IRP

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The Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care
39 Victoria Street
London SW1H 0EU

28 October 2020

Dear Secretary of State

REFERRAL TO SECRETARY OF STATE
Improving Healthcare Together 2020 to 2030
London Borough of Merton Healthier Communities and Older People Panel

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Peter McCabe, Chair, Healthier Communities and Older People Panel (HCOPP), London Borough of Merton. NHS England and Improvement completed the IRP information template. A list of all the documents received is at Appendix One. The IRP provides this advice in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services.

In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State may be made. The IRP provides the advice below on the basis that the Department of Health and Social Care is satisfied the referral meets the requirements of the regulations.

Before beginning this commission, I declared to IRP members that between May 2016 and September 2019 I had been a non-executive director of St George's Hospital NHS Foundation Trust which neighbours the Epsom and St Helier University Hospitals NHS Trust (ESTH) that is the subject of this referral. I also disclosed that I had recently been in discussion with several senior consultants at ESTH about individual clinical outcome measures in my role as Chair of the National Clinical Improvement Programme (NCIP). The Panel Members and Secretariat considered the matter and confirmed that, in their view, these tangential connections with the case did not represent a conflict of interest and agreed that it was not relevant to my role in chairing the formulation of this advice.

The Panel considers each referral on its merits and concludes that, taking account of the observations below and specifically the requirement for ongoing financial assurance, the proposals should proceed.

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Background
Improving Healthcare Together 2020 to 2030 was established jointly by the three clinical commissioning groups (CCGs) - Surrey Downs, Sutton and Merton[1] – together serving a population of more than 700,000. ESTH is the main provider of hospital services within the combined geographical area. It provides a wide range of hospital services from Epsom Hospital, St Helier Hospital and Sutton Hospital for around 500,000 people living in the London Borough of Sutton, the south of the London Borough of Merton and, in Surrey, for the people of Epsom and Ewell and parts of the Mole Valley, Elmbridge, Reigate and Banstead.

Epsom and St Helier hospitals, which (depending on route) are around 7-9 miles apart, provide major acute services including acute medicine, emergency departments, obstetrics and inpatient paediatrics along with 'district' services including urgent treatment centres, outpatients, daycase surgery, diagnostics and chemotherapy. Sutton Hospital, in the Belmont part of the borough, lies broadly between Epsom and St Helier and provides blood tests, outpatient services for pain education and chronic fatigue, the headquarters for the Trust Patient Transport Service and a community services training facility. ESTH has, for a number of years, experienced problems with staff retention and recruitment coupled with substantial financial difficulties and this trend is set to continue unless action is taken. There are particular challenges with ageing buildings with some 57 per cent of the estate (91 per cent at St Helier and 14 per cent at Epsom Hospital), built before 1948.

Across the area, there are wide differences in demography, ranging from densely populated urban housing to sparsely populated rural villages. Most people living in Surrey Downs, Sutton and Merton are generally in good health and use hospital services less regularly than in other areas of England. Surrey Downs has an older and less ethnically diverse population living in more rural areas. It sees better health outcomes and is wealthier than the average for England as a whole. Health outcomes in Sutton are also better than the average for England and the borough is wealthier than the England average. However, there are pockets of deprivation resulting in differences in life expectancy across the area. In Merton, the population is older and while health outcomes are better than average there is, again, a gap in life expectancy between the most and least deprived areas.

Cllr McCabe's referral letter and supporting evidence describe a long history of proposals for change to the provision of healthcare in south west London dating back to the 1990s when the Epsom and St Helier trusts were merged. Proposals drawn up in 2000, known as *Investing in Excellence,* proposed downgrading services in Epsom to centralise acute

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[1] From 1st April 2020, four CCGs in Surrey, including Surrey Downs CCG have joined together to create a new singular commissioning organisation across the area - the Surrey Heartlands CCG. Similarly, CCGs in South West London, including Sutton and Merton CCGs, have joined several other CCGs to form South West London CCG.

services at St Helier Hospital. In 2003, a proposal emerged to close Epsom Hospital's A&E department and centralise services temporarily at St Helier Hospital pending the building of a new critical care centre. In the same year, a consultation, *Healthcare Closer to Home,* proposed the closure of both Epsom and St Helier hospitals to be replaced by a new single site 500-bed critical care hospital at three possible locations - St Helier, Sutton (Belmont) or Priest Hill. Further proposals in 2006 for a single site critical care hospital in Belmont did not proceed, nor did 2009 plans to refurbish St Helier Hospital through a private finance initiative or the 2010 proposals *Better Services, Better Value.* In 2014, a new five year strategy document was published by the south west London CCGs but was largely superseded in 2016 by the emergence of plans to create a new 800-bed single site hospital to replace the existing Epsom and St Helier hospitals.

The *Improving Healthcare Together 2020 – 2030* programme was established in January 2018 with a vision for future healthcare based on preventing illness, integrating care and ensuring high quality major acute services. The programme sought to address longstanding issues around delivering clinical quality (including staffing), providing healthcare from buildings fit for purpose and financial sustainability. Five key processes were initiated to support the development of a pre-consultation business case:

- Developing a case for change by reviewing evidence of the challenges facing the population and the Trust
- The development of a clinical model overseen by a Clinical Advisory Group
- An options consideration process for developing long and short lists for options
- Developing a finance and activity model overseen by a Finance, Activity and Estates Group
- Commencing deprivation studies, early equality impacts and an integrated impact assessment

This work led to the publication, in June 2018, of an Issues Paper. This was followed by a pre-consultation exercise to gauge the views of the local population on preliminary proposals, in particular focussing on those groups most impacted by the potential changes to major acute services, such as users of paediatric, maternity and emergency services. An initial scoping equality analysis and a deprivation analysis were also undertaken. A number of key themes emerged from the engagement work with the public including dissatisfaction with current services, support for a clinical vision centred on integration and prevention, concern about transport and accessibility, and the impact of change on deprived, elderly and less mobile members of the community.

A sub-committee of the South West London and Surrey Joint Health Scrutiny Committee (JHSC), with representatives from Merton, Sutton and Surrey councils, was established to scrutinise further work. The Sub-committee met for the first time on 16 October 2018 to hear and discuss progress to date and continued to meet regularly throughout the remainder

of 2018 and into 2019[2] receiving oral and written reports from members of the *Improving Healthcare Together* programme team.

In December 2018, the Clinical Senate for London and the South East provided an initial review of the case for change, the emerging clinical model and a longlist of options. A full review of a draft pre-consultation business case in March 2019 provided 94 recommendations to the programme grouped into seven main areas – finance, activity and estates; risk and benefit analysis; transfers and ambulance impacts; workforce; district hospital and urgent treatment centres; patient pathways; and general clarifications - and outlined the potential benefits of bringing major acute services onto one site.

Taking account of the Clinical Senate review, work continued through to autumn 2019 to consider all possible solutions to the challenges facing Epsom and St Helier Hospitals. Focus groups were used to develop a longlist of options and then workshops involving members of the public and stakeholders from across the combined area analysed and assisted in narrowing the longlist down to a shortlist. Three tests were applied:

- Does the potential solution maintain major acute services[3] within the combined geographical boundaries?
- Is there likely to be a workforce solution to deliver the potential solution?
- From which sites is it possible to deliver major acute services?

Applying the first two tests led to the elimination of any solutions that did not retain major acute services within the geographical area and (due to workforce limitations and co-dependencies) any potential solution with more than one major acute site or relying on external workforce. After application of the third test, it was concluded that only existing sites appeared feasible resulting in a shortlist for a clinical model with the following potential options:

- (a no service change 'counterfactual', continue current services at Epsom and St Helier hospitals – this was included solely for comparator purposes)
- A single specialist emergency care hospital at Epsom Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier hospitals
- A single specialist emergency care hospital at St Helier Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier hospitals
- A single specialist emergency care hospital at Sutton Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier hospitals

[2] 28 November 2018, 7 February, 30 April, 4 July 2019. A new South West London and Surrey County Council Joint Health Overview Scrutiny Committee (Joint HOSC) with additional representatives from Croydon, Kinston-upon-Thames and Wandsworth met on 30 July, 26 September 2019, 4 June 2020.

[3] Defined as major emergency department, acute medicine, critical care, emergency surgery, inpatient paediatrics and obstetrics

Financial and non-financial criteria were used to produce two independent rankings of the options and were reported to the *Improving Healthcare Together* Programme Board. Both the non-financial and financial rankings placed the Sutton (Belmont) site first followed by St Helier and then Epsom. The CCGs' Committees-in-Common (CIC) met on 6 January 2020 to review the evidence and consider recommendations from the Programme Board. The CIC approved a pre-consultation business case and agreed to proceed to consultation on the proposals and the three options for change (excluding no service change) with the preferred option of locating a specialist emergency care hospital at Sutton (Belmont). Under the proposals, the majority of services would remain at Epsom and St Helier hospitals in refurbished buildings with both hospitals running 24 hours a day, 365 days a year and with urgent treatment centres at both hospitals. The six major acute services would be brought together for the most unwell patients, those who need more specialist care, and births in hospital, onto one site in new state-of-the-art buildings allowing clinical staff to work together providing round-the-clock specialist care. NHS England and Improvement provided assurance to proceed to consultation and confirmed that approval in principle had been provided for a source of capital via the Health Infrastructure Plan.

The *Improving Healthcare Together* consultation describing the case for change and options for delivering the clinical model was launched on 8 January 2020 and ran for 12 weeks. A variety of methods were used to reach and hear the views of the community including eight public listening events, community outreach work, funding voluntary groups, three deliberative events, 11 focus groups, six one-one interviews, telephone surveys, 17 mobile roadshows, 13 clinical pop-ups, leaflet drops and consultation material distribution, and use of media, social media and the internet. Two local MPs submitted comments to the consultation. Siobhain McDonagh, MP for Mitcham and Morden, raised issues around staffing, the clinical model, the consultation process, deprivation analysis and weighting/scoring of criteria, impact on other providers, transport, impact on maternity services, and environmental considerations. Dr Rosena Allin-Khan, MP for Tooting, expressed concern about the knock-on effects of the proposals for the neighbouring St George's Hospital. The consultation closed on 1 April 2020.

Independent reports of findings were produced by YouGov and IpsosMori. These, along with other findings, were combined into a report for the CCGs by Opinion Research Services (ORS) which found that the proposed investment was welcomed, widespread support for the clinical model (though less so amongst Merton respondents), support for the Sutton (Belmont) site (though dependent on respondents' place of residence), concerns about access and longer journey times leading to poorer health outcomes, separation of support in maternity care and the impact of three-site working.

Further work was undertaken to develop a decision-making business case (DMBC) encompassing additional evidence coming to light post-consultation. This included updates to the interim draft integrated impact assessment taking account of feedback from

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consultation, refreshed deprivation and travel analyses and an additional deprivation analysis following a request by Merton Council for further research on the impact of proposed changes on those living in deprived areas across the three CCG areas.

The Joint HOSC established by the London Boroughs of Croydon, Kingston upon Thames, Merton, Sutton and Wandsworth and Surrey County Council to scrutinise the proposals met on 4 June 2020 to consider its response. The Joint HOSC received an update from members of the *Improving Healthcare Together* programme team including an independent analysis of feedback by ORS, an integrated impact assessment update by Mott MacDonald, and a draft final integrated impact assessment report. That report described key findings for each option for change across four assessment areas – health, equality, travel and access, and sustainability. It recognised that people living in deprived areas could be disadvantaged in terms of increased travel times to the specialist emergency site but that the district hospital model could provide an overall positive impact on health inequalities. A number of measures to mitigate the potential negative impacts were proposed. Committee members expressed concern that the most up-to-date report had not been made available to the meeting.

The Committee submitted comments to the CCGs on 22 June 2020 but did not make any recommendations. It supported the case for change acknowledging that without significant capital investment the current model was unsustainable. The Joint HOSC was unable to express a consensus view on the location of the specialist emergency care hospital and raised some concerns about the proposed clinical model. It asked commissioners to consider and explain further issues around access and transport, action to mitigate the impact for deprived communities, the impact of Covid-19, impact on local economies and the development and timing of wider community-based services.

Prior to its decision-making meeting, the CCGs' CIC received submissions from Chris Grayling, MP for Epsom, calling for the CIC to delay taking decisions. Siobhain McDonagh, MP for Mitcham and Morden, re-iterated her concerns and opposition to the proposals. On 3 July 2020, the CIC made the decision to build a specialist emergency care hospital at the Sutton (Belmont) site with around 500 beds and 85 per cent of services remaining in modernised buildings at Epsom and St Helier hospitals[4].

On 21 July 2020, Merton Council considered the CIC's decision and, by a majority decision, resolved to make a referral to the Secretary of State citing six main reasons – a failure to tackle health inequalities, failure to model the effect of displacing patients towards other hospitals and social care, whether achieving clinical standards would lead to the best use of limited resources, failure to learn lessons from the Covid-19 pandemic, misrepresentation of the public voice and concerns about finances.

[4] With around 280 and 220 beds respectively.

Government agreement to investment of £500m in ESTH through the Health Infrastructure Plan, announced earlier in the year, was confirmed by the Prime Minister in a DHSC press release[5] on 2 October 2020.

Basis for referral
Cllr McCabe's letter of 27 July 2020 states that:

> *"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 CCGs' 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."*

IRP view
With regard to the referral by Merton Council HCOPP, the Panel notes that:
Scrutiny

- A joint scrutiny committee comprised, initially of three later six, relevant local authorities was correctly formed – this was the appropriate body through which to conduct scrutiny
- Some requests for information were left unfulfilled – the maintenance of good working relationships requires that this is rectified

Consultation issues

- Extensive engagement and consultation work was undertaken
- Public consultation continued according to schedule notwithstanding the onset of Covid-19 – it is not clear whether a suspension would ultimately have influenced the outcome
- Criticism has been levelled at the coverage of the public consultation and at the interpretation of the responses and their presentation in the decision-making business case
- The context of the proposals within the wider south west London and Surrey health services, together with the potential benefits for patients and service quality, have been underplayed

Whether the proposals are in the interests of local health services

- Sustaining safe, high quality hospital emergency services for the population served by ESTH is a real cause for concern
- Significant capital investment is required to enable change to a sustainable model for acute hospital provision

[5] PM confirms £3.7 billion for 40 hospitals in biggest building programme in a generation, DHSC press release, 2 October 2020

- The proposed clinical model of care – a specialist emergency care hospital centre complemented by district and out of hospital services – offers some clear benefits for patient care
- The appraisal of options for implementing the new model of care, leading to the decision to locate the specialist emergency care hospital at Sutton, has been the subject of scrutiny, criticism and dispute
- The financial assumptions underpinning the proposals have been questioned

Moving forward

- Questions remain about how some aspects of the new model of care will work in practice and how the changes can be delivered successfully

Advice

The Panel considers each referral on its merits and concludes that, taking account of the observations below and specifically the requirement for ongoing financial assurance, the proposals should proceed.

Scrutiny

Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, a joint health scrutiny committee was required to be formed to consider and be consulted on the *Improving Healthcare Together* proposals. A committee known as the JHSC was initially formed from representatives of Merton, Sutton and Surrey Councils and then later expanded to include, additionally, representatives from Croydon, Kingston upon Thames, and Wandsworth councils (the Joint HOSC).

The proposals have become the subject of referral to the Secretary of State by one of the constituent committees, namely the Merton HCOPP, which from the outset retained its right to do so. Referral has been made, in part, under Regulation 23(9)(a) of the regulations which concerns the conduct of consultation with the appropriate scrutiny body. In this case, the Joint HOSC was the appropriate and only scrutiny body which those responsible for developing the *Improving Healthcare Together* proposals needed to consult. The minutes of relevant Joint HOSC meetings suggest that the information exchange between the Committee and the NHS[6] could have been better, particularly towards the end of the process. This view is supported by comments made by the Joint HOSC in its response to the CCGs of 22 June 2020.

The Panel notes that the Joint HOSC's response of 22 June 2020 contained no recommendations to the CCGs and also that no meetings of the Committee appear to have taken place between September 2019 and May 2020 – the period covered by preparations for the public consultation, public consultation itself and then post-consultation analysis. No doubt the exceptional circumstances of much of that time, brought about by the onset of Covid-19, played a part in this.

[6] The term "NHS" used here to indicate all representatives of CCGs, EHST, *Improving Healthcare Together* programme team etc

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Gaps in the knowledge base identified by scrutiny need to be filled to maintain trust moving forward. Ultimately though, the Joint HOSC decided not to refer the proposals and, for this reason, the Panel does not consider that referral under Regulation 23(9)(a) requires any further consideration beyond fulfilling any outstanding requests for information. In accordance with the extant departmental guidance on health scrutiny[7], consideration of matters relating to public engagement and formal public consultation are dealt with under Regulation 23(9)(c) as not being in the interests of the health services and are set out below.

Consultation issues

The background section to this advice describes the extensive engagement and consultation work that was carried out in developing these proposals utilising a wide variety of tools and methods. However, the process has been criticised by the Merton HCOPP which included in its referral evidence from Siobhan McDonagh, MP for Mitcham and Morden, a proportion of whose constituents access services provided by ESTH.

The Merton HCOPP asserts that the consultation process should have been halted with the onset of Covid-19 to allow time to assess its impact fully and, in many respects, the Panel agrees that extending the public consultation beyond 1 April 2020 would have been a common-sense response to the situation at the time. But while having some sympathy with this point of view, the Panel questions whether, in practical terms, it would have made any material difference to the outcome. It is true that some later events had to be conducted virtually rather than in person but there appears to be little evidence that anyone who wished to respond to the consultation was unable to do so as a consequence of the Covid-19 lockdown. It is clear now that Covid-19 is set to be with us for some considerable time to come. The problems facing the Epsom and St Helier University Hospitals NHS Trust are real and require urgent attention. The NHS cannot simply mothball its plans to tackle longstanding problems until Covid-19 has been overcome. Difficult though it undoubtedly is, work must continue on schemes throughout the country to improve services and facilities taking account of our growing knowledge of Covid-19 as we proceed.

The HCOPP has expressed criticism about whether people in all areas affected by the proposed changes were included in the consultation. The interpretation of the responses from consultation and their presentation in the decision-making business case has also been criticised. With regard to the former, the boundaries for the catchment area served by ESTH are indistinct, both in the rural south and in the urban north where the Panel noted the close proximity of several neighbouring hospitals trusts. On the latter, it has been acknowledged that the views expressed in consultation varied largely according to where people live and that support for the proposed model of care was least strong in Merton. Support for siting the specialist emergency care hospital at either Epsom or St Helier was strongest amongst residents of those locations who, unsurprisingly, wish to retain acute services at their local hospital. Such findings, independently verified, are only to be expected. The fact that,

[7] Local Authority Health Scrutiny, Department of Health, 2014

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ultimately, different conclusions were reached does not mean that findings were misrepresented in the decision-making process. The Panel rejects the assertion that the programme was *"ego driven"* rather than evidence driven and considers that such comments are not helpful to the ongoing maintenance of good working relationships.

As the HCOPP rightly points out, the wider configuration of health and social care across south west London and Surrey Heartlands needs to be taken into account and, again, gaps in knowledge or consideration should be addressed as work progresses. Additionally, the Panel considered that the consultation tended to focus more on buildings than on patients and health outcomes. Although the reasons for this are understandable and are explored more fully in the next section, the Panel felt that the potential benefits to patients had been underplayed and a clearer explanation of the model could have helped to alleviate some of the local concern that has arisen.

Overall, while there are always some aspects of consultation that with hindsight could have been done better, **the Panel did not consider that the criticisms levelled in this case, whatever their merits or not, unduly or unfairly affected the decision-making process.**

Whether the proposals are in the interests of local health services

This proposal is the latest in a series over the last twenty years that seeks to address the sustainability of acute hospital services in the area. Over that time, in the absence of an agreed plan, services provided from Epsom and St Helier hospitals have been changed incrementally to address issues that have arisen. Most notably in terms of emergency care, Epsom no longer has either intensive care or emergency surgery on site, both being consolidated at St Helier.

In the context of wider plans for meeting the needs of the local population the local CCGs, as commissioners of services, have recognized the need to address the challenges faced by ESTH. Buildings that are not fit for purpose, a pattern of services that drives financial deficit and the absence of the workforce in emergency care to deliver accepted clinical standards, combine to provide a compelling case for change.

The Panel agrees that the current pattern of acute services provided by ESTH is neither sustainable nor desirable. Change is essential and requires significant new capital investment to provide appropriate buildings.

The Panel has reviewed the clinical model which seeks to address the case for change. It describes how health care will be delivered in the future to meet the needs of the local population based on clinical standards and evidence based best practice. The model sees major acute services co-located for the treatment of those who are acutely unwell or at risk of becoming unwell while district hospitals at Epsom and St Helier continue to provide a range of community facing hospital services, including beds, urgent treatment centres,

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outpatients, diagnostics and day case surgeries. Out of hospital services will be integrated with both.

Given the potential implications of the clinical model for the configuration of hospital services, the Panel considered carefully Merton Council HCOPP's assertion that the workforce case for bringing major acute services together is *"contrived"*, being driven more by clinician interest than patient need or better outcomes. The Panel does not agree with this characterisation. The clinical case for concentrating all the relevant services for those with emergency needs in one location and separating these from planned care is based on the available evidence, the associated professional consensus and relevant standards. In summary, the greater availability of senior staff across a range of specialist expertise leads to better, faster decisions about the sickest patients. Separating planned care from emergency care reduces cancellations, complications and delays. This arrangement of services is even more pertinent in a pandemic environment, be it the present one or subsequent ones, so that sites designated for planned care can be kept as 'virus free' as possible.

The Panel understands that putting a new clinical model at the centre of proposals for changes to local health services brings many practical challenges, risks and issues. As the Clinical Senate report noted, the model's development requires detailed clinical pathways and protocols that will make an operational reality of which patients are treated where, by whom and how they will be moved between the major and district services when necessary whilst continuity of care is delivered. However, these are not new issues in the delivery of NHS services. Indeed, comparable issues must already have been negotiated to support the current model of service between Epsom and St Helier and to support models such as that implemented some five years ago[8] in Northumberland where a specialist emergency centre is integrated with a network of local hospitals to deliver care across a wide geography.

The Panel agrees that the clinical model of care provides a basis to address the case for change and inform the formulation of options for change.

It is clear to the Panel (and to many stakeholders including Merton Council HCOPP) how the new clinical model leads inevitably to the trade-offs and choices captured in the options appraisal, consultation responses and final decision about the location of the specialist emergency care hospital.

Given the controversy and criticism from some stakeholders, the Panel has reviewed the process and material used to reach the final decision, noting that it had been the subject of formal assurance by NHS England and Improvement, including assessment of the five tests. The Panel found that the options appraisal systematically captures differences between each of the three possible locations (Epsom, Sutton (Belmont) and St Helier) across a range of relevant non-financial criteria. These include evidence of impact on different sections of the

[8] By Northumbria Healthcare NHS Foundation Trust

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population in terms of access to services and inequalities. The financial appraisal captures differential impacts on the size of catchment population and the effects on neighbouring providers such as St George's are modelled and reflected in the financial costs of options. The Panel noted that Sutton (Belmont) offers some unique advantages in terms of synergy with the other organisations on site, notably the Royal Marsden Hospital.

In the Panel's view, the options appraisal captures and presents appropriate and relevant evidence of differences between the three options. Consultation, the integrated impact assessment and subsequent deliberation provided the opportunity to test and weigh the balance of evidence before making a final decision and associated recommendations for implementation. In this context, the Panel did not accept the assertion that the move of specialised acute services a relatively short distance within the Borough of Sutton need have a significant adverse effect on health inequalities.

Having reviewed the evidence provided by the NHS and Merton Council HCOPP, and taking account of the specific recommendations for implementation, the Panel finds no reason to contradict the choice of Sutton (Belmont) as the location for the specialist emergency care hospital centre, complemented by district hospital services at Epsom and St Helier and the development of out of hospital services.

Alongside delivering high quality acute hospital services from fit for purpose buildings, *Improving Healthcare Together* also aims to achieve financial sustainability in the face of ESTH's perennial deficit. In reviewing the financial modelling, the Panel considered carefully Merton HCOPP's comments. The Panel received confirmation from the NHS that the financial modelling and assumptions underpinning the preferred option and final decision had been subject to assurance by NHS England and Improvement.

The Panel notes that the financial assumptions include an ambitious programme of reductions in non-elective activity and substantial revenue savings. There is a significant risk that these will not be delivered and that the new hospital will have to cater for higher levels of activity than currently assumed with higher running costs than planned. These risks could have a negative impact on the financial sustainability of ESTH and the ability of the CCGs to invest in essential out of hospital and mental health services. In these circumstances, the Panel shares the view that the activity and financial plans underpinning the proposals must be the subject of review, have mitigation plans put in place and be assured at each stage of the programme's implementation by NHS England and Improvement.

The Panel expects the normal approvals process for major capital schemes will provide further scrutiny and assurance. Whether the predicted financial benefits and reductions in acute admissions are delivered is a material risk that the *Improving Healthcare Together* programme must address. NHS England and Improvement must provide rigorous assurance for the programme's finance, activity and mitigation plans going forward

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Moving forward
It is the nature of significant proposals with long term goals and consequences that, at this point of decision making, they rely on assumptions with some known risks and uncertainties. The Panel understands the heightened sense of uncertainty created by Covid-19 but does not believe the interests of local health services will be served by pausing – rather work should proceed on the basis that there may well be benefits should another pandemic arise in the future.

The evident risks and issues must be acknowledged and managed effectively through close working by the local NHS, continuously engaging partners and stakeholders and oversight with support and assurance from NHS England and Improvement. There will inevitably be the need for flexibility going forward as has been learnt from other areas that have undergone similar substantial reorganisation of services. An example of such flexibility may include the consideration of conducting more planned care than is currently envisaged on the district hospital sites.

The *Improving Healthcare Together* proposition for the local population is about much more than opening a new specialist emergency care hospital at Sutton (Belmont). As the DMBC recommendations for implementation clearly illustrate, to address broader health needs, tackle inequalities, improve access to services and reduce demand on acute services, the NHS must deliver large scale transformation of district hospital and out of hospital services. The NHS will wish to assure itself and its stakeholders that the scale of the task is matched by the necessary leadership and resources to succeed. This includes making explicit the improved health and wellbeing outcomes envisaged for the local population. Patients and the public will need to be engaged in shaping and understanding the new landscape of services to gain maximum benefit from them.

At the point of decision, the CCGs and NHS England and Improvement assured themselves that the proposals would achieve the aim of financial sustainability for ESTH and are affordable. Given the assumptions made, all parties will need to track progress alert to the risk that rising costs undermine the ability to invest in other priorities. The risks identified must not be allowed to impact on wider prevention and community strategies that in time could negatively impact on health inequalities if not appropriately funded.

Conclusion
In the course of producing its advice, the Panel learnt of the major programme of refurbishment that is already underway at both the Epsom and St Helier sites. This work, costing more than £100 million, is badly needed on buildings that in many cases pre-date the NHS itself. It is inevitable that much of the work currently being undertaken will have been predicated on the basis that ESTH is to have a *"major new hospital"* as confirmed by the Prime Minister on 2 October 2020 having previously been announced at the start of the year. The IRP's advice reflects the realities of the current position.

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It is clear that work is also already well advanced to plan for the transitional period while the new hospital is built. Additionally, work is progressing to develop and improve potential transport links between the sites that will do much to mitigate adverse effects for a portion of the population of some services moving location. News of such work is welcome and has, perhaps, been understated in communicating with the local community to date. On a similar theme, there are positive messages to be promoted about how the changes will improve health and wellbeing outcomes for the population across the whole catchment area.

These proposals have - understandably given the pressing need finally to tackle problems that have affected the Trust for decades - advanced outside of the wider umbrella of the STP/ICS[9] for the area. There is an opportunity to address this now. The challenges that lie ahead are not to be underestimated, not least the financial sustainability of the proposals. There is much work still to be done and implementation should proceed with the public's voice represented in the governance arrangements. Flexibility in approach and a spirit of co-operation will be required to ensure the best outcomes for the whole population being served.

Yours sincerely

Professor Sir Norman Williams
IRP Chair

[9] Sustainability and Transformation Plan / Integrated Care System

APPENDIX ONE

LIST OF DOCUMENTS RECEIVED

Merton Council HCOPP

1 Referral letter to Secretary of State from Cllr Peter McCabe, Chair, London Borough of Merton HCOPP, 27 July 2020
Attachments:
2 Submission from Merton Council
3 Siobhain McDonagh MP's July 2020 response to the consultation and submission to the CIC meeting on 3 July 2020
4 Statement from Chris Grayling MP
5 Submission from Dr Rosina Allin-Khan MP whose constituency includes St George's Hospital and who works there
6 Submission from Sutton Council
7 From Community Action Sutton
8 From Merton Voluntary Services
9 Submission from GMB Union
10 Submission from Trades Council
11 Submission from Epsom and St Helier Unison branch
12 Report from the Clinical Senate, June 2019
13 Link to IHT website

NHS

1 IRP template for providing assessment information with embedded links
2 Responses to IRP questions, 19 October 2020
3 Photographs of Epsom and St Helier sites
4 Trust video from outset of *Improving Healthcare Together 2020 - 2030* programme
5 Travel map
6 CAG paper, Benefits of the clinical model
7 CAG summary slide, Clinical benefits

OTHER

8 South West London and Surrey JHSC sub-committee, minutes of meeting, 16 October 2018
9 South West London and Surrey JHSC sub-committee, minutes of meeting, 28 November 2018
10 South West London and Surrey JHSC sub-committee, minutes of meeting, 7 February 2019
11 South West London and Surrey JHSC sub-committee, minutes of meeting, 30 April 2019
12 South West London and Surrey JHSC sub-committee, minutes of meeting, 4 July 2019
13 South West London and Surrey JHOSC, minutes of meeting, 30 July 2019

14 South West London and Surrey JHSC sub-committee, minutes of meeting, 26 September 2019*
15 South West London and Surrey JHSC sub-committee, minutes of meeting, 4 June 2020*
16 IHT JHSC response to NHS consultation and covering letter, 22 June 2020
Note* although headed South West London and Surrey JHSC sub-committee, the IRP understands that these were meetings of the wider South West London and Surrey Joint HOSC
17 Videoconference with representatives of Northumbria Healthcare NHS Foundation Trust (plus slides from past Trust presentation), 14 October 2020
18 Siobhain McDonagh, MP for Mitcham and Morden, official response to *Improving Healthcare Together 2020 - 2030*
19 Siobhain McDonagh, MP for Mitcham and Morden, submission to *Improving Healthcare Together 2020 - 2030* Committees-in-Common

Independent Reconfiguration Panel
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Website: www.gov.uk/government/organisations/independent-reconfiguration-panel