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

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

Issues Paper

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Foreword

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

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

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

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

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

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

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

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

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

We look forward to hearing from you.

Yours faithfully,

[subject to CiC approval]

Dr Russell Hills
Clinical chair of
NHS Surrey Downs CCG

[subject to CiC approval]

Dr Jeffrey Croucher
Clinical chair of
NHS Sutton CCG

[subject to CiC approval]

Dr Andrew Murray
Clinical chair of
NHS Merton CCG

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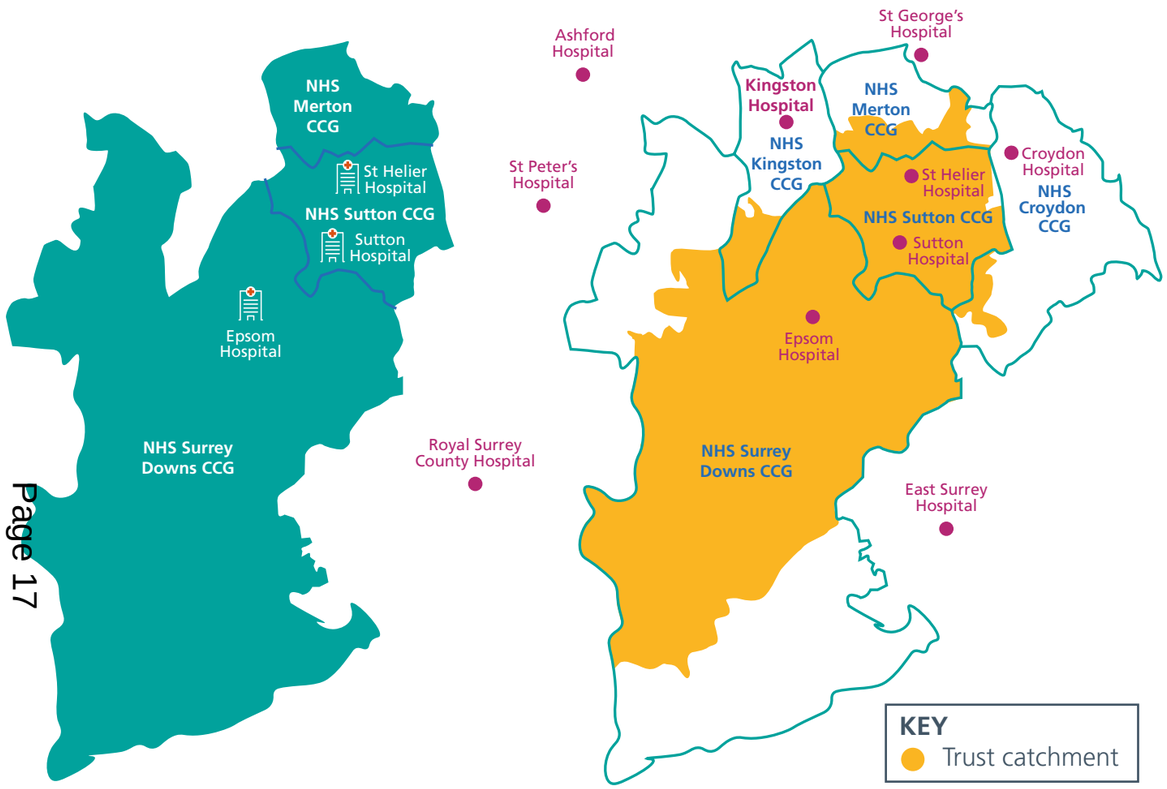
A compelling case for change

Geography of CCGs

Catchment area for Epsom and St Helier University Hospitals NHS Trust



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

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

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

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

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

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

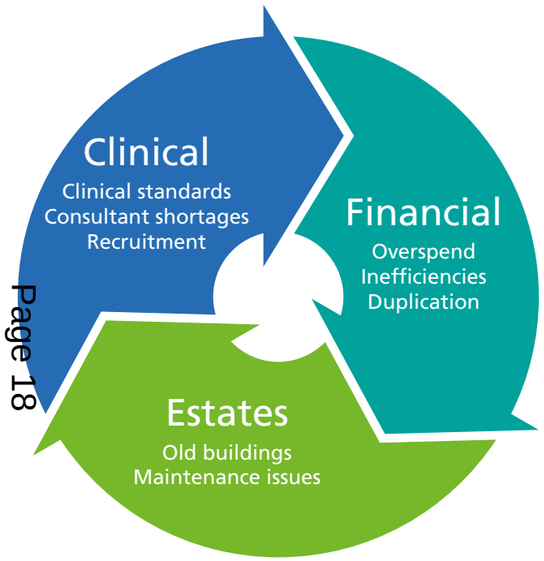
Providing healthcare from modern buildings
The buildings of Epsom and St Helier, in particular, were built before the NHS was founded and are ageing. They are not designed for modern healthcare, an issue repeatedly highlighted by the CQC, including in its latest report (May 2018). Epsom and St Helier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

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

Conclusion

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

Local NHS cycle of challenges



We would like you to consider the following question:

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

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

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

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

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

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These aims are:

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

This will be achieved through:

- Greater prevention of disease
- Improved integration of care
- The delivery of enhanced standards in major acute services

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

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

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

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

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

Sutton Health and Care

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

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

Epsom Health and Care

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

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

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Merton Health and Care Together

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

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

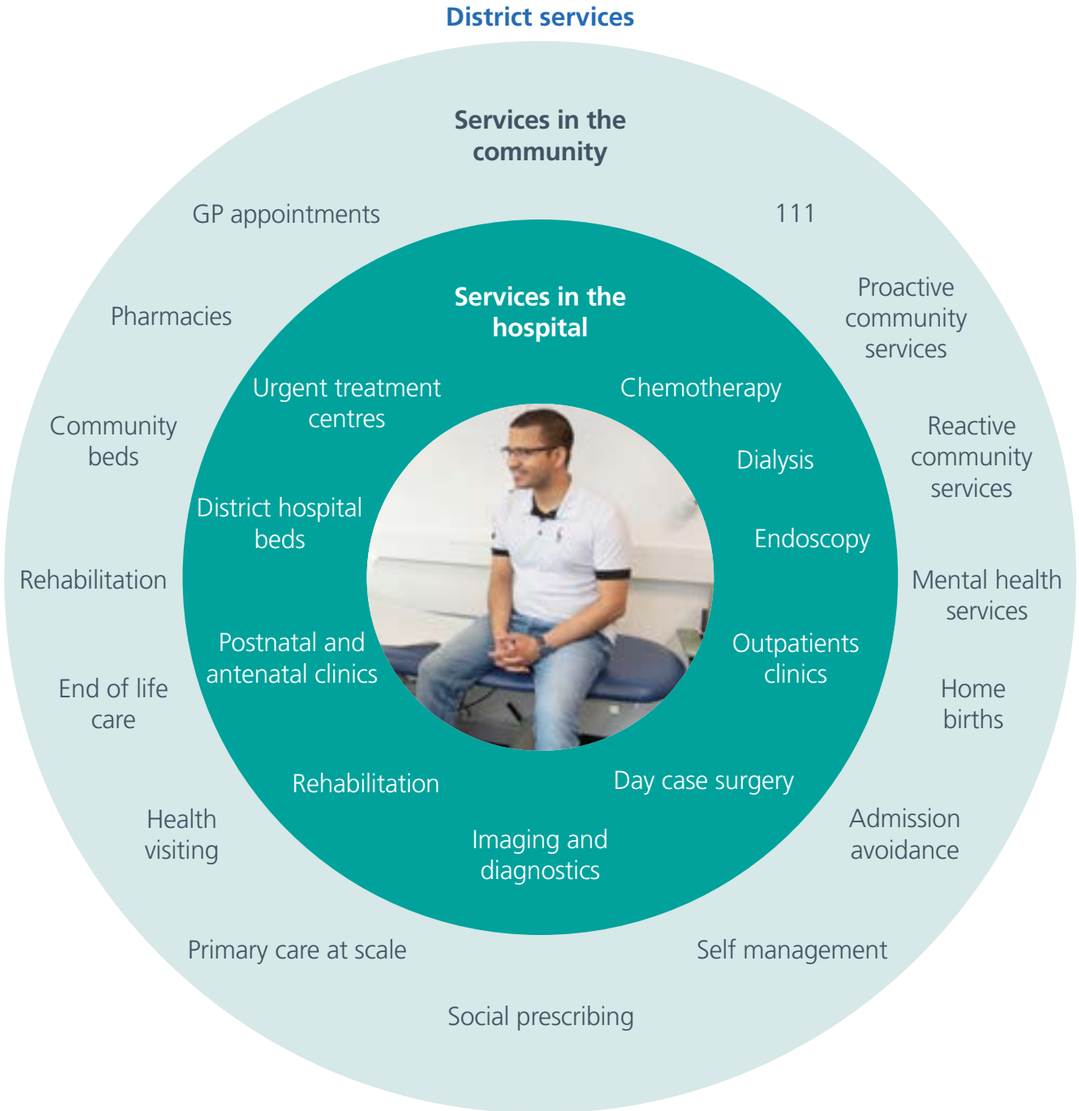
Merton has also been working closely with local A&E departments to help them determine which patients may have urgent rather than emergency care needs, and provide the right care.

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

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

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

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



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

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

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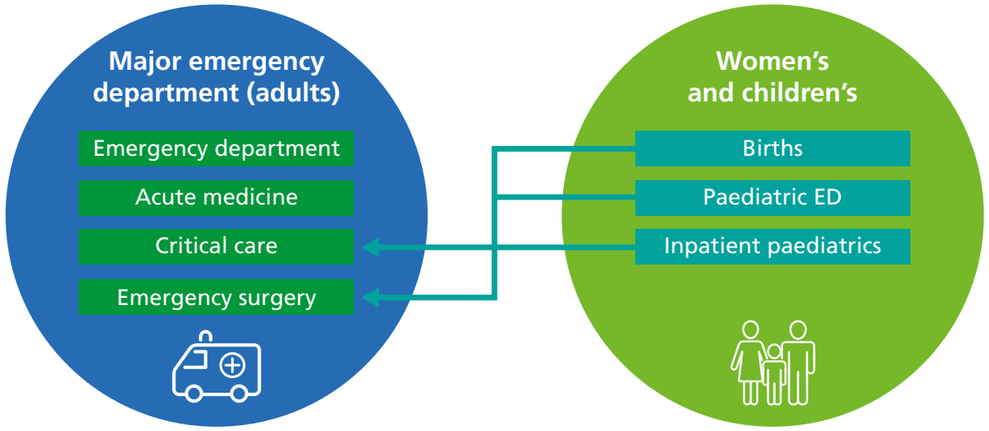
Co-dependent major acute services



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

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

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

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

We would like you to consider the following question:

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

Developing potential solutions

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

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

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

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

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

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

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

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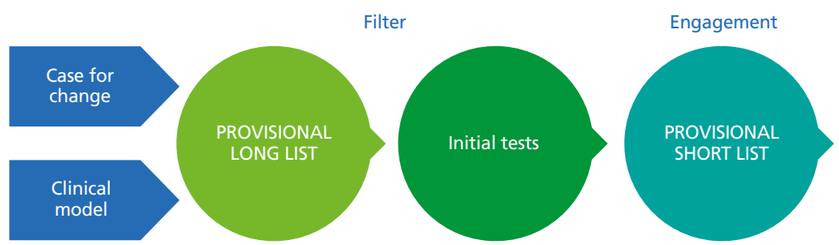
Our long list is refined by testing these potential solutions against three initial tests, which are in line with our case for change and include whether services are maintained in our combined geographies. This is shown in this diagram.



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

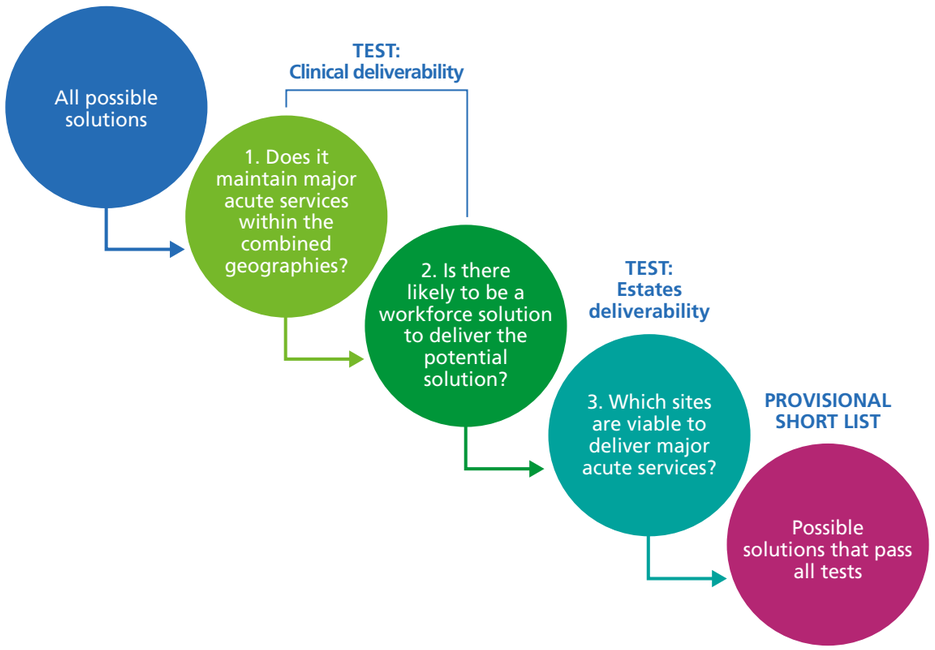
The initial tests we have applied are:

1. Does the potential solution **maintain major acute services within the combined geographies**? This is a key commitment for us and any potential solution must maintain all major acute services within our combined geographies.

2. Is there likely to be a **workforce solution** to deliver the potential solution? This includes ensuring any potential solution meets our standards for the quality of major acute services with the available workforce.

3. From which **sites** is it possible to deliver major acute services? This considers whether different sites are feasible for the delivery of major acute services.

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



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

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

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

This provisional short list includes:

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

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

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

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

The case for change makes clear that we need to consider our plans for the future and explore the ways in which the issues we face can be addressed. We are clear that any potential solutions must address the three main issues of clinical quality, estates and financial sustainability, while supporting our broader plans for healthcare locally. Further work is required, and we will continue to explore:

- How the clinical model can change to address our challenge of clinical quality and ensure that care is integrated and standards for major acute services are met
- The potential solutions which deliver this clinical model to our populations while addressing our challenges of workforce, estates and financial sustainability

Other important things to consider

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

- **Travel and access**
  What kind of journey would patients have, and what kind of distance would they need to travel, in order to access care? What public and patient transport would be available or needed?

- **Impact on deprived communities**
  We will consider how potential changes might affect communities within our local area which are affected by deprivation, such as poverty, poor education or housing, all of which can affect health and wellbeing.

- **An equality impact analysis**
  This will consider the impact of any change on our communities, including people with protected characteristics.

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

We would like you to consider the following question:

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

Next steps

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

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

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Potential timeline

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

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

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

We would like you to consider the following questions:

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

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

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

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How to get involved

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

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

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

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

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

Online:
[To follow after CiC approval]

By email:
[To follow after CiC approval]

In writing:
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