



IMPROVING HEALTHCARE TOGETHER 2020-2030 STAKEHOLDER BRIEFING

Surrey Downs, Sutton and Merton Clinical Commissioning Groups

July 2019

STAKEHOLDER BRIEFING

THIS IS NOT A CONSULTATION DOCUMENT

All content included in this document is draft and subject to change. No decisions have been made regarding any preferred solution(s). Any preferred solution(s) if determined would be subject to consultation in advance of any final decision on an agreed option.

The purpose of this briefing is to update on the Improving Healthcare Together 2020 – 2030 programme as we begin assurance of our draft pre-consultation business case (PCBC) with NHS England and NHS Improvement.

We (NHS Surrey Downs Clinical Commissioning Group (CCG), NHS Sutton Clinical Commissioning Group and NHS Merton Clinical Commissioning Group) have been exploring how to meet the healthcare needs of our populations in a sustainable way.

The Improving Healthcare Together programme has been working to produce a pre-consultation business case detailing the key challenges faced by our healthcare system and describing why change is necessary. It details a sustainable clinical model for our combined geographies based on clinical standards and evidence based best practice, and sets out an approach for options consideration to address our case for change and deliver the clinical model, resulting in a non-financial and financial appraisal of a short list of options.

These options include consolidating major acute services (which comprise c.15% of activity) onto one site within our combined geography – at Epsom, St Helier or Sutton Hospital. No hospitals would close. In all options, both Epsom and St Helier hospitals would remain open to provide local district hospital services; the majority of activity (c.85%) would remain on the same site as it is currently provided.

This stakeholder briefing has been developed to provide a summary of our PCBC work to date.

This includes the latest evidence base we have developed and an initial pre-assurance ranking (as at July 2019) of the three options we have identified to resolve the issues in our local area. The potential ranking of these options is only included at this stage to enable our regulators to understand the status of the programme and, as the options require significant capital investment, to support our ongoing discussions of potential sources of capital to finance the options.

This is not a consultation document.

The evidence and position on options set out in this briefing is subject to change as further evidence is developed and assurance by NHS England and NHS Improvement is completed. This briefing does not include detailed underlying analysis, as this is subject to assurance and regulatory oversight and is therefore not appropriate to publish at this stage.

Following this – and subject to the timing of assurance feedback, decision in principle on availability of capital and revisions of the draft PCBC – we will be taking the following decisions in public as a Committees in Common:

- **Approve the final PCBC** with a range of options and a preferred option(s) if determined, alongside making the decision to proceed to consultation following JHOSC approval of the consultation plan. The timing of these is to be agreed and may be simultaneous.

- **Make a formal decision post-consultation** on a preferred option with input from the integrated impact assessment and subsequently develop a decision-making business case for approval by NHS England and NHS Improvement.

No decision will be made until after consultation.

Within this stakeholder briefing document, we describe our thinking to date across key areas

We have summarised:

1. **The health needs of our combined geographies and our case for change:** The case for change describes the key challenges faced by the local health economy – and in particular by Epsom and St Helier University Hospitals Trust – and explains why change is necessary.
2. **The process we have followed:** This describes the governance of the Improving Healthcare Together programme, and the process we have followed to ensure any decision-making is supported by underlying evidence and local stakeholders.
3. **How key stakeholders and the public have been engaged and involved in our process:** Our early engagement has been extensive and captured a wide range of views. We also set out how we will plan to consult if a decision is made to proceed.
4. **The clinical model and potential benefits thereof:** The clinical model has been developed to meet local needs for our combined geographies based on clinical standards and evidence based best practice.
5. **Our options consideration process:** We have followed a standard approach to understand the possible options to address the challenges set out in our case for change and deliver our clinical model. This briefing describes a long list, initial tests to reach a short list, and criteria draft assessment of the short list through defined criteria.
6. **An analysis of financial impact and affordability:** We have used a range of financial metrics to assess the financial impact of the shortlisted options, and to test the affordability of each.
7. **How we will assure our plans if a decision is made to move forward:** This describes the role of assurance bodies and governance around decision-making.

Surrey Downs, Sutton and Merton CCGs are continuing to work with health and care services across our combined geography to address the challenges set out in our case for change

Surrey Downs, Sutton and Merton CCGs are located across the Sustainability and Transformation Partnerships of Surrey Heartlands and South West London, and commission services for a combined population of 720,000.

We are continuing to work with all local health and care organisations to improve healthcare for our populations. This includes but is not limited to primary care, community care, mental health, social care and acute care.

As commissioners of healthcare across Surrey Downs, Sutton and Merton, we are clear that we must ensure that the needs of our populations are met and support improved health of our populations, both currently and in the future. This includes rapid access for urgent care needs, consistency in care for long-term conditions and access to specialists for the sickest patients or those most at risk.

To meet these needs, we have a vision for future healthcare:

- **Preventing illness**, including both preventing people becoming sick and preventing illness getting worse.
- **Integrating care** for those patients who need care frequently and delivering this integrated care as close to patients' homes as possible.

- **Ensuring high quality major acute services** by setting clear standards for the delivery of major acute emergency, paediatric and maternity services.

We have identified a number of barriers to delivering this vision. In particular, we have three core challenges with our main acute provider, Epsom and St Helier University Hospitals NHS Trust (ESTH):

- **Delivering clinical 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.
- **Providing healthcare from modern buildings:** Our acute hospital buildings are ageing and are not designed for modern healthcare delivery. Over 90% of St Helier Hospital is older than the NHS and it has the 16th highest backlog maintenance in the country; its condition has been highlighted by the Care Quality Commission as requiring improvement.
- **Achieving financial sustainability:** The cost of maintaining acute services across two hospital sites is a major driver of the system's deficit. In particular, by 2025/26, ESTH may need c. £23m of additional annual funding above that which is likely to be available, based on current services. This is a major challenge to the sustainability of the local health economy.

We have followed a defined process to address our case for change, develop options to solve our challenges and carry out any decision-making

Improving Healthcare Together has developed principles, processes and governance that will support any decision-making. The programme has been clinically led, informed by engagement with key stakeholders and the public and worked with partners across our combined geographies.

Governance groups were established to make recommendations that would be considered by the Committees in Common as part of any decision-making process. These groups were supported by workstreams to carry out key elements of work.

Four key processes supported the development of our work:

- **The development of the clinical model**, overseen by the Clinical Advisory Group, which included initially defining an emerging clinical model for public engagement, and a further phase where areas of work were identified following a review by the Joint Clinical Senate for London and the South East.
- **The development of the finance and activity model**, overseen by the Finance, Activity and Estates Group, which modelled the short list of options to determine their impacts.
- **The options consideration process**, which established the approach to developing a long list, short list and any evaluation thereof and involved the public in the consideration of a short list of options.
- **Public and stakeholder engagement**, which tested proposals and the options consideration process with the public.

The programme has engaged the public and wider stakeholders, capturing a wide range of views and informing our proposed consultation process

We have undertaken a significant amount of patient and public engagement during our programme of early engagement. This initial engagement has ensured patients, carers and residents were fully involved in the development of the case for change, clinical model and potential solutions.

Our overarching aims in undertaking this engagement activity were to seek feedback on:

- the emerging **clinical model**;

- the **case for change** – our vision and challenges;
- the **potential solutions** developed by the programme; and
- how the **short list of potential solutions** may affect different groups

Our early engagement was undertaken as part of a four stage process which includes pre-consultation, consultation and post consultation. During this stage, we have engaged with a wide and diverse range of interest groups.

Through this engagement 3,000 people and staff across our geography were informed and asked to give their views on the work of the programme. There was a particular focus on those groups most impacted by the potential changes to major acute services, such as users of paediatric, maternity and emergency services.

The feedback we have received has informed the further development of our plans.

During engagement, we heard that:

- there was support for the main areas of the **clinical vision**;
- there was a widespread recognition of a **need for change**;
- there is not a clear consensus over what that change should be;
- no new alternative proposals were identified;
- there is an underlying concern about **potential loss of services**; and
- people tend to advocate for the **services that they are familiar with** and hospitals that are closer to them;
- there is particular concern about **transport and accessibility** and the impact on proposals to those who are perceived to be most in need; in particular older and less mobile people and those in areas of higher deprivation.

Feedback gathered from pre-consultation engagement with local residents, patients, carers, staff and equality groups informed each stage of the development of proposals. Local priorities and needs for healthcare services were gathered and fed directly into the options consideration process. This feedback included the views of equality groups potentially impacted by the proposals and their specific needs.

We will continue our programme of engagement through our proposed consultation process. We will aim to obtain a broad range of views from a wide variety of communities, services users and their representatives on our proposals.

The consultation will seek to:

- Ensure the population of our combined geographies are **aware of and understand the case for change and the proposed options for change**, by providing information in clear and simple language and in a variety of formats.
- Hear people's views on the proposed changes to major acute services.
- Ensure the CCGs as decision-makers are made aware of **any information which may help to inform the proposals** and the decision-making process.

We will commission an independent company to formally analyse the consultation responses and outputs from all engagement methods. On conclusion of the analysis the independent company will produce a final written report which will be publicly available. The report will be used to inform the Decision-Making Business Case, on which the Committee in Common of the three local Clinical Commissioning Groups final decision will be based.

We are clear that the results of consultation are an important factor in health service decision making, and are one of a number of factors that need to be taken into account.

Our clinical model describes how we will deliver healthcare in the future to meet local needs

We have set out a clinical model to meet the needs of our populations and deliver our vision. This improved clinical model is based on clinical standards and evidence based best practice. This model has been developed by our Clinical Advisory Group, which has a membership drawn from acute and non-acute clinical leaders from across the Surrey Downs, Sutton and Merton area. Additionally, this model has been refined both by working groups of clinicians and other stakeholders from across primary and secondary care including through two clinical workshops involving stakeholders from across the area. A review by the Joint Clinical Senate for London and the South East as part of the assurance process supported the aims and direction of our clinical model.

As our challenges are local, this emerging clinical model focuses only on the combined geographies of Surrey Downs, Sutton and Merton. Wider changes, such as the clinical model for South West London and Surrey, are out of scope. However, the impact of local changes on other local providers has been considered as part of detailed analysis.

Our clinical model aims to ensure the very best quality of care is available to our populations and sets the direction for care in our combined geographies.

It describes how we will deliver **district hospital services** and **major acute services** to provide excellent care in the future, integrated with and supported by **out of hospital services**.

- The aim of our **community-facing, proactive health, wellness and rehabilitation district hospital model** is to support people who do not require high acuity services but who still need some medical input. This includes district beds for patients 'stepping down' from a major acute facility, 'stepping up' from the community and directly admitted via an urgent treatment centre(s). These services are frequently used, meaning access is important. Our clinical model therefore keeps district services as local as possible and these services will continue to be delivered from both Epsom and St Helier Hospitals, while being further integrated with other services people use.
- **Major acute services are for the treatment of patients who are acutely unwell or are at risk of becoming unwell**, such as those treated within the emergency department. These are services that require 24/7 delivery and include the highest acuity services. We have considered the co-dependencies between these services, to define the minimum set of services that need to be co-located. For major acute services clinical standards of care and co-location are central to clinical outcomes due to the importance of consultant input and critical nature of the care – and the aim is to ensure these services are co-located appropriately.

We believe that this clinical model – where local access to district services is maintained and major acute services are co-located – will benefit the quality of our services and the experience offered to patients.

We are already providing the district hospital model locally.

We have very deliberately called our community-facing, proactive health, wellness and rehabilitation model the district hospital model. This future model builds on existing work and practice that is already happening across our combined geographies and is in line with the direction of travel for healthcare across the country, including the NHS Long Term Plan.

District hospital services do not require critical care or services on which critical care depends. District hospital services are those that patients may require more frequently and should be accessible closer to patients' homes through close links with community health and care settings.

While major acute hospital beds will be used for our sickest and highest risk patients, multiple bed audits have identified a cohort of c. 47–60% of existing inpatients who require a hospital bed but do not require any of the major acute services.

These audits suggest there is a patient cohort that needs inpatient care but within a lower acuity setting. Our clinical model proposes that this is a cohort of patients whose care requirements could be met via a district hospital bed, supported by a new model of care.

At both Epsom and St Helier hospitals, these patients are already being treated in a different manner as inpatients. In the clinical model these beds would remain at each site with a new model of care.

Our clinical model will allow us to deliver major acute standards and evidence based best practice through co-location of major acute services.

Major acute services include the highest acuity services offered in our combined geographies and are subject to specific clinical standards. Major acute services include:

- Major emergency department (ED)
- Acute medicine
- Critical care
- Emergency surgery
- Inpatient paediatrics
- Obstetrician-led births

The changes to the clinical model aim to meet the latest clinical standards and evidence based best practice for major acute services. For women planning to give birth in our combined geographies, a choice of home birth, midwife-led birth and obstetrician-led birth will be maintained. Clinical Advisory Group has recommended that midwife-led births and obstetrician-led births should be co-located.

Our case for change has identified that there are issues with the current provision of major acute services. Therefore, how these services are delivered in the future will need to be considered as part of the options consideration process.

The clinical model is expected to bring a wide range of positive impacts, including clinical benefits, workforce benefits, technology benefits and estates benefits.

Overall the clinical model is expected to translate into improved clinical outcomes for patients, an improved way of working for staff, opportunities for the implementation of new technology, fewer patient falls and transfers, fewer adverse drug events and infections, an improved patient experience and shorter stays in hospital.

This clinical model forms the basis of our planning for potential solutions for our combined geographies. It will be tested with the public and clinical senates and may be refined if additional evidence emerges.

We have followed a defined options consideration process to address our challenges and deliver our vision

This process has been informed by previous engagement with the public on potential solutions to the issues we face and extensive discussion within the local area, including amongst clinicians, commissioners, providers and regulators. This includes previous public engagement on potential scenarios for Epsom and St Helier University Hospitals Trust, which was completed to support the development of their *Strategic outline case for investment in our hospitals 2020-2030*.

In order to determine the options to address our case for change and deliver the clinical model, we have continued to follow a standard approach for options consideration. This involved:

1. Developing an **initial long list of options** to address our case for change and deliver the clinical model.
2. Developing and applying **initial tests to reduce the long list** to reach a manageable short list. This allowed us to focus on evaluating the short list to ensure they are feasible.
3. Developing and **evaluating the short list of options** through non-financial evaluation criteria in line with guidance from The Consultation Institute. The Consultation Institute is an independent body which has been guiding the programme.
4. Carrying out a **financial analysis** and reporting a series of financial metrics for each short listed option.

We have developed an initial long list of options to address our case for change and deliver the clinical model.

Our development of potential solutions explores ways our case for change can be addressed, our clinical model can be delivered and our hospitals maintained into the future. We have focused this process in two ways.

- **First, we have focused on major acute services only**, as there is a need for significant changes in these services. District hospital services will continue to be developed as described in our existing plans.
- Second, we have focused only on changes **within our combined geographies**.

Based on this, we have then considered how potential solutions might vary to develop a long list of potential solutions. This is intended to capture a wide range of potential solutions – consideration of their viability is a subsequent step. We have considered:

- **How many major acute hospitals are provided in the combined geographies?** Possible solutions include sites providing district hospital services alongside up to two sites delivering major acute services. Although no major acute hospital sites would not align with our commitment to maintaining major acute services within our combined geographies, it has been included for completeness.
- **Which major acute services do these hospitals provide?** There are two potential configurations of major acute services: major acute hospital(s) could provide adult major emergency department(s) with supporting major acute services only or provide major adult emergency department(s) with supporting major acute services alongside women's and children's services.
- **Is workforce from outside the area used to supplement rotas?** Possible solutions include relying only on workforce within our local area and using workforce from nearby providers to supplement rotas.
- **Which sites could be used to deliver major acute services?** Possible solutions include using existing acute hospital site(s) (i.e., Epsom, St Helier and/or Sutton Hospital site) and/or using a new site within our combined geographies.

All the combinations of these factors leads to 73 potential solutions. This forms our long list.

Our long list is refined by testing the viability of potential solutions against three initial tests

We have applied three initial tests, aligned to our case for change, to this long list to reach a shorter list we can consider in detail. The most important of these concerns our collective commitment to maintaining services within our combined geographies, so long as a viable potential solution is available. Our other two tests concern deliverability based on available workforce and estates.

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 a major acute hospital.

Applying these tests 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 co-dependencies 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 (Epsom Hospital, St Helier Hospital, Sutton Hospital, or a new site within our combined geographies).
- After the third test, **only existing sites appear feasible**. This provisionally results in three potential solutions.

In addition, our provisional short list includes a ‘no service change’ counterfactual – continuing with existing service provision at both Epsom Hospital and St Helier Hospital.

There are therefore four potential solutions in our provisional short list, which includes:

- **The ‘no service change’**: Continuing current services at Epsom Hospital and St Helier Hospital.
- A **single major acute site at Epsom Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
- A **single major acute site at St Helier Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
- A **single major acute site at Sutton Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.

This provisional short listing process and supporting evidence was tested with the public before further analysis was completed.

We developed and evaluated the short list of options through non-financial evaluation criteria in line with guidance from The Consultation Institute.

The short list of options was considered through non-financial criteria and financial metrics, including metrics defined by our regulators.

We have undertaken a standard process for the development of the non-financial criteria and scoring of options against these criteria. This is based on the recommendation of The Consultation Institute, which offers expert advice and guidance of public consultation and engagement, based on relevant legislation and case law, and informed by previous experience of this process from across the UK.

There were three steps to this process:

1. Pre-consultation engagement captured **public priorities and feedback**.
2. Three different groups of balanced representative people were identified, drawn from across the three CCGs (including the public, clinicians and professionals), where:
 - the first facilitated group agreed **non-financial criteria**;
 - the second facilitated group agreed what **weighting** each non-financial criterion should carry; and
 - the third facilitated group **scored the shortlisted options** against the non-financial criteria, without sight of the weightings.
3. Application of the weightings to the scores and reporting to Programme Board and the Joint Governing Body of the **outcome of the non-financial scoring process**.

Following the first two workshops, 16 weighted non-financial criteria across six domains were established. For the scoring of the short list against the non-financial evaluation criteria, the participants of the third and final workshop were provided with the best available evidence for each shortlisted option and the no service change comparator, as developed by the programme.

Based on the workshop participants:

- **Sutton** scored most highly for **11 criteria**: availability of beds, delivering urgent and emergency care, workforce safety, recruitment and retention, alignment with wider health plans, integration of care, complexity of build, impact on other providers, time to build, deprivation, health inequalities and safety.
- **Epsom** scored most highly for **1 criterion**: older people.
- **St Helier** scored most highly for **3 criteria**: staff availability, clinical quality and patient experience.
- **No service change** scored most highly for **1 criterion**: access.

Following these workshops in October and November 2018, as a result of further evidence development and assurance by NHS England, NHS Improvement and the Joint Clinical Senate, further work was undertaken in areas relevant to the scoring workshop. This is focused across three main areas:

1. Clinical Senate review of the clinical model
2. Interim integrated impact assessment development
3. Other local provider impacts

The further evidence was assessed by the Clinical Advisory Group and Programme Board to establish whether there would be any impact on the scores for the options in the relevant criteria as part of the decision-making process. Table 1 demonstrates how this further evidence development supports the option potential ranking as established through the options development process by relevant domains.

Table 1: Further evidence development impact by relevant domain and respective scores.

Domain	Changes to evidence
Accessibility	Small changes to travel times as a result of the updated analysis, which does not result in a change in the direction of potential rankings.
Availability of beds	Small changes to bed numbers as a result of the updated analysis, with all options providing the same number of beds.
Impact on other providers	The provider impacts are consistent with the initial analysis. With the right mitigations, all providers have indicated that the options would be deliverable. The Epsom option has the greatest impact on other providers, with a significant flow of patients to providers to the north. Sutton has the lowest impact on other providers, being in the middle of the current catchment.
Deprivation	The IIA has indicated that the Epsom option may have a greater impact on deprived groups due to the increased length of journey, and increased complexity and costs of the journey for deprived areas which are predominately located in Sutton and Merton.
Health inequalities	The IIA reconfirms the evidence base for the importance of district services in impacting positively on reducing health inequalities.
Older people	The IIA has indicated that the St Helier option may have a greater impact on older people due to the increased length of journey, and increased complexity and costs of the journey for older communities which are predominately located in Surrey Downs.

As a result of the workshops and further evidence development, the current relative non-financial ranking of options as of July 2019 is shown by domain in Figure 1 below.

Figure 1: Relative option potential rankings

Domains	Epsom	St Helier	Sutton
Access	Greatest increase in median travel time Least favourable	Second greatest increase in median travel time Favourable	Smallest increase in median travel time Most favourable
Clinical sustainability	Given the model of care is the same across the options, it is expected that all options will deliver similar benefits Less favourable	Given the model of care is the same across the options, it is expected that all options will deliver similar benefits Favourable	In addition to the benefits for Epsom and St Helier options, Sutton delivers an additional urgent treatment centre Most favourable
Contribution to healthcare aims	Given the model of care is the same across the options, it is expected that all options will deliver similar quality of care benefits Equally favourable		
Deliverability (inc. provider impact)	Second longest time to build and second most complex; highest impact on providers Favourable	Longest time to build and most complex; mid impact on providers Least favourable	Shortest time to build and least complex; lowest impact on providers Most favourable
Meeting population health needs	Greater impact on deprived communities Least favourable	Greater impact on older people Least favourable	Less impact on older and deprived communities Most favourable
Quality of care	Given the model of care is the same across the options, it is expected that all options will deliver similar quality of care benefits Equally favourable		

The programme has used a range of standard financial metrics to assess the financial impact of the short listed options, and to test the affordability of each

To determine the financial impact of the shortlisted options, a range of financial metrics were reported to determine the affordability and feasibility of delivering the options.

The clinical model and consolidation of key services is expected to result in a range of financial benefits.

These primarily relate to the benefits of consolidating major acute services on a single site and operating more efficiently. In addition, the option of co-locating with The Royal Marsden Hospital at Sutton offers further benefits from joint working. Overall, these benefits are significant (c. £33 - 49m per annum by 25/26), and are expected to result in a financially sustainable trust.

In order to deliver these significant benefits, a large capital investment in the hospital sites is required across all options.

The capital requirement of the options is driven by:

- The catchment size and therefore the number of beds required for each of the options
- The type of build required, as a new build requires more capital than a refurbishment.
- The capital requirements at other local providers as a result of changes in patient flow.

We are exploring a number of ways we can fund this capital requirement, recognising the constraints in public financing.

Our initial analysis suggests all options are affordable.

The significant benefits from consolidation offset the cost of capital required for each option, resulting in a positive I&E position for ESTH. This also translates into a positive return on investment for all the options.

We have considered the overall financial value offered by all three options.

Considering all the costs and benefits over 50 years, the net present value (NPV) enables us to compare the overall costs and benefits of each option.¹ This shows all the options offer considerably more value than maintaining our current configuration and, overall, Sutton offers the greatest financial value.

Table 2 below shows a summary of these key financial metrics for each of the options.

Table 2: Summary of key financial metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
ESTH key financial metrics	Total capital investment (£m)	(225)	(466)	(430)	(511)
	ESTH 25/26 in year I&E (£m)		6.5	5.2	12.7
System key financial metrics	System return on investment 25/26 (£m)		5.3%	7.4%	7.3%
	System net present value (50 years, £m) (<i>ranking</i>)	50	354 (3)	487 (2)	584 (1)

Programme Board considered all this evidence and, based on NPV as the most appropriate composite metric, identified a financial initial pre-assurance ranking (as at July 2019) of the options.

Programme Board has considered the evidence to determine the relative initial pre-assurance ranking (as at July 2019) of options

Programme Bboard agreed based on the current evidence there is a clear ranking of the options which should be included as part of the draft PCBC. The evidence to date has been summarised below for each of the options.

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 geography, 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.

Major acute services at St Helier Hospital

¹¹ NPV is used as best practice within HMT The Green Book as an objective measure for comparing total benefits for different options over an extended period of time. (*The Green Book, Central government guidance on appraisal and evaluation*, HM Treasury, 2018)

- **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 Sutton 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 than the Sutton 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.

Major acute services at Sutton

- **Non-financial:** All the options deliver the clinical model and associated benefits, with the addition of a third UTC on the Sutton site. The Sutton 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 Sutton 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 Sutton option has the lowest impact on other providers. It requires the least incremental capital and has the lowest impact in terms of numbers of beds.
- **Interim integrated impact assessment:** The median increase in travel time is lowest for the Sutton 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.

Based on this, we have established an overall initial pre-assurance ranking (as at July 2019) to submit for assurance.

Figure 2: Summary of non-financial, financial and overall initial pre-assurance ranking (as at July 2019) of options

Domains	Epsom	St Helier	Sutton
Access	Greatest increase in median travel time Least favourable	Second greatest increase in median travel time Favourable	Smallest increase in median travel time Most favourable
Clinical sustainability	Given the model of care is the same across the options, it is expected that all options will deliver similar benefits Less favourable	Given the model of care is the same across the options, it is expected that all options will deliver similar benefits Favourable	In addition to the benefits for Epsom and St Helier options, Sutton delivers an additional urgent treatment centre Most favourable
Contribution to healthcare aims	Given the model of care is the same across the options, it is expected that all options will deliver similar quality of care benefits Equally favourable		
Deliverability (inc. provider impact)	Second longest time to build and second most complex; highest impact on providers Favourable	Longest time to build and most complex; mid impact on providers Least favourable	Shortest time to build and least complex; lowest impact on providers Most favourable
Meeting population health needs	Greater impact on deprived communities Least favourable	Greater impact on older people Least favourable	Less impact on older and deprived communities Most favourable
Quality of care	Given the model of care is the same across the options, it is expected that all options will deliver similar quality of care benefits Equally favourable		
Finance	Lowest system value Least favourable	Second highest system value Favourable	Highest system value Most favourable
Overall ranking	Lowest overall potential ranking	Second highest overall potential ranking	Highest overall potential ranking

Based on this, the Programme Board agreed that the draft PCBC should be submitted for national assurance and sufficient capital requested.

The outputs of the PCBC are draft. Any new options, new evidence and information can be considered by CCG Governing Bodies up to the point of the decision after consultation.

The work set out within the draft pre-consultation business case will be assured by a range of organisations prior to any final decision-making

We are at the stage of submitting the draft PCBC for national assurance; following this, we will consider the PCBC and all the options further.

The draft pre-consultation business case and the work set out within it will be assured by:

- **NHS England:** Any proposal for service change must satisfy the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks and be affordable in capital and revenue terms.

- **NHS Improvement:** Together with NHS England, NHS Improvement will ensure each option submitted for public consultation is sustainable in service and revenue and capital affordability terms.

At this stage in the process we are submitting the draft PCBC to NHS England and NHS Improvement for assurance and decision in principle on availability of capital. Any final decision-making by the Committees in Common will be informed by this assurance and the reviews that have already taken place, including:

- the outputs of **early engagement**;
- the **options consideration process**;
- the outputs of the detailed **provider impact analysis**;
- assurance by **NHS England and NHS Improvement** of this pre-consultation business case;
- assurance by the **Clinical Senate** of the clinical model;
- outputs of the **integrated impact assessment**; and
- public **consultation**.

Following assurance and consultation, a decision-making business case (DMBC) will be developed to review the outcomes and set out any decisions.

This stakeholder briefing summarises the work we have carried out to date: there is more work to do before we will be able to identify any preferred option(s)

This is not a consultation document.

The evidence and relative ranking of options set out in this briefing is subject to change as further evidence is developed and assurance by NHS England and NHS Improvement takes place. We have established a position on option potential rankings within the briefing to enable NHS England and NHS Improvement to understand the likely direction of travel of the programme. Subject to assurance feedback, decision in principle on availability of capital and revisions of the draft PCBC, we will make decisions as a Committees in Common in public:

- **Approve the final PCBC** with a range of options and a preferred option(s) if determined, alongside making the decision to proceed to consultation following JHOSC approval of the consultation plan. The timing of these is to be agreed and may be simultaneous.
- **Make a formal decision post-consultation** on a preferred option with input from the integrated impact assessment and subsequently develop a decision-making business case for approval by NHS England and NHS Improvement.

No decision will be made until after consultation.