act.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. The provision of accessible comprehensive health services, particularly in areas of deprivation, as is the case in many wards in this borough, are fundamental to addressing health inequalities.

9 CRIME AND DISORDER IMPLICATIONS

9.1. None for this report

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. None for this report.

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- Appendix A – Proposed letter of referral to the Secretary of State for Health and Social Care
- Appendix B - Consultation response submitted on behalf of the Council
- Appendix C – Comments submitted by the an Improving HealthCare Together Joint Health Scrutiny Committee

12 BACKGROUND PAPERS

12.1.

APPENDIX A

Draft letter to the Secretary of State for Health and Social Care

Dear Mr Hancock,

I am writing on behalf of the London Borough of Merton ("**the Council**") to make a formal referral to you of the decision proposed to be made by the Surrey Heartlands and South West London CCG ("**the CCGs**") as a result of the meeting of the Committee in Common of the CCGs at their meeting on 3 July 2020 to approve the Decision Making Business Case ("**DMBC**") for the reconfiguration of hospital services in CCGs' areas in accordance with the Improving Healthcare Together 2020 to 2030 ("**IHT**") programme.

This reference is made under Regulations 23(9)(a) and (c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("**the Regulations**"). The Council makes this report to the Secretary of State because it is considered that the CCG's consultation on the IHT has been inadequate in relation to content or time allowed, in the context of the increased demands on NHS resources as a result of the COV19 pandemic (and potential future pandemics), and because the Council considers that the proposed decision would not be in the interests of the health service in its area.

The full suite of documentation relating to the IHT can be found on the dedicated website, a link to which is set out below:
IHT website

The Council would draw the Secretary of State's particular attention to the following

1. Submission from Merton Council
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.2.1-Merton-Council-Submissions.pdf

2. Siobhain McDonagh MP's July 2020 response to the consultation and submission to the CIC meeting on 3 July 2020

Siobhain McDonagh's response to consultation

Siobhain McDonagh MP's Submission to the CIC

3. From Community Action Sutton

https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/Community-Action-Sutton_CVS-Scheme_Report_FINAL_Apr-2020-2.pdf

4. From Merton Voluntary services

https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/Merton-Voluntary-Services-Council_CVS-Scheme_Report_FINAL_Apr-2020.pdf

5. Submission from Sutton council

https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.2.6-Sutton-Council.pdf

6. Submission from MP from St Georges Hospital: Dr Rosena Allin-Khan MP

https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.3.1-DrRosena-Allin-Khan.pdf

7. Submission from GMB union

https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.4.1-GMB.pdf

8. Submission from Trades Council https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E42MER1.pdf

9.Submission from Epsom and St Helier Unison branch

https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E.4.3-UNISON-Epsom-and-St-Helier-University-NHS-Trust.pdf

10. Submission on behalf of local campaigners (KOSH and KOEH)

https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/05/E51KEE1.pdf

These documents detail the shortcomings of the proposals in full and explain the errors made in the documents and processes undertaken by the CCGs. This letter seeks to summarise key points but the Secretary of State is asked to consider these reports in full.

The Council invites the Secretary of State to refer the proposed decision to the Independent Reconfiguration Panel ("**IRP**"). The Council is confident that the IRP would conduct a proper analysis of the merits of the proposal and will see the obvious flaws in the approach taken by the CCGs. For the reasons set out below, the Council does not accept that there has been an adequate and thorough evaluation of the many criticisms made of the PCBC nor any opportunity for stakeholders to respond and engage with the DMBC. Further, there has been no proper evaluation of future health and social care needs notwithstanding the COV19 pandemic and the potential for future pandemics. The Council considers that anyone outside the CCGs and the Epsom and St Helier Hospitals NHS Trust ("**the Trust**") would inevitably reach the conclusion that this proposal is premature, does not represent the best option commanding the agreement of stakeholders and is not convincing as a robust and resilient solution to current and future requirements. It is detrimental to the interests of Merton residents and would result in (or introduce a substantial and unacceptable risk of) a substantially inferior health service for NHS patients generally.

The background.

There is a long history of proposals for radical change to the provision of healthcare in South West London going back to at least the 1990s when the Epsom and St Helier Trusts were merged. Each of these plans has presented differing rationales for changes to NHS acute services and each has offered different potential solutions to perceived problems.

At the end of 2000 the "Investing in Excellence" plan proposed downgrading services in Epsom to centralise acute services at St Helier Hospital, which is located within the area of Sutton Council. In the autumn of 2003 a Clinical services Review Team proposed closing

Epsom's A&E and temporary centralisation at St Helier pending the building of a new critical care centre: the plan was abruptly dropped, but not before the Epsom MP had proposed the expansion of Epsom and the downgrade of St Helier as a counter proposal. This was followed by the 2003 consultation on "Better Healthcare Closer to Home" ("**BHCH**"), which involved the proposed closure of both Epsom and St Helier hospitals to be replaced by a new single site 500-bed 'Critical Care Hospital' at St Helier, Sutton or Priest Hill, and a group of ten local care centres which were said to facilitate a reduction in activity of up to 50%.

These proposals were rejected at the end of 2005 following strong local opposition. In January 2006 plans for a single site critical care hospital on the Sutton Hospital site collapsed, and the project director resigned. In 2009 with the future of services secured at Epsom Hospital after Surrey PCT dropped proposals to divert patients elsewhere, plans were approved for the complete refurbishment of St Helier hospital at a cost of £219m, and it was agreed that this would be government funded, and not paid for through the Private Finance Initiative. However it came to nothing.

After the election of the coalition government in 2010, another reconfiguration proposal, "Better Services, Better Value" ("**BSBV**"), was introduced in May 2011 and in effect killed off the refurbishment plans. BSBV was put forward as a clinical initiative led by local GPs and hospital clinicians, and included some of the original proponents of BHCH. Ostensibly its aim was to improve the quality of services in South West London and to contribute to the need to ensure financial sustainability in the wake of the financial crash and the Government's austerity policies. However, common to both BHCH and BSBV seems to have been an antagonism to the continuation of services on the St Helier site.

The next proposals were to break up the Epsom St Helier Trust, with St Helier to be merged with St George's and Epsom to be merged with Ashford and St Peter's in Surrey. Both of these proposed mergers collapsed in 2012 because of unresolved financial problems. Eventually in 2014 after much controversy BSBV plans were dropped after failure to present a compelling business case and to secure agreement across stakeholders in SW London and in Surrey. Just 3 months later a new 5-year "strategy" document was published by the South West London CCGs, now working together as "South West London Collaborative Commissioning,"

effectively cutting the links with Surrey Downs CCG. The Strategy proposed "vacating and disposing of" the Sutton Hospital site, but also called for "service changes ... across the provider landscape which would deliver financial savings while also making it easier to deliver the improved services Commissioners want to achieve for their patients." It proposed to expand Kingston Hospital and increase bed numbers at St George's.

By 2016, much of the "strategy" appeared to be forgotten or discarded because the new Epsom St Helier Chief Executive began promoting plans for a new 800-bed single site hospital. This hospital was proposed to replace the 1,162 beds provided in the existing Epsom and St Helier hospitals.

The most recent IHT proposals, formulated in 2017/18, have sought to overcome past problems by:

- narrowing the scope of proposals to three CCG areas rather than as a pan South West London solution
- cost shifting the impact of reducing local capacity to other providers, social care providers and community services;
- using the main argument that this is because staff cannot be recruited to support two A&E departments at St Helier and Epsom ,and,
- securing pre-approval from the Secretary of State for up to £500m of resources ear marked now in future capital spending rounds as an incentive to proceed quickly.

These announcements were made in the run up to the last election and thus there is legitimate public expectation that spending pledges will be fulfilled; albeit that the caveat was made that plans would be subject to business case approval. Many may be forgiven for thinking this is a minor technicality but in reality it remains a significant hurdle, not least in that the financial case seems weak and stakeholders are fiercely divided on the legitimacy of the processes for selecting options to be shortlisted, on the adequacy of the analysis presented so far, the viability of the severely reduced scale of acute bed provision outlined in the preferred option, and for the selection of the preferred option for centralising major

services at Sutton. These doubts have now been compounded by fears of inadequate capacity revealed by the COV19 pandemic and the need for the NHS to be ready to meet the demands of future pandemics.

IHT seeks to promote a preferred option of removing all major services (A&E services, maternity and paediatrics, emergency surgery and acute medicine) from both Epsom hospital and St Helier hospital to a site in Sutton where, in effect, a new hospital will be built. The pre-consultation business case ("**PCBC**") suggests there should be what are termed "district hospital services" based on the existing sites at Epsom and St Helier. This is a mis-use of language. The proposal does not intend to create the same range of services at Epsom and St Helier as would usually be provided at a "District General Hospital". The range of services at a "district hospital" will be substantially reduced because there will for example, be no A & E service , no consultant-led maternity service or access to emergency surgery ,intensive care and other back up as would be expected at a District General Hospital. Specifically in relation to maternity services, there appears to be an assumption that more women will choose to have home births although there is little or no evidence to support this assumption.

The Council and other stakeholders have been led to believe this will be cheaper, safer and provide higher quality accommodation on a more sustainable basis, principally by being easier to recruit and retain staff. However, the Council remains unconvinced because the new model will treat fewer patients with a significantly reduced number of consultants. There are significant concerns about the complex, risky and expensive three site configuration proposed and the credibility of the claims for increased efficiency, cost savings and improved quality of services.

There are equally some difficult issues around the proportion of qualified nurses required to cover the reduced number of acute beds and downgraded beds at Epsom and St Helier.

The CCGs have proceeded with public consultation quickly before establishing a broader understanding and agreement across stakeholders of the risks the NHS would be taking in making these changes without having secured the necessary support.

The nature of the Council's objections to the proposed CCGs decisions.

The Council has reached the view that the CCGs consultation on the IHT has not been adequate in relation to content or time allowed and that the proposed reconfiguration decision would not be in the interests of the health service in its area, for the reasons set out below.

1. The decision fails to give effect to the NHS's commitment to tackle health inequalities.

The Council is hugely sceptical about whether it is in the interests of the users of the health service in its area for acute services at Epsom and St Helier hospitals, in effect, to be amalgamated on a single site. The reasons for that scepticism are set out below. However, if the acute services at Epsom and St Helier hospitals are to be amalgamated on a single site, the Council considers that there is an overwhelming financial, clinical and legal case for that site to be St Helier Hospital as opposed to either Epsom Hospital or a new build on the Sutton site.

A proposal to locate acute facilities in Sutton would be yet another example of the NHS taking decisions to move acute care facilities away from lower socio-economic areas and to build them up in more affluent areas, despite the benefits of improved access for poorer people of developing service where those services are most needed.

The proposal to invest the bulk of £500M of public money to create a single major acute site at Sutton Hospital, the location of a new Specialist Emergency Care Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals involves moving substantial services away from St Helier Hospital and thus reducing the ability of poorer communities with higher levels of deprivation and greater health inequalities to access NHS services. The plans are redolent of thinking which has failed to learn lessons from the original Marmot Report into health inequalities in 2011 (which build on a series of earlier reports) and the recent Marmot review report in February 2020. The 2020 Report said:

"Life expectancy follows the social gradient – the more deprived the area the shorter the life expectancy. This gradient has become steeper; inequalities in life expectancy have increased. Among women in the most deprived 10 percent of areas, life expectancy fell between 2010-12 and 2016-18 ….

The national government has not prioritised health inequalities, despite the concerning trends and there has been no national health inequalities strategy since 2010"

An approach which fails to give proper regard to health inequalities breaches the CCGS' duties under section 14T of the National Health Service Act 2006 ("**the NHS Act**"). Endorsing such an approach would breach the Secretary of State's duties under section 1C of the NHS Act.

The DMBC found:

"This analysis shows a clear and consistent association of higher rates of A&E attendance for those living in the more deprived communities" [p100]

It then said:

"The IIA found that the planned changes to district services may lead to the enhancement of local service offerings which may in turn lead to improved health outcomes for those from deprived areas and bring about changes which may help to reduce health inequalities [p101]"

The Council considers that the IRP will see the obvious flaws in that approach, namely that this wording appears to suggest that <u>reductions</u> in the range of Accident and Emergency Services at St Helier, which is the hospital serving the populations with the highest level of health inequalities, will "*help to reduce health inequalities".* That is an example of a conclusion being drawn before the evidence is considered. It is totally nonsensical because there is no evidence that a reduction in services to the poorest communities will or even has the capacity to reduce health inequalities.

The methodology used in the DMBC to analyse inequalities is also at fault. No proper age weighting appears to have been used for the analysis. One key aspect of health inequalities is that people in poorer populations suffer illnesses earlier in life than those in more affluent areas. That flaw is shown clearly in the DMBC at p113 where is says:

> *"Of note within the analysis overall is the increased rate of non-elective medical admissions for the Surrey Downs area per 1,000 residents in comparison with either the Merton area and Sutton area. This is largely attributable to the higher proportion of elderly residents in the Surrey Downs area. In terms of the association between lengths of stay in hospital and deprivation, there is no pattern of consistency"*

Thus, in assessing health inequalities, the DMBC made fundamental errors. The extent to which the DMBC has totally failed to understand or take account of health inequalities is demonstrated by the recommendation that further work should be undertaken on health inequality issues. Recommendations 12 and 13 were:

> *"12. Review district service provision against local health inequalities*
>
> *13. Re-assess accessibility issues for deprivation groups for preferred option"*

However the Council believes that this work ought to have been undertaken before the decision is made on location, not afterwards. In any case it is impossible to believe that any objective assessment could reach the conclusion that the relocation of services serving the most disadvantaged away from the location at which such persons live could be to their advantage when it is fully justifiable to develop those services on the site closest to those with greatest disadvantage. There are no compelling advantages that could not have been secured more directly otherwise e.g. by .training more staff.

This absence of due regard being had to health inequalities is shown in the list of "legal duties" to which the CCGs had regard as set out at page 31 of the presentation to the final decision making meeting. The key duty to tackle health inequalities was absent from this list.

The final integrated impact assessment recognised that socio-economic status and deprivation is directly linked to health inequalities [see p97]. That report noted:

> *"Of the 11 LSOAs in the top quintile, none are in Surrey Downs, four are in Merton, and seven are in Sutton. Sutton also has the LSOA with the most deprived population (in Beddington South)"*

These LSOAs are substantially in the area around St Helier Hospital.

The report recognised that there was disadvantage to people in deprived areas of the chosen location for acute services, albeit that it suggested that other factors had a greater impact. However, as the IHT decision was only about acute services, the impact of other measures to tackle health inequalities was irrelevant unless it also contained detailed other proposals to tackle health inequalities, which it did not.

Thus the Report recognised that there were disadvantages for deprived communities in moving services away from locations where they could access them easily but the CCGs failed to take that into account when making this decision.

2. The failure to model the effect of displacing patients away from the Trust and towards other hospitals and social care.

The Council is concerned that, despite the considerable proposed investment, the plans will result in fewer doctors, fewer beds and an overall reduction in services for local people. That reduction is planned against the background of a historically low level of hospital beds to meet the needs of local people. The DMBC assumes a 2% per annum reduction in emergency admissions up to 2025/26 and a 3% per annum reduction in activity overall, with a 3% per annum bed savings by reducing length of stay. These are not only untested assumptions but the evidence from elsewhere in the NHS shows they have not been achieved. Overall the new configuration proposes a reduction of 80 acute hospital beds but this number is arrived at taking into account by "district" hospital beds which lack the necessary comprehensive

support found in acute settings. The real cut in major acute beds is 452. The problem, from the Council's perspective, is that fewer hospital beds being provided in a less convenient location will lead to the following outcomes.

a) Merton residents will not seek emergency NHS treatment in Sutton, they will go to their nearest hospital which is likely to be another London hospital, notably St George's, Tooting. Thus downgrading St Helier will not result in patients relocating from St Helier to Sutton but from St Helier to St George's. That transfer will put additional pressure on St George's. There is no assessment as to whether St George's can absorb that additional work. However the movement away from "payment by results" means that (unless financial arrangements change) the St George's Trust will not be provided with further financial resources to fund this additional work, nor is the physical capacity available at St George's (and no expansion is planned or budgeted for);

b) There will be fewer patients attending the Sutton Hospital and thus, in effect, the block payment to the Trust by the CCGs will fund services for significantly fewer more affluent patients. Whilst that may well be good news for the more affluent patients, it is really bad news for those with the highest level of health needs. They will find fewer services for them and less funding for those services; and

c) Fewer patients will be seen within acute hospitals, causing increasing strain on already overloaded community and social care services.

Thus Merton residents will not only find acute services harder to access as those services move away from them if this misguided decision is implemented but they will also have fewer services to access if they do seek to access services.

3. The Council refutes the suggestion that achievement of defined clinical standards make the best use of limited NHS and social care resources.

The Council challenges whether there is a proper evidence basis to support larger hospitals based on the achievement of clinical standards. The problem, in summary, is that clinicians have looked at the type of environment that works best from a clinician perspective within a hospital. That approach inevitably leads to larger and larger hospital units, which can only operate successfully if these larger units serve the needs of more and more patients. However there are serious questions about whether improved clinical standards do, in fact, come from larger hospitals. Fewer, larger, hospitals mean increased lengths of journey for patients and visitors, with the risk of creating a reluctance for patients or visitors to attend because of the distance and there is real doubt as to the evidence that, despite predictions "bigger is best" for health outcomes. This consultation was supposedly based on a desire to achieve these standards but the real question for debate should have been whether those standards were realistic, achievable and make the best use of limited NHS and social care resources. If the questions were posed in that way, the obvious answer is that a sole focus on achieving these standards does not make the best use of limited NHS and social care resources.

Indeed the CCGs appear to be saying that the most telling argument for reducing services is that it is not possible to train and recruit sufficient staff locally, not that there isn't a need for local services. The Council would like to see this problem addressed strategically rather than be asked to accept that services must be built around the contrived constraint of a shortage of clinical staff.

4. Learning the lessons of the Covid-19 pandemic.

Fourthly, the CCGs have moved too quickly and, as a result, will almost certainly have failed to learn the lessons of the Covid-19 pandemic. It is far too early properly to learn the entirety of the lessons from the pandemic, but the emerging evidence is that more hospital beds will be needed in the future, not less. The days of NHS hospitals being able to run at capacity rates of more than 95% ought to be over. If the CCGs had a combination of wisdom and humility, they would accept that this is <u>not</u> the time for the NHS to be making long-term decisions to reduce capacity further. The work that the CCGs have done to assess the impact of Covid-19 has been superficial and inadequate. In particular, no proper account has been

taken of the emerging evidence that people from BAME communities have been disproportionately affected by Covid-19, both in terms of susceptibility to the virus and the seriousness of its impact. In fact, the 5 page document produced by the CCGs in seeking to assess the impact of the Covid-19 failed even to mention BAME communities. This work came to the conclusion that the strains that the pandemic had put on the NHS in fact supported their plans. However that conclusion does not bear proper examination as it is frankly far too early to know how the pandemic will affect future NHS planning.

Thus the Council believes that the CCGs ought to have halted this consultation process, waiting until it was clear what lessons were being learned from the pandemic and then recommenced the consultation process. We consider that the need to learn lessons from the pandemic means that this was the wrong time to complete the consultation and thus the Secretary of State should set aside this decision under Regulation 23(9)(a).

5. The misrepresentation of the public voice in the DMBC.

The DMBC substantially misrepresents the outcome of the consultation exercise. It misrepresents the views expressed by the public and misunderstands the way in which the public responded to the consultation process. The details of the errors are set out in the excellent and detailed report prepared by the local Member of Parliament, Ms Siobhan McDonagh which is annexed to this letter. We can do no better than to refer you to the details set out in that report which it makes it clear that in almost every aspect of the consultation responses there was overwhelming opposition to the Belmont option.

The way in which the CCGs explained how the public responded to the consultation has been indicative of the fact that this appears to the Council to be a reconfiguration project which has been “ego driven” by senior Trust managers who have used force of personality to drive forward the reconfiguration agenda rather than being an “evidence driven” process. Senior managers at the Trust have created a wholly artificial focus on the hospitals within the Trust instead of focusing the planning around the needs of health and social care more generally across South West London. As a result the NHS has developed plans which do not make any sense for the wider health and social care economy.

As a result, the plans are a colossal waste of tax-payers' money. There are far better ways to apply the substantial investment monies than those proposed in the DMBC, as the material provided by the Council to the CCGs has clearly demonstrated. However, once the NHS train was put on the track with the aim of creating, in effect, a new white elephant hospital in Sutton and down-grading the services at St Helier, no amount of evidence appears to have been able to persuade the CCGs that this was a crazy plan.

6. The money does not add up.

The Trust is in significant financial deficit and requires support from NHS England to continue in operation. However, the plans are built on expectations of financial savings by the creation of new clinical models which have not worked elsewhere. An Independent expert review has cast doubt on the reliability and accuracy of the savings claimed and it is significant that the plans have not been assured by NHS London or NHE England finance professionals as is stipulated in guidance.

The Treasury, who approve all capital projects of more than £50m at the moment, issue the Green Book and the Guide to developing the Project Business Case. These lay down clear guidance for on the process involved in investment appraisal, particularly the options appraisal process and the requirement to consider properly lower cost do-minimum options. Further guidance on multi –criteria analysis of the type deployed in the PCBC can be found in a manual issued by central government and the guidance on economic modelling issued in December 2019. This guidance does not appear to have been followed, with inadequate consideration of lower cost options and options involving behavioural changes which, taken together with some much needed capital investment in the existing buildings would reduce the need for such radical and expensive changes to buildings as a so-called solution to recruitment difficulties. Further detail of the flaws in the financial analysis and particularly the assessment of net present value can be provided in due course. It should be noted that in making the announcement of the funding for Epsom and St Helier capital development, you also said that future details of a new capital funding regime would be published before the

end of 2019. It is still not clear either what that the future system will be; or the system for future funding of social care, again long promised.

Page 31 of the DMBC contains a long list of services that the Trust would like to see delivered in the community. But there is no agreed funding to expand community services to pay for those services. Hence the clinical model proposes moving services out of an existing hospital environment (where they are funded) to community locations (with no identified funding).

If funding is diverted to support all of the community services that are described in the DMBC, the proposal becomes unaffordable. However without that funding being part of the overall plan, it is unrealistic.

Overall, the Council does not consider that this proposed decision is well thought through or has been subject to the type of thorough analysis needed before major changes are made to NHS services. That so many other key stakeholders, including the staff, and many thousands of the public think similarly reinforces our position.

The consultation should not have continued through the Covid-19 pandemic and everyone should have stopped and asked themselves difficult questions about whether this was the right way forward. That was not done. The Council thus invites the Secretary of State to refer this matter to the IRP for a thorough analysis.

The matters set out in this letter and the attached documents are, by definition, at a high level. The Council will co-operate the IRP to develop the arguments and analysis.

Yours sincerely,

E.2.1 Merton Council - Submission

COUNCILLOR STEPHEN ALAMBRITIS
LEADER OF THE COUNCIL
(Labour, Ravensbury Ward)

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Stephen.alambritis@merton.gov.uk

Date: 6 April 2020

By email only: hello@improvinghealthcaretogether.org.uk

Dear Sirs

Re: Improving Healthcare Together 2020-2030: Consultation

I refer to your consultation on the above programme. Whilst I am grateful for the short extension that Sarah Blow gave the Council in an email dated 26th March 2020 for filing its response to the consultation, given the unprecedented circumstances healthcare staff in the NHS and the Council are currently facing, I am astonished that you chose not to suspend the consultation.

By way of response I enclose the following documentation:

1. Completed Questionnaire.
2. Report commissioned by the London Borough of Merton of Roger Steer, Independent Consultant of Healthcare Audit Consultancy.
3. Report of the Council's own consultation process together with comments.

As you are aware the Council has regularly and consistently raised concerns about process, gaps in the analysis being undertaken and impact on other providers since the Trust first engaged on these proposals in 2017, and over the past two years through the Improving Healthcare Together Programme. Whilst the programme team has attempted to address some of these concerns, through the commissioning of the Deprivation Impact Assessment and recent work with the Council's Public Health team on additional analysis in the Integrated Impact Assessment, many of our concerns remain.

As such, the Council formally expresses its opposition to the Pre Consultation Business Case and to the preferred option put forward in the consultation.

The reasons are set out in the questionnaire and our Consultant's report. The result of the local consultation undertaken by the Council also overwhelmingly indicate that respondents strongly agree that Emergency Services, Maternity Services and Queen Mary's Hospitals should remain at St Helier Hospital.

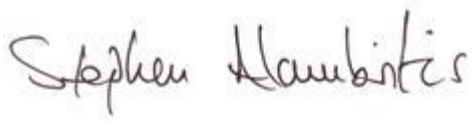
Further the Council recommends:

1. That you undertake additional work on lower capital cost options for services on two sites not three;
2. That the NHS seeks additional trainees, rota changes and incentives to staff to improve recruitment and retention; and
3. That you work with Merton's Health and Wellbeing Board to reappraise the longer term priorities and the need for (and possibility of achieving) additional savings in the light of the government's declared intentions to respond to disquiet on the funding of the NHS and the current crisis which has exposed the lack of capacity within the NHS.

I also confirm that the Council will be tabling its response at the South West London & Surrey Joint Health Scrutiny Sub-Committee at its forthcoming meeting currently scheduled for 4 June 2020 in order that it can be taken into account as part of their considerations further to the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Finally, I would like to place on record my thanks to everyone working in the healthcare sector in this extremely challenging time. As the circumstances we are facing are unprecedented in recent times, I strongly urge you to reassess and re-evaluate the assumptions made in your proposals in light of COVID-19, to properly address the questions of capacity and resourcing that the pandemic has exposed within the healthcare system.

Yours faithfully,



Councillor Stephen Alambritis
Leader of the Council

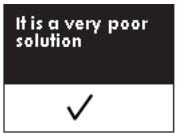
Councillor Tobin Byers
Cabinet Member for Adult Social Care, Health and the Environment

cc.
Sarah Blow, Accountable Officer SWL CCG
Dr Andrew Murray, Clinical Chair, SWL CCG
Dr Vasa Gnanapragasam, Chair, Merton Borough Committee
James Blythe, Managing Director, Merton Borough Committee
Councillor Colin Stears, Chair, SWL & Surrey JHSC Sub Committee

Q1 Our model of care (or new way of working)

Our proposal is to keep most services at their present hospitals in refurbished buildings, and bring together six core (main) services for the most unwell patients, those who need more specialist care, and births in hospital, onto one site in a state-of-the-art new specialist emergency care hospital.

In the table below, please tick a box to tell us how good or poor you think this proposal would be for people living in the Surrey Downs, Sutton and Merton area.



Please give the reasons for your answer in the space below.

There is a prima facie case for the solution identified being against the interests of local people; particularly at this time.

The local authority has commissioned independent advice on the question and would wish to engage the NHS in further discussion on the issues raised: in particular the advice that lower cost options should be more fully considered at this stage.

The conclusions to that advice were:

Clinical:

7.1 The objectives being pursued, of defining the best healthcare as compliance with "London" clinical quality standards are unrealistic and restrictive. The CCGs also prejudge the issue of reconfiguration and whether this is really the answer to London's problems or more particularly the clinical issues in Merton, Sutton and Surrey Downs.

7.2 The preferred option is promoted without properly discussing the potential benefits of other more modest, realistic options.

7.3 There is a major risk that plans will not adequately provide for the increased demand expected in future years and that assumptions that major reductions in beds can be achieved will not be borne out in reality. This has been the case over the last twenty years. Various assumptions that the development of out of hospital care could substitute for hospital beds have remained unproven to the extent claimed. NB Better Healthcare Closer to Home (BHCH) claimed in 2003 up to 50% cuts in activity were possible.

7.4 There is a further major risk that the solution promoted to overcome current staffing problems will not succeed, and that the national and London wide staffing issues will transfer into the new improved premises – or be displaced to elsewhere in SW London.

7.5 There is a real risk that by offering the opportunity for further sub-specialisation (see Impact assessment) and the development of specialised services at Sutton that the focus of services will shift towards the interests of clinicians and not the interests of patients needing generalist services and skills.

7.6 There is a prima facie case that the proposed reductions in A&E catchment areas incorporated in plans for the preferred option (16%), reductions in consultant staff available (69wte), middle ranking and junior medical staff (73wte), qualified nurses (33%) and in access to major acute beds (452 beds) are not in the interests of local health services.

Financial/Economic

7.7 The options appraisal does not offer a proper consideration of lower cost options, including Business as Usual (BAU), a do –minimum option and retention of just the two existing sites, with either one as the centralised facility.

7.8 The benefits of the 3-site "centralised" option appear mis-stated and misleading. Further scrutiny and assurance is required. It appears costs are merely being shifted to other trusts in SW London who will face the additional operational costs and problems of the shift in patient flows being directed away from St Helier and Epsom sites.

7.9 Claims that the resulting three site configuration will be cheaper, more efficient and will solve staffing problems appear unrealistic and overoptimistic.

7.10 The risks of the proposals have not been quantified in the financial analysis

7.11 There is a significant risk that cost overruns in the main project at Sutton would "crowd out" the viability and investment funds available at the other sites and resources available to invest in out of hospital services

Access

7.12 The proposed preferred option is worse than BAU or any option retaining services at two sites. It is significantly worse for those relying on public transport and in deprived groups.

7.13The weighting given to access issues and transport issues appears small in the overall weighting in the Multi criteria analysis.

7.14 LB Merton may wish to consider undertaking its own research on the importance of access to services for local people.

Process

7.15 The public consultation seems to have been initiated too soon before issues relating to the options considered and the impact assessment were fully understood and agreed.

7.16 Important information on assurance and on the supporting detail to the proposals is missing at time of public consultation.

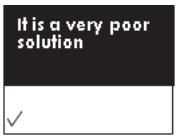
7.17 There is still time for shortfalls in the process to be corrected but it is unlikely that the flaws in the process will be corrected in the absence of a fuller, balanced, and detailed evaluation and discussion.

7.18 There is a major risk that the NHS will proceed to DMBC with the proposals substantially the same without any further opportunity for stakeholders to be consulted and to influence the decision.

Q2 The location of the specialist emergency care hospital

Q2a Sutton Hospital as our preferred location

In the table below, please tick a box to tell us how good or poor you think building the new specialist emergency care hospital on the Sutton Hospital site would be for people living in the Surrey Downs, Sutton and Merton area.



It is an inferior location to the existing location of services for local people in Merton and overall for the peoples over the whole area compared to lower cost options designed to address staffing issues and estates issues at lower cost.

These lower cost options need to be considered in more detail prior to the re-presentation of plans.

Q2b St Helier Hospital as the location of the new specialist emergency care hospital

Q2c Epsom Hospital as the location of the new specialist emergency care hospital

LB Merton has not responded to these options as we feel it inappropriate until such time as the case for centralisation has been more firmly established. More facilities made available for local people more accessibly is attractive but only if plans are realistic, affordable and not at the expense of staff, other localities , and patients generally.

Q3 What would help improve transport and travel?

What would improve public transport and travel to the new specialist emergency care hospital for any of the three options?

The obvious answer to the question is for access to be at least as good as the current situation for most people requiring public transport, and the most disadvantaged in particular. Given the investment of £500m an improvement would be beneficial and persuasive.

The evidence from the impact assessment is that all options would be a deterioration compared to the status quo requiring patients to travel to other hospitals outside of the boroughs and face longer and more time consuming journeys.

Q4 How would our proposals affect you and your family?

If you think any of our proposals would affect you, your family or other people you know, either positively or negatively, please tell us why you think this using the space below.

The potentially adverse consequences of these plans may be to divert scarce resources into expensive facilities at the expense of staff and services based more locally and accessibly.

The plans are likely not to address the general staffing problems and may paradoxically make them worse by creating an overcrowded difficult to manage, complex configuration. We would prefer more obvious solutions to be more vigorously pursued.

We also refer you to the qualitative responses in our survey for some of the ways residents in Merton believe the proposals would impact them.

Q5 What else should we consider?

Please use the space below to tell us about anything else you think we should consider when deciding the best option for specialist emergency care hospital for people living in the Surrey Downs, Sutton and Merton area.

By framing the question as it is the questioners appear to pre-empt a decision that has not yet been made which involves the public as to whether centralisation of specialist emergency care in a new hospital represents the best compromise solution for local people taking all issues of resources, accessibility, location and clinical issues into account.

This prior question needs to be addressed more openly and settled satisfactorily for the local authority and other stakeholders.

LB Merton consider that options involving a two site solution, costing less should be considered more fully and be presented to the public.

Q6 Do you have any other solutions that we should consider?

This is a very difficult question to answer and impossible for most people without access to information, knowledge and expertise in these matters.

Where we believe answers and potential solutions may emerge for stakeholders to consider is if information and data could be presented which can persuade people that the reasons for financial difficulties, any poor clinical and efficiency performance against appropriate bench marks, statistics on the rising clinical needs and population, and the evidence that proposed changes will fully address these matters reliably and sufficiently to cover their high costs.

What is striking to us as outsiders is that the numbers of clinical staff appears high and yet there are acute shortages in those areas where we would see the priorities of the local health service should be: in helping those with the greatest urgent and emergency need. It is possible a reprioritisation of available resources towards generalist and emergency services is appropriate and should be considered. In addition we note that there is a very unstable context for making radical changes and

we consider more time should be taken to ensure that such changes are the right ones and are fully supported in the community.

The risks of challenges, mistakes and undue haste leading to costly errors appear to us as very high.

Report for London Borough of Merton on

'*Improving Health Together*'

Public Consultation

Roger Steer

March 2020

About the Author

Roger Steer is a senior and experienced healthcare manager and management consultant. He has worked in the NHS in Chief Executive and Director of Finance roles, but has also been a Regional Performance manager of very large capital programmes and is familiar with the issues of gaining Treasury approval for large schemes and planning large scale change.

Since 2003 he has been a Director of Healthcare Audit Consultants which specialises in providing advice to Local Authorities scrutinising NHS Plans, including reviews in 2005 and 2013 of previous reconfiguration proposals in south west London and more recently of very large reconfigurations proposed in north west London, where he is engaged in a monitoring role ensuring he is current with the latest issues and thinking. He co-authored a large review of STPs for South Bank University and has acted as an expert witness in two recent judicial reviews on reconfiguration proposals.

1 Introduction

This briefing has been commissioned by the LB Merton in order to help them discharge their public duty to scrutinise NHS plans, specifically proposals for major changes in local health services in Merton, Sutton and Surrey Downs, contained in public consultation documents and supporting documents for "'Improving Health Together'[1].

The current advice provided to the NHS [2] on scrutiny usefully summarises these duties (page 38):

"Local authority overview and scrutiny committees have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health services in their local area.

• Commissioners must consult the local authority when considering, or a provider is considering, any proposal for a substantial development or variation of the health service in the area. The local authority may scrutinise such proposals and make reports and recommendations to the NHS commissioning body (CCG or NHS England) or referrals to the Secretary of State for Health.

• As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from local Healthwatch. The overview and scrutiny process can therefore enhance public involvement in the commissioning process.

• The threshold for reporting proposals to the local authority under the overview and scrutiny process is higher than that for the duty to involve the public under section 14Z2 and 13Q. However, the duties frequently overlap, particularly where significant changes to the configuration of local health services are under consideration.[3]

The advice is further elaborated in the following sections of the 2018 advice in regard to Public Consultation:

7.6 Health scrutiny

NHS bodies have a legal duty to consult the local authority in certain circumstances.

Although it is strongly advised that local authority scrutiny functions are involved throughout development, commissioners should hold a separate formal discussion on the final set of proposals on which they intend to consult.

7.8 Public consultation

[1] All documents are listed on the Improving Health Together website https://improvinghealthcaretogether.org.uk/important-documents/

[2] *Planning, assuring and delivering service change for patients* NHS England March 2018

[3] For further information, see s.244 NHS Act 2006 and Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (*http://www.legislation.gov.uk/uksi/2013/218/pdfs/uksi_20130218_en.pdf*

Subject to feedback from local authorities, the proposing body may decide to progress to public consultation on the range of options that will be tested with staff, patients and the public, subject to assurance by NHS England.

NHS England has a role in the assurance of all commissioner-led schemes. This will ensure consistency across the NHS commissioning system and ensure that good practice and lessons learnt are shared.

And in regard to decisions:

8.1 Situations may arise where consensus over service change cannot be agreed between the commissioner and relevant local authority. Wherever possible, decisions about how the NHS is run should be made locally by those directly involved. Local authorities may refer proposals to the Secretary of State, if:

• The consultation has been inadequate in relation to the content or the amount of time allowed.

• The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.

• A proposal would not be in the interests of the health service in its area.

The NHS is further reminded of what can go wrong:

3. The high costs of getting it wrong

A high profile programme that has been subject to both Judicial Review and referral to the Secretary of State is estimated to have cost >£6m. The proposed changes remain unimplemented. (p23)

I would add this is not the greatest risk: a greater risk is of proposals being inadequately scrutinised leading to uneconomic or risky proposals being implemented which prove more costly than expected, which fail to deliver the benefits and reduce the quality and quality of services delivered to patients.

In NW London following closures of A&E departments as the first stage of its "Shaping a Healthier Future" reconfiguration plan, emergency building of expensive, additional capacity at London North West University Healthcare NHS Trust (LNWH) had to be arranged as remaining capacity could not cope. A Confidential Inquiry[4] organised by NHS England found that there had been errors in calculations, lack of scrutiny in plans and inadequate account taken of the increases in demand and population. The costs of this programme reached £250m before it was eventually scrapped.

There is every reason therefore for the local authority to closely scrutinise plans and for the NHS to pay due regard to the feedback of local authorities.

In section 2 I draw attention to the history and the changing nature of proposals in this part of SW London and highlight issues from the process for making decisions around the

[4] Retrospective review of impact in NWL of A&E changes at CMH and HH NHS England 20thMarch 2015.pdf

proposals being made in the Improving Health Together (IHT) Pre-consultation business case (PCBC)[5]. In particular I draw on the extensive guidance that exists around the subject. I further discuss the key issues that emerge from the IHT process and proposals in terms of the clinical arguments (section 3), the financial and economic arguments (section 4) and the impact on access for local people (section 5). In addition I make suggestions for how the ongoing process can be improved to ensure that as much consensus can be reached in future decision making and that stakeholders can be persuaded that the processes are fair (section 6). Finally I provide some concluding remarks, recommendations and a way forward.

2 Background to the IHT proposals

There is a long history of proposals for radical change to the provision of healthcare in South West London going back to at least the 1990s when the Epsom and St Helier trusts were merged. Each of these plans has presented differing rationales, and not all have involved the creation of a new hospital at Sutton as the solution. At the end of 2000 the "Investing in Excellence" plan proposed downgrading services in Epsom to centralise at St Helier. In the autumn of 2003 a Clinical services Review Team proposed closing Epsom's A&E and temporary centralisation at St Helier pending the building of a new critical care centre: the plan was abruptly dropped, but not before the Epsom MP had proposed the expansion of Epsom and to downgrade of St Helier as a counter proposal.

This was followed by the consultation on Better Healthcare Closer to Home (BHCH 2003), which involved the closure of both Epsom and St Helier hospitals to be replaced by a new single site 500-bed 'Critical Care Hospital' at St Helier, Sutton or Priest Hill, and a group of ten local care centres which were said to facilitate a reduction in activity of up to 50%. These proposals were rejected at the end of 2005 following strong local opposition.

In January 2006 plans for a single site critical care hospital on the Sutton Hospital site collapsed, and the project director resigned.
In 2009 with the future of services secured at Epsom Hospital after Surrey PCT dropped proposals to divert patients elsewhere, plans were approved for the complete

[5] Improving Health Together 2020-2030 Pre-Consultation Business Case Surrey Downs, Sutton and Merton Clinical Commissioning Groups December (2019)

refurbishment of St Helier hospital at a cost of £219m, and it was agreed that this would be government funded, and not paid for through the Private Finance Initiative.

However it came to nothing. After the election of the coalition government in 2010, another reconfiguration proposal, Better Services, Better Value (BSBV), was introduced in May 2011 and in effect killed off the refurbishment plans. BSBV was put forward as a clinical initiative led by local GPs and hospital clinicians, and included some of the original proponents of BHCH. Ostensibly its aim was to improve the quality of services in South West London and to contribute to the need to ensure financial sustainability in the wake of the financial crash and the Government's austerity policies. However, common to both BHCH and BSBV seems to have been an antagonism to the continuation of services on the St Helier site.

Then came proposals to break up the Epsom St Helier Trust, with St Helier to be merged with St George's and Epsom to be merged with Ashford and St Peter's in Surrey. Both of these proposed mergers collapsed in 2012 because of unresolved financial problems.
Eventually in 2014 after much controversy BSBV plans were dropped after failure to present a compelling business case and to secure agreement across stakeholders in SW London and in Surrey.

Just 3 months later a new 5-year "strategy" document was published by the South West London CCGs, now working together as "South West London Collaborative Commissioning," effectively cutting the links with Surrey Downs CCG. The Strategy proposed "vacating and disposing of" the Sutton Hospital site, but also called for "service changes … across the provider landscape which will deliver financial savings while also making it easier to deliver the improved services Commissioners want to achieve for their patients." It proposed to expand Kingston Hospital and increase bed numbers at St George's.
By 2016, with much of the "strategy" apparently forgotten or discarded the new Epsom St Helier chief executive began promoting plans for a new 800-bed single site hospital – to replace the 1,162 beds provided in the Epsom and St Helier hospitals.

The most recent IHT proposals, formulated in 2017/18, have sought to overcome past problems by:

- narrowing the scope of proposals to three CCG areas rather than as a pan SW London solution,

- cost shifting the impact of reducing local capacity to other providers, social care providers and community services;
- using the main argument that this is because staff cannot be recruited to support two A&E departments at St Helier and Epsom ,and,
- securing pre-approval from the Secretary of State for up to £500m of resources earmarked now in future capital spending rounds as an incentive to proceed quickly.

These announcements were made in the run up to the last election and thus there is legitimate public expectation that spending pledges will be fulfilled; albeit that the caveat was made that plans would be subject to business case approval. Many may be forgiven for thinking this is a minor technicality but in reality it remains a significant hurdle, not least in that the financial case seems weak and stakeholders are fiercely divided on the legitimacy of the processes for selecting options to be shortlisted, on the adequacy of the analysis presented so far, for the viability of the severely reduced scale of acute bed provision outlined in the preferred option, and for the selection of the preferred option for centralising major services at Sutton.

IHT seek to promote a preferred option of removing all major services (A&E services, maternity and paediatrics, emergency surgery and acute medicine) from both Epsom hospital and St Helier hospital to a site in Sutton. The pre-consultation business case (PCBC) suggests there should be what are termed District hospital services (a novel term) based on the existing sites at Epsom and St Helier. Stakeholders are led to believe this will be cheaper, safer and provide higher quality accommodation on a more sustainable basis, principally by being easier to staff fully – but only as a result of significantly reducing the number of consultants and proportion of qualified nurses required to cover the reduced number of acute beds and downgraded beds at Epsom and St Helier.

In proceeding with public consultation quickly before establishing a broader understanding and agreement across stakeholders the NHS risks taking short cuts in the complicated business of winning the necessary support. I have referred to NHS guidance to planning change earlier but there is further extensive guidance that has been published by government and HM Treasury in particular which is required to be followed or is provided to help proposers in the process.

Thus the Treasury, who approve all capital projects of more than £50m at the moment, issue the Green Book[6] and the Guide to developing the Project Business Case[7]. These lay down clear guidance for on the process involved in investment appraisal, particularly the options appraisal process and the requirement to consider properly lower cost do-minimum options. Further guidance on multi –criteria analysis of the type deployed in the PCBC can be found in a manual issued by central government [8] and the guidance on economic modelling issued in December 2019. [9]

It should be noted that the Secretary of State in making the announcement of the funding for Epsom and St Helier capital development[10] also said that future details of a new capital funding regime would be published before the end of 2019. In his September statement criticisms of the current system were made but at time of writing it is still not clear either what that the future system will be; or the system for future funding of social care, again long promised.

A further complicating factor in the context for decisions on the proposals is that the local CCGs and the ESTH are to be incorporated in 2021 into new Integrated Care systems meant to centralise major commissioning decisions and to plan more formally across SW London and Surrey Heartlands, a separate Integrated Care system for Surrey.
Finally the ESTH trust is in significant financial deficit requiring support from NHS England to continue in operation. This effectively means that NHS England is closely involved in the ongoing management of the Trust.

3 Clinical arguments for IHT

The key clinical argument underlying IHT is the need to reduce the number of sites providing the major acute health services of the three CCGS areas of Merton, Sutton and Surrey Downs so as to improve the quality and sustainability of clinical care. This is intended to stand independent of financial consideration although, as I argue, this clearly cannot be the

[6] The Green Book : central government guidance on appraisal and evaluation –HM Treasury 2018
[7] Guide to developing the project business case- HM Treasury 2018
[8] Multi-criteria analysis: a manual Department of Communities and Local Government 2009 Department for Communities and Local Government: London January 2009
[9] Comprehensive Investment Appraisal (CIA) Model-User Guide DHSC December 2019
[10] Health Infrastructure Plan A new, strategic approach to improving our hospitals and health infrastructure DHSC September 2019

case as questions of affordability set the framework for all decisions and ultimately HM Treasury will approve all plans. Nevertheless if IHT's key argument is accepted, the choice then becomes which acute hospital sites should be closed or downgraded. However the underlying argument for the closure of services on some sites is flawed. In addition, the argument for removing services from the hospital used by many of the residents of Merton – St Helier – is also flawed.

The clinical argument is based on three key claims: first, that increased specialisation improves quality of care; and second, that new models of care reduce the need for hospital beds and that care can be provided by other means in the community and thirdly and most emphatically, it is not possible to offer a full range of services on the existing sites at the existing hospitals due to shortages of clinicians, specifically key consultants in emergency medicine and acute medicine. I examine each of these in turn.

3.1 Specialisation

In our previous report in 2013 we examined the general evidence for specialisation as the key to improved quality. Our references bear repeating before I go onto update the advice we gave at that time.

We referred in 2013 to a report from Tony Harrison in which he concluded (Harrison 2012),

I have argued that volume and outcome studies do not provide, in themselves, an adequate justification for centralizing hospital services.

The same also applies to the association between efficiency and size of unit. Thus, in a Nuffield Trust report, Hurst and Williams (2012, p59) observed,

There is also a large literature on the effect of changes in size on unit costs in hospitals. Reviews suggest that cost per case declines as hospitals increase in size to about 200 beds. There appear to be roughly constant returns to scale between 200 and 600 beds; however, above approximately 600 beds diseconomies of scale seem to set in, possibly because larger hospitals become more difficult to manage[11].

[11] NB the authors do not consider the economics of a three site solution with transfers between the major acute and district hospital beds across three sites.

On this basis neither St Helier (594 beds) nor Epsom (454 beds) hospitals are small hospitals. It is perfectly feasible to provide high-quality services from the sites, and indeed they have scored well on quality in recent and past assessments. As sites with a significant proportion of older accommodation they should benefit from reduced capital charges and depreciation and be better able to focus on the delivery of services compared to other hospitals burdened by the added costs of new PFI funded schemes. Where they seem exclusively to be marked down is in relation to 'London quality standards'[12] (which seem to have been established purely to promote reconfigurations) and in the quality of accommodation (which can be rectified by investment).

Moreover, in the case of emergency care, centralisation may have a negative impact with mortality increasing the greater distances that have to be travelled. Thus Harrison (2012) has found,

Even if gains in outcomes are achieved by centralization, the longer journey times that it entails for some patients may offset them to some extent. One study of stroke care found that the clinical risks of longer journeys outweighed the benefits of centralization. Nicholl et al. found that for every mile a seriously injured person had to travel to hospital, the risk of death increased by one per cent. Other work has found that the longer journeys discouraged use of health-care services.

These findings were echoed by a more recent report by Shropshire, Telford and Wrekin Defend Our NHS[13] for the West Midlands Clinical Senate on the local reconfiguration plan known as Future Fit.[14] This points out that Nicholl's study in 2007 is one of the more important pieces of UK research on the relationship between journey length and mortality, looking at survival rates for patients with life threatening conditions, relating this to the distance between home and hospital. For patients travelling up to 10 km, the overall mortality rate was 5.8%; for those travelling 11-20 km, 7.7% died; and for those travelling 21 km or more, 8.8% died. Overall, people who travelled more than 20 km to access treatment were 50% more likely to die than those living close to the hospital. Those with

[12] London Quality Standards (2013) https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf

[13] Shropshire, Telford and Wrekin Defend Our NHS (STWDON) (2016). *Future Fit A commentary for the West Midlands Clinical Senate*. Health Campaigns Together, https://nhsfuturefit.org/key-documents/draft-public-consultation-documents/full-consultation-document-1/506-public-consultation-document-english/file

[14] https://nhsfuturefit.org/key-documents/draft-public-consultation-documents/full-consultation-document-1/506-public-consultation-document-english/file

acute respiratory conditions fared even worse, and were around twice as likely to die if they had to travel the longer distance to access A&E. Although distances in South London are less of an issue, travel times, because of congested roads do become an issue and are clearly a local concern.

STWDON reports (p16),

"More recent research confirms the pattern. A 2013 Japanese study looked at distance to hospital for patients with acute heart attacks, strokes and pneumonia – a sub-set of the conditions examined by the Sheffield study. The study found a strong correlation between transport distance and mortality for acute heart attack and for ischaemic stroke; and a moderate correlation between distance and mortality for pneumonia and for subarachnoid haemorrhage".

And goes on (p16) to draw attention to a 2014 York University analysis[15] of Swedish data that,

"… compared survival rates from myocardial infarction for people having to travel different distances to emergency care. The author concluded 'The results show a clear and gradually declining probability of surviving an acute myocardial infarction as residential distance from an emergency room increases'. People travelling 50 to 60 km to emergency care were 15% less likely to survive than those living close to the hospital. Most of the excess deaths were of people dying on the way to hospital. The author noted an inherent bias in much medical research, as studies typically look only at outcomes for people who arrive alive at hospital. Those who die on the way are excluded. Most research also takes place in urban areas, with little research on the impact on survival of rurality and/or long journey distance. The few studies that do exist strongly support the case that longer journeys to A&E result in higher rates of mortality."

Finally STWDON refers (p16) to,

"… evidence from the USA of Emergency Department closure having a strong 'ripple effect', with mortality increasing by 5% for patients at neighbouring Emergency Departments that remained open. Existing facilities can easily be overwhelmed by increased demand. A strong and growing body of anecdotal UK evidence is of severe pressure on A&Es that remain following the closure of a neighbouring unit."

[15] Avdic, D (2014). A matter of life and death? Hospital distance and quality of care: evidence from emergency room closures and myocardial infarctions. HEDG: Health, Econometrics and Data Group. University of York

My own experience in NW London was of major unplanned operational difficulties caused by early closure of two A&E departments as the first stage of reconfiguration plans leaving A&E services in NW London amongst the worst in the country both then and now.

I will go on to consider access issues later in section 5 but it is clear that public transport users face significantly longer journeys of around 20 minutes, with a minority even longer. This is not only dangerous for those accessing emergency and urgent services but discouraging for attendees, when it is known that late presentation still remains a significant risk factor, contributing to relatively poor UK performance in international comparative studies. *"Access, public transport, parking and travel times and their impact for patients , relatives and visitors"* were flagged up as the biggest concern in early consultation around development plans. (PCBC p87)

In this consultation we note that despite previous claims[16], there is now no reference to '*over 500 avoidable deaths in London a year due to different consultant hours at weekends and in evenings at hospitals across the capital*', and no attempt to use this justification for centralisation of services.

In fact subsequent work by Professor Sutton and colleagues[17] debunked this theory and demonstrated the "weekend effect" as almost wholly a result of differing case mixes at the weekend. I would like to see a quantification of the risks associated with additional travelling times and the additional complexities of transferring patients across three sites in any next stage business case.

A&E services are something of a 'Cinderella' service providing care disproportionately to the disadvantaged; it is difficult to attract consultant staff partly because there is little opportunity for private earnings as exist in most other clinical areas. Utilisation of A&E services has increased in recent years as access to GP services has deteriorated and the population has grown older. The size of Emergency department seen as a minimum by the

[16] BSBV 2012, p5

[17] Meacock, R., Doran, T. & Sutton, M. (2015). What are the Costs and Benefits of Providing Comprehensive Seven-day Services for Emergency Hospital Admissions? Health Economics, 24(8), 907-912. DOI: 10.1002/hec.3207
http://www.manchester.ac.uk/discover/news/new-study-shows-major-omission-in-evidence-of-weekend-effect-on-mortality-rates-in-hospitals/

Royal College of Emergency Medicine would cover a catchment area of 300,000. Given the actual population for the existing three CCG's covers 720,000 people this suggests that two A&E departments are required. By planning for much smaller catchment areas for future A&E departments (PCBC table119 p267)[18] in effect these plans merely cost shift the problem of A&E provision to other providers.

Updating these arguments using more recent information I can now refer to further work by the Kings Fund[19], House of Commons Library[20] , Monitor [21] a, the Nuffield Trust [22] and the Royal College of Emergency Medicine[23].

The Kings Fund concluded in regard to specialisation:

The reconfiguration of clinical services represents a significant organisational distraction and carries with it both clinical and financial risk. Yet those who are taking forward major clinical service reconfiguration do so in the absence of a clear evidence base or robust methodology with which to plan and make judgements about service change. In particular:
– Evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking.
– Evidence on the impact on quality is mixed, being much stronger in relation to specialist services than other areas of care.

This latter finding point to a negative aspect of the IHT proposals in that one of the claimed advantages of the proposals for the Royal Marsden hospital is that it provides the necessary infrastructure to establish a new specialist children's cancer centre. However this would detract from existing specialist cancer centres at St Georges and Guys and St Thomas' and represents proliferation of yet more specialist centres when it can be argued there are already too many in London[24]. The existence of a major centre for acute services is also likely to act as a magnet for consultants looking to establish their own unplanned specialist services and is contrary to what seems a more sensible direction for ESTH of becoming part

[18] The table shows the planned emergency catchments for the new proposed major centres as respectively Epsom 312-316,000; St Helier 331-360,000 and Sutton as 404-422,000.
[19] The reconfiguration of clinical services: What is the evidence?, The King's Fund, November 2014, p23
[20] Briefing Paper House of Commons Library Number 8105, 9 October 2017
Reconfiguration of NHS services (England)
researchbriefings.files.parliament.uk/documents/CBP-8105/CBP-8105.pdf
[21]Facing the Future : Smaller Acute Providers Monitor 2014
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/320075/smalleracuteproviders-report.pdf
[22] "Rethinking acute medical care in smaller hospitals" by Dr Louella Vaughan, Nigel Edwards, Candace Imison and Ben Collins . Nuffield Trust 2018
[23] Reconfiguring Emergency Medicine Services Royal College of Emergency Medicine April 2017
https://www.rcem.ac.uk/docs/Policy/Reconfiguration%20guidance%20April%202017.pdf
[24]https://www.hsj.co.uk/specialist-care/inherently-risky-childrens-cancer-service-to-be-overhauled-after-hsj-revelations/7026834.article

of a pre-existing hospital chain , probably with St Georges or possibly Guys and St Thomas'.[25]

The House of Commons Library report (2017) provides a very good summary of the reconfiguration debate and the opposition this created. They point both to the widespread opposition to A&E closures and the "limited evidence linking hospital unit size and quality of outcomes".

The Monitor report (2014) on the other hand points to the need to reach a balance between the conflicting objectives:

We need to better understand the factors that are affecting change, such as workforce issues, clinical specialisation or increased staffing levels, and consider how best to balance competing objectives.[16]

The Nuffield Trust (2018) finds in relation to smaller hospitals, but of relevance in examining the continuation of services at Epsom that:

The tendency for some specialists to opt out of the general medical rota has increased staffing problems and has increased the pressures on the remaining staff. There is limited evidence that the benefits outweigh the problems that this can create, and more imaginative networked solutions have been adopted in some places.

These problems with staffing are further exacerbated by the imposition of minimum staffing levels, specific rota designs and other standards by external regulators. In many cases these rules are based on guidance developed for larger (often urban) centres, and there is limited evidence that these standards translate into improved outcomes. Smaller and remote hospitals need to be free to design the acute medical service in a less rigid way.

What this points to is standards being an obstacle to finding creative solutions that best meet local needs, as these further quotes from the Nuffield report signify.

The benefits of specialist services and staff should be set against the increased costs, fragmentation and threats to viability that can result and that can reduce hospitals' ability to effectively deal with multi-morbid patients whose severity and urgency of need has not yet been determined. Policy and

[25] Dunhill, L. (2020) We've proved hospital chains work, says CEO HSJ 7 February 2020 https://www.hsj.co.uk/pennine-acute-hospitals-nhs-trust/weve-proved-hospital-chains-work-says-ceo/7026875.article

training models need to recognise the importance of generalist skills. Proposals that allow further opting out of acute medical on-call care in small hospitals require very careful thought.

*(*p8) *Regulators and clinical senates should take a more critical and innovative approach to the application of standards. At present many standards have a relatively low level of evidence underpinning them*. (p10)

The Royal College of Emergency Medicine in 2017 stated in the summary of its report specifically addressing reconfiguration:

5. Most EDs are already crowded. Actively deciding to increase attendances into crowded EDs will harm patients. This will be made worse if bed closures are also planned in the same systems.

And ,

7. Emergency Departments can become too big to work effectively.

It is remarkable that the PCBC do not discuss this guidance or refer to it in their references. This reveals a bias in my view to promote reconfiguration. The IHT programme actively promotes many of the things the Royal College specifically warn against. (See later sections for further discussion).

Increasingly it appears that the London quality standards in pursuit of the "Very best healthcare" are creating more problems than they are solving and undue weight to meeting these standards should not be used in any options appraisal evaluation.

3.2 Reductions in demand justify A&E closures

The crucial assumption justifying reduced provision of A&E services in the locality in the future and hence savings in capacity and staffing is that investment in out-of-hospital care will reduce demand. But the evidence for this did not stand up at the time of the BSBV proposals.

Carson *et al.* (2011, p19) found no direct link between A&E attendance and hospital admission, and moreover diversion schemes are generally ineffective. They state,

There is some evidence that when A&E departments become overwhelmed junior staff will admit more people – the primary failure is in the A&E system not the volume presenting.

There is little or no evidence for the effectiveness of diversion schemes on admissions; some have had serious safety questions raised; while diversion schemes tend to focus on people who are never likely to be admitted because all they needed was advice or more basic care.

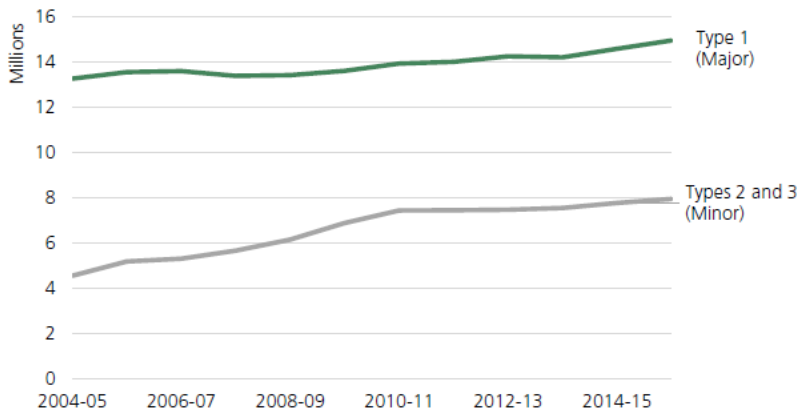
The same study (p22) also examined the use of urgent care centres and walk-in clinics. They found that,

There is a lack of published evidence to support the hypothesis that urgent care centres and walk-in centres will reduce attendances at emergency departments; in contrast, indications suggest they increase total burden on the NHS. Where the vision of the urgent care centre is that it is fully integrated part of the A&E service … it will take time to establish and much longer for the relationships and mutual trust to grow so that the centre functions with full effectiveness.

BSBV in 2012 claimed that there would be a decrease of around 50% in A&E attendances from development of Out of Hospital services. In fact the Trust has seen an increase of 11% in hospital admissions overall, and a 31% increase in emergency admissions, despite the development of these services. This is not to deny that reductions in inappropriate attendances would be desirable but to point to the weight of evidence suggesting it is more difficult to achieve than current plans acknowledge (see below).

The graph below, from another House of Commons report, instead points to stable trends of A&E admissions with large increases in overall attendances as a result of the opening of more urgent care and walk in centres.

Chart 1: Annual A&E attendance, England, 2004-2016



More recent trends reported by the latest (2018-19) DHSC Annual report reveals that demand is increasing more rapidly:

The demand for services provided in the health and care system continues to rise above population and demographic growth as better diagnosis and medical advancement means more treatment is possible, 24.8 million people attended an A&E facility in England in 2018-19, an increase of 4.1% compared with 2017-18.

Despite this the plans contained in IHT project 2% per annum (pa) reductions in emergency admissions up to 2025/26 , a 3% pa reduction in activity overall and a 3% pa bed savings by reducing length of stay. Overall a reduction of 80 beds from the grand total of 1014 is planned, but that assumes that the expected increases in demand for community beds and extra activity calculated of 243 beds (PCBC p201) can be accommodated by reducing length of stay and other efficiencies.

Many people including myself are sceptical about the NHS's ability to continue significantly to reduce length of stay [26] (as day case expands for patients with simple requirements and as the complexity and multi-morbidity of remaining patients increases at the same time as availability of social care decreases). IHT risks entering a "counterfactual" world of trying to convey a story to stakeholders which is divorced from reality. This is what eventually sank the "Shaping a Healthier Future" project in NW London in 2019 when it became impossible

[26] Jones R (2017) Growth in NHS admissions and length of stay: a policy based evidence fiasco. British Journal of Healthcare Management 23(12); 603-606

for the project leaders to justify ambitious attempts to reduce NHS capacity further whilst surrounded by evidence on the ground of rapidly rising demand, very high occupancy rates and inefficient bottlenecks in crowded A&E departments.

In addition, demand for healthcare in general is rising for a number of reasons:

- increasing population in London and the South East;
- rising birth rates;
- an ageing population with associated rising morbidity;
- social fragmentation and increased lone living;
- And, reducing social services budgets.

It makes little sense to undermine local successful units that have some capacity to absorb any extra workload that may emerge. It has been little appreciated that London health services are now funded at national average rates as a result of the surge in population in recent years. There is thus no imperative to be seen to be reducing capacity and every reason to ask for more. It is the paradox of the preferred options that while spending £500m key capacity in A&E, intensive care and acute care will be reduced at a time when recent events would suggest the opposite is required.

In relation to planning reductions in activity as a justification for reconfiguration, the Royal College of Emergency Medicine[27] states:

Basing reconfiguration decisions around planned reductions in demand for urgent and emergency care, or around hoped-for effects of redirection strategies, is not recommended.(p3)

Again it is not clear why confidence is placed in major reductions in capacity when such doubts have been expressed.

3.3 Difficulties in recruitment of clinicians

As the arguments above have weakened the greatest emphasis is now placed on the argument that it is impossible to find the staff to support existing services.
The Strategic Outline Case (SOC) presented by ESTH in 2018 puts it clearly:

[27] https://www.rcem.ac.uk/docs/Policy/Reconfiguration%20guidance%20April%202017.pdf

What is clear from all of our work is that we cannot continue to run all our acute services on two sites because we will not have the clinical staff to deliver all of the standards.

The PCBC puts it thus:

ESTH is the only acute trust in South West London that is not clinically sustainable in the emergency department and acute medicine due to a 25 consultant shortage against our standards. Additionally there are shortages in middle grade doctors, junior doctors and nursing staff. The Care Quality Commission has highlighted workforce shortages across its two sites as a critical issue.

This follows the tradition of those that have promoted reconfiguration for many years. The same arguments were raised when BHCH was presented in 2003 and BSBV in 2012. The international evidence is that the UK lags other comparable countries in numbers of doctors and nurses.

	UK	US	France	Germany	Netherlands
Physicians per 1000 popn	2.8	2.6	3.2	4.3	3.6
Nurses per 1000 popn	7.8	11.7	10.5	12.2	10.9

Source : OECD Health at a Glance 2019

This has been the position for many years. It is a general policy, not a local problem. The actual number of students accepted into medical schools has actually declined.[28]

Problems of staffing have been attributed to the European Working Time Directive, but as the Chairman of the Independent Reconfiguration Panel (IRP) in reviewing the Panel's work stated (Barrett 2012, p5),

With the benefit of hindsight, I think it is fair to say that the EWTD did not turn out to be the insurmountable obstacle it was originally perceived to be. Instead, in many cases it forced the NHS to think more imaginatively about how best to utilise its staff.

It is particularly dismaying in this respect to note within the Technical annex to the Consultation exercise (p37) that it is implied that the HEE (Health Education England)

[28]https://www.gmc-uk.org/static/documents/content/SoMEP_2017_chapter_2.pdf
https://infogalactic.com/info/Medical_school_in_the_United_Kingdom

allocate medical trainees on a simple per trust basis rather than taking into account the needs at a particular two centre trust. The HEE have therefore ensured that a shortage of staff has been created by restricting the supply of junior staff on the two sites and cutting off a major source of potential future recruitment. This coupled with the government policy not to increase the numbers of medical students and instead to cut the number of trainees in 2012[29] has manufactured a crisis which was preventable. The College of Emergency Medicine produced a report in 2011 [30] calling for urgent action! Future staff shortages have been predicted for many years. In the 2017 and 2019 elections the RCEM called for a programme to create 2000 more consultants.

The work of the House of Commons Library in summarising problems with the reconfiguration policy (see footnote 15) in general shows it is an example of confused objectives, where it is not clear whether it is a solution to problems of recruitment in certain local services which is being pursued or the objective in itself.

Monitor in its excellent report on small acute hospitals also identified that there are a range of responses to workforce problems:

There are other ways in which providers are responding to the developing challenges. For example, we were told of many different ways in which providers are working around staff shortages and responding to other recruitment needs. This included:

• *conducting international recruitment campaigns, particularly for qualified nurses and for junior and middle doctors in some specialties*

• *developing new roles and re-designing existing roles, eg new roles for advanced practitioners in diagnostic areas, hybrid roles for nurses and therapists that include hospital and community care skills or new roles for physician associates*

• *employing a pool of trained nurses who may be used to address shortages in staff and skills mix without relying on agency staff*

• *making joint appointments with neighbouring providers*

[29]https://www.telegraph.co.uk/news/health/news/9724532/The-NHS-will-train-fewer-doctors-to-avoid-future-brain-drain-report-warns.html

[30] CEM Emergency Medicine Taskforce Interim Report 2011

The Nuffield Trust[31] note in the first paragraph of their report:

"Too often, the knee-jerk reaction has been to try to close or downgrade these services rather than to develop solutions that better suit the needs of the local community".

They cite various reasons for low staffing levels which I have already referred to (p16) which point to resource allocation issues being at the heart of the issue rather than the need for reconfiguration; but they go on to point to additional problems that may be presented by the complex web of services across three sites rather than two:

• *The fragmented and complex systems that have emerged for EDs, acute medical units (AMUs), frailty units and a variety of other internal systems are often hard for hospitals to coordinate. Moving patients between units, and the handovers of responsibility that accompany this, becomes inefficient. Work is duplicated, reducing the overall resilience of the system and creating potential for delays and even harm.(p4)*

The report goes on to list a number of suggestions for managing problems. It advises, (echoing my own view) that support should be sought from other neighbouring hospitals and those resources from a wider network of sources within the STP footprint. The retort that they have troubles of their own undermines the case for transferring a large portion of the workload to other hospitals and doesn't contradict my point (along with the sources quoted) that greater use of networked solutions, hospital chains and reprioritisation toward generalist services everywhere is a more positive route than increased specialisation at a local level.

Much is made of the importance of integrated working, and it is disappointing that the PCBC specifically rejects any STP-level approach and restricts itself to the smaller footprint of the 3 CCGs. This means it has not fully explored resolving problems across the STP /ICS footprints, particularly as the "solution" of centralisation is unlikely to be realised for a further five years. This period would allow initiatives to train additional doctors, to fast track consultant appointments and to extend the membership of medical rotas as an alternative to expensive and risky centralisation. I say risky because it can only be done under existing financial constraints by restricting the number of beds built to replace those closed. It is again paradoxical that Planning Guidance recently issued by the NHS stresses the need to

[31] "Rethinking acute medical care in smaller hospitals" by Dr Louella Vaughan, Nigel Edwards, Candace Imison and Ben Collins Nuffield Trust October 2018

end the reduction in bed numbers, and maintain or increase numbers from the expanded provision over the winter period 2019-20[32]:

In 2020/21 A&E performance must improve, and all providers should plan to deliver a material improvement against a 2019/20 benchmark. To achieve this, systems and organisations will be expected to reduce general and acute bed occupancy levels to a maximum of 92%. This means that the long period of reducing the number of beds across the NHS should not be expected to continue.

The conclusion I come to is that it is not clear to me that the staffing problems being encountered in ESTH are as a result of an inefficient configuration (the size of the hospitals would suggest not) or that a reconfiguration will in fact resolve these problems. The risk is that, after spending £500m, the new hospital continues to have staffing issues which may be made worse by crowding A&E and centralising services into far fewer acute beds. It is a further paradox that the solution to staffing problems is to decrease the numbers of staff planned in the new configuration: cutting consultants by 69wte and middle ranking and junior staff by 73 wte (PCBC p259) and concentrating the entire consultant workforce in the new hospital. You would have thought that if this were possible it could be planned within the existing facilities as less space would presumably be required.

The following graphic extracted from a Health Foundation report of 2019[33] addressing the staffing problems in England's NHS shows that staff stability, i.e. the ratio of staff in post at the end of the year compared to the beginning of the year has decreased in general since 2010/11 and that South London is not the area of London suffering the worst, although all areas of London suffer more than the rest of the country. The problems of ESTH are not local but general.

There are a range of explanations offered for this but they conclude:

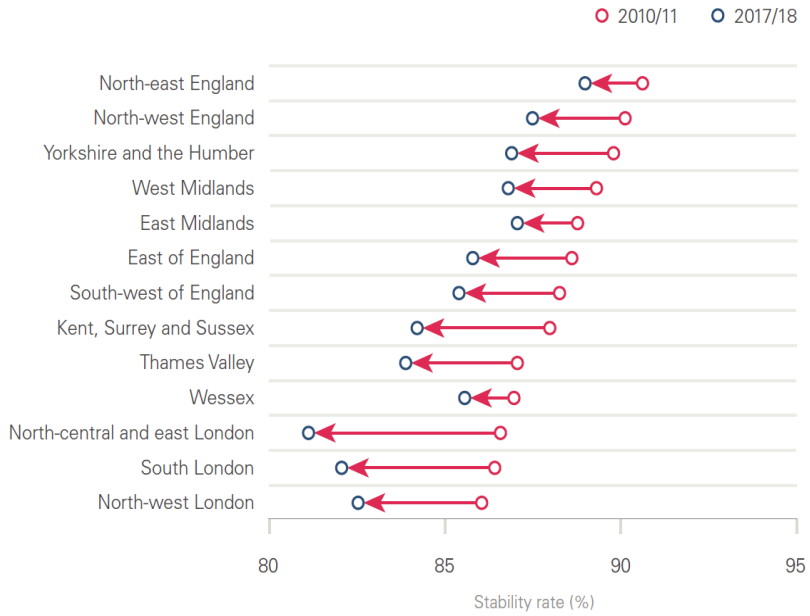
…*that a lack of coherent policy that takes into account both funding and staffing has been a recurring theme. The combined effect has been to undermine any long-term consistency in the NHS's approach to workforce policy and planning*.(p4)

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

[33] A critical moment: NHS staffing trends, retention and attrition Health Foundation 2019

NHS staffing issues and NHS funding streams are inextricably linked – staffing challenges cannot be solved without consideration of funding, and funding decisions should not be made without consideration of the impact on NHS staffing. (p32)

Figure 17: Regional-level NHS trust stability-rate, 2010/11 and 2017/18



Source: Health Foundation analysis of NHS Digital data. Excludes doctors in training.

Medical staffing problems are a subset of these general problems but if anything these seem to arise from:

- the high cost of living and housing in London,
- failure of pay policy to keep pace with high London costs of living ,
- failure of the NHS to create enough trainees to keep up with demand,
- policies that have incentivised junior medical staff to pursue careers as specialists rather than generalists,
- allowing specialists to opt out of medical rotas,
- the attractiveness of locum and agency staff working ,
- changes in the gender mix of the workforce and expectations of work life balance.
- barriers to entry for foreign doctors and incentives to work abroad for UK trained doctors,

- the hot house working in London that can be attributed to surging levels of demand not compensated by increased resources (which results in very high occupancy levels in acute hospitals),
- burn out of staff , and staff voting with their feet etc.

It is not clear to me that concentrating major acute services on the one hand, creating a new major acute hospital site requiring its own 24/7 management on the other and an increased number of patient transfers between sites are necessary and sufficient conditions to resolving these problems. In certain respects this approach may make matters worse by creating instability, disrupting other A&E departments and hospitals across South London and Surrey and by taking the focus away from more obvious ways of addressing staffing problems more directly i.e. by increasing numbers of trainees and the incentives for generalists and A&E consultants such as housing.

3.4 The Dis-benefits of centralisation

Any clinical benefits of centralisation and reconfiguration need to be balanced by a better appreciation and an honest appraisal of the clinical dis-benefits and a more thorough appraisal of alternatives to improve clinical quality, other than the removal of key services from some hospital sites.

The new configuration proposed replaces two sites, not by one new integrated hospital, but by three sites separated by distances requiring ambulance transfers between sites of a significant number of patients. This will be more complex, pose additional management problems and costs, and be potentially disruptive for patients and staff. There will also be additional clinical risks of patients presenting to the wrong site, of risks during transfers and of additional travel time for staff who may be required on more than one site.

The new major centre, as the only centre providing front line acute beds, is likely to be working at high levels of occupancy. The pressure of the new configuration will be borne by fewer staff than currently, and this in turn may discourage potential recruits.

The plan also expects one in six (16%) of patients to travel outside the current catchment area to travel further to alternative A&E departments while most people within the area will be required to travel further for longer. The costs, risks and uncertainties associated with planning for this are not addressed sufficiently within the Consultation document or PCBC.

On reading the proposals there is no identification of possible disadvantages, which is necessary to enable patients and staff to make an informed and balanced judgement. Many

will detect therefore a biased presentation, raising suspicions that the scheme is being promoted to satisfy vested interests.

4 Financial and economic arguments for IHT

4.1 Introduction

As mentioned previously there is clear national guidance on how to go about presenting the economic and financial case for local change**.**

The requirement to follow guidance and due process is a clearly understood stipulation in public sector commissioning, investment and expenditure. Guidance has been prompted by a history of problems with large-scale public planning, procurement and implementation which have resulted at times in judicial review, lengthy and costly public inquiries, planning blight, construction of the wrong facilities in the wrong place, and excessive costs.

There is therefore a strong presumption that guidance should be followed wherever possible to help avoid potential pitfalls and risks associated with complex and controversial reconfiguration proposals.

I would add however that it is not just the letter but the spirit of the guidance that needs to be followed.

It is in this respect that I find the presentation in the PCBC lacking.

A naïve reading of the documentation might conclude that for the sake of 25 extra consultants the proposals rush to the conclusion that £500m of capital resources should be committed to a scheme that reduces the numbers of consultants required by 63.

There seems to have been no conscientious attempt either to identify lower cost options or, where alternatives have been identified, subject them to serious consideration.

The rationale for expensive centralisation and the building of an entirely new hospital at substantial additional cost is not firmly established. If a rationale can be inferred from the proposals it is that the costs and difficulties of providing services which are unattractive (for clinicians) can be shifted to other providers. Thus the catchment areas of the new centralised facility are to be significantly reduced leaving St Georges, Kingston, Croydon, St Peters, and Royal Surrey County Hospitals to take the displaced patients (see footnote 13).

Treasury guidance is quite clear that the principles of economic appraisal are those of welfare economics (providing a net improvement in social welfare) and not of calculating a local advantage. Thus the decision not to include the necessary cost of enabling capital in neighboroughing hospitals, which will require additional capital investment, appears to be in error and a potential distortion of the economic appraisal.

The case for change appears over-reliant on compliance with London clinical standards which appear excessively prescriptive and not justifiable, failing to take account of wider issues of both the economy and the wishes of patients for easier access to services. I have examined the current clinical evidence and thinking and I am clear that a more balanced view is required (see Section 3 above).

There appear to be lower cost options that require to be fully evaluated as alternatives to the three centralised options chosen. These would be:

- no change ("Business as Usual"),
- a do–minimum option which fulfils investment objectives (which in the absence of clearly stated objectives I take to be to create sustainable clinical services of high standards serving the local community)
- and other lower cost options (centralisation on one of the existing two sites at Epsom and St Helier and the conversion of the other into a district Hospital –thus foregoing the Sutton site).

The expressed aim of ensuring the very best quality of care available (PCBC p5, 19, 105, 106, 205) appears extravagant in the circumstances of the advice published by NHS Improvement in November 2016.[34]

"2.2 Financial discipline is necessary in a tight spending environment. Resource spending is increasing in real terms but capital expenditure will be more constrained. As a result this is a medium-term challenge for the NHS.

2.3 In this context trusts should be aware that access to Department of Health (DH) capital financing will be more restricted than in previous years and expenditure that scores against the DH capital departmental expenditure limit (CDEL) will be subject to increased control and scrutiny going forward. Trusts should also note that all capital expenditure, however financed (whether through self-generated resources, DH financing or borrowing from financial institutions, local government or other sources), scores against the DH departmental spending limit.

…

4.1 NHS Improvement will require assurance that a capital investment business case has been subject to an appropriate level of scrutiny and governance by the trust proposing the investment, before the case is submitted to NHS Improvement

- *The trust has the resource and capacity to deliver the investment programme within a realistic timeframe. (p14)*

[34] NHSI Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts https://improvement.nhs.uk/resources/capital-regime-investment-and-property-business-case-approval-guidance-nhs-trusts-and-foundation-trusts/

Of course since then there have been changes in the NHS, changes of government ministers and a change in attitude to investment in the NHS, making it a more attractive proposition. However I believe it is still incumbent on the proposers of this programme to be mindful of the limited resources available generally and the need to persuade stakeholders that all options have been properly considered, including lower cost options impacting less on users of services.

This point is made in the NHS England Planning guidance (2018), which goes on to spell out the key requirements of the Pre-consultation Business case: the table below contrasts the requirements with the content of the IHT PCBC and Consultation.

Key requirements from NHS England 2018 Guidance ***Planning, assuring and delivering service change for patients (page 27-28)***	**PCBC and Consultation document approach**
Summary financial statements and supporting financial modelling which shows the impact of each option on commissioners/providers revenue financial position supported by activity, income and cost modelling which is sufficiently robust for both commissioners and providers to be confident that options would be sustainable;	There is no supportive financial modelling provided, making full scrutiny impossible. The explanation for excluding options from evaluation is insufficient and inappropriate, and clearly in breach of the guidance.
Confirmation of assumptions made in the financial modelling for both commissioners and providers e.g. commissioner growth in allocations, provider inflation, levels of efficiency savings;	Assumptions are provided but the levels of efficiency savings assumed appear unrealistic.(see discussion under 4.3 Financial Appraisal)
Reconciliation of the scheme's financial impacts to the STP financial plan	The STP/ICS financial plan has still not been released for to the public to enable the public and stakeholders to give feedback
Credible activity/throughput analysis that translates sustainably to the scale of infrastructure change anticipated;	It is not clear from the analysis when and if the enabling capital investment will be funded and implemented to

	ensure that the displacement of activity planned and the cuts in activity planned can be achieved in practice. The scale of activity changes planned are very large (16% diversion of A&E activity and a reductions of by 452 of beds accessible for major acute patients!! (PCBC p201) This is not only contrary to recent NHS Planning guidance to avoid planning reductions in bed capacity but in the light of recent events foolhardy.
A clear assessment of the financial benefits of the scheme e.g. provider efficiency savings, system reductions in activity levels and the basis of these calculations;	Table 110 p257-8 of the PCBC summarises the benefits of the options compared to Business as Usual. The task is to demonstrate how net benefits compared to the baseline budget can be achieved not how benefits assuming that the medical establishment, incorporating new unfunded standards, can be calculated. Furthermore other major benefits claimed e.g. benefits of using new technology; reductions in recurrent cost pressures seem either to be irrelevant to the consolidation of major acute services or a desperate attempt to shore up the benefits (see further discussion in the next section). The basis of the calculations both for these benefits and assumptions justifying the evidence that capacity can be safely cut and diverted to low dependency settings is inadequate and unconvincing in the light of failures in the past to achieve such targets and given the extent of the supporting evidence to justify the success of

	community care initiatives to reduce demand and divert care into community settings,
A high level source and application of capital funds, to demonstrate capital costs and how these are expected to be funded. It should be noted that every effort should be made to generate local capital funding including land disposals or internally generated capital and initial assessments of this should be included;	I can find no high level source and application of capital funds that. Claims are made on pages 263-267 in the PCBC in section 13.7 discussing Financing options but the level of supporting detail is inadequate and certainly is not a 'source and application of funds'. Further discussion on p308 seeks to provide reassurance but lacks supporting detail.
Indicative capital costs recorded using OB forms and recognisable benchmarks and which assume compliance with all applicable design, technical, building and space standards and known site constraints, and key adjacencies should be identified;	Indicative capital costs are included in the PCBC but it is not clear how reliable they are, what standards have been used, and for example what additional space is being created under the options proposed. We note that recent tenders have demonstrated unexpected cost increases over those estimated in the 50-100% range.
Indicative designs that demonstrably reconcile to up-to-date estates strategies at site, provider and STP levels;	Given the STP/ICS strategy has yet to be made public it is impossible to verify whether the strategy reconciles. The indicative designs made public shows attractive facilities but raises immediate questions as to their affordability.
Confirmation of support from all commissioners proposing the scheme and acknowledgement from all providers who will be significantly affected by the scheme that	The PCBC describes the assurance process in some detail but it is by no means clear that the process was completed prior to the release for public consultation. There is in my view

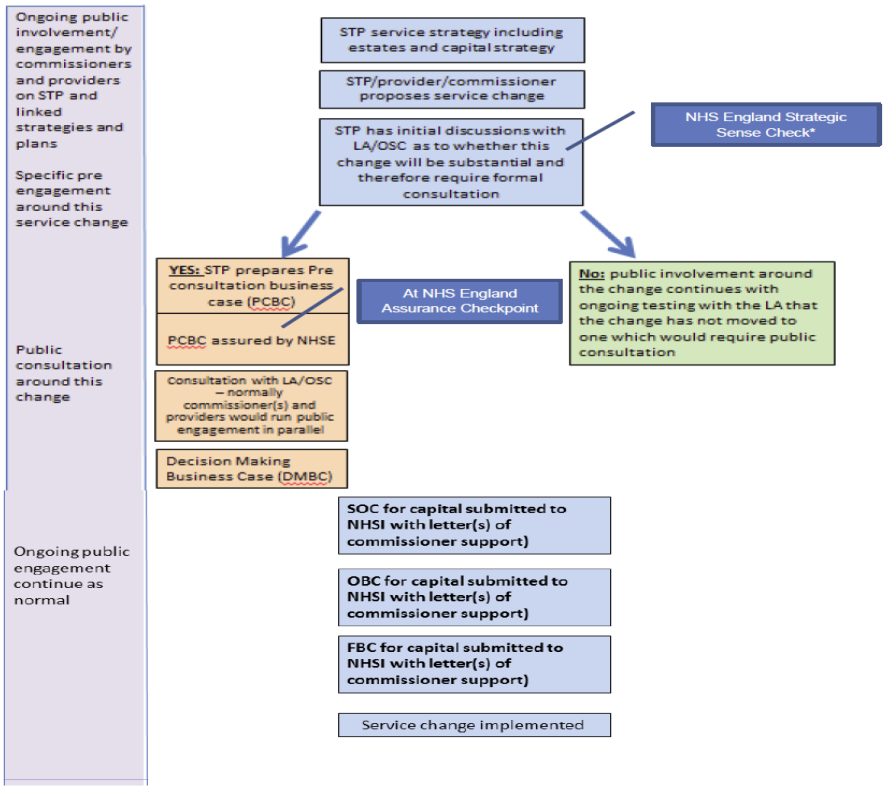
their views on any impact on them have been sought. **All options requiring capital will be assured prior to consultation by NHS Improvement and NHS England, and, where appropriate, through them the Department of Health and Social Care to ensure each option is sustainable in service and revenue and capital affordability terms, that the scheme size is proportionate and that it is capable of meeting applicable VFM and return on investment criteria.** **Schemes requiring larger amounts of capital (i.e. over £100m) will be required to provide more detail and be subject to higher levels of scrutiny prior to going out to consultation.** **Following this assurance the following letters of support will be required prior to consultation being launched:** **…** **where options require capital above £100m the scheme will be considered by the NHS Improvement Resources Committee and a letter of support from the NHS Improvement Chief Finance Officer provided.**	a serious danger therefore that the public consultation was undertaken too soon and may be potentially misleading to the public who may think the level of assurance is greater than actually seems to be the case.
At this early stage, before pre-consultation business case (PCBC), , if service change options will require capital, it is helpful to take account of the requirements that individual providers' capital investment business cases will need to satisfy if they are to be able to support the formal proposals. These are set out in NHS Improvement's guidance Capital regime, Investment and Property Business Case Approval for NHS Trusts and Foundation Trusts.	The PCBC as it stands does not provide evidence that the NHS Improvement Chief Financial Officer has expressed support. One problem is that there has been a delay in the SW London STP/ICS publishing its plans – which normally signals some disagreements. For my part the level of detail provided in the PCBC itself and indeed in supporting documentation makes it difficult to be sure that the outputs

Therefore in preparing the PCBC advice/input should be sought from NHS Improvement and NHS England (and through them, the Department of Health and Social Care and HM Treasury if appropriate) so that they can as far as possible underpin subsequent provider business case processes and NHS Improvement's subsequent assurance of them.	from modelling are supported by the necessary supporting detail. I sought to secure further detail from the IHT programme director to ensure scrutiny can be completed but at time of writing this was not available to me . Copies of correspondence between NHS Improvement and the IHT Programme Director and Programme Board was also sought to ensure that assurance issues seem to have been appropriately flagged and responded to prior to consultation being triggered. I would have advised if requested that the PCBC be extended to allow for more options to have been evaluated prior to launch of the public consultation and that the claimed system benefits could have been better scrutinised and confirmed pre-consultation.

Nonetheless the benefit of these issues being flagged at this stage is that they can be raised by the Local Authority on behalf of stakeholders so to ensure the Decision Making Business Case could be adjusted prior to the real business planning process being initiated as outlined in the graphic taken from the planning guidance (ibid p51):

Annex 11 - Flowchart for service change for scheme including capital.

If it does not require capital, then those elements in bold will not be required



4.2 The Economic Appraisal

This I believe is fundamentally flawed for two main reasons:

- Options have been too hastily limited and exclude lower cost options risking the choice being variants of three 'gold plated' schemes. It would be better to face up to this now rather than it is pointed out later in the process.
- Benefits claimed for centralisation in Table 110 of the PCBC seem to exclude the likely full additional costs for other providers created from the changes in the patient catchment area. The assumption that capital enabling costs can be excluded and that non A&E flows will remain the same and not follow urgent flows seems overly optimistic. Furthermore benefits are calculated as the avoidance of the costs of higher clinical standards rather than as a saving to the current financial baseline. In addition significant benefits are claimed from use of technology (which does not require centralisation to be realised). The avoidance of recurrent cost pressures is also referred to, in what seems to be a desperate effort to bulk up the benefits. In practice new builds are subject to unplanned price uplifts, transitional problems and in this case additional operational and space costs not seemingly taken into account. Benefits are thus mis-stated and exaggerated.

While it is appreciated that the economic appraisal uses as its baseline the BAU position, rather than a Do minimum position, by artificially raising this to incorporate the full costs of implementation of improved clinical standards it exaggerates the "benefit" and moreover is not a benefit that would improve the overall financial affordability of the scheme as might be understood by readers.

Without wanting to labour the point The Green Book is quite specific that the short-list should include the "preferred way forward" (the combination of choices most likely to deliver the SMART[35] objectives), the Business As Usual benchmark; a viable "do-minimum" option that meets minimum core requirements to achieve the objectives identified and at least one viable alternative option[36]. As described in Section 3 above there is a tendency in reconfiguration proposals to dismiss a "do–minimum" option as impossible to achieve but that is not what the Independent Reconfiguration Panel, Monitor and the Nuffield Trust have said, nor the Treasury. Furthermore it is the flaw in the methodology adopted that options are seen as hard and fast, whereas in reality the BAU and do–minimum options can be subject to behaviour modifications that can render these options viable e.g. making changes to national training policies, allocations of trainees, increasing the numbers of generalists and those on take within medical rotas, networking with other hospitals , altering terms and conditions, targeting recruitment and retention policies , adjusting case flow etc.

Above all it creates suspicion and ill-will amongst the local population who often prefer to retain improved local services (as was indicated in this case in pre-consultation) and cannot see why this option has been dismissed seemingly out of hand. This is not to say that it will be the best option but it should be properly evaluated as a means of moving stakeholders to a position where they can recognise the reasons why the preferred option is the best , for whom and to what extent. Only in this way is consensus likely to be built.

4.3 The Financial Appraisal

The question to be addressed here is:

What is the impact of the proposal on the public sector budget in terms of the total cost of both capital and revenue?

[35] Specific Measurable Achievable Realistic and Time-limited

[36] Please note I am aware of a recent legal case based on the South Tyneside hospital reconfiguration which ruled that the NHS could rule out unrealistic options but that was in the particular circumstances of that case which did not include the necessity for major capital investment. This is not the circumstance in SW London.

This means that the total costs of the additional capital invested has to be included in financial analysis including the enabling capital seemingly excluded. This includes interest payments, capital charges and additional depreciation. These are known collectively as availability charges and are around 10% per annum, although under PFI they were often more. They play an important part in determining the financial health of a local health economy. Their importance was discussed fully in an important study by Keith Palmer for the Kings Fund in 2011 based on the experience of reconfiguration in SE London.[37]

These need to be understood in terms of the impact on the finances of the Trust and on the wider health economy outside of the three CCGs. There can be a tendency for clinicians and others in the NHS to misunderstand positive statements from ministers on the availability of up to £500m of capital for investment. It is not a free gift: it is conditional on presenting a business case that can at least cover the revenue impact of capital costs (which are not possible to fully identify in the analysis as presented) and so generate surplus benefits to deliver the main investment objectives of the proposals.

This represents a tall order as not only do the additional costs (excluding capital charges) of an extra hospital have to be covered (which is also not possible to identify in the PCBC) but also the loss of income to the Trust as a result of restricting the patient flows by adopting a more limited catchment area for those services where patients will want to opt for the closest hospital rather than the preferred option (£17m PCBC p253); on top of the £69m of CIPS (PCBC p64) and loss of income from changes to the Market Forces Factor used to adjust tariffs paid to the Trust (£11m PCBC p64).

The risks that could threaten these plans, but which do not seem to have been quantified and considered, are:

- that elective patients will follow flows of non-elective patients to the nearest hospital with the consequent loss of income,
- that CIP savings will not be achieved,
- and that it will no longer be possible significantly to reduce length of stay and hence achieve savings in major acute beds

None of this is clearly laid out in the PCBC although elements can be pieced together and some estimated.

In effect the consultation documentation is probably misleading, and the PCBC together with the accompanying documentation of over 1200 pages represents in my view an

[37] Reconfiguring hospital services Lessons from South East London Keith Palmer Kings Fund 2011

obfuscation of the issues and choices facing local stakeholders. The public will either be cowed into accepting the advice of the CCGS or resentful and suspicious of the motives of those who have made the attempt to mislead them.

I recommend that a better summary of the major categories of additional costs for an enlarged range of options is presented, making it easier for stakeholders to better understand the key differences between all the options and whether the plans as they exist are likely to be affordable.

This is supposed to have been assured by the Chief Financial Officer of NHS England. Copies of that assurance have not been made available.

5 Access for Local People

In this section a summary of the implications for increased travel times, reduced accessibility and the disproportionate impact this has on disadvantaged groups is provided plus consideration on the location of services and legal safeguards for the most disadvantaged.

It relies on the work that the IHT programme is obliged to undertake but it presents it differently and identifies further work that could be undertaken to reveal more precisely the impact to the various stakeholders.

The key document examined is the Draft Interim Impact Assessment. Judging from minutes of meetings examined and correspondence seen there has been controversy over whether the impact assessment properly considers all the issues and whether the information contained within it is reliable enough for the purposes of decision making.

The document itself defines Integrated Impact assessments (IIAs) as:

…a continuous process to evaluate the reasons for intervention, to weigh up various scenarios for achieving objectives, and to understand the consequences of a proposed intervention. They are used as a tool to develop policy by assessing and presenting the likely costs and benefits and the associated risks of a proposal that might have an impact on the public, private or third sector, the environment and wider society over the long term.

It is important to note that the purpose of impact assessments is not to determine the decision but act to assist decision-makers by giving them better information on how best they can promote and protect the wellbeing of the local communities in which they serve.

It is not surprising that this has been a focus of controversy as it is one of the grounds to challenge any future decision if the decision is seen not to be in the interest of the health service, particularly those that need it the most.

From the evidence presented it seems to be unequivocal that compared to the current baseline of major services at the two existing sites at Epsom and St Helier the preferred option of centralisation at Sutton represents a deterioration in accessibility of major acute services. By adding further distances to travel it adds to travel times and this disproportionately will affect those in disadvantaged groups and the elderly. This in turn adds risk during longer journeys, discourages utilisation of services, and by necessitating the greater use of patient transfers between sites adds a further tier of risk not otherwise borne. Furthermore it is not clear whether the analysis takes into account that for many people (over 100,000) the additional distances will require them to plan to go to another hospital during the spell , breaking continuity of care, adding problems on accessibility of records and notes, and thus representing an additional clinical risk.

This table drawn from the data supplied by Mott McDonald shows the impact of the increased travel time for public transport users.

Public Transport Tuesday - Morning peak protected characteristic data tables								
	% population within 30 mins travelling time				**Worse than Baseline %**		
	Baseline	**Epsom**	**Sutton**	**St Helier**	**Epsom**	**Sutton**	**St Helier**
Overall Population	69%	49%	59%	53%	20%	10%	16%
Relatively deprived (quintiles 1&2)	91%	58%	75%	83%	33%	16%	8%
BAME (Black , asian , minorities)	82%	63%	75%	73%	19%	8%	10%
Female population (16-44)	74%	53%	64%	59%	21%	11%	15%
Population 65+	62%	44%	52%	43%	17%	9%	18%
Unpaid carers	70%	49%	60%	55%	21%	11%	15%
Population with LTHD	68%	48%	58%	52%	21%	10%	16%
Male population	69%	49%	59%	53%	20%	10%	16%

This is why it is surprising that the draft Impact assessment summarises the adverse impacts on those in greatest needs (with protected characteristics) as follows:

Table 2: Protected characteristics expected to experience disproportionate adversely impact as a result of change

	Patient provision	Longer journey times to acute services for patients	Longer journey times to acute services for visitors	Transportation costs and accessibility of acute services on a single site	Other providers	Wider sustainability
Children and young people (under 16s and those aged 16-24)					N/A	✓
Older people (65 year and over)		✓(In relation to Option 2 St Helier for blue light ambulance)		✓	N/A	
People with a disability				✓	N/A	
Pregnancy and maternity				✓	N/A	
Race and ethnicity				✓	N/A	
People living in deprived areas		✓(In relation to Option 1 Epsom for car and blue light ambulance)	✓(In relation to Option 1 Epsom car and public transport and Option 3 Sutton, public transport)	✓	N/A	✓

Source: Mott MacDonald

This appears to present a positive gloss on the fact that a large number of people will feel obliged to travel to other hospitals outside the locality as a result of losing local major acute provision; that travel times for all options will be worse for each of the centralised sites for both patients and visitors; and that the public transport difficulties for many of travelling to Sutton will be significant. In this regard the words of the Impact assessment itself bear repeating:

Public transport options to the Sutton site are predominately via bus. While some bus services do run directly to the hospital site, others stop within a 10 to 15 minute walk of the site. The nearest rail stations are located approximately 10 to 20 minute walk from the site.
Consequently, those who may struggle with walking long distances may experience particular difficulties with accessing this site, such as those with a disability or illness, pregnant women and older people. Further, those travelling from Surrey Downs may also be disproportionately impacted when accessing the site compared with those in Sutton and Merton, due to fewer bus routes travelling within this area which are directly connected to Sutton Hospital. (p27)

This description furthermore undermines the credibility of claims that very high percentages of patients will be able to travel to Sutton within 45-60minutes. It is not clear that waiting and walking times at the beginning and end of journeys have been taken into

account, or the particular difficulties of travelling by public transport at or even before peak traffic to arrive for an early morning appointment, or travelling in either direction during the evening (returning from a late afternoon/early evening appointment, or visiting relatives in hospital). These times are irrelevant for car and ambulance journeys but not public transport journeys. Furthermore the likely consequence is that there will have to be greater use of ambulance services or patient transport services for patients for whom public transport is not a viable option. This is made clear in the interim draft impact assessment (p114):

The proposed service model is likely to have a negative impact on the capacity of the ambulance service through:

- *Increased journey times conveying some patients who require access to major acute services such as the ED or maternity services to the major acute hospital (rather than their nearest local hospital which may now be a district hospital). This is a model which is already in place for emergency general surgery which is provided from a single site.*
- *Increased turnaround times for ambulances at the major acute hospital given the greater number of critically ill patients arriving by ambulance at a single site. Around 20% of all current ED attendances are conveyed by ambulance.130 Ambulance handover delays often occur as a result of a mismatch between ED/hospital capacity and the number of elective or emergency patients arriving.131*
- *Emergency transfers for those patients who inappropriately present at a standalone UTC at a district hospital but require the services of the major acute hospital, or those patients whose conditions unexpectedly deteriorates at the district hospital.*
- *Increased volumes of patients drawing on ambulance services to convey them to acute services. Engagement with equality groups highlighted that a number of participants felt that potential increased journey times, complexity and cost would result in them calling an ambulance to take them to acute services where as previously they would have taken alternative transport modes.*

There is no quantification of the financial or clinical impacts of this in the PCBC.

The draft report is only a draft as further information is expected as a result of engagement with staff. However the report itself identifies that:

…for some staff, the proposed changes may have an adverse personal impact as they become accustomed to:

● *A change in their place of employment. This would be particularly evident under the option in which Sutton Hospital is the major acute hospital, as staff (including medical staff and specialist nursing staff) would be required to transfer from Epsom and St Helier Hospitals.*

● *Potential changes to the rota patterns, positions and teams within which they work.*

No quantification is as yet available nor is there any analysis of where staff live, which would enable a picture of the likely impact of additional commuting times, difficulties from using public transport out of normal working hours and paint a picture of which groups might be advantaged by the preferred option.

Nonetheless the draft impact assessment purports to identify a range of additional benefits from centralisation for various groups for whom special regard should be kept (protected characteristics):

Table 1: Protected characteristics expected to experience disproportionate positive impact as a result of change

	Patient outcomes	Accessibility of district health services	Health inequalities	Patient experience	Service delivery	Workforce	The physical accessibility of services
Children and young people (under 16s and those aged 16-24)	✓	✓		✓	✓		
Older people (65 year and over)	✓			✓	✓		✓
People with a disability	✓	✓		✓	✓		✓
Gender reassignment	✓			✓	✓		
Pregnancy and maternity	✓			✓	✓		
Race and ethnicity	✓	✓	✓	✓	✓		
Sexual orientation	✓			✓	✓		
People living in deprived areas	✓	✓	✓	✓	✓		

Source: Mott MacDonald

The criticism I would make of this analysis is that it is neither quantified, nor justified beyond vague assertions:

Across all options for change patients are likely to experience improved outcomes arising from:

- *The achievement of workforce standards which promote consultant delivered care.*
- *Reducing variation through the establishment of seven-day services.*
- *A model which allows for a critical mass of cases to be undertaken and provides opportunities for sub-specialisation.*

- *Timely access to co-dependent services as a result of their co-location, in fit for purpose facilities. (Draft IIA p7)*

As I argue elsewhere it is not clear that staffing problems will be eradicated by simply building a new hospital (it merely exports them elsewhere, or will be imported into the new hospital). Variation will not be reduced to a significant extent by additional A&E coverage at the weekend as the work of Professor Sutton has established (see footnote 17). By incentivising sub-specialisation the local NHS will be promoting further inefficiencies in staffing structures and causing the proliferation of specialist services not in the interests of the NHS; and, separation of district and centralised services across three sites will increase problems of transfers in all weathers and the complexity of co-ordination of services (a problem noted earlier when the size of hospitals exceed 600 beds).

No detailed analyses of these issues appear despite the significance of the assessment.

Rather the focus of the report is to down play the overall impact to patients and key groups of the centralisation process and to support Sutton as the centralised option despite the transport and access issues being worse at Sutton for the deprived communities, who would be forced to undertake either complex bus journeys with long walks to get to the hospital or require greater use of an already overstretched ambulance service.

Insufficient weight seems to have been given to this in the quantification of non-financial factors incorporated in the PCBC options appraisal.

A recommendation will be for the local authority to undertake its own market research on the importance of this issue in any final decision making.

Considerations on the Location of services

The NHS has an obligation to fulfil its Public Sector Equality duty as described in the Draft Interim Impact assessment.(ibid p38):

The PSED is a legal obligation for public sector organisations to consider how they could positively contribute to the advancement of equality and good relations and requires equality considerations to be reflected in the design of policies and delivery of services.

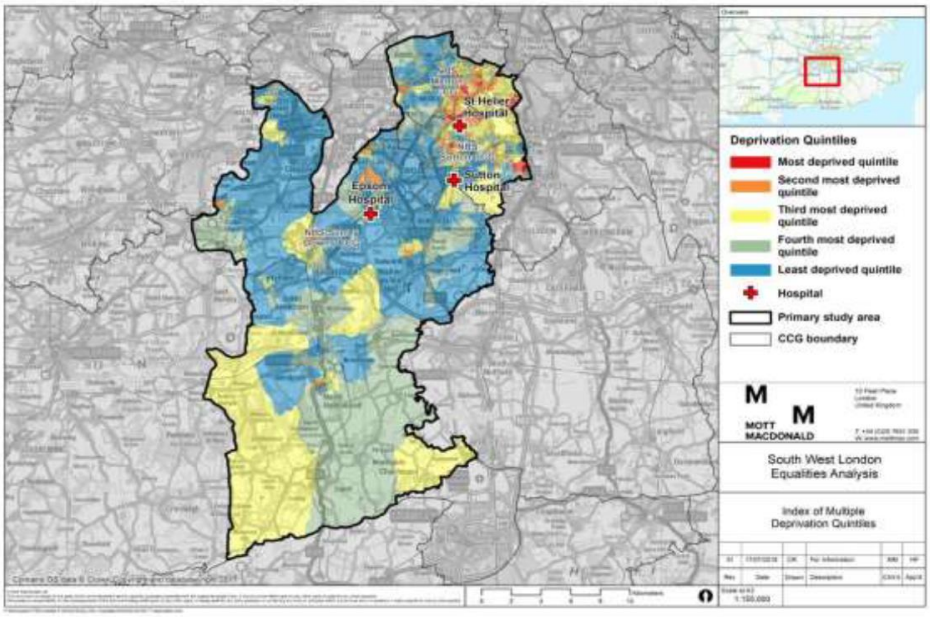
In this respect I find it surprising that the consultation document itself (p36) while acknowledging that health inequalities may be made worse by longer journey times, still

endorses these proposals. The case made is that improving non major services will have a bigger improving effect. My case is that the squeeze likely to be exerted on non-major services as a result of the high costs of centralising major services and any failure to achieve savings targets and to substitute for acute services through the planned expansion of out of hospital care will compound the negative impact of changes to major services.

In the PCBC itself very little coverage is provided to this issue in the light of its importance. It appears obvious to me that the geography dictates that more serious consideration should be given to locating services close to where the services are needed.

The diagram that makes it clearest appears in the initial equalities analysis in 2018 but not in the PCBC or interim draft impact assessment:

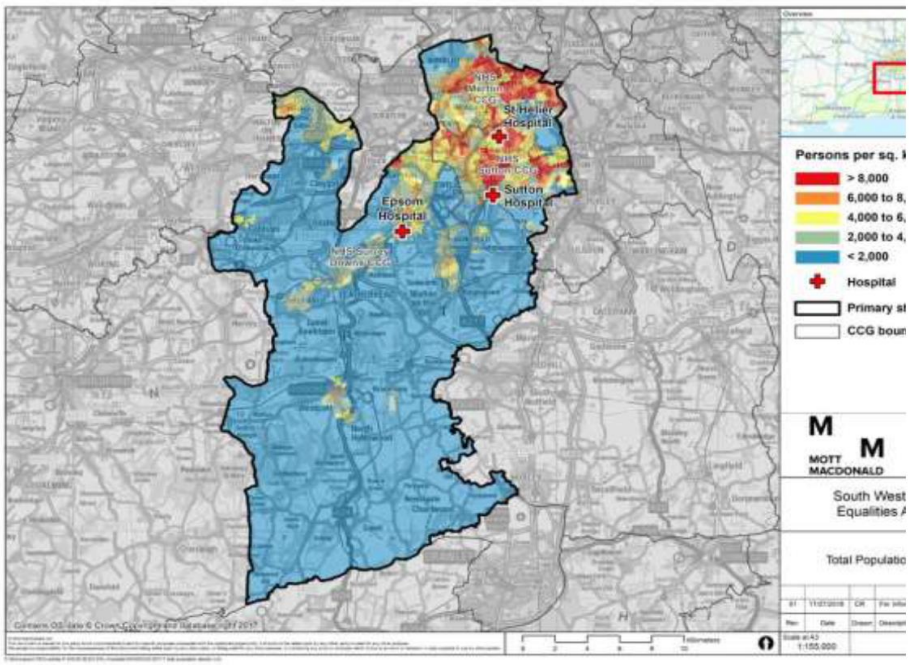
Figure 14: Overall deprivation quantiles for the study areas



Source: Mott MacDonald

This diagram coupled with the separate diagram on population density below speaks to the benefits of a two centre solution and the location of services close to St Helier:

Figure 2: Population density



Furthermore additional analysis conducted on the Lower Super Output Areas (the most deprived areas) in the Trust's catchment area copied by researchers for the local MP Siobhain McDonagh shows that:

- The more deprived the area the higher the reliance that area has on Epsom and St Helier's A&Es.
- Of the 51 most deprived parts of the Trust's catchment, just 1 is nearest to the Belmont/Sutton site. Meanwhile, 42 out of the 51 are nearest to St Helier Hospital.

6 Process Improvements

The Introduction touched on the problems with large scale reconfigurations and planning of controversial schemes. This has triggered the creation of comprehensive guidance for those promoting schemes, those assuring them and decision makers. I would add there is a comprehensive literature of where things have gone wrong in the past and is summed up in the following list of the reasons for errors in large scale projects, as summarised by King and Crewe [38].

- *Cultural Disconnect: The people behind some of the ideas didn't understand what they were talking about. They were on another planet culturally.*

[38] The Blunders of Our Governments by Anthony King and Ivor Crewe (2013)

- *Groupthink: The problems that arise when people become focused on doing something forgetting to ask whether it is the right thing to do.*
- *Intellectual Prejudices: These can act to rule out more obvious options.*
- *Operational Disconnect: Most focus is placed on this and the military example of nominating those responsible for planning with the responsibility for implementation is commended.*
- *Decision making in a hurry driven by panic, and the need for symbolic victories and political spin*

It doesn't take a great leap of imagination to see how these errors may have intruded in this case. Thus clinicians, eager for funding for a new hospital or expanded community services, may not appreciate that there are revenue costs and that for most people access to services is more important than creating the very best healthcare facilities.

It is clear that a group of clinical leaders have become convinced amongst themselves that a new Sutton site is the answer, even if the supporting arguments have changed over the years and remain weak. Obvious alternatives seem to have been dismissed out of hand.

In my view these risks should be acknowledged before decisions are taken.

The NHS in its current guidance[39]recommends tests of the proposals to try to avoid such risks. The five tests are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from commissioners.
- Additional checks where significant bed closures are planned to :
    - demonstrate that sufficient alternative provision, such as increased GP or

      community services, is being put in place alongside or ahead of bed closures,

      and that the new workforce will be there to deliver it; and/or
    - show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or

[39] NHS England, *Planning, assuring and delivering service change for patients*, 2018, page 8

- where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time Programme).

In my view although the PCBC puts its case strongly in presenting its case for passing these tests on pages 305-308, it has in reality failed to persuade and engage the vast majority of the local population, with the numbers involved in the processes very small and in situations where lay interests are surrounded by health professionals. It would be very difficult to express opposition in these circumstances. Despite this there is ample evidence from Healthwatch, local scrutiny committees and from carers that there is a strong undercurrent of opposition.

In reality choice is limited because for the majority of people in the area there is no choice but to travel further for major services.

The clinical evidence has not focussed on the real issue of what lies at the root of staffing difficulties and whether the proposals represent a full and adequate solution.

The discussion of bed numbers is conducted in vague and general terms, focussing on a total figure that includes day only beds, maternity beds, "District" beds and community beds as well as the crucial numbers of acute beds. This appears to seek to avoid any focused discussion on what would be the near-halving of numbers of front line acute beds open overnight to just 386, and the significant reduction in numbers of downgraded beds at both Epsom and St Helier. Although local commissioners are said to be in favour it is not clear that GPs have been fully consulted, or explored the full details. Nor is it clear whether successor bodies will necessarily be bound by the decisions of the current committees, who are due to be merged shortly.

The checks requesting demonstration of evidence justifying reduction in bed numbers beds are not presented in detail to enable proper scrutiny. In fact some evidence cited actually says the opposite of the implied use[40].

[40] Sixteen references are made to "Imison et al Insights from the clinical assurance of service reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed-methods study. Health Services and Delivery Research, No. 3.9 "We could not find

It is not clear in reading the PCBC document whether it has actually received a letter of support from the Chief Financial Officer of NHS England as required.

A very large portion of the PCBC is devoted to a detailed description of the methodology and tests that have succeeded in reducing the options given serious analysis, and to denying consideration of the option many people would want of simply improving existing services. Broadly what is presented is a simplified multi criteria analysis which attempts to reduce the acknowledged complexities of the decision involving multiple stakeholders to a quantified scoring system.

Although it attempts to present a rational mask, such methodologies are only as good as the base data. In this case it is based on small numbers of people who may or may not be representative of local communities and service users, and who have either established criteria or success factors, or scored options. It is not clear that invitees and participants were well briefed or can be relied upon to reflect public opinion, views of staff, carers or the range of stakeholders.

They may indeed have given too much attention to the views of senior clinical staff in arriving at conclusions. The level of openness and transparency does not extend to explaining clearly why a do minimum option, or options retaining either of the existing hospital plus the other as a district hospital have not been examined more fully as cheaper options to the one recommended. As described by HM Treasury, only 'gold plated 'options have been examined.

The summary analysis fails to present a complete net position for the NHS and public sector as a whole and merely looks at the local position for the Trust.

The financial analysis seems contrived to demonstrate the affordability of the three chosen options. Estimated costs of the new hospital are not substantiated with any supporting detail. However given the rapid increase in the estimated cost of rebuilding the William Harvey Hospital in Ashford – from £160m in November 2017 to £351m now[41],

evidence that service reconfiguration would save significant amounts of money. There is also little evidence to help hospitals find ways of overcoming their staffing difficulties."

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

and similar large and rapid increases in the costing of previous plans for Epsom & St Helier, there must be doubts over the reliability of these estimates.

It appears that although the NHS submitted draft proposals to scrutiny committees and other stakeholders, decisions were made to proceed to public consultation despite expressed reservations on the data presented and the processes undertaken.

The analysis is presented as objective, summarising rankings on both financial grounds and non-financial grounds. It does not attempt to differentiate the differing views of stakeholders or to identify additional areas for investigation or analysis to be undertaken prior to the Decision Making Business Case being presented. At present neither risk nor the level of uncertainty involved in the decision have been quantified, although some unquantified sensitivity analysis is presented which does not change the ranking of the options.

As it stands therefore there is a risk that CCGs will proceed quickly to DMBC and will attempt to assert that the Sutton option is the dominant option for which further discussion is pointless. But this would be to miss an opportunity to properly reflect on the results contained in the process so far.

Section 7.6 of the Manual on Multi Criteria analysis referenced earlier (see footnote 8) attempts to illustrate how the methodology might be used more positively.

In their words (pps 109-11), analysis very early in the life of the project *'can guide the search for further information '.*

The first attempt at modelling will highlight many inadequacies, in identifying and defining options and criteria, in the provision of data, in the inability to agree scores, and in judgements of trade-offs. At this point, the newcomer to Multi Criteria Decision Analysis (MCDA) may become discouraged, but, take heart, this is a good sign, for it identifies areas where further work is required. Thus, the MCDA modelling process provides an agenda for systematically tackling difficult issues, and shows which issues are important because their resolution could affect the overall result.

…the process should be an open consultative process

…the analysis reveals the value judgements that are a necessary part of any informed decision, so the social process must allow for the open expression of those views in the appropriate forum.

…it is an iterative fashion. There is no need to get every input to the model correct on the first go.

… Subject vague inputs to sensitivity analyses, and find which inputs really matter to the overall results.

… Leave time to explore the model fully. The model is a 'divide and conquer' strategy in the sense that a complex issue is subdivided into parts that are easier to deal with separately,

… Creating different displays, changing scores to explore disagreements, doing sensitivity analyses on weights, all these help participants to gain a better qualitative feel for the issues. That leads to increased confidence in taking a decision.

People make decisions, not models. … models can assist people in making decisions, but the assistance can take many different forms: providing structure to debates, ensuring quality conversations,

documenting the process of analysing the decision, separating matters of fact from matters of judgement, making value judgements explicit, bringing judgements about trade-offs between conflicting objectives to the attention of decision makers, creating shared understanding about the issues, generating a sense of common purpose, and, often, gaining agreement about the way forward.

…there is no theory of objective decision making, decision making is necessarily a human function. …The methods covered in this manual draw on decades of psychological research showing how it is possible to elicit from people judgements that are precise, reliable and accurate…and highlights the key value judgements, providing realistic freedom of choice, within bounds, for the decision maker.

Taken in the right spirit therefore the analysis and work done so far can be used positively to better isolate where more work is required so that information on the issues can be better presented to decision makers and stakeholders to clarify for them the trade-offs that may be necessary in making final decisions.

In the event of disagreements the Local authority can however ask for reconfiguration proposals to be referred to the Secretary of State, which by precedent involves referral to the Independent Reconfiguration Panel. This often leads to delays and requests for adjustment to plans.

In addition there is a history of independent legal challenges through requests for judicial review.

In my direct experience these are successful more often than the NHS expects. The NHS falls foul of rushed decision making, failure to present its case following guidance and failing to convince a significant number of key stakeholders. On occasion they have acted ultra vires (outside their legal powers) and often the NHS agrees to go back and resubmit plans more properly and with significant changes. The Independent Reconfiguration Panel publishes reports and periodic reviews detailing the many changes that have taken place as a result of local challenges to decisions.

As outlined in the introduction grounds for referral are:

• *The consultation has been inadequate in relation to the content or the amount of time allowed.*
• *The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.*
• *A proposal would not be in the interests of the health service in its area.*

In the final analysis the local authority and others will take account of the following legal issues:

Reasonableness

It is accepted that the threshold for intervention by the Courts should be high. In the normal course of events CCG Boards and Public Authorities can be trusted to work within their powers such that when questions of major importance come to be discussed and decisions made, there is an assumption, made reasonably, that arguments take place at the decision making forum within a reasonable range, where guidance has been followed and due process observed.

In this case however there seems to be a misunderstanding of the powers and responsibilities of the CCGs in respect of the PCBC. The IHT programme appear to think that decisions binding their consideration of options have already been made, that the requirement to follow guidance is not obligatory; that errors in either completeness, accuracy or in relation to the range of strategic options that should be considered cannot be corrected, and that the duty to complete due diligence does not fall on them but others; and that it is a waste of time to delay.

An argument could be made therefore that there is unreasonable behaviour.

Vires

The powers of the CCGs are not untrammelled and their general powers do not excuse them from following guidance in relation to investment decisions. In particular in the context of the forthcoming abolition of CCGs and the creation of two separate Integrated Care Systems covering the area considered, it appears that existing office holders are looking to bind the hands and pre-empt the powers of those that will succeed them. This appears controversial as an outside observer and could be challenged.

Pre-judgement

By doggedly pursuing reconfiguration as a goal prior to the presentation of a business case and securing the necessary resources the CCG's could be prejudging whether in the

particular circumstances applying in the locality this makes strategic or operational sense given the costs and risks involved.

Bias and conflicts of interest

Without pointing fingers there are risks that in decisions of this nature that bias and vested interests will fail to be fully recognised and allowed for. Both GPs and consultants working in hospitals make high earnings from the NHS, directly (contractually for GPs) and indirectly (private practice), which can be significantly affected by decisions to reconfigure services.

This makes it more important that proposals are subjected to high levels of detailed scrutiny and that conflicts of interest are fully disclosed.

Proportionality

It is very often the case that the pro-reconfiguration lobby is able to expend very considerable resources on what is in effect propaganda in pursuit of their aim.

By contrast the resources available to read, digest, and understand and then to challenge the case put are tiny and the opportunities to make an effective intervention scarce.

So much so that the Institute for Government has in a recent publication[42] recommended the French approach for large contentious public infrastructure schemes:

"The French Commission Nationale du Débat Public (CNDP) provides a particularly good model for how this can work in practice. The CNDP was founded in the late 1980s in a similar context to that facing the UK now: declining central state power and well organised local opposition to strategically important rail projects. In response, the French Government set up the CNDP to ensure 'public participation in the decision making processes of major infrastructure projects of national interest that present important socio-economic stakes'.

To do this, the CNDP hosts local public debates on contentious major projects as early as possible in their development. All participants – for or against a project – are given equal resources to make their cases. The CNDP then summarises these views in a report, to which project sponsors must respond.

The CNDP has no ability to enforce recommendations; but most project sponsors act on them. Of the 61 projects on which the CNDP facilitated debates between 2002 and 2012, 38 made modifications, including 25 that changed their plans based on options that emerged from the public debate (see Figure 2).

[42] How to transform infrastructure decision making in the UK. Institute of Government February 2018

French project sponsors have come to view the CNDP process as a valuable exercise in public engagement and data collection, rather than as a burden or threat."

The principle that there should be a more open debate, where each side of the debate can be properly represented and resourced seems to me a good one that should be applied to the NHS in decisions of this nature, where the scale of the commitment is so large and the consequences will be so long lasting.

7. Conclusions and the Way forward

In this briefing I have considered the arguments in favour of the proposals.

My conclusions in respect of the main categories of argument are:

Clinical:

7.1 The objectives being pursued, of defining the best healthcare as compliance with "London" clinical quality standards are unrealistic and restrictive. The CCGs also prejudge the issue of reconfiguration and whether this is really the answer to London's problems or more particularly the clinical issues in Merton, Sutton and Surrey Downs.

7.2 The preferred option is promoted without properly discussing the potential benefits of other more modest, realistic options.

7.3 There is a major risk that plans will not adequately provide for the increased demand expected in future years and that assumptions that major reductions in beds can be achieved will not be borne out in reality. This has been the case over the last twenty years. Various assumptions that the development of out of hospital care could substitute for hospital beds have remained unproven to the extent claimed. NB Better Healthcare Closer to Home (BHCH) claimed in 2003 up to 50% cuts in activity were possible.

7.4 There is a further major risk that the solution promoted to overcome current staffing problems will not succeed, and that the national and London wide staffing issues will transfer into the new improved premises – or be displaced to elsewhere in SW London.

7.5 There is a real risk that by offering the opportunity for further sub-specialisation (see Impact assessment) and the development of specialised services at Sutton that the focus of services will shift towards the interests of clinicians and not the interests of patients needing generalist services and skills.

7.6 There is a prima facie case that the proposed reductions in A&E catchment areas incorporated in plans for the preferred option (16%), reductions in consultant staff available

(69wte), middle ranking and junior medical staff (73wte), qualified nurses (33%) and in access to major acute beds (452 beds) are not in the interests of local health services.

Financial/Economic

7.7 The options appraisal does not offer a proper consideration of lower cost options, including Business as Usual (BAU), a do –minimum option and retention of just the two existing sites, with either one as the centralised facility.

7.8 The benefits of the 3-site "centralised" option appear mis-stated and misleading. Further scrutiny and assurance is required. It appears costs are merely being shifted to other trusts in SW London who will face the additional operational costs and problems of the shift in patient flows being directed away from St Helier and Epsom sites.

7.9 Claims that the resulting three site configuration will be cheaper, more efficient and will solve staffing problems appear unrealistic and overoptimistic.

7.10 The risks of the proposals have not been quantified in the financial analysis

7.11 There is a significant risk that cost overruns in the main project at Sutton would "crowd out" the viability and investment funds available at the other sites and resources available to invest in out of hospital services

Access

7.12 The proposed preferred option is worse than BAU or any option retaining services at two sites. It is significantly worse for those relying on public transport and in deprived groups.

7.13The weighting given to access issues and transport issues appears small in the overall weighting in the Multi criteria analysis.

7.14 LB Merton may wish to consider undertaking its own research on the importance of access to services for local people.

Process

7.15 The public consultation seems to have been initiated too soon before issues relating to the options considered and the impact assessment were fully understood and agreed.

7.16 Important information on assurance and on the supporting detail to the proposals is missing at time of public consultation.

7.17 There is still time for shortfalls in the process to be corrected but it is unlikely that the flaws in the process will be corrected in the absence of a fuller, balanced, and detailed evaluation and discussion.

7.18 There is a major risk that the NHS will proceed to DMBC with the proposals substantially the same without any further opportunity for stakeholders to be consulted and to influence the decision.

The final question of why the local NHS seems so keen on these proposals to build a new hospital at Sutton remains hanging in the air. Various arguments have come to the fore at various times;

- either beds were not needed and there was an opportunity to save money as patients transferred to services in the community;
- or that patients would die and existing services were unsafe ;
- or that the buildings were falling down and were incapable of being refurbished;
- or, more recently that staff were impossible to recruit.

None of these arguments have been or are convincing.

Recommendations

Discussions with stakeholders have in the limited time available confirmed modified and crystallized my findings and have enabled me to propose the following recommendations:

Recommendation 1: LB Merton should formally express its opposition to the PCBC as drafted.

Recommendation 2: LB Merton should call for further work on lower capital cost options for services on two sites not three.

Recommendation 3: The NHS should seek additional trainees, rota changes and incentives to staff to improve recruitment and retention.

Recommendation 4: The local Health and Wellbeing Board should reappraise the longer term priorities and the need for additional savings in the light of the government's stated intentions to respond to disquiet on the funding of the NHS and the current crisis which has exposed the lack of capacity within the NHS.

Way Forward

In line with the final recommendation above the clear way forward is to jointly reappraise plans across the new planning boundaries, to pool resources and look again at priorities.

It is clear to me that the results of such a process are unlikely to result in the reduction of major acute services at this time.

The priority for investment should be increasing the staffing capacity and additional acute and intensive care capacity; not their reduction. In addition the existence of two A&E departments is likely to be a more resilient solution than one.

My advice would be to not rush to make decisions on irrevocable long term reconfigurations before there are a better understanding, better plans, a broader range of options examined and more confidence amongst stakeholders that plans can be achieved without excessive risks and that makes the best use of resources, both existing and future investment .

Roger Steer 22.03.2020

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Improving Healthcare Together Joint Health Scrutiny Committee (IHT JHSC)
Response to NHS consultation on plans for Epsom and St Helier Hospital under their programme Improving Healthcare Together 2020-2030.

1. Summary

1.1. The IHT JHSC asks that NHS commissioners consider the following. The JHSC has resolved to provide comments to the CCGs but none of the comments set out below should be interpreted as recommendations.

(i) commissioners to provide further explanation of what they will do to provide better access and transport services ; how they will work with relevant partners to deliver and ; how funding will be secured to deliver (see paragraphs 4.1, 4.4, 4.9 - 4.15)
(ii) commissioners to further address actions to minimise impact on deprived communities (see paragraphs 4.19 - 4.21)
(iii) commissioners provide further information on the impact of Covid-19 in particular addressing implications for bed numbers and infection control ; deprivation and ; the impact on BAME communities (both patients and staff). (See paragraphs 4.4, 4.19 - 4.21, 5.3 - 5.6)
(iv) Commissioners to work with relevant Local Authorities regarding the wider impact on the local economies of both the chosen Specialist Emergency Care Hospital (SECH) site and the District Hospital sites (see paragraphs 4.1, 4.18, 4.22 - 4.23)
(v) commissioners ensure that development of the wider community based services and facilities happens before or in parallel with move to the new clinical model (see paragraph 4.2 , 4.4)

2. Background

2.1. Since being established in October 2018 the JHSC, (in its discretionary stage and post-publication of the formal public consultation in its mandatory form), has scrutinised the work being undertaken by the 3 CCGs responsible for the NHS plans,(NHS Surrey Downs, Sutton and Merton), exploring ways we can address local health challenges and make sure NHS services are sustainable and fit for the future.

2.2. Improving Healthcare Together (IHT) 2020 to 2030 sets out proposed changes to hospital services across the Epsom and St Helier University Hospitals NHS Trust. To summarise;

- Both Epsom and St Helier hospitals are facing significant challenges to delivering services across the two sites
- In September 2019, the trust was allocated £500 million to improve the current buildings at Epsom and St Helier hospitals as well as build a new specialist emergency care hospital on one of the three sites – Epsom, St Helier or Sutton.
- IHT proposes to bring together at one site (Epsom, St Helier or Sutton) six core (major) services for the most unwell patients and those who need more specialist care in the form of a single specialist emergency care Hospital
- The specialist emergency care hospital would be complemented by the existing district hospitals each with its own Urgent Treatment Centre (UTC), open 24 hours a day 365 days per year, continuing to treat a significant proportion (80%) of existing demand.

2.3. The IHT process has resulted in a shortlist of three options.

- Epsom as the site of the specialist emergency care hospital This would include UTCs at both Epsom and St Helier hospitals
- St Helier as the site of the specialist emergency care hospital This would include UTCs at both Epsom and St Helier hospitals
- Sutton as the site of the specialist emergency care hospital This would include UTCs at Epsom, St Helier and Sutton hospitals (IHT preferred option).

2.4. The role of the JHSC is to scrutinise the proposals of the NHS and take a policy view which takes into account the collective view of the Councils represented on the committee and all of the issues which impact on residents' use of healthcare, including access, transport and the consequences for employment, the local economy and wider public services.

2.5. As part of its responsibilities during the mandatory stage the JHSC is permitted to delay making its consultation response until after the full public consultation has been completed so that it can then be informed by the findings and conclusions arising from the public consultation.

2.6. On this basis the JHSC held a meeting on 4 June 2020 to receive and be briefed on the analysis and findings of the public consultation and the latest version of the Integrated Impact Assessment (IIA).

2.7. The IHT JHSC response to the consultation below is informed by the information and briefings it has received, the questions asked of NHS commissioners, other stakeholders and members of the public across all the meetings held since October 2018.

2.8. The response uses the questions as set out in the public consultation to provide a framework for the responses to more specific areas. The response also raises a number of concerns regarding the process that has been followed, particularly in light of Covid-19 outbreak.

3. **Points related to consultation questions** (original consultation questions shown in italics)

3.1. As representatives of the local communities affected by these plans the committee focuses its attention on the wider non-clinical aspects of the proposals and wishes here to re-enforce the points it has made over the duration of the committee's oversight. In particular this concerns issues around:-

- Consideration of transport and accessibility issues including the balance between public and private transport modes
- Consideration of the impact on deprived communities resulting from changes to the location of certain service provision
- Consideration of the impact on the wider local economies and potential regeneration
- Impact on staff not only in the Trust itself but also support organisations such as the voluntary sector and local government (adult social care)
- Impact on the environment eg: air quality.

3.2. It is acknowledged by the JHSC that without significant capital investment the model for acute hospital provision within the borough is currently unsustainable and needs to change. Whether this investment needs to include a new third site is the subject of this consultation.

3.3. *Our Model of Care (or New Way of Working) Our proposal is to keep most services at their present hospitals in refurbished buildings, and bring together six core (main) services for the most unwell patients, those who need more specialist care, and births in hospital, onto one site in a state-of-the-art new specialist emergency care hospital.*

3.4. Whilst the committee welcomes some aspects of the new model of care, most members believe that there are also a number of areas of concern where we have not been able to get the assurance we would need to fully support these ideas. There are continuing concerns around:

- The fact that the new model will both be new and unique in London
- The extent to which preparations would be in place to ensure patients, families and carers understood the effect of the new 'architecture' of care,
- The extent to which the companion community-based service changes and facilities would be ready in time and sufficiently bedded-in
- The implications for existing users from deprived communities resulting from changed locations of provision
- The travel, transport and accessibility (public and private) issues arising from the changes
- The impact on staff and the ease with which new or replacement staff can be recruited to work for the Trust, particularly at the site(s) which are not chosen to be the major centre.
- The costs and complexity of district hospital services and major acute services being on different sites requiring inter-site patient transfers

If the new model of care is adopted then these concerns will need to be addressed, and a Sub-Committee of the JHSC will be tasked with assuring that this happens. To ensure that the views of all affected areas are properly represented, working groups of the Sub-Committee will ensure that they include representation from local Borough and District Councils.

3.5. *The location of the specialist emergency care hospital : Sutton Hospital as our preferred location / St Helier Hospital as the location of the new specialist emergency care hospital / Epsom Hospital as the location of the new specialist emergency care hospital*

3.6. As the IHT JHSC is made up of members of six local authorities who are in varying degrees impacted by the proposals it will necessarily be the case that the different local ambitions and priorities will influence the responses. This IHT JHSC response is therefore a combination of aspects where there is broad agreement and more specific local views. This is specifically the case when it comes to the location of the new acute hospital. NHS commissioners will also need to take into account the specific responses made here and in the individual responses as below. The IHT JHSC cannot therefore express a consensus view on the location of the specialist emergency care hospital.

3.7. The individual views of the councils involved in terms of the options presented in the consultation are available via the links in Appendix one.

3.8. *What would help improve transport and travel? What would improve public transport and travel to the new specialist emergency care hospital for any of the three options?*

3.9. As noted above issues around travel transport accessibility and the increase / changes to flows around the re-modelled sites is a very important issue. The committee has seen various information based on traffic modelling which provides some theoretic outcomes for travel times etc. The Integrated Impact Assessment notes that some people from deprived communities and older people are disproportionately affected by the increased travel times. These disparities are accentuated when public rather than private transport needs to be used as is often necessary for these groups of people.

3.10. Regarding the transport considerations for each site this needs to include more detail on those groups whose travel times are lengthened by the Sutton site option and link this to higher historic use of A&E by these groups, which will not necessarily be mitigated by an Urgent Treatment Centre at St Helier.

3.11. While the committee understands that major public transport providers such as Transport for London (TfL) have been involved in some early discussions by necessity these can only be very provisional, being based on the possibility of any one of the three options being chosen. It is also not clear that any required additional funding would be provided for the relevant transport providers, the committee's understanding being that the £500M relates to hospital spend only. It is not clear whether the mitigations for adverse impacts proposed in the IIA final report are feasible or affordable.

3.12. The JHSC notes that further work will be needed to improve transport access, both public and private, to the new SECH and ensure that these improvements are in place by the planned opening date in 2025. The JHSC expects the design and implementation of this improved public transport and road network will be carried out in conjunction with local authorities and will address issues and concerns raised by the JHSC relating to travel times, transport costs, parking and other access issues impacting on residents, particularly those in areas of high deprivation. The JHSC calls on NHS commissioners to work closely with the relevant local authorities to make the case to the Government to give assurance that sufficient funding is available to deal with transport issues arising from the anticipated increased population of the wider catchment area, together with the impact of the implementation of the IHT programme.

3.13. We also believe that the impact of longer journey times, poor bus connections and insufficient train routes and car parking are inter-related risk factors which require further mitigation. Some of the evidence presented in the Deprivation Analysis indicates greater healthcare usage by deprived communities. We note that a key concern from the formal consultation has been about poor health outcomes as a result of longer journey times.

3.14. Longer journey time concerns have repeatedly surfaced throughout the process and in particular in the consultation process. The YouGov and Ipsos MORI findings support this feedback. The London Borough of Merton St. Helier Survey results also refer to longer journey times. Importantly, across the entire formal consultation exercise, concerns were

raised about longer travel times, separation of services/maternity services and pathways and patient flow.

3.15. A potential risk to parking capacity at the preferred acute site may also materialise if "non-patient" usage exceeds expectation. Parking capacity at Sutton hospital is currently well below that of Epsom and St. Helier. Considerable investment would be required to allow for increased number of visitors at the preferred site, especially in acute maternity/birthing and paediatrics.

3.16. *How would our proposals affect you and your family? If you think any of our proposals would affect you, your family or other people you know, either positively or negatively, please tell us why you think this using the space below.*

3.17. As noted above in the general section the JHSC's response reflects our position as local community leaders for both our individual communities and across the sub-region.

3.18. Recognition should be given to the role of the local councils with regard to their communities in terms of accessibility, transport, deprivation and the impact on local economies.

3.19. Throughout both the engagement phase and during the public consultation members have expressed concerns about and pressed IHT Commissioners about the impact of the proposals on deprived communities. The deprivation impact analysis and Integrated Impact Analysis have provided some information with regard to these concerns.

3.20. However the JHSC is still concerned that the particular impacts of changes to the location of services for deprived communities are not sufficiently considered in terms of accessibility and transport and the specific clinical needs of those from such communities. This is also shown in the actions and mitigations which reflect on these issues in the Integrated Impact Analysis.

3.21. As the programme moves to the development of its Decision Making Business Case the JHSC would like to see more substantive detail on the implications and mitigations which would be necessary.

3.22. At this stage of the proposals it is not possible to provide anything like a full consideration of the potential impact of the choice of one site over the other two in terms of resulting development (opportunities) or diminution of the impact on local economies for each site.

3.23. As local authorities with responsibility for our areas as a whole it is vitally important for JHSC members to consider this alongside the medical aspect of the proposals. The JHSC and relevant local councils will therefore want to work closely with NHS commissioners as and when the project moves forward to ensure that full and proper consideration is given to maximising benefits and avoiding or minimising any possible downsides irrespective of the site chosen.

4. **Procedural Considerations**

4.1. The Committee does not believe it has been presented with the information needed to effectively carry out its scrutiny in a timely manner. From the start and during the process

the JHSC has been concerned about and registered comments about the way in which the information provided by the NHS has often been in an incomplete or draft form and has had the impression of the JHSC being 'drip-fed'. Whilst fully recognising the range and complexity of the issues it has too often felt as if the JHSC involvement was being treated as a series of steps to be achieved on a largely predetermined path.

4.2. On a similar theme members were also not helped by the fact that important contributory papers such as the IIA were still not being provided to them in final version form. In particular the final report of the IIA was not made available to the JHSC members before the 4 June meeting. JHSC members understand the iterative nature of such work and the timing issues that can arise when having to work to statutory publication deadline for committee papers but the fact is that the timelines for this piece of work were in the control of the programme and the committee management deadlines are well known in advance.

4.3. The JHSC and some of the individual councils raised concerns towards the end of the period of public consultation when the lockdown effects of Covid-19 were introduced and caused face-to-face elements in the remaining consultation period to be cancelled. Whilst recognising that online paths did remain open, members were concerned that people would not have the opportunity to respond and would rightly be prioritising themselves and their families health rather than participating in a consultation.

4.4. The JHSC is disappointed that requests either for an extension to the consultation or a pause were rebuffed. The committee has not seen any evidence to support the stated view that the impact of Covid-19 was minimal and is concerned that this demonstrates a continuation of approach whereby the IHT programme presses ahead on the basis of its own timetable with little or no thought for the impact on wider stakeholders.

4.5. At the JHSC meeting on 4 June the committee heard that the programme was undertaking work to inform itself of potential issues arising from the recent and ongoing Covid-19 pandemic. This is to be welcomed. However members were very concerned to hear that the information, which would be being shared with the CCGs, would not be available to the JHSC to help inform their considerations to this written response. This would appear to be a major hindrance to the JHSC's ability to carry out its statutory function. In particular it is stated in the IIA final report (published after the 4 June meeting) that if any changes to the programme are proposed in the light of COVID, the impact assessment "should be reviewed and reassessed". Until JHSC has seen the work on COVID-19, it will be unable to take a view on whether the IIA is sufficient in its present form.

4.6. Whilst some further information was shared with the committee after the meeting and there was also more information contained in the IIA final report which was also published after the 4 June meeting which is to be welcomed members were concerned to see that more work particularly in the areas of the impact of Covid-19 on deprived communities and BAME groups should be included and be available for the JHSC to consider. Members would expect the findings and mitigations of this work to be fully reflected in the final business case and would therefore be available for the JHSC to review.

APPENDIX ONE

Council	Preferred option	Link
Croydon	Not available	Not available
Kingston	Sutton (with essential actions and mitigations to ensure those “patients” and “non-patients” in the more deprived areas can access the new SECH site via bus or tram link).	Not available
Merton	St Helier	See item 6 here
Surrey	Supports the new model of care but has not received the assurances needed to give its support to a specific location.	See item 5 here
Sutton	St Helier	See item 45 here
Wandsworth	Sutton	See item 16 here

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Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 21 July 2021

Wards: ALL

Subject: Nomination for membership of Community Subgroup of the Health and Wellbeing Board

Lead Officer Dagmar Zeuner, Director of Public Health
Dagmar.zuener@merton.gov.uk

Lead Councillor: Councillor Peter McCabe, Chair of the Healthier Communities and Older People Overview and Scrutiny Panel.

Recommendations:

A. The Panel are asked to nominate a representative to the Community Subgroup of the Health and Wellbeing Board.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The Director of Public Health will provide a brief verbal update on the work undertaken to establish a new sub-committee of the Health and Wellbeing Board on COVID-19 outbreak control.

2 DETAILS

2.1. The Health and Wellbeing Board is overseeing Merton's Covid-19 outbreak control plan implementation. In order to facilitate further community engagement and make sure that outbreak protection and control will benefit the whole community and reduce disproportionate Covid-19 impact, the HWBB has agreed to set up a Community Subgroup.

2.2. It will consist of core board members, including councillor members and some additional diverse nominees with the right skills and community connections. The Subgroup is proposed to be chaired by the Health and Wellbeing Board Chair and will meet monthly, with the first meeting planned for beginning of August to be prepared for potential outbreaks and / or second wave of Covid-19 in the autumn/winter. We are seeking a nominee from the Healthier Communities and Older People Overview and Scrutiny Panel.

3 ALTERNATIVE OPTIONS

The Healthier Communities and Older People Overview and Scrutiny Panel can select topics for scrutiny review and for other scrutiny work as it sees fit, taking into account views and suggestions from officers, partner organisations and the public.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The Panel will be consulted at the meeting

5 TIMETABLE

5.1. None relating to this covering report

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. None relating to this covering report

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. None relating to this covering report. Scrutiny work involves consideration of the legal and statutory implications of the topic being scrutinised.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. It is a fundamental aim of the scrutiny process to ensure that there is full and equal access to the democratic process through public involvement and engaging with local partners in scrutiny reviews. Furthermore, the outcomes of reviews are intended to benefit all sections of the local community.

9 CRIME AND DISORDER IMPLICATIONS

9.1. None relating to this covering report. Scrutiny work involves consideration of the crime and disorder implications of the topic being scrutinised.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. None relating to this covering report

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

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12 BACKGROUND PAPERS

12.1.

Healthier Communities and Older People Work Programme 2020/21

This table sets out the draft Healthier Communities and Older People Panel Work Programme for 2020/21. This Work Programme will be considered at every meeting of the Panel to enable it to respond to issues of concern and incorporate reviews or to comment upon pre-decision items ahead of their consideration by Cabinet/Council.

The work programme table shows items on a meeting by meeting basis, identifying the issue under review, the nature of the scrutiny (pre decision, policy development, issue specific, performance monitoring, partnership related) and the intended outcomes. The last page provides information on items on the Council's Forward Plan that relate to the portfolio of the Healthier Communities and Older People Panel so that these can be added to the work programme should the Commission wish to.

The Panel is asked to identify any work programme items that would be suitable for the use of an informal preparatory session (or other format) to develop lines of questioning (as recommended by the 2009 review of the scrutiny function).

Scrutiny Support

For further information on the work programme of the Healthier Communities and Older People please contact: -
Stella Akintan (Scrutiny Officer)
Tel: 020 8545 3390; Email: stella.akintan@merton.gov.uk

For more information about overview and scrutiny at LB Merton, please visit www.merton.gov.uk/scrutiny

Meeting date 21st July

Scrutiny category	Item/Issue	How	Lead Member/ Lead Officer	Intended Outcomes
Scrutiny of Health Partners	Discussion on the final decision of the Improving Healthcare Together Programme.	Report to the Panel	Hannah Doody, Director of Community and Mike Robinson, Consultant in Public Health	Panel to discuss the final decision and its implications for Merton residents.

Meeting Date 2 September 2020

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
	COVID-19 – How the Council is managing the response over the next 12 months and preparing for wave two. Including lessons learned from the early outbreak and work with partners, impact on specific communities within care homes and support to those who are shielding.	Report summary and verbal update.	Director of Community and Housing	Panel to get an overview of the impact on the COVID-19 Pandemic in Merton and consider areas they may wish to do further scrutiny.

	NHS South West London - response to COVID-19	Report summary and verbal update.	James Blythe Locality Executive Director, Merton and Wandsworth	Panel to consider how the SW London CCG has responded to COVID19 to support Merton residents.
	Commissioning arrangements in South West London – Update on the new merged CCG's and the implications for Merton as a place.	Report summary and verbal update.		

Meeting date – 3rd November 2020

Scrutiny category	Item/Issue	How	Lead Member/ Lead Officer	Intended Outcomes
Scrutiny of Health Partners	Mental Health Services – Update on support provided to the community as a result of COVID-19	Reports/verbal updates to the Panel	South West London Mental Health Trust, Community Mental Health Services	Panel to ensure local residents are receiving the support they need following the Pandemic
Budget Scrutiny	Draft Business Plan	Report to the Panel	Director of Corporate Services	Panel to review draft budget and provide comments to the Overview and Scrutiny Commission.
Scrutiny of Adult Social Care	Discussion on Adult Social Care Budget including the Adult Social Care Precept	Report to the Panel	Director of Community and Housing	Panel to gain a better understanding of the budget and the impact on Merton residents.

	and an update on the impact of COVID-19			

Meeting Date – 11th January 2021

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Budget scrutiny	Draft Business Plan	Report to the Panel	Director of Corporate Services	

Meeting date – 9th February 2021

Scrutiny of Health Partners	Access to GP Surgeries –update report setting out comparative data on access to GP appointments across South West London. The Panel will also	Report to the Panel	**South West London Clinical Commissioning Group**	

	consider out of hours GP Services			
Scrutiny of Adult Social Care	Safeguarding Adults Annual Report			
Scrutiny of Adult Social Care	Safeguarding Adults Reviews			

Meeting date – 26 April 2021

Scrutiny category	Item/Issue	How	Lead Member/Lead Officer	Intended Outcomes
Budget Scrutiny				
Scrutiny of Health Partners				

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