## Committee: Cabinet

## Date: 16 November 2023

Wards: All

## Subject: St Helier Hospital & New Hospital Programme

Lead officer: John Morgan, Executive Director Adult Social Care, Integrated Care & Public Health

Lead member: Cllr Peter McCabe, Lead Member for Adult Social Care & Health

Contact officer: Phil Howell, AD Commissioning ASC, IC & PH

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**Recommendations:**

A. To note the content of the report and associated appendices, documenting the independent analysis undertaken by Newton Europe on behalf of the Council

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**1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY**

1.1. On 3rd of July 2020, NHS South West London and NHS Surrey Heartlands Clinical Commissioning Groups (CCGs) met 'In Common' to agree investment decisions for the £500m capital allocated in September 2019, under the New Hospitals Programme. These decisions were aimed at addressing the long-standing challenges currently facing Epsom and St Helier hospitals. At this meeting the CCG members agreed to adopt the following resolutions:

- To agree and adopt the clinical model, described in the Decision Making Business Case for the delivery of district hospital services and the specialist emergency care hospital (SECH).
- To agree that the preferred option for the location of the SECH is Belmont, with continued provision of district hospital services at Epsom Hospital and St Helier Hospital (ESTH)

1.2. In 2020 The Trust set out three main drivers underpinning the business case development and this is documented on the Improving Healthcare Together programme website. They report these as:

- **Quality:** ESTH is the only acute trust in South West London that is not clinically sustainable in the emergency department and acute medicine due to a 25 consultant shortage against our standards. Additionally there are shortages in middle grade doctors, junior doctors and nursing staff. The Care Quality Commission has highlighted workforce shortages across its two sites as a critical issue.
- **Buildings:** The acute hospital buildings are ageing and are not designed for modern healthcare delivery. Over 90% of St Helier hospital and 14% of Epsom hospital is older than the NHS. Buildings' condition has been highlighted by the Care Quality Commission as requiring improvement. Significant investment is needed to make sure hospital buildings are safe.

- **Finances:** Epsom and St Helier hospitals operate in a budget deficit, spending more than they receive. Pertinent issues are; increases in costs for temporary clinical staff to cover vacancies and gaps in staff rotas, the increasing costs of maintaining hospital buildings, and the reduction in opportunities to make savings. Financial sustainability is an imperative.

1.3. The proposal and accompanying business case was originally submitted in June 2020, with plans to complete the new site by 2027. Since then, there has been a global pandemic, the NHS now finds itself in a workforce and demand crisis with backlogs having increased 20% from June 2020 figures. The NHS local commissioning bodies have been through further fundamental reorganisations, forming Integrated Care Boards which have been operational from July 2022. Whilst the acute Trust responsible for this programme has now merged with St Georges NHS Trust to form Georges & Epsom & St Helier Hospitals NHS Foundation Trust.

1.4. The National Audit Office has recently published a report on the new hospitals programme and raised concerns. Including risks associated with the capacity of some of the proposed hospitals to meet future demand, and the feasibility of building new infrastructure according to planned budgets and timelines.

1.5. Following the updated statement from Secretary of State in May 2023, that the hospitals were going to proceed and be built by 2030. Merton council commissioned an independent analysis, since the business case as it stood is now three years old and conceived prior to the COVID-19 Pandemic. The data used for the initial draft business case ranged from 2011 to 2019. The independent analysis was commissioned to understand the potential effects of the proposed changes on Merton residents, using the more recent available information. This involved analysing:

- impact on travel times;
- (ii) current area providers' care quality and volumes;
- and (iii) Merton demographic changes.

1.6. The purpose of this report is to inform Cabinet of the outcomes and findings of recently commissioned independent analysis, which revisited and reviewed the Decision-Making Business Case and Integrated Impact Assessment associated with the decision to invest the national New Hospitals Programme allocation in building a new hospital at Belmont, in Belmont. The purpose of the analysis was specifically to review findings in the context of impact on Merton as a borough and it's residents.

## 2 DETAILS

2.1. The Improving Healthcare Together 2020 to 2030 programme (IHT) was set up by NHS Surrey Heartlands and NHS South West London CCGs* in January 2018 to develop, consult on and propose decisions to be made to address the long-standing issues facing Epsom and St Helier hospitals. As organisations responsible for planning, commissioning and making decisions about healthcare services for Surrey Downs, Sutton and Merton areas at the time, the two CCGs led the development of proposals for potential service

change. In September 2019, the IHT programme was allocated £500 million to improve the current buildings at Epsom and St Helier hospitals as well as build a new specialist emergency care hospital on one of the three sites – Epsom, St Helier or Belmont. The new facility would bring together six services for the most unwell patients, as well as births in hospital.

2.2. The Business Case Paper-3_Paper_Draft-Decision-Making-Business-Case_03.07.20.pdf (improvinghealthcaretogether.org.uk) considered options for implementation of the capital programme as well as setting out the appraisal criteria for selection of a preferred model. Both financial and non-financial (clinical model) criteria were applied to the assessment process.

2.3. The Committees in Common considered all the evidence and established a preferred option. The Committees in Common considered all the evidence set out within the PCBC and concluded that: The three options are viable and should be included in any public consultation, with the no service change comparator not included in consultation as it is not a proposal for change.

2.4. The options continued to be ranked as:

- Belmont as the top ranked and, on this basis, the preferred option;
- St Helier as the second ranked option;
- Epsom as the lowest ranked option.

2.5. Programme Board and the Committees in Common considered the evidence to determine whether the options were viable, and whether there was a preferred option. This evidence is summarised below for each of the options.

2.6. **Major acute services at Epsom Hospital**

- **Non-financial:** All the options deliver the clinical model and associated benefits. The non-financial analysis suggests Epsom is the least favourable of the short list of options (excluding the no service comparator). In addition, there is a risk that the level of births expected for the Epsom option may impact on the viability of a level 2 neonatal unit.
- **Financial:** The Epsom option has the lowest system NPV and the second highest capital requirement.
- **Local provider impact:** The Epsom option has the highest impact on local providers outside of the combined geographies, with the highest outflow of beds and highest capital requirement.
- **Interim integrated impact assessment:** The change in median travel time is highest for the Epsom option. While the Epsom option has a lower impact than other options on older people, it has the greatest impact on deprived communities.

2.7. **Major acute services at St Helier Hospital**

- **Non-financial:** All the options deliver the clinical model and associated benefits. The non financial analysis suggests St Helier is mid-ranked of the short list of options (excluding the no service

change comparator). Building this option is the most complex of the three options, due to the difficulties redeveloping the St Helier site.

- **Financial:** The St Helier option has the lowest capital requirement of the options, but does not deliver the highest NPV of the options, with the Belmont option having a higher NPV.
- **Local provider impact:** There is a lower impact on other providers for the St Helier option than the Epsom option, although there is a higher capital requirement for other providers than the Belmont option.
- **Interim integrated impact assessment:** St Helier has the lowest impact on deprived communities, however it also has the highest impact on older people of the options.

2.8. **Major acute services at Belmont**

- **Non-financial**: All the options deliver the clinical model and associated benefits, with the addition of a third UTC on the Belmont site. The Belmont option ranks most highly against non financial criteria. As a new build on an unused site, it is the simplest option to build. In addition, co-locating with the Royal Marsden Hospital offers further opportunities for joint working.
- **Financial:** The Belmont option has the highest capital requirement of the short list of options, however it also delivers the highest NPV of the options.
- **Local provider impact:** The Belmont option, located between Epsom and St Helier, has the lowest impact on other providers. It requires the least incremental capital for other providers and has the lowest net impact on numbers of beds.
- **Interim integrated impact assessment:** The median increase in travel time is lowest for the Belmont option. It has a lower impact on deprived communities compared to the Epsom option, and a lower impact on older people compared to the St Helier option.

2.9. The Improving Healthcare Together consultation on the options for delivering the clinical model and addressing the case for change was launched on 8 January 2020, for 12 weeks, and closed on 1 April 2020.

2.10. Under the Belmont site proposal, put forward as the preferred option, it was stated around 85% of current services will stay put at Epsom and St Helier, with six major services being brought together in a new specialist emergency care hospital (SECH), including A&E, critical care and emergency surgery, at Belmont. Patients will also be able to access urgent treatment via urgent treatment centres (one at Epsom Hospital, one at St Helier Hospital and one at Belmont Hospital) which will be open 24 hours a day, 365 days a year.

2.11. Findings from the independent analysis, the national audit office report, and Merton resident inputs raise concerns around:

- The validity of original business case assumptions and modelling (based on data ranging from 2011 – 2019) given changes in population demographics and health care provider capacity levels.

- Capacity of healthcare providers to cope with increased demand resulting from proposed changes.
- Mitigation measures to reduce the impact on travel times and quality of care experience for Merton residents.

2.12. The independent analysis suggests:

- There will be an increase in demand from Merton residents to neighbouring providers, with local hospitals likely serving an additional 50,000 Merton residents, which are currently performing below national standards.
- Merton's population is getting older, which is likely to further increase demand for health and social care services.
- Merton's residents, particularly those living in deprived areas, will experience increased travel times to their closest ED, Maternity and Paediatric services.

2.13. There are concerns around the additional pressure this could put on other healthcare providers in the area. The independent analysis suggests St. Georges, Croydon, and Kingston would likely serve an additional 50,000 Merton residents.

2.14. In addition, quality indicators for healthcare providers serving the Merton population indicate a decline in performance compared to 2019 levels. Emergency Department attendance times remain below the 95% target for 4h performance. Waiting times from decision to admit to admission and bed occupancy rates appear to be increasing for most providers, indicating declining capacity. This raise concerns around the ability of these providers to cope with additional demand resulting from the relocation of key services from St. Helier Hospital.

2.15. Furthermore, following the March CQC inspection, St. George's maternity services have been downgraded to "inadequate" due to inadequate safety measures, including failure to address stillbirths and severe bleeding as "serious incidents," along with concerns about staffing, triage, and leadership.

2.16. Merton has experienced key demographic changes, namely that the population is getting older (6.85% growth compared to 5.8% for entire population). This represents 27,100 people over 65 as of 2021, as opposed to 25,362 in the draft business case. The population over 65 is a key driver of both health care demand. 20-25% of A&E attendances, and 42-53% of A&E admissions, are from people over 65 years old, yet they account only 12-13% of Merton's population. There are concerns that an ageing population would put additional pressure on a health and social care system that is already under stress. The business case should re-evaluate capacity and demand models based on updated demographic and provider performance information.

## 3 ALTERNATIVE OPTIONS

3.1. Given all of the programme activity detailed above took place prior to mid 2020, it is the Council's opinion it does not accurately reflect the current

position on both financial and non-financial considerations. Central to this assertion is that, for a business case to be presented in 2020, the latest data it practically can be founded on is from the financial year 2018/19. This means relying on projections of demand and capacity a minimum of 11 years into the future, by the time a new hospital is operational. Any demand and capacity modelling will not at that time have been able to consider the material impact a global pandemic has had on the health service nationally and on the, now significant and fundamental shift in healthcare needs as a result.

3.2. Of equal importance to the Council's assertion that all services should be retained from a fully functioning and fit for purpose St Helier hospital is the current absence of any clear and appropriate capital maintenance and refurbishment programme for that site. Even if the preferred option of the business case were to materialise, and a new hospital built in Belmont, it is a stated fact in the business case that St Helier remains part of the approved clinical model, providing 85% of the services it currently provides. The Council is concerned the hospital is being managed into decline with the capital unavailable to maintain suitable buildings over the next 7 years, at least, whilst a new hospital is built and further into the future, allowing to play even the stated role within the current proposals.

3.3. It is the Council's clear view that redevelopment of the St Helier site is it's preferred option. There are elements of the business case assessment that would support this view; The option was assessed as the least expensive capital development. This would be potentially be ever more the case now, given the significant inflationary impact of rising costs on construction in the intervening period since the business case. It is also the option that presents least impact on the residents of Merton and a reduction in demand for already stretched services at the other local major acute hospital that Merton residents access.

3.4. Despite the statements from the Secretary of State in May and from the Chief executives of the local hospitals since (and expressed publicly on the official hospital website) the reality of the current situation is reflected in the National Audit Office report on the New Hospitals Building programme of 17th July 2023. Although much was made of 'promises' of commitment from current government ministers in May 2023 to the project as envisaged in 2020 for a new hospital by 2024/25, the reality is that no real progress has been made.

3.5. The original designs were too expensive, and the project was sent back to look at utilising cheaper and faster methods for realising the hospital projects (along with all the other projects in Cohort 3 of the New Hospitals Building project). The approach termed Hospital 2.0 has however stalled, not least because of the fact that similar prefabricated techniques have been identified as flawed in the New Schools programme. This necessitated demolition and reconstruction of schools using traditional techniques. Although little public information has been made available the fact that the Construction industry has yet to approve the construction methods leaves the programme still shrouded in uncertainty.

3.6. Natalie Forrest, the new hospitals programme director has declared the intent to deliver a revised programme business case by the late spring/ summer of 2024 but there is major challenges to achieve an approval of any draft business case until late 2025.

3.7. As the National Audit Office (NAO) make clear any capital funds earmarked earlier have had to be reapplied to other more urgent projects to rebuild collapsing hospitals. New funds will not be available until after the next scheduled Spending Review scheduled to *commence* in April 2025. Para 2.29 of the NAO report states "*It has been clear since the 2020 Spending Review that the schemes in cohorts 3 and 4 could not commence major capital works until after the start of the next Spending Review period in April 2025*". This will be after the next general election, with a new government and a new health minister in all likelihood.

3.8. It will not be taken for granted that new ministers in a new government will be so supportive of schemes which, in the words of the NAO, has yet to *"demonstrate that this level of (increased efficiency in building and delivering complex building project*) *efficiency is achievable*"; in which the "*DHSC and NHS England want to shift care increasingly out of hospitals in future but do not have a funded strategy to deliver these shifts on this scale*"; and rely on NHP assumptions of *"building future hospitals with only single-bedded rooms, instead of open wards, which will enable them to run at 95% occupancy and with average patient stays reduced by 12%"*.

3.9. There is competition within the NHS for the limited funds, with priority being given to the most urgent replacements, and outside of the NHS, with other large infrastructure schemes vying to take up the limited construction industry capacity (likely made worse by the inflationary impacts on cost of construction and constrained access to adequate construction wokrforce).

3.10. The NAO warn the *"NHP has affordability challenges to address in its third programme business case, which may reduce the scope of future hospitals or cause it to delay more schemes until the 2030s" and "In developing its third business case, NHP will need to find more savings, possibly by reducing the specification of its MVP (Minimum Viable Product) version of Hospital 2.0 or by rescheduling more schemes so that they are not completed until the 2030s (paragraphs 2.25, 4.2 and 4.5)".*

3.11. This is not an ideal starting point for the project. Many people involved at Merton, both in previous efforts to realise the new hospital building project, and most recently will not have been surprised at any of this and these discussions have been ongoing for many years. Following the NAO advice, a programme reset has been suggested to the local NHS leaders which would reopen consideration of less costly and more deliverable options. The Council will continue to argue this case on behalf of residents.

3.12. Following taking professional advice, the Council warned that the promise of getting three hospitals for the price of two was challenging; made more challenging with the current financial issues. It also warned it would be difficult to receive business case approval and that cheaper, more deliverable options should have been more seriously considered at the outset.

3.13. The council have continued however to express concern for the deteriorating condition of existing hospitals and the projected impact of reduced local hospital capacity for Merton residents. Paragraph 1.2 of the National Audit Office report cites the Health and Social Care Act 2008 and the NHS Constitution, NHS providers are required to comply with **legal requirements** to deliver care in a clean, secure and suitable environment that is properly maintained.

3.14. The Council commissioned a review of the evidence and impact assessment on the most deprived communities in Merton. The independent analysis undertaken by Newton Europe confirmed that the plans would worsen access for the most deprived but it also drew out that far from 85% of patients being unaffected the impact for those Merton residents using the most urgent services (A&E/maternity/paediatrics) would be to scatter them to alternatives outside the existing catchment area:

| | **Merton population served now (estimate)** | **Merton population served after (estimate)** | **Difference # Merton residents** | **Difference % Merton residents** |
|---|---|---|---|---|
| St George's Hospital | 173,766 | 197,246 | 23,480 | 14% |
| Kingston Hospital | 63,951 | 99,209 | 35,258 | 55% |
| Croydon University Hospital | 22,657 | 66,977 | 44,320 | 196 % |
| St Helier Hospital | 131,078 | - | - 131,078 | - |
| Planned Belmont Hospital | - | 28,020 | 28,020 | - |
| Epsom | 3,040 | 3,040 | - | - |

Table 1: *Estimate of Merton population served by provider before and after proposed changes.*

3.15. The proposed changes would also have an impact on Merton residents, particularly those living in deprived areas, who would have to travel further for these services. For example, Ravensbury, St Helier, and Cricket Green residents could see an increase of 10-20 mins travel time to their closest ED after proposed changes. The analysis suggests there have been important changes since 2019 that warrant a revaluation of key aspects of the business case.

## 4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The independent analysis of the Decision-Making Business Case and Integrated Impact Assessment could only be undertaken using, in the main, publicly available data published through NHSE and NHS digital. It was therefore, in several examples, difficult to replicate demand and capacity modelling in the same way that it would have been completed for the business case. It is also much more difficult to obtain data at a single

hospital level when it is published at Trust level and therefore not easy to disaggregate. It is also acknowledged it is even more difficult to disaggregate data to a borough population when several boroughs are served by an acute hospital. So effective conclusions; on the impact of demand and capacity modelling, whether an accurate model or not; for Merton residents was a particularly difficult task in the time allowed for the this independent analysis. Impacts pertinent to Merton's residents are therefore primarily focused on the analysis of the Integrated Impact Assessment.

4.2. Nonetheless, the independent analysis did lead to a set of further questions to put to the Trust and Programme team behind the work. It also set out several further considerations that are recommended to be put to the Trust for a response in order for there to be both meaningful engagement with affected communities and local partners to the healthcare system, which finds itself under the new governance structures of an Integrated Care System with an Integrated Care Board, Partnership and Borough Committee(s).

4.3. **Governance.** Since the original business case was written, governance structures have changed from CCGs to ICBs. We would like to know what the new process and governance structure for developing and signing of the new business case would be, including:

- What stage gates will the formal approval go through and what will be the considerations at each stage e.g., clinical model, demand and capacity, financial case.
- What is the plan for local engagement during the development and approval of the revised business case, given our local agreements and relationships.

4.4. **Demand and Capacity modelling.** It is essential to ensure that the new hospital provides high-quality care for the population, and that capacity would meet expected demand. Updated view of demand and capacity is required to cover the period up to (as a minimum 2029/30) for entire population (given demographic changes in the population and care model performance). Including how demand will be met.

- What is the overall bed/staff requirement for the target population – at system level?
- The NAO report indicates some planned hospitals will not have enough capacity to meet future demand. How will future demand be met under proposed plan?
- What does the updated acute and community models of care look like, and how has it performed since the development of the draft business case. Have they helped with acute demand reduction, as envisioned in the business case?
- Can the data sources, used for the business case demand and capacity analysis and work force assumptions be shared to support local planning?

- Have workforce changes since the development of the draft business case affected the business case strategy and assumptions around workforce requirements?

4.5. It is essential to ensure that the neighbouring care providers can deliver quality care for residents, and were necessary, have appropriate investments plans and funds to carry them out. We require an updated view of demand shift to neighbouring providers were the proposed changes to be implemented. Providing details on data used for bed and capacity modelling, as well as assumptions used.

4.6. During the 2019 IIA – provider boards believed they could cope with additional demand under the Belmont option – provided investments were made. The independent analysis suggests St. Georges, Croydon, and Kingston would likely serve an additional 50,000 Merton residents. In addition, quality indicators for healthcare providers serving the Merton population indicate a decline in performance compared to 2020 levels. ED attendance times remain below the 95% target for 4h performance. Waiting times from decision to admit to admission and bed occupancy rates appear to be increasing for most providers, indicating declining capacity. Additional evidence required includes:

- *Update on investment plans and/or implemented changes since Business Case from neighbouring providers to cope with increased demand. Including the capital investment and delivery plan for St Helier Hospital through to 2030, when the new site is due to be completed.*
- *Are provider boards still confident they can deliver care to population if demand increases? Including appropriateness of investment plans and funding required to implement them.*

4.7. **Inequalities.** The proposed changes would also have an impact on Merton residents, particularly those living in deprived areas, who would have to travel further for these services. For example, Ravensbury, St Helier, and Cricket Green residents could see an increase of 10-20 mins travel time to their closest ED after proposed changes. What specific travel time increase mitigation measures are proposed for Merton residents living in deprived areas?

## 5 TIMETABLE

5.1. This report is on the agenda for Cabinet for 16 November

## 6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. There are no direct financial implications for the Council.

6.2. The key financial considerations of the business case relate to the capital allocation currently approved for the new hospital proposal and the capital provided to maintain St Helier in an adequate state of repair to continue to provide services, fit for 21 century health care and that are of high quality given the stated intent that St Helier remains a critical part of the overarching

clinical model, irrespective of whether a new hospital is situated on the St Helier site.

## 7 LEGAL AND STATUTORY IMPLICATIONS

7.1. n/a

## 8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. There are no direct implications for the Council.

8.2. The integrated impact assessment referred to throughout this report was undertaken as part of the Improving Healthcare Together programme and is available here: Final Integrated Impact Assessment Report - Improving Healthcare Together

8.3. The independent analysis has drawn attention to a number of inequalities that would arise from the proposals in their current form. These centre on equity of access to adequate healthcare facilities and the impact on relocation of vital services on things such as extended travel times, which are shown to disproportionately affect residents from some of the most deprived wards of the borough. Further lobbying of the programme, to revisit the integrated impact assessment, will be pursued.

## 9 CRIME AND DISORDER IMPLICATIONS

9.1. n/a

## 10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. n/a

10.2. n/a

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

1. Newton Europe Independent Analysis report.

## 12 BACKGROUND PAPERS

12.1. Home - Improving Healthcare Together. This is the website for the local programme associated with the proposals, the process of consultation, engagement and decision making.

12.2. 40 new hospitals - NHS Recovery : NHS Recovery (dhsc.gov.uk). This is the national Government website detailing the new hospital programme across the country.

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