Committee: Cabinet

Date: 23 March 2020

Wards: All

Subject: LBM Response to formal public consultation on Improving Healthcare Together 2020-2030

Lead officer: Hannah Doody, Executive Director Communities and Housing

Lead member: Cllr Tobin Byers, Cabinet Member for Adult Social Care, Health and the Environment

Contact officer: Dr Mike Robinson, Consultant in Public Health

Recommendations:

1. Cabinet to note that the formal public consultation on plans to centralise major acute services within Epsom and St Helier's NHS Trust is open until 1 April 2020.
2. Cabinet to note the key lines of enquiry that the Council will propose in its response as described in paragraph 2.16 below.
3. Cabinet notes that the Director of Communities and Housing in consultation with the Cabinet Member for Adult Social Care, Health and the Environment, will finalise and submit the Council's response to the Improving Healthcare Together 2020 – 2030 consultation..

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The Improving Healthcare Together 2020 to 2030 programme (IHT) was set up by Surrey Downs, Sutton and Merton CCGs in January 2018 to find the best solutions for the long-standing issues at Epsom and St Helier University Hospitals NHS Trust (ESTH).

1.2. On 6 January 2020, the Committee in Common of the three CCGs agreed to launch a formal public consultation on proposals to centralise major acute services with ESTH on a single site. Belmont was agreed by the CCGs as the preferred location, but the CCGs were clear that all three options could be delivered and would be consulted on.

1.3. The purpose of this report is to outline the Council's intended response, which in summary is that the published Pre-Consultation Business Case is inadequate in a number of respects, and there are several key lines of enquiry which should be pursued before any decision is made.

1.4. Ever since the launch of the IHT programme, the Council has expressed reservations about the scope and process of its development, as summarised in paras 2.5-2.14 below. The Council has questioned the analysis undertaken by the programme at each step to the extent possible using in-house expertise. Despite this, the NHS has proceeded to formal public consultation.

1.5. On reviewing the consultation documentation, the Cabinet Member and Leader recommended that officers commission external consultancy

support, in order to ensure that the response was able to address matters that lie outside of Council officers' areas of expertise. The Council has, therefore commissioned a report from an independent consultant who has a background in the NHS and is an expert in hospital redevelopment.

1.6. Roger Steer has previously worked in the NHS in Chief Executive and Director of Finance roles 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, and has reported on the previous reconfiguration proposals in South West London.

1.7. As the Consultant's report will not be finalised with officers until shortly before the deadline for consultation responses, Cabinet is asked to delegate authority to the Director of Community and Housing in consultation with Cabinet Member for Adult Social Care, Health and the Environment to finalise the Council's response in line with the key lines of enquiry detailed below.

2 DETAILS

2.1. The Council has long resisted NHS proposals to down-grade facilities at St Helier, not supporting two previous NHS plans with similar intentions, namely "Better Care Closer to Home" (2005) and "Better Services Better Value" (2013).

2.2. The Council's position has consistently been to support all services being retained on the St Helier site, and to argue for capital investment into that site in order to deliver 21st century healthcare. The Council's particular concerns have focused on the communities immediately surrounding the St Helier site and the impact any relocation of services would have on them. The Council also has concerns over the impact any relocation would have on other acute hospitals relied on by residents in the borough, principally St George's. The Council has a legal duty to improve health for its residents and to carry out scrutiny of major NHS service changes.

2.3. The Council accepts that the best way to provide health care for the most seriously ill patients has to be guided by scientific evidence of effectiveness, clinical opinion, practicality and affordability. The Council notes that the Improving Healthcare Together programme has attempted to consider all these factors and has been led by clinicians.

2.4. However, the Council believes that the conclusions reached to date and now put forward for public consultation are flawed for the following reasons:

2.4.1 Major acute services are only one part of the overall health and care system. Due to the increasing numbers of people with frailty and a complexity of health and social care needs, any decisions about the location of major acute services need to be informed by a full analysis of the impacts of other parts of the system. This has not been the IHT approach

2.4.2 The costs of changing the location of major acute services do not fall solely on ESTH. The financial analysis of the proposed changes has only been detailed for ESTH itself, not other parts of the system.

2.4.3 Whilst NHS provides universal services, there are some parts of the population with protected characteristics who have greater needs. The IHT programme has not adequately considered the impact on those people who make the greatest use of acute 24/7 services who are from the poorest areas of Merton.

2.5. The Council has expressed these concerns through both Officers and Members consistently over the past few years.

2.6. The Council has been engaging with the CCG since July 2017 when the ESHT commenced a patient involvement exercise in order to explore patient views concerning a range of possible reconfigurations of the acute services by the Trust.

2.7. In November 2017 the Council informed the CCG that there was a gap in the existing Joint Strategic Needs assessment and the Health and Wellbeing Strategy in that these documents contained very little about the needs of the local people to access NHS secondary care services and in particular, where NHS acute services should be provided to meet the needs of Merton residents. At this time the Council was proposing commissioning an independent needs assessment through the Health and Wellbeing Board to assist in filling the gap. As a result of discussions between Councillors, Council Officers and colleagues in the CCG, agreement was reached that the wider piece of work would be undertaken through the Sustainability and Transformation Plan and Estates Strategy. The Council has been clear from the outset that this work needed to include the impact of the proposed service changes on the other acute trusts in South West London.

2.8. The CCG commissioned the work through independent agencies to produce a deprivation impact analysis, a transport analysis and an overarching integrated impact assessment. The Council challenged the CCG on a number of occasions about the deprivation report not having considered the impact of proposed service changes on the other acute trusts.

2.9. The Council through its Public Health team was an active participant in the workshops held as part of the Deprivation Impact Analysis (DIA) which was published in the summer of 2018. Following publication of the DIA the Council was given repeated assurances that the areas which it had highlighted would form part of the Integrated Impact Assessment, prior to any decision being taken on a preferred option.

2.10. Despite these assurances, the CCG departed from the previously agreed process in November 2018 when it rapidly set up three workshops to agree criteria, weighting and a preferred option for a pre-consultation business case, despite the work that had previously been committed to not having been undertaken. In the Council's view, the data sets for decision-making were partial or not yet available. This included the deprivation analysis, the equalities impact, the travel data, the financial data and the impact on other acute hospitals.

2.11. The Council was particularly concerned that there were significant gaps in the DIA. It was aware that a number of GP practices which had been excluded from the DIA sent a significant proportion of patients to St Helier. The report indicated that further work could be carried out to inform decision

making, including that the local population characteristics should be investigated further where more granular information was needed, for example at Lower Level Super Output Area (LSOA) level for the most deprived communities. The DIA provided national and London wide evidence that needs for health care, usage of health care facilities and the outcomes for residents were affected by deprivation but it did not drill down into detail. The Council provided LSOA information illustrating the distribution of deprivation for three sentinel variables, which demonstrated that more substantial investigation was required.

2.12. The CCG did not agree that the workshops had been held prematurely and confirmed that no final decisions had been taken and would not be taken until the matter had been through public consultation. They also confirmed that the Integrated Impact Assessment would not be completed until after the public consultation process and prior to the final proposals being presented to the CCG Governing Bodies (despite the options already having been scored using the criteria and weighting agreed at the workshops).

2.13. In March 2019, an Independent Chair, Professor Andrew George, was appointed to the Integrated Impact Assessment Steering Group and the Leader wrote to him informing him of the Council's concerns and seeking clarification on certain issues. On 7 June 2019, the Leader wrote to Professor George again and amongst other issues raised the issue that over the previous 12 months the Council had consistently raised the need for more detailed small area analysis of the impact of deprivation. The Council had been informed that this would be difficult for the programme to undertake because of data sharing issues. The Leader urged further work to be undertaken to obtain this data. The response from Professor George indicated that the consultancy undertaking the work had approached the data gathering based on best practice and this had allowed for a robust analysis through providing a means to further interrogate, corroborate and challenge the findings gathered from the data broken down by LSOA area. The consultancy questioned the added value that the provision of GP level data would provide.

2.14. Following submission of the Pre-Consultation Business Case, (PCBC) the Leader wrote to the CCG again in September 2019 requesting further work be undertaken in relation to the Integrated Impact Assessment (numbers of patients affected by longer journey times to and from hospital from deprived areas), response to the recommendations of the Independent Clinical Senates (interface between NHS and Local Government services), and the Provider Impact Assessment. The Leader wrote again upon the Council learning that formal consultation was to begin, reiterating the Council's view that the work was incomplete and therefore consultation should not proceed.

2.15. On reviewing the consultation document, the Cabinet Member and Leader recommended to Officers that external consultancy support should retained. The work of the external consultancy will supplement the work undertaken by the Public Health team, providing an expert view on some of the areas outside of the expertise of Council Officers. The Council has therefore commissioned a report from an independent expert in how local government can inform hospital reconfigurations.

2.16. Interim advice from the independent expert is that the PCBC does not adequately address the concerns listed above or the requirements of the Treasury and Department of Health and Social Care. It is recommended that the Council should respond accordingly to the consultation and propose the following key lines of enquiry, so that the best decision can be made in line with required process:

2.16.1 Regarding medical staffing, where predicted shortages are argued to make the status quo untenable, have other solutions besides centralisation on one site been adequately explored? Simple reasoning would suggest that three sites will be more difficult to staff than two.

2.16.2 Regarding the splitting of hospital services into “district hospital services” and “major acute services” on different sites, has the downside in terms of extra transfers between sites, and safety and quality issues been described, with mitigations being costed?

2.16.3 What will be the impact of additional travel times on clinical outcomes, on greenhouse gas emissions, and on accessibility for people who rely on public transport for the preferred option? It is noted that Belmont often requires a 10-15 walk as part of journeys by such means.

2.16.4 What mitigations are planned to address the particular needs of people living in the most deprived parts of Merton, who disproportionately need Accident and Emergency services and whose travel times would be increased?

2.16.5 Has the financial impact of each option in terms of the whole health and care systems for Merton, Sutton and Surrey Downs been modelled? What are the implications of the planned move in 2021 to Integrated Care Systems (ie a single financial control total) separately for South West London and Surrey?

2.16.6 Have the predicted numbers of beds required for each option taken into account increasing demand for health and care overall, and that expected reductions in bed requirements from previous reconfigurations have failed to materialise?

2.16.7 What would be the costs and outcomes from the “minimal change” option i.e. investment to retain and improve services using the present 2-site configuration? It is understood this is a Treasury requirement.

3 ALTERNATIVE OPTIONS

3.1. Not to respond to the consultation outside of the scrutiny process; This option is not recommended as the joint scrutiny process is not solely representing Merton Council’s voice.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. No consultation has been undertaken specifically to develop the Council’s response to the present consultation but the matter has been debated by Council and motions agreed on the following occasions:

4.1.1 On 1st February 2017 the Council passed a motion which noted its" absolute opposition to any closure or downgrading of St Helier Hospital"

4.1.2 On 5th February 2020, the Council passed a motion supporting the proposed investment "as long as that includes the retention of accident and emergency, maternity and all existing services at St Helier hospital in order to protect the interests of the most disadvantaged residents living in the catchment area "

5 TIMETABLE

5.1. There has been a relatively short time in which to identify and contract with suitable external expertise. As the report from this is not expected until shortly before the deadline for consultation responses (1 April 2020), so the Director of Community and Housing will be exercising her delegated authority, in consultation with the Cabinet Member for Adult Social Care, Health and the Environment to finalise the Council's response in line with the key lines of enquiry detailed below.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. No direct financial costs for the Council apart from external consultancy support. For this appointment financial consideration of affordability and best value for money formed part of the business case. There is no impact on additional borrowing.

6.2. There may be a significant impact of the costs of delivery of community care services, depending on the decision made.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. There are two routes for the Council to respond to the consultation process. This report details the proposed action being taken by the executive function to respond to the consultation. At the same time Health are under a duty to consult scrutiny in the form of the South West London and Surrey JHSC sub-committee.

7.2. When a health body has under consideration any proposal for a substantial development of the health service in the area of a local authority under Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 they must consult the authority.

7.3. Where a health body consults more than one local authority under Regulation 23, those local authorities must appoint a joint overview and scrutiny committee for the purposes of the consultation and only that joint overview and scrutiny committee may:

(i) make comments on the proposal consulted on (ie rather than each individual local authority responding separately);

(ii) require the provision of information by the health body about the proposal;

(iii) require a member or employee of the health body to attend before it to answer questions in connection with the consultation.

7.3 The Accountable Officers for the CCGs have given notice under Regulation 23 and the South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030 is in the process of scrutinising the proposals.

7.4 In addition to the scrutiny process the Council can submit a response to the Consultation on behalf of the Executive and this report outlines work to date on the IHT programme and notes the action by the Director of Communities and Housing in consultation with the Cabinet Member to finalise the response prior to the deadline of 1 April 2020.

7.5 The Council has also convened its Healthier Communities and Older People Overview and Scrutiny Panel to be held on 25 March 2020 which will assist the work of the JHSC sub-committee.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. None

9 CRIME AND DISORDER IMPLICATIONS

9.1. None

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. Not applicable

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

12 BACKGROUND PAPERS

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