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

NHS

Improving Healthcare Together 2020 - 2030

South West London and Surrey Joint Health Overview Scrutiny Committee

Impact on other providers summary assessment

July 30th 2019

1.1 Purpose of report

This paper provides an update on the provider impact work as requested by the SW London and Surrey Joint Health Overview Scrutiny Committee (JHOSC).

The paper includes:

- A description of the process undertaken; and
- A summary of potential impacts based on work undertaken jointly by the IHT programme and local providers and,
- Next steps

Members are asked to note the provider impact assessment was scrutinised at the IHT JHOSC Sub-Committee on the 4th of July 2019.

This report has been shared with the provider technical group (see point 1.2) for their review.

Each provider has stated that all options would be deliverable with the right level of investment and mitigations, while noting the scale of the challenge and investment varies by option

1.2 Introduction

We need to understand the impacts of different options on local providers. We have considered impacts on six local providers, excluding ESTH:

- Ashford and St Peter's Hospitals NHS Foundation Trust (St Peter's Hospital, ASP)
- Croydon Health Services NHS Trust (Croydon University Hospital, CRY)
- Kingston Hospital NHS Foundation Trust (Kingston Hospital, KGN)
- Royal Surrey County NHS Foundation Trust (Royal Surrey County Hospital, RSU)
- St George's University Hospitals NHS Foundation Trust (St George's Hospital, STG)
- Surrey and Sussex Healthcare NHS Trust (East Surrey Hospital, ESU)

We have co-developed the process and approach with providers. A Technical Group has been convened, comprising provider Directors of Strategy from each provider, as well as representation from ambulance providers. This group has considered the activity impact on affected Trusts including bed, theatre and diagnostics capacity and the resulting requirements for estates, finance (revenue and capital) and workforce.

There has been significant clinical input from medical and nursing directors through the IHT Clinical Advisory Group, to support the development of a number of assumptions.

Individual trusts have sought approval of impacts from their statutory boards. Following this, impacts will be used as an input to the IHT financial model; and detailed commentary will be

included in the draft pre-consultation business case document which will be submitted to regulators at the end of July.

A provisional analysis of the early provider impact work has been referenced in the interim Integrated Impact Assessment (IIA) report; and the full provider analysis will be incorporated into the IIA assessment.

1.3 Approach to provider impact assessment

A consistent view of patient flows has been developed, through a co-developed activity model with providers, and a range of sensitivities have also been developed to test how impacts changes based on flexing key assumptions. Providers agreed that the core scenario (based on travel time), will be used as an input to the IHT financial analysis.

Capacity, estates, capital and finance impact analysis includes assessing the impact of potential changes in patient flow on the range of areas. Components have been estimated by individual provider trusts based on a consistent and agreed set of assumptions.

In terms of feedback, providers have reported back to the IHT programme, using a standard report format for consistency.

1.4 Key messages

There are a number of key messages from the impact analysis:

- Each provider has stated that all options would be deliverable with the right level of investment and mitigations, while noting the scale of the challenge and investment varies by option.
- Impacts on other providers are greater for the Epsom option and lower for the Sutton and St Helier options. This is because there are currently more patients using St Helier than Epsom, as well as the proximity of other hospitals to St Helier.
- For the Epsom option, London providers are expected to be impacted more significantly – particularly St George’s and Croydon hospitals. A high level of capital investment is likely to be needed and additional workforce will also be needed. Surrey providers are not impacted in this option, given services at Epsom remain largely unchanged.
- For the St Helier option, Surrey providers – particularly Ashford and St Peter’s and East Surrey hospitals will be impacted. This includes additional capacity and associated capital investment needed to accommodate demand. The overall impacts on these hospitals is smaller than the impact on St George’s and Croydon for the Epsom option. With the exception of Kingston, London providers are not impacted in this option, given services at St Helier remain unchanged.
- For the Sutton option, impacts are distributed more evenly across providers in both London and Surrey. This is driven by the location of the Sutton site, in between the Epsom and St Helier sites. A small amount of additional capacity and associated capital investment is needed for each provider to accommodate additional demand.

1.5 Summary outputs

Table 1 shows the capital needed in total across all providers for each option. Regulators requested that providers estimate incremental capital only, for the purposes of including in the financial appraisal; as well as broader enabling capital, to be included in the narrative of the draft PCBC:

- Incremental capital describes capital investment which is needed as a direct result of IHT proposals, and will be included in the IHT financial appraisal of options and part of the direct capital 'ask' for IHT; and
- Enabling capital describes broader changes that will be needed over the next ten years to support any incremental changes and will need to be in place before any IHT options can be delivered – i.e. IHT impacts are dependent on these other plans.

In order to ensure a robust financial appraisal, only incremental capital has been included in the IHT financial analysis – and enabling capital has been included in the PCBC narrative. Including additional enabling capital in the financial analysis would distort the financial appraisal.

It should be noted that all draft provider impact estimates include outputs developed at a point in time, and reflect the joint work undertaken with providers to date based on the agreed methodology and assumptions. The analysis is expected to be refined and updated as new information becomes available, including as part of any next stage business cases.

Table 1: Incremental other provider total capital associated with each option

Capital / option	Total (£m)
Major acute services at Epsom	174
Major acute services at St Helier	44
Major acute services at Sutton	39

1.6 Provider assessments

The programme asked providers to assess their impacts based on the common activity and bed information, agreed methodology to estimate capacity and costs, as well as each organisation's own analysis and deliberation. Each provider has returned a report in a standard format to the programme, summarising the impact of each option. Impact was assessed based on a scale of low (L), medium (M) and high (H), with providers offering further description and rationale as appropriate.

Table 2, Table 3 and

Table 4 give an overview of the draft impact assessment across options by individual providers. All provider boards have agreed these impact assessments.

Table 2: Assessments submitted by providers – major acute Epsom

MA Epsom	STP	KGN	RSU	ESU	STG	CRY
Capacity (inc. A&E, theatres, wards, support services)	L	L	L	L	H	H
Estates and capital	L	L	L	L	H	H
I&E	L	L	L	L	H	H
Work-force	L	M	L	L	M	H
Deliverability	L	M	L	L	H	H

KEY: L = low impact; M = medium impact; H = high impact

Table 3: Assessments submitted by providers – major acute St Helier

MA St Helier	STP	KGN	RSU	ESU	STG	CRY
Capacity (inc. A&E, theatres, wards, support services)	M	M	L	M	L	L
Estates and capital	M	L	M	H	L	L
I&E	M	L	M	L	L	L
Work-force	H	M	M	M	L	L
Deliverability	L	M	M	M	L	L

KEY: L = low impact; M = medium impact; H = high impact

Table 4: Assessments submitted by providers – major acute Sutton

MA Sutton	STP	KGN	RSU	ESU	STG	CRY
Capacity (inc. A&E, theatres, wards, support services)	M	M	L	M	M	M
Estates and capital	M	L	M	M	M	M
I&E	M	L	M	M	M	M

MA Sutton	STP	KGN	RSU	ESU	STG	CRY
Work-force	H	M	M	M	L	M
Deliverability	L	M	M	M	M	M

KEY: L = low impact; M = medium impact; H = high impact

1.7 Provider specific observations

All providers have stated that all options would be deliverable with the right level of investment and mitigations, while noting the scale of the challenge and investment varies by option. There are also a number of specific observations by provider:

- **Ashford and St Peter's:** The ASP Board believes all scenarios are technically deliverable, although there is some risk in relation to the St Helier and Sutton options relating to the availability of workforce to support increased demand at ASPH which is exacerbated by adherence to current care models.
- **St George's:** STG identified that providing major acute service at Epsom would have a high impact, Sutton a high / medium impact and St Helier a low impact. This included a significant capital investment requirement.
- **Kingston:** The KGN Board agreed impacts for each option, and considers both the core and maximum impact sensitivities as deliverable. The Trust expects broadly consistent impacts across the options, with limited differentiation between them.
- **Croydon:** CRY identified a low impact for the major acute at St Helier option, medium for the Sutton option and a high impact for the Epsom option. It stated that while all three options are deliverable, there is a financial cost within the various options, and particular challenges with the Epsom option (significant inflows), which would require significant capital investment.
- **Surrey and Sussex:** ESU expect overall impacts to be low for the Epsom option, medium for the St Helier option (due to additional emergency demand) and medium for the Sutton option (due to additional emergency demand). Both the St Helier and Sutton options require capital investment to support an expansion.
- **Royal Surrey:** The Board agreed that the core scenarios of each option and the max sensitivity of the Epsom option are deliverable. The max sensitivity for the St Helier and Sutton options are not deliverable but the Trust does not believe the sensitivities modelled to be material as the likelihood of them happening is deemed to be small.

Next steps

The programme will submit a draft PCBC to NHS England and NHS Improvement for the next stage of the national assurance process. This document sets out all the work we have done to date and all the research and evidence we have collated (including the provider impact analysis).

Any future consultation will only take place once we have agreement in principle for the capital.

No decisions about any changes to services will be made until after a full public consultation has taken place and all the information has been considered by the CCGs.

Andrew Demetriades
Joint Programme Director for Improving Healthcare Together