



Strategic outline case for investment in our hospitals 2020–2030

Trust Board
November 2017

IMPORTANT NOTICE

This is an Epsom and St Helier University Hospitals NHS Trust document.

Its purpose is to describe the Trust's current position on different scenarios for delivering its proposed clinical model. It is being shared with commissioners, and the Trust requests they consider the conclusions of the document and appropriate next steps.

The document is the Trust's strategic outline business case for investment in its hospital sites. It includes:

- The case for change
- The proposed clinical model
- Feedback from the public on this model and the ways it can be delivered
- Initial analysis of the potential financial impact of some of the ways the clinical model can be delivered
- Proposed next steps.

The approach taken to the financial analysis included in this document has been agreed with the Trust's commissioners and regulatory bodies. Capital costs have been estimated based on the prescribed Department of Health methodology and include contingency to reflect the uncertainty at this stage in planning.

The financial analysis has been submitted to the Trust's commissioners and regulators for them to assure. This process is expected to take several months, following which, the Trust intends to publish further details of the financial analysis undertaken.

As this assurance has not been completed, the financial information in this document is not final, and is subject to change.

The Trust believes this document will form a solid basis for any further work required. It is prepared to support commissioners in any next steps, potentially including a pre-consultation business case if required.

STRATEGIC OUTLINE CASE

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1. Introduction

1. Epsom and St Helier University Hospitals NHS Trust (the Trust) is a safe and effective Trust, primarily operating across two sites (Epsom Hospital and St Helier Hospital) with a small presence at Sutton Hospital. The Trust has made significant improvements since 2015, investing in over 300 more frontline staff and stabilising its finances.
2. However, the Trust faces a number of challenges:
 - Working across its two main sites, the Trust will increasingly be unable to deliver all the required quality standards across two sites because it will not have sufficient specialist staff across key services¹
 - Under current plans, the Trust's buildings will only have had sufficient investment to be structurally safe and will not provide the facilities necessary for the delivery of twenty-first century care
 - The Trust will continue to have a large and increasing annual deficit; by 2025/26, it expects a c. £40 million deficit if current services and trends (including rising demand and cost pressures) continue – this is despite significant productivity savings included as part of the Trust's 'business as usual' efficiency plans.
3. This strategic outline case explores ways the Trust can address these challenges. The purpose of this document is to describe:
 - How the Trust can meet the clinical, estate and financial challenges it faces in the next ten years
 - Different scenarios to achieve this
 - Some preliminary analysis of these scenarios and which scenarios appear potentially viable
 - The next steps for further consideration of the potentially viable scenarios available to the Trust.

¹ Quality standards refer to the standard of care that commissioners expect the Trust to provide in order to ensure care is safe and high quality, including levels of staffing and availability of key diagnostics. The standards need to be met on each site delivering certain services. Key standards include national seven-day service standards, which require consistent consultant-delivered care in particular specialties seven days a week, and locally agreed South West London quality standards.

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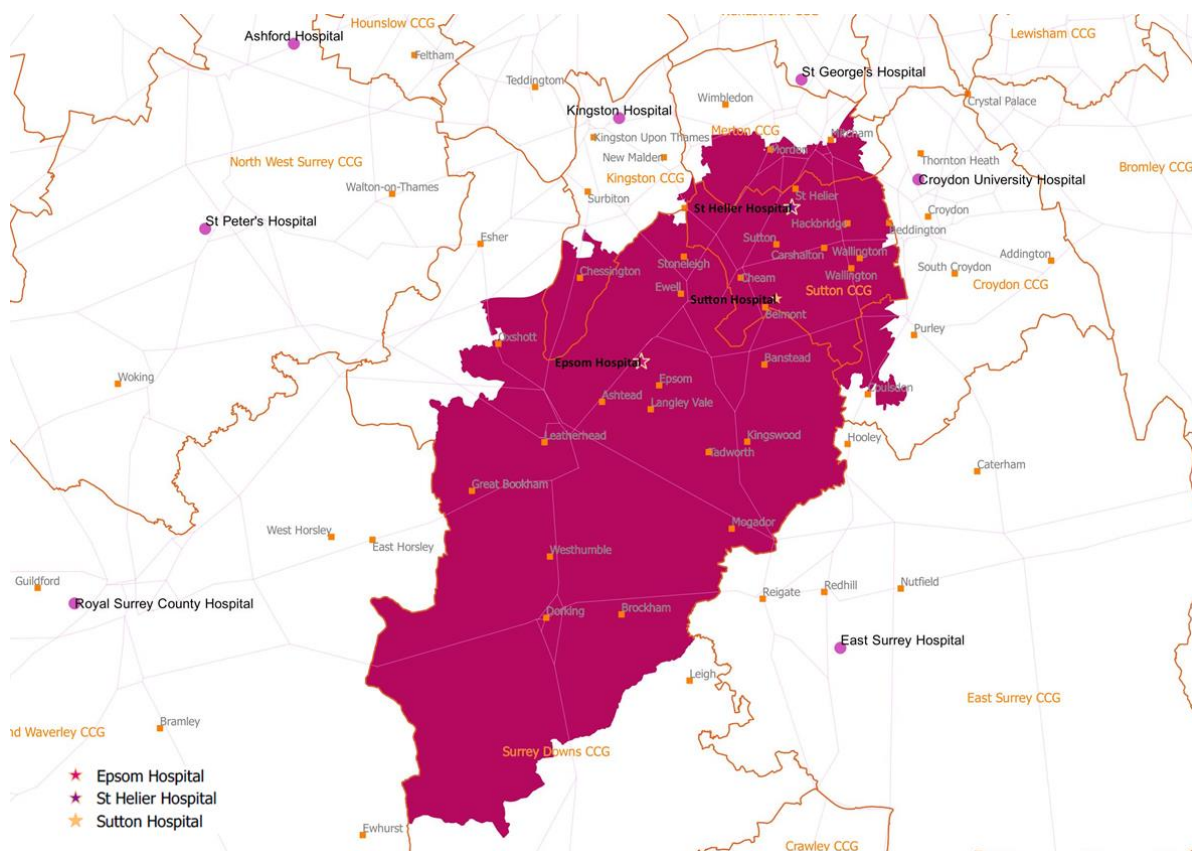
1.1. This strategic outline case

4. The Trust has been exploring different potential scenarios in order to support clinical and financial sustainability. These two elements are critical to the Trust and must form the basis of any long-term planning.
5. This strategic outline case is a first stage to understand whether there are scenarios worth exploring in greater detail as fully developed business cases.
6. The different scenarios describe different ways of delivering care which could provide benefits to patients and the Trust. They have been informed and drawn from the significant engagement the Trust has undertaken with the public over the past two years, including its most recent public engagement which concluded in October 2017, where respondents broadly supported the Trust's proposed clinical model and efforts to address its challenges (see Section 6).
7. A range of analyses have been undertaken to support this strategic outline case. However, not all of the work has been included in this document, as some of the analysis is pending regulatory assurance. The purpose of publishing this document at this stage is therefore to be open and transparent in communicating the Trust's current thinking at the earliest opportunity, and to continue the ongoing conversation with the public about the future of the Trust. The Trust will publish further information as it becomes available.
8. If this strategic outline case is approved, the next step would be for commissioners to consider its implications and respond. They would potentially then proceed with a pre-consultation business case, if public consultation is necessary.

2. Where the Trust is now

9. The Trust provides services primarily to patients who fall under three clinical commissioning groups (CCGs) – Surrey Downs, Sutton and Merton – across two major planning areas, South West London and Surrey Heartlands. In addition, NHS England directly commissions the Trust’s renal services.
10. The Trust owns three hospital sites: Epsom Hospital, St Helier Hospital (which includes Queen Mary’s Hospital for Children) and Sutton Hospital. Figure 1 shows the catchment covered by the Trust.

Figure 1: Current Trust catchment

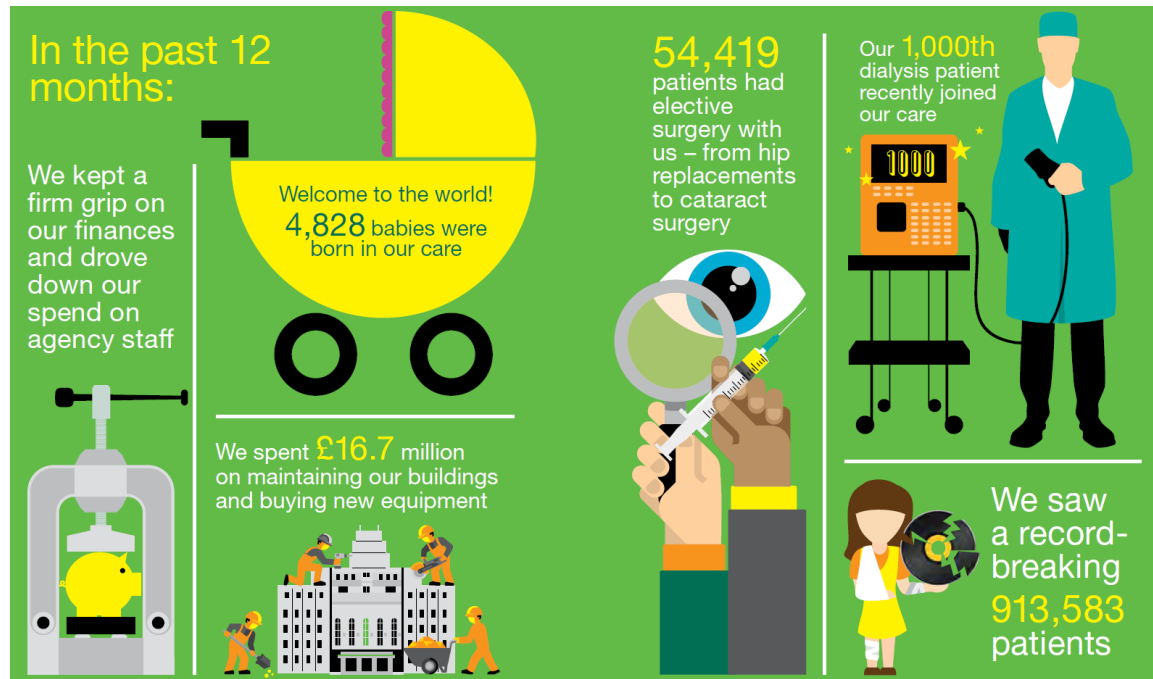


11. The Trust currently provides services from all three sites. Epsom Hospital and St Helier Hospital are district general hospitals, each providing a 24/7 consultant-led accident and emergency (A&E), acute and general medicine, surgery (non-elective only at St Helier Hospital), maternity, children's services and outpatients. In addition:
- **Epsom General Hospital** hosts the South West London Elective Orthopaedic Centre (SWLEOC), an NHS treatment centre providing regional elective orthopaedic surgery services for four South West London trusts;
 - **St Helier Hospital** provides a regional renal service, a stroke unit, and undertakes all the emergency surgery for the Trust and is the main pathology centre; and

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- **Sutton Hospital** is mainly vacant and only provides a few services for outpatients. The site is adjacent to The Royal Marsden NHS Foundation Trust's Sutton site.
12. The Trust currently provides services for a population of around 490,000 people, and in 2016-17, had over 913,000 patient contacts, summarised in Figure 2.

Figure 2: Overview of the Trust in the past twelve months



13. The Trust currently employs a team of c. 5,000 staff and 600 volunteers across its sites.
14. The Total income received by the Trust during 2016-17 was £392 million. This reflects an increase of £20 million compared to 2015-16.
15. The Trust currently has 1,048 beds, which are described in Figure 3.

Figure 3: Current Trust bed breakdown²

(Beds)	Epsom Hospital	St Helier Hospital	Sutton Hospital	TOTAL
Non-elective overnight (inc. maternity) ³	263	443	-	706
Elective overnight	40	68	-	108
Critical care	-	13	-	13
Day	36	34	-	70
SWLEOC	80	0	-	80
Other	35	36	-	71
TOTAL	454	594	-	1,048

Source: Trust analysis

16. The cohort of patients accessing the Trust's services has started to change in recent years. In particular, more patients in Surrey Downs are accessing services at the Trust compared to Merton. This is also reflected in the Trust's commissioning income, where

² Other beds includes escalation beds, day and overnight chairs, and private patient beds.

³ Includes high dependency beds.

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the share of income related to Surrey Downs commissioners has increased (see Figure 4).

Figure 4: Share of the Trust's commissioning income

% Trust income	2014-15	2016-17
Surrey Downs Clinical Commissioning Group	26%	30%
Sutton Clinical Commissioning Group	27%	29%
Merton Clinical Commissioning Group	10%	10%
NHS England	13%	14%
Other Clinical Commissioning Groups	24%	17%

Source: Trust analysis

2.1. The Trust's strategic objectives

17. The recent improvements, such as the investment in more than 300 additional frontline staff, has helped to form the Trust's current strategy. For 2015–2020 the Trust has committed that:
 - Both Epsom Hospital and St Helier Hospital will continue to provide 24/7 care across A&E, maternity and inpatient children's services
 - St Helier Hospital will provide specialist and emergency care, such as acute surgery for the sickest patients, and Epsom Hospital will expand its range of planned care
 - Work will continue with patients, GPs, commissioners, NHS England, NHS Improvement and other partners to provide significantly more care in community settings – closer to home for patients – so that they only have to come to hospital when they really need to.
18. This strategic outline case considers developments over a longer time horizon, seeking to ensure that the Trust is clinically and financially viable over the next ten years and beyond. This has required broader consideration of the Trust's clinical model.
19. The Trust and its commissioners have a commitment to deliver more person centred care closer to patients' homes. Person centred care is already being provided through a number of initiatives, including:
 - **Epsom Health and Care**, a leading partnership of providers supporting the over-65s to receive care at home and avoid unnecessary stays in hospital
 - **Sutton Homes of Care**, a national vanguard programme, which is improving hospital experiences for care home residents.
20. Linked to this, local and national strategy is targeting better patient care to support shorter lengths of stay in hospital beds and provide more joined up care when patients

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are discharged from hospital and require follow up services, for example in the community.

21. The Trust has engaged with leadership from South West London and Surrey Heartlands throughout the design process.

3. Challenges and the need for a new model of care

22. Over the next ten years, the Trust faces three main challenges:
- **Clinical sustainability**, whereby the Trust can deliver high quality care, including meeting relevant clinical standards across two acute sites with the workforce available
 - **Addressing critical issues with the Trust's buildings** and ensuring care is delivered from twenty-first century buildings
 - **Achieving a financially sustainable** position.
23. Together, these challenges mean that the Trust needs to fundamentally consider how it organises itself and how it delivers care most effectively to the populations it serves.

3.1. Clinical challenges

24. A number of developments in clinical care create challenges for the Trust that it must meet in the next ten years.
25. Specifically, challenges include:
- **Providing care to the sickest patients across two acute sites:** Clinically, standards are improving the quality of care delivered to patients, including moving the NHS to delivering consistent, consultant-led care seven days a week across many services. Providing care to the sickest patients across two acute sites means it is increasingly challenging to meet clinical standards. These standards, together with the staffing needed to provide care for the sickest patients across two acute sites, creates a need for a workforce larger than that available to the Trust.
 - **Meeting local healthcare needs:** There are clear local healthcare needs in the Epsom and St Helier localities that the Trust must meet, including delivering more care closer to patients' homes.
26. In addition, the national cancer vanguard creates the opportunity for improved cancer care across South West London and Surrey, led by Royal Marsden Partners (RMP) (a collaboration to deliver cancer services across West London, which includes the Trust and The Royal Marsden, among other partners). Realising these opportunities is central to the Trust's aims for clinical care in the future.⁴
27. These challenges mean the Trust needs to consider how to change its clinical model.

⁴ See, for example: https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf.

Challenges associated with providing care to the sickest patients across two acute sites

28. Providing care for the sickest patients across two acute sites creates a number of issues with meeting clinical standards, including:
 - Ensuring on-site emergency medicine consultant staffing in the emergency department for 16 hours a day and seven days a week (with off-site back-up and the ability to arrive on-site within 30 minutes if needed outside of these 16 hours)
 - Achieving actual admission to a ward for patients within one hour of the decision to admit
 - Providing timely access to 24/7 emergency key diagnostics
 - Having sufficient 24/7 on-site obstetrics consultant coverage.
29. Meeting these standards and providing care for the sickest patients across two acute sites means the Trust needs c. 52 more consultants to meet current seven-day standards across both sites (a c. 22% increase in consultant staffing).
30. This would create a significant cost pressure for the Trust. But more importantly, due to shortages in available consultants (in particular in emergency and acute medicine), the Trust will continue to struggle to recruit to these additional posts and will increasingly be unable to provide the required level of consultant coverage.⁵
31. In addition, providing care for the sickest patients across two acute sites means the Trust will need additional middle grade and junior doctors to staff its rotas.
32. Currently, the Trust struggles to recruit to these posts and relies on temporary staff; from February to April 2016, the Trust spent over £2.1 million on temporary medical staffing (see Figure 5). This is expensive and creates issues with governance, continuity and team working.
33. These issues will increase as the need for additional doctors grows; again, this reflects national and regional challenges around the recruitment of doctors.

⁵ For example, see: House of Lords (2017) *The Long-term Sustainability of the NHS and Adult Social Care*, <https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf>; Health Education England (2016) *Workforce Plan for England 2016*, https://www.hee.nhs.uk/sites/default/files/documents/HEE%20Workforce%20Plan%20for%20England%202016%20180516_0.pdf.

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Figure 5: Three month temporary midgrade and junior doctor spend (Feb–Apr 2016)

Specialty	Midgrade doctors (£000)	Junior doctors (£000)	Total (£000)
General and acute medicine ⁶	399	289	688
Emergency	365	128	493
Paediatrics	203	50	253
Surgery	195	173	368
Anaesthetics	109	46	155
Maternity	69	26	95
Renal	14	11	25
Stroke	6	14	20
Radiology	8	-	8
Other	4	9	13
TOTAL	1,372	746	2,118

Source: Trust analysis

34. This means that meeting clinical standards will become increasingly challenging due to shortages in the workforce available. Over the next 10 years, it is unlikely the Trust will be able to meet clinical standards while delivering care to its sickest patients across two acute sites.

Meeting local healthcare needs

35. Analysis of the Trust's patients suggests that the needs of the patient population could be better met by a different model of care – a model that helps to deliver more person centred care closer to patients' homes where possible, and which brings services together where there is a clear quality argument.
36. Multiple audits of patients in Trust beds suggest that up to c. 55% could be better managed in a different ward type.⁷ The current clinical model offers limited capacity to provide beds which are appropriate for these patients' needs, meaning that they will continue to be treated on wards where the level of care is higher than it needs to be. This leads to other patients waiting longer than necessary to be admitted.
37. The different local populations served by the Trust have some specific needs that must be met, including:
- The community around Epsom Hospital is older than the rest of the Trust's surrounding population, and the area has a lower population density than the community around St Helier. This creates specific challenges in ensuring access, particularly for urgent care, and delivering services to more elderly patients.
 - There are pockets of higher deprivation and less affluent communities around St Helier Hospital. This creates a specific need for a level of service provision from the St Helier site. Moreover, any subsequent work on the clinical model would need to consider these issues in more detail, including the relationship with

⁶ Including acute medical specialties.

⁷ Bed audits have included: South West London bed audit (March 2016), Trust analysis of patient acuity (April 2015) and Epsom Health and Care analysis of Epsom Hospital patients (August 2015).

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health inequalities and impacts on travel and transport for different patient groups.

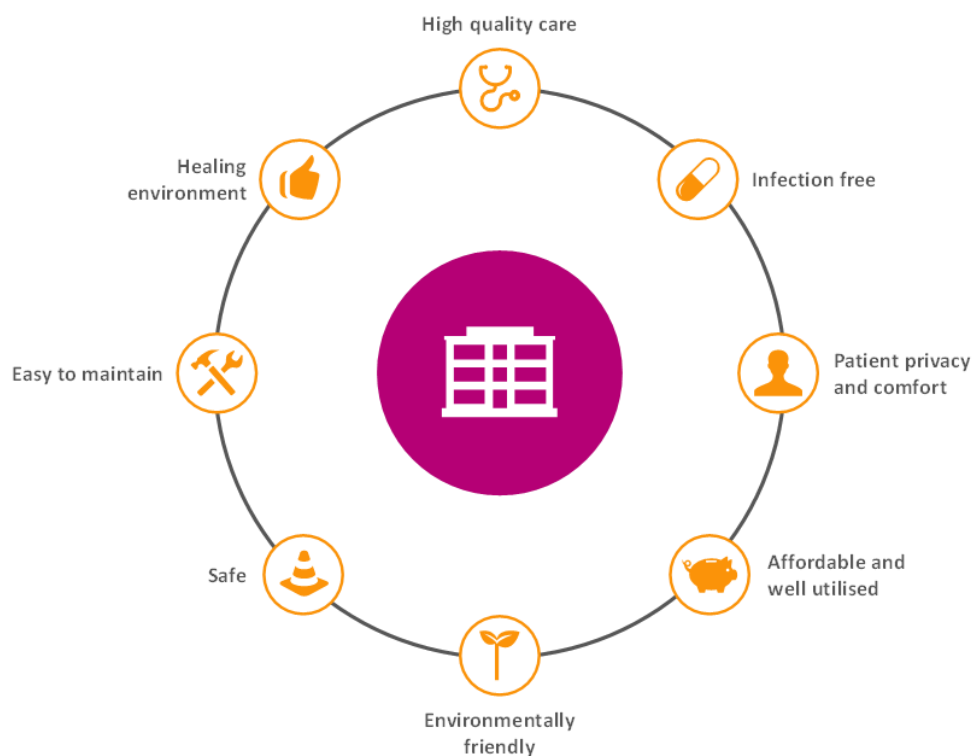
Continuing with two acute sites is unlikely to be viable and a new clinical model is needed

38. It is unlikely the Trust will be able to deliver clinical standards by providing care to its sickest patients across two acute sites. Therefore, continuing with this configuration is unlikely to be clinically viable. The Trust can only meet clinical standards if the care for the sickest patients and those at greatest risk of becoming sicker is consolidated.
39. Moreover, the healthcare needs of the Trust's patients could be better met by changing the way that care is delivered to ensure it is appropriate to their level of need and delivered as close to home as possible.
40. This suggests that the needs of local patients could be better met by a different model of care that consolidates the care for the sickest patients while providing enhanced services more locally.

3.2. Estates challenges

41. The Trust has an ambition to develop its estate to match its mission to put patients first, and help to deliver improved clinical care. The objective of its estates development is summarised in Figure 6.

Figure 6: Objectives of the Trust's estates redevelopment



Source: Trust estates strategy

42. Delivering the clinical model will require changes to the Trust's estate. The current estate falls far short of what patients should expect from twenty-first century

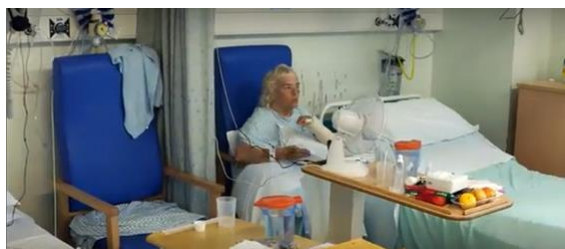
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healthcare facilities. There are significant structural constraints at the St Helier site in particular, which mean that the Trust can only make basic repairs. This maintenance is also a significant ongoing cost to the Trust.

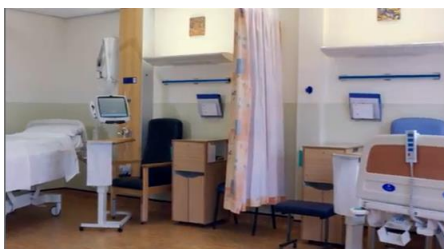
43. Approximately 55% of the Trust estate – and 90% of St Helier Hospital – was built before the NHS was established in 1948, limiting the Trust's ability to deliver its aims for clinical care. A significant part of the estate is not functionally suitable for modern healthcare delivery. The design of the buildings means infections are difficult to control and beds are too close together. The design also drives unavoidable inefficient practice – for example, it is difficult to co-locate services together when required, which can mean that patients often have to be transferred distances, sometimes outside, from one department to another. The inflexibility of the building design makes it difficult for the Trust to reconfigure services to support closer working with community and primary care.
44. Figure 7 illustrates some of the current insufficient bed spacing at St Helier, compared to the improved bed spacing at the purpose-built SWLEOC site at Epsom Hospital, which opened in 2004.

Figure 7: Bed spacing at St Helier Hospital compared to a SWLEOC ward

Insufficient bed spacing at St Helier Hospital



Improved bed spacing at purpose-built SWLEOC



Source: <https://epsom-sthelier.nhs.uk/epsom-and-st-helier-2020-2030>

45. To address some of these challenges, the Trust plans to invest c. £91m in its estate over the next three years. This is described in the Trust's Estate Strategy 2015–2020 and will go some way to resolving the issues the Trust has with its estate, including:
- **Addressing critical maintenance issues:** In particular, addressing the issues at St Helier raised by the Care Quality Commission. This includes new boilers and plant for the heating and hot water systems and investment to ensure compliance with asbestos, fire and water regulations. At Epsom, this includes investment in Wells Wing and other infrastructure.
 - **Supporting changes in clinical services to meet standards and patient demand:** At St Helier, this includes a new critical care unit, a new renal dialysis unit, a second computerised tomography (CT) scanner, a new adult audiology unit, co-location of outpatients and re-configuration of wards to improve patient flow. At Epsom, this includes a sixth theatre for SWLEOC, provision of community beds

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and day units (in partnership with Epsom Health and Care), and co-location of outpatients.

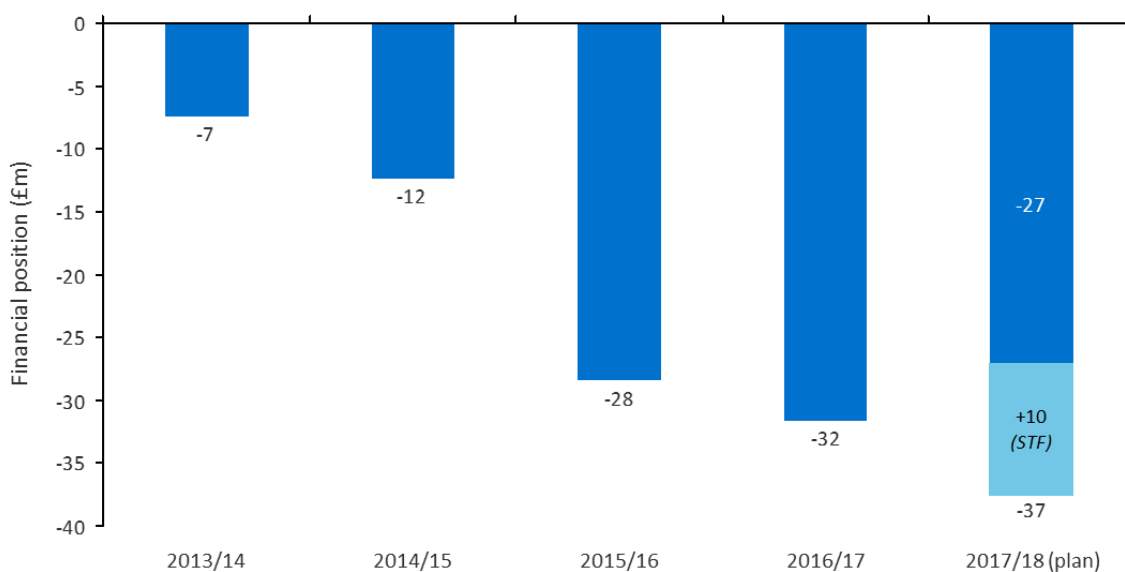
- **Addressing other estates issues at St Helier and Epsom:** Including replacing the endoscopy reprocessing facility at St Helier, moving the sterilisation and decontamination unit service at Epsom off site, and addressing underutilised buildings and the space vacated by Surrey and Borders Partnership NHS Foundation Trust at Epsom.
 - **Rationalising the estate:** Including moving corporate services off site, moving services at St Helier and Epsom hospital from peripheral buildings into other parts of the hospitals, and providing deck car parks at both Epsom and St Helier hospitals. Surplus land at St Helier, Epsom and Sutton will be disposed of.
46. However, this investment does not address all the issues the Trust faces. It does not significantly reconfigure the estate to allow for new ways of working and delivering care in line with the local and national clinical strategies.
47. This means the Trust needs to consider how it can invest in its estate over the next 10 years to achieve its aims and support clinical care delivery.

3.3. Finance challenges

Current financial position

48. With the agreement and support of NHS Improvement and its commissioners, the Trust is currently spending c. £37 million more annually than it receives in funding. This position has been progressively deteriorating over time since 2013-14. This is shown in Figure 8 around the Trust's historical financial performance, where the financial position has worsened from a c. £7m deficit in 2013-14 to a c. £37m planned deficit for 2017-18.
49. Contributory factors to this financial challenge include:
- Increasing investments in its clinical workforce
 - The cost of maintaining its estate
 - Reduced opportunities for efficiencies to be made within existing operating and clinical models
 - Lower overall funding made available.

Figure 8: Trust historical financial performance⁸



Source: Trust analysis

50. The financial challenge should be seen in the context of the overall funding challenges in South West London and the wider NHS.⁹

⁸ Sustainability funding (STF) refers to the additional planned funding made available by NHS England to support the suitability of providers. The £27m deficit which is the starting point for this analysis includes this planned funding amount for 2017/18, and it is assumed that this funding is recurrent. This approach is in line with other recent business cases, for example: <http://www.wnecumbria.nhs.uk/wp-content/uploads/2016/09/Financial-analysis-addendum-Jul-2016.pdf>. All financial estimates in this section are in nominal terms.

⁹ See, for example: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

Future financial challenges

51. By 2025-26, in order to meet expected increases in demand and cost pressures, the Trust may need an estimated c. £40 million of additional annual funding above that which is likely to be available (based on current services). This forecast has been developed based on a set of assumptions which have been agreed with commissioners and regulators.
52. In particular, average increases in funding are outstripped by demand growth, cost inflation and local cost pressures, the cost of meeting clinical standards while delivering care to its sickest patients across two acute sites, and the high cost of maintaining the existing estate.
53. The financial challenge also includes significant efficiency programmes and demand management plans (e.g. reducing average length of stay safely and avoiding unnecessary admissions). These schemes reflect 'business as usual' improvements which can be delivered within the current clinical and operational models; without these the financial challenge would be much greater.
54. Figure 9 summarises the financial challenge from 2017-18 to 2025-26.¹⁰ It shows:
 - **Activity growth and demand management:** The additional income from treating more patients, after accounting for demand management plans, which involve working with commissioners to ensure that patients receive the right care in the right setting.
 - **Cost pressures and cost inflation:** The growth in costs related to key areas such as pay increases as well as drugs and equipment, based on national assumptions.¹¹
 - **Efficiencies:** The savings that the Trust plans to achieve through improving productivity, similar to other hospitals across the country, including plans such as replacing as much agency usage as possible with substantive workforce. These 'business as usual' efficiencies are significant: the c. £73 million savings over the eight year period reflects almost 20% of the Trust's current income, or c. 2.3% per year. These efficiency assumptions have been agreed with regulators and were developed based on benchmarking (i.e. comparing the Trust's costs with other similar Trusts), in line with best practice methods.¹²
 - **Other costs:** The cost of borrowing money from the government to finance key investments such as medical equipment and improving the estate.

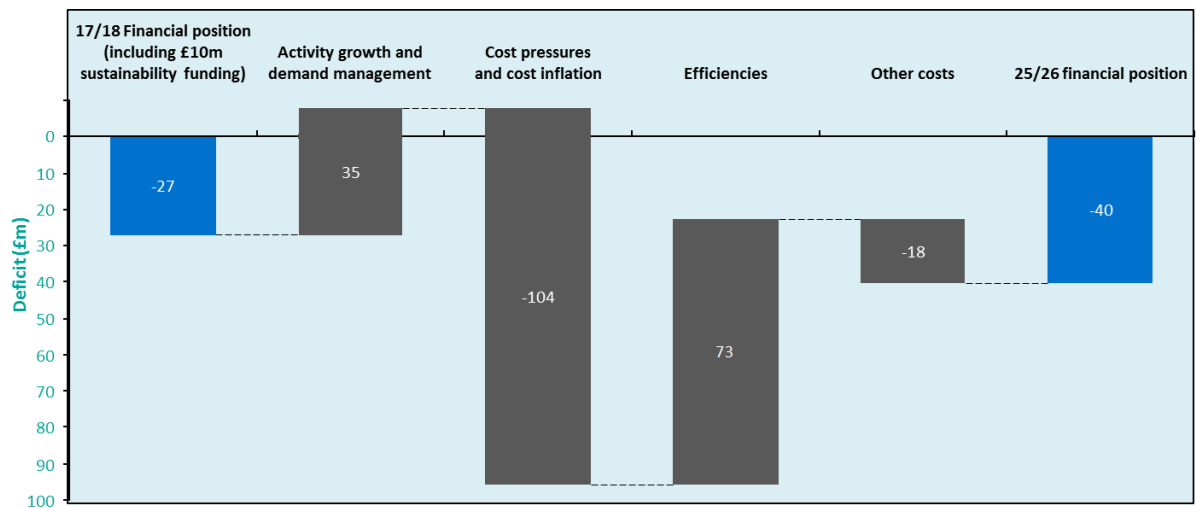
¹⁰ Further detailed work will be required to refine these estimates including developing the year on year profile of the financial position.

¹¹ See the national tariff: <https://improvement.nhs.uk/resources/national-tariff-1719/>.

¹² The NHS National Tariff – which specifies the methodology and prices to be paid to providers for a series of agreed services – includes an expectation for improved efficiency on the part of providers of 2% per year, which is a further point of triangulation around the c. 2.3% per year assumption included.

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Figure 9: Trust 2025-26 position (£m)



Source: Trust analysis

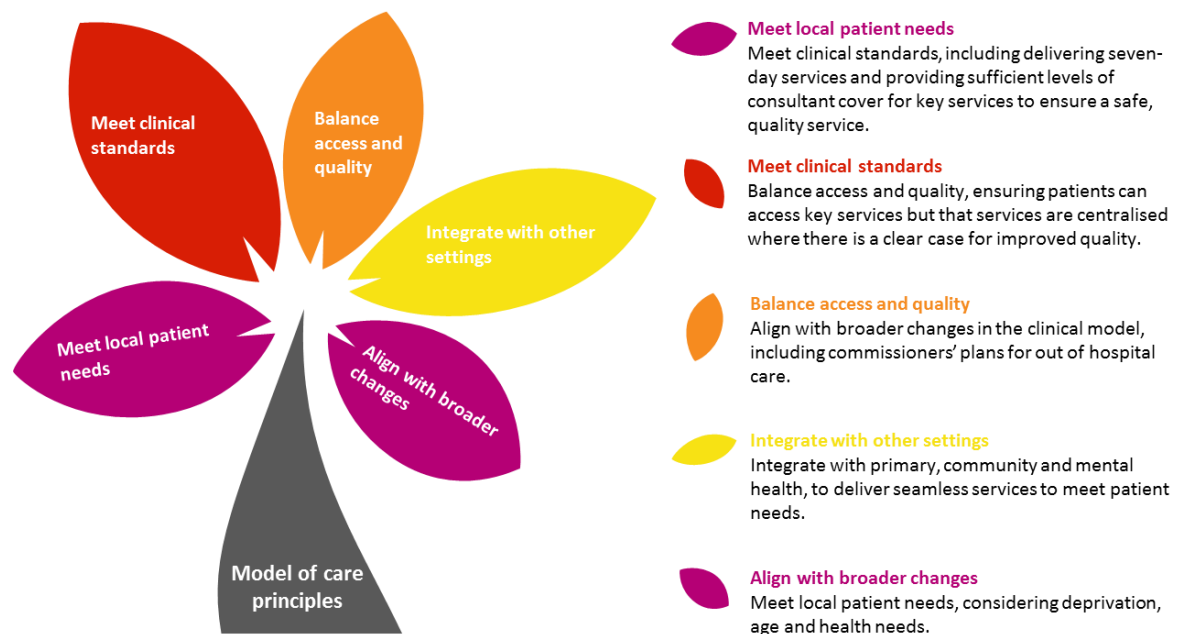
3.4. Need for a new clinical model

55. Based on this analysis, continuing with the current configuration of providing care to the sickest patients across two acute sites will mean the Trust will be increasingly unable to meet clinical standards, working from buildings that are unfit and financially unsustainable. In particular, it is clear that maintaining the current two acute site configuration will not enable the Trust to address these fundamental issues.
56. Addressing these issues requires the Trust to consider both how it can deliver care differently in the future and the different ways it can organise itself to deliver this.
57. The Trust has described below a clinical model to achieve its aims for clinical care and then a series of scenarios describing how it can organise itself to deliver this.

4. The future of healthcare – the clinical model

58. A process has been undertaken to design a new clinical model to address the challenges the Trust faces and meet clinical standards. This process has included significant engagement from a variety of stakeholders including Trust clinicians, commissioners, other providers and local GPs. The clinical model has also been informed by the public.
59. In 2016, the Trust engaged the public on the model of care for the future. The feedback was clear that people wanted as much care as possible to be delivered closer to home, but people also recognised that there is a case for consolidation where the quality of care will be improved. This is aligned with feedback from the most recent public engagement in 2017 (described in detail in Section 6); the public has been broadly supportive of the new clinical model as a means for the Trust to achieve its aims for the next 10 years.
60. The clinical model has been developed based on achieving local and national clinical strategies for improved care delivery and patient outcomes. This aims to meet the needs of the local population, deliver commissioners' requirements and improve the quality of care provided.
61. The Trust is clear that any future clinical model must, at a minimum, align to the principles included in Figure 10.

Figure 10: Principles of the new model of care



Source: Trust analysis

62. The clinical model follows these key principles, with a combination of local services (delivered from specific sites in all scenarios) and centralised services (delivered from

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one of three sites under different scenarios). The proposed model therefore has two main features:

- **Keeping services local:** That is, meeting the needs of local populations and delivering care closer to home by working more closely with community and primary care to deliver consistent and joined-up services to the Epsom, Sutton and Merton communities.
 - **Improving care for the sickest and most at-risk patients:** That is, consolidating acute services onto a single site for the sickest patients and those most at risk of becoming acutely unwell; for these patients, there is a clear quality argument for consolidation.
63. This clinical model aligns closely with local plans (including the plans of Surrey Downs, Sutton and Merton clinical commissioning groups and the South West London and Surrey Heartlands sustainability and transformation partnerships) for the development of acute and out of hospital care, including increasing the delivery of out of hospital, elderly care and rehabilitation care.
64. This also builds on the Trust's work with both Epsom Health and Care – which has significantly increased the amount of care provided in people's homes and will be expanded to Sutton from April 2018 – and Sutton Homes of Care.

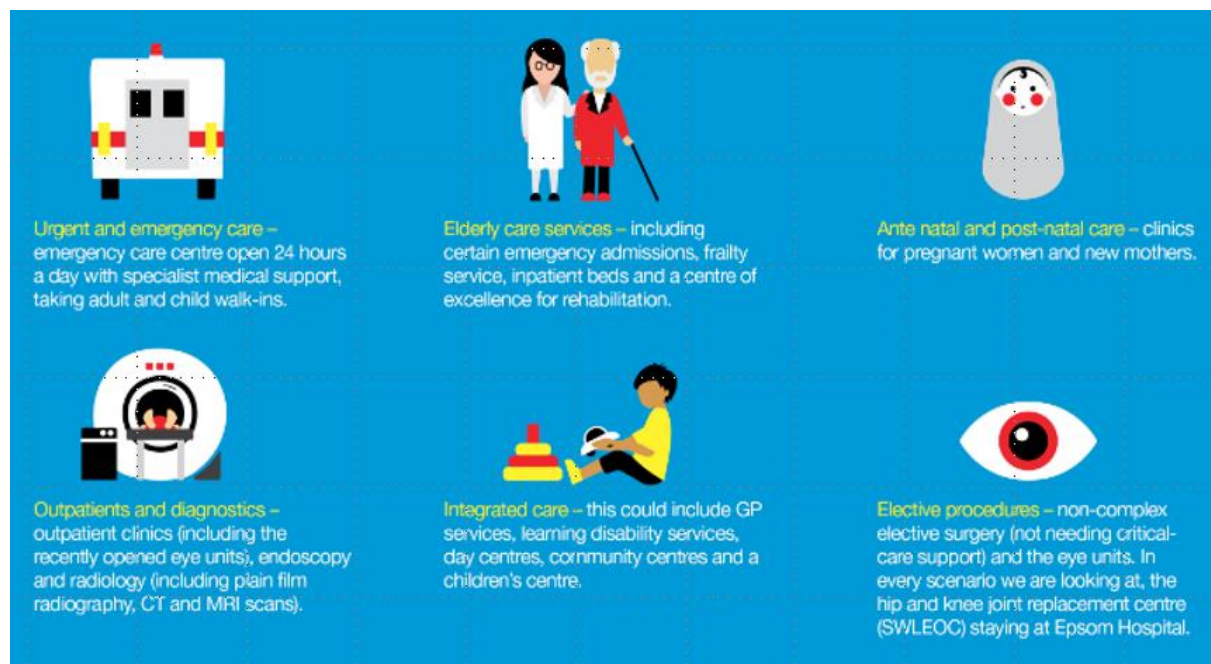
4.1. Keeping services local

65. To meet the needs of local populations, the clinical model proposes that at least c. 85% of patients will continue to be treated locally at Epsom and St Helier hospitals in any scenario. These include:
- **Urgent and emergency care:** For the c. 100,000 people presenting with urgent treatment needs there would be generalist-run (either by a GP or a generalist doctor), 24/7 urgent treatment centre(s) with specialist medical support as required.
 - **Outpatients and diagnostics:** Patients would receive outpatient services, screening endoscopy and radiology.
 - **Elderly care and rehabilitation beds:** Elderly care, community and rehabilitation beds (including a Centre of Excellence for Rehabilitation) would be available for those patients that require lower acuity support.
 - **Integrated care:** Multi-functional spaces would be available for community-facing services, including primary care, social services and community services. For example, this could include learning disability services, a day centre, community centre and/or a children's centre.
 - **Antenatal and postnatal care:** Ante and post-natal clinics for pregnant women and new mothers.

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- **Elective procedures:** Non-complex elective surgery and the eye unit.
- **South West London Elective Orthopaedic Centre:** Epsom Hospital would continue to host SWLEOC.
- **Renal dialysis:** This specialist service, commissioned by NHS England, would continue at St Helier Hospital.

Figure 11: Services to be delivered locally



Source: <https://epsom-sthelier.nhs.uk/>

4.2. Improving care for the sickest and most at-risk patients

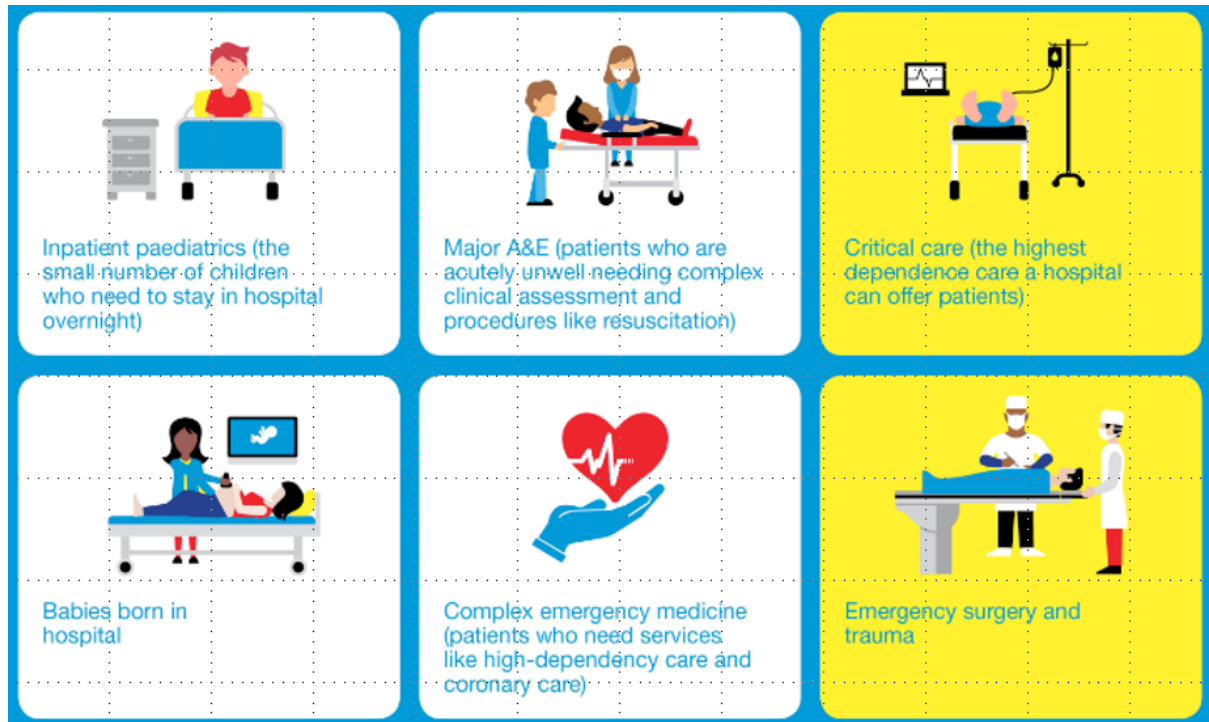
66. The clinical model then proposes that care for the c. 15% of patients who are either acutely unwell or are at risk of becoming acutely unwell are treated at a single location.
67. There are six services in this category, of which two (critical care and emergency surgery and trauma) are already consolidated at St Helier (these services have specific clinical challenges associated as described in Section 3).¹³ The six services are summarised in Figure 12 and would include:
- **Inpatient paediatrics** (inpatient and specialist): Including paediatric A&E.
 - **Major A&E:** The 24/7 emergency department taking major cases.
 - **Births:** For maternity services, the Trust aims to provide at least two resident doctors onsite at all times.
 - **Complex emergency medicine:** Medical care for the sickest medical patients (e.g., those needing high dependency care and coronary care).

¹³ These services align with the published evidence for the benefit of consolidating the most acute services (King's Fund (2014) *The Reconfiguration of Clinical Services: What is the evidence?*, <http://www.kingsfund.org.uk/publications/reconfiguration-clinical-services>).

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- **Critical care:** The critical care unit currently consolidated at St Helier (currently 13 beds, with an additional two planned).
- **Emergency surgery and trauma:** Services currently consolidated at St Helier, a change which has resulted in improved quality for patients.

Figure 12: Services delivered from a consolidated site (yellow indicates services already consolidated)



Source: Trust analysis

68. Consolidating these services is expected to improve the quality of care provided and meet relevant quality standards without the need for additional consultant recruitment. This will also enable the Trust to reduce its reliance on agency staff, and ease other potential recruitment challenges for other local NHS organisations – see Section 7.

4.3. Alignment of the model with clinical commissioning group plans and local sustainability and transformation partnerships

69. The clinical model has been developed in partnership with local commissioners (Surrey Downs, Sutton and Merton clinical commissioning groups) and sustainability and transformation partnerships (South West London and Surrey Heartlands). It aligns directly with commissioners' plans for care in South West London and in Surrey.
70. For example, the design of the elderly care and rehabilitation bed model aligns with Merton Clinical Commissioning Group's plans for intermediate care, including the cohort of patients and leadership (i.e., generalist-led care). Merton has identified a growing demand for intermediate care, which the Trust's plans for elderly care and rehabilitation services will help to address. There is also a clear link with their 'One

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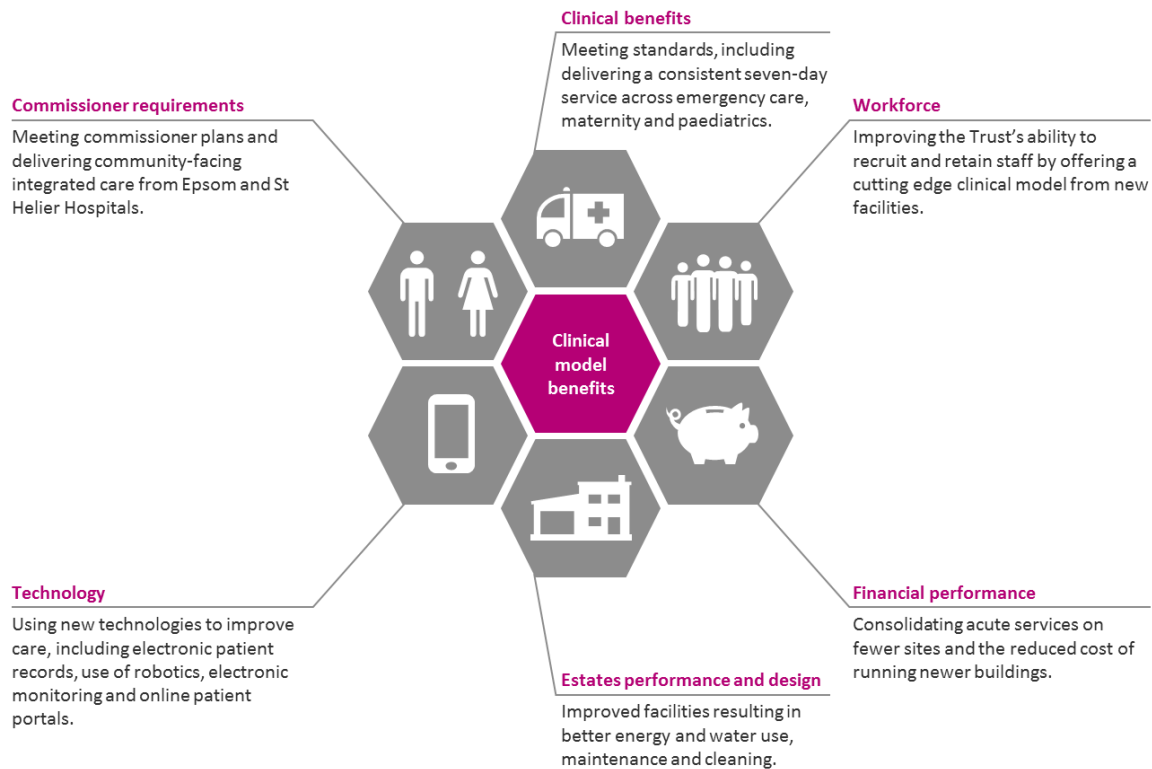
Public Estate' strategy, which is in development but will be supported by the Trust's plans for local care.

71. The Trust's plans for local care also align closely with the Sutton Health and Care model and the Epsom Health and Care model, which the Trust has been involved with from its inception.
72. The South West London sustainability and transformation partnership has a clear aim to move care closer to home. It emphasises increased support at home for those in need and a shift to more out of hospital care where possible. The delivery of local services, integrated into community and primary care, means that the Trust can support this change in emphasis. Moreover, the delivery of elderly care and rehabilitation and urgent treatment services locally reduces the dependence on acute care.
73. Assumptions used in the scenario analysis have been aligned with sustainability and transformation partnership assumptions where relevant.

5. Benefits of the new clinical model

74. This clinical model is expected to deliver significant benefits to patients and the Trust. The benefits of the new clinical model are summarised in Figure 13.

Figure 13: Benefits of the new model of care



Source: Trust analysis

Clinical benefits

75. Changing the model of care enables a range of clinical improvements, including:
- Delivering **more consistent care** seven days a week
 - Providing **greater consultant presence on site** for key specialties, improving the quality of care provided
 - **Improving the patient pathway** during patients' time in hospital
 - **Integrating care** with other local providers, including community services and GPs to offer a seamless experience for patients
 - Ensuring **patients receive care appropriate to their level of need** (including offering different types of bed for patients with lower acuity needs).

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Workforce

- 76. By increasing the consultant coverage in hospital, the Trust can maximise its existing workforce and reduce dependence on bank and agency staff.
- 77. In addition, the Trust can use different combinations of staff (for example, with consultants supervising more midgrade doctors and nurse practitioners) to provide better quality care and enable the Trust to be less reliant on scarce middle grade and junior doctors.
- 78. Finally, changing the clinical model will provide enhanced opportunities for training across different settings of care.

Financial performance

- 79. Consolidating services offers financial benefits, as the new model of care would be significantly more efficient than delivering care to the Trust's sickest patients across to acute sites.
- 80. This is detailed in Section 8.2, including estimates of the financial benefits of changing the clinical model.

Estates performance and design

- 81. New facilities offer direct benefits – by being more efficient and easier to maintain and clean, and ensuring a much reduced risk of hospital-acquired infection such as meticillin-resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile* (C. Diff) – as well as offering a better environment for healing.
- 82. These design benefits include more single rooms; flexibility in room design to meet patient needs; quieter, lighter and airier rooms and wards; improved visibility for nurses; and improved hand-washing facilities.

Use of technology

- 83. A new model creates the opportunity to use cutting edge technology to support care, including electronic patient records (that can be shared across different providers), use of robotics, electronic monitoring in wards and critical care, and an online patient portal to ensure patients are involved in their care.

Meeting commissioner's requirements

- 84. Delivering more care closer to home, including integrating care with other providers, supports local commissioners' plans to change the way care is delivered in the area.

6. Engagement on the Trust's clinical model and scenarios

6.1. Engagement with the public

85. Over the 13 weeks from 10 July to 6 October, the Trust engaged extensively with the local communities, including producing a detailed engagement document, a smaller leaflet, a ten-minute video and a four page advertorial in the local newspapers.
86. The outcomes of this engagement are described in the Trust's public engagement report (available on the Trust's website),¹⁴ and are summarised in this section.

The Consultation Institute

87. The Trust commissioned The Consultation Institute to review and advise on the feedback received as part of the engagement process, and the engagement report was drafted by the Trust based on this support. In addition, the report also makes reference to questionnaires and petitions which were independently circulated. These represent a campaign response and have been included to ensure that all opinions and views are recorded in this phase.
88. Feedback from The Consultation Institute confirmed that the Trust's engagement work has met the institute's criteria for best practice pre-consultation and suggested that future work should further explore the key themes emerging from engagement (see Section 6.6).

"tCI is happy to confirm that your pre-engagement work so far – leading to your Pre-engagement Report – has met tCI's criteria for best-practice pre-consultation"

The Consultation Institute (tCI)

¹⁴ www.epsom-sthelier.nhs.uk

6.2. Reach of engagement

89. The Trust has reached over 25,000 people, via a variety of methods, including:
- 31 internal drop in sessions meeting with over 2,500 staff;
 - 47 local meetings and events attracting over 2,000 people;
 - 11,977 people visiting the Trust's 2020–2030 webpage since the launch;
 - 6,310 people viewing the Trust's video;
 - 441 people pledging their support;
 - More than 270 senior clinical staff signing a letter of support;
 - More than 8,000 people engaging through Healthwatch Surrey; and
 - Distributing circa 50,000 leaflets.

6.3. Pledges of support

90. Using cards and the online form, 441 people have pledged their support for the case to be made for an investment of between £300 million and £400 million, keeping services local and developing a new specialist acute facility.

6.4. Individual responses

91. Of the 1,059 people to date completing the questionnaire, the following responses were given to each of the questions:

Do you agree with our aim to provide as much care as possible from our existing hospital sites at St Helier and Epsom and do this by working more closely with the other local health and care providers?

- 941 people answered yes (89%);
- 19 people answered no (2%);
- 16 people said that they either did not know or needed more information (2%);
- 2 people stated that they wanted no change (<1%);
- 34 people answered N/A (3%);
- 40 people made general comments (4%); and
- 7 people said that they wanted just one hospital site (1%).

Do you think we have made the case that we will improve patient care by bringing together our services for our sickest or most at-risk patients on a new specialist acute facility on one site?

- 803 people answered yes (76%) with an additional 42 saying yes, as long as the site is at a specific site (4%), bringing the total in support to 79.8%

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- 73 people answered no (7%);
- 63 people said they did not know or need more information (6%);
- 9 people said that they wanted both sites to stay as they are (1%);
- 44 people said N/A (4%);
- 24 people left general comments (2%); and
- 1 person wanted one hospital site (<1%).

Do you think we should consider any other scenarios?

- 149 people responded yes (14%) and of these 50 people gave proposed scenarios (5%);
- 446 people responded no (42%);
- 88 people said that they preferred one of the scenarios we had presented (8%);
- 71 people said they didn't know or needed more information (7%);
- 189 people responded N/A (18%);
- 8 people responded that they wanted no change or the status quo (1%);
- 4 people said that they thought we should have a single site (<1%); and
- 104 people left general comments which did not relate to the question (10%).

92. Of the 50 people who made suggestions for alternative scenarios, these have been grouped in to six main themes:

- Build a new super hospital
- Close one or both hospitals
- Acute facilities on both or all three sites
- Separate Epsom and St Helier or merge with another trust
- Rebuild St Helier Hospital
- Change services or location.

93. 88 respondents replied to say they preferred one of the scenarios presented by the Trust. These break down as:

- 3 people preferred either Epsom or St Helier primary (3%);
- 1 person preferred Epsom or Sutton primary (1%);
- 2 people preferred either St Helier or Sutton primary (2%);
- 15 people preferred Epsom primary (17%);

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- 13 people preferred St Helier primary (15%);
 - 42 people preferred Sutton primary (48%); and
 - 12 people preferred Sutton primary specifically mentioning The Royal Marsden (14%).
94. Responses were also received to questions asking how individuals would like to be engaged with in the future, as well as other comments. These are detailed fully in the Trust's engagement report, available on its website (www.epsom-sthelier.nhs.uk).

6.5. Responses from stakeholders and groups

95. The Trust received formal responses from a range of key stakeholders, which are categorised below.
96. Many stakeholders, as expected, commented on the site that they thought would be best for the specialist acute facility and there was a diverse range of views. Some people explained why they had chosen a specific site ranging from accessibility, needs of deprived communities and the benefits for cancer patients, which helps to inform further potential work.

Stakeholder responses broadly in favour of the clinical model and/or scenarios

97. Stakeholder responses broadly in favour included:
- **Trust staff:** A large number of senior clinicians (all 36 senior nurses and over 240 consultants) within the Trust signed a public letter, which supports the hospitals remaining as one Trust and the development of a new acute facility for the acutely unwell and most at-risk located on one of the Trust sites. Key consultants also produced public statements, including the Clinical Director of Gynaecology and Head of the Haematology Department. A wider letter of support from all staff was also signed by 189 members of the team.
 - **Trade unions** and Staffside partnership representatives have stated: *"support of the proposals that Epsom and St Helier stay together as one Trust...A new purpose built building would go a long way to meeting the training and development needs of staff whilst providing state of the art care to our ageing population and increasing patient numbers. It would mean that more money could be diverted from crumbling building repairs to frontline patient services."*
 - **Surrey Heartlands Health and Care Partnership Transformation Board (STP).**
 - **Local authorities:** Including London Borough of Sutton, Reigate and Banstead Borough Council, Mole Valley and Epsom and Ewell Borough Council.
 - **Residents' associations:** 15 local residents' associations have written in with their broad support for the clinical model and investment locally, including a joint letter from the Chair of the Standing Committee of Residents' Associations; the chairs of

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Ewell Village, Epsom Town, Ewell Downs, Nonsuch, Stamford Ward, College Ward, Ashtead, and West Ewell and Ruxley Residents' Associations.

- **The Royal Marsden Hospital NHS Foundation Trust:** The Royal Marsden *"welcomes the opportunity to work with Epsom and St Helier Hospitals on the development of modern healthcare facilities on the Sutton site."*
- **South West London acute hospital trusts:** Kingston Hospital NHS Foundation Trust, Croydon Health Services NHS Trust and St George's University Hospitals NHS Foundation Trust have written to the Trust with their broad support for improvements in the infrastructure and environment for acute services across South West London.
- **Friends of Epsom and West Park Hospitals:** In favour of keeping services locally specifically at Epsom, but: "A new build hospital on the combined site of Sutton and The Royal Marsden Hospital would have some benefit, which we recognise... however, it is on the edge of the catchment area, which would make it less attractive to those living on the western side... the buildings are of poor quality."
- **Local members of parliament:** The following members of parliament have written with their broad support for a specialist acute facility on one of the three sites (however, they have different views on which of the sites this should be built):
 - Sir Paul Beresford MP for Mole Valley
 - Crispin Blunt MP for Reigate
 - Tom Brake MP for Carshalton and Wallington
 - Stephen Hammond MP for Wimbledon, Raynes Park, Morden and Motspur Park
 - Paul Scully MP for Sutton and Cheam.

"The Board believes that there is a case to consolidate the Acute services the Trust provides but when these are worked up in detail they must fully consider the impact on the other Acute hospitals within our STP so that we do not inadvertently compromise any other hospitals' clinical viability."

Surrey Heartlands Health and Care Partnership Transformation Board (STP)

"The Council generally agrees with the aim of retaining as much care as possible at the existing hospital sites. However, this should be seen in the context of our overall policy objective of keeping people as healthy as possible within the community... The Council accepts that there is a strong clinical link and financial case for the concentration of services for those people who are most ill."

London Borough of Sutton Scrutiny Committee

"Epsom and Ewell Borough Council fully supports the need for a new specialist acute facility within the Trust's area which brings together services for our most sick and most

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at-risk patients, as we believe this will secure the future of the Trust and its two main sites...

Epsom and Ewell Borough Council

"The populations of Epsom and Ewell are growing and ageing. At some times we may need treatment in specialist hospitals further away but we can reasonably expect 95% of our health needs to be met properly, locally and in 21st century facilities. Although there are advances in tele-medicine and care at home, child birth and second tier rehabilitation treatment should also be accessible to us, to visits from our relatives and local to our home communities... Whether we live on the borders of Sutton, Kingston, Ashted or Banstead, residents of Epsom and Ewell want to live no further than 30 minutes away from an ambulance reaching us and getting us to appropriate emergency treatment."

Joint letter from residents' associations

"We fully support the need to improve the infrastructure and environment for acute services across South West London and note the particular challenges at St Helier. Given the need for major capital investment across the South West London acute sites, it is important that within the options appraisal for acute services across Epsom and St Helier, there is careful consideration to the services that should be provided alongside the six core acute services, so that we have vibrant, sustainable acute hospitals at Kingston and Croydon and a regional centre of excellence at St George's to go alongside the acute solution for Epsom and St Helier."

Joint response from Kingston Hospital, Croydon Health Services and St George's University Hospitals CEOs and Chairs

"Having met with the Chief Executive and Senior Managers from Epsom and St Helier today, I am convinced that it is essential to have a new acute care facility, otherwise the hospital service provided to my constituents north of Reigate and Redhill faces inevitable long term decline. The current facilities are out of date and the recruitment of doctors and nurses is increasingly challenging. It is absolutely essential that as many residents as possible respond to the consultation. The public need to show their support for the proposal to add weight to the argument for new, improved, life-saving, acute care facilities in order to prevent this unique opportunity from being lost."

Crispin Blunt MP (Reigate)

"I am pleased to see that the Epsom and St Helier is putting together a case to secure up to £400m of investment to replace out of date buildings with modern purpose built facilities."

Tom Brake MP (Carshalton and Wallington)

"This is a conversation initiated by the Epsom and St Helier... and is supported by local senior clinicians. I welcome the Chief Exec's decision to listen to local people about his plans to seek more investment and I am glad that it is absolutely clear that St Helier hospital is safe."

Stephen Hammond MP (Wimbledon, Raynes Park, Morden and Motspur Park)

"Securing the long-term future of healthcare in Sutton has always been my top priority... I am pleased that Epsom and St Helier are seeking opinions from Sutton residents...making

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it clear that St Helier hospital will stay open... For the first time in years we have a proposal from the NHS which doesn't risk Sutton residents having to travel to St. George's for A&E and maternity, instead protecting them in the area already covered by the Trust."

Paul Scully MP (Sutton and Cheam)

Neutral stakeholder responses

98. One neutral stakeholder response was received from Surrey County Council.

"Surrey County Council supports Epsom and St Helier University Hospital NHS Trust's need to engage with Surrey residents on the quality and sustainability of their local health services..."

"Surrey County Council recognises the case for change to provide as much care as locally possible and supports the case for improving hospital services."

"Surrey County Council supports the Trust and commissioners taking the next step in working up in more detail how best to meet the needs of local residents."

Surrey County Council

Stakeholder responses not in favour of the clinical model and/or scenarios

99. Stakeholder responses not in favour included:

- **Carshalton and Wallington Labour:** In particular, the group opposed centralisation of acute services.
- **London Borough of Merton:** The council raised particular concerns about deprivation. This opposition included the Council Leader encouraging people to sign up to a campaign to build a new hospital at St Helier.
- **Merton councillors:** The following Merton councillors wrote to the Trust strongly supporting services remaining at St Helier:
 - Cllr Agatha Akyigyina;
 - Cllr Mark Allison;
 - Cllr Stan Anderson;
 - Cllr Laxmi Attawar;
 - Cllr Caroline Cooper;
 - Cllr Pauline Cowper;
 - Cllr Nick Draper;
 - Cllr Ross Garrod;

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- Cllr Joan Henry;
- Cllr Sally Kenny;
- Cllr Philip Jones;
- Cllr Dennis Pearce;
- Cllr Geraldine Stanford;
- Cllr Martin Whelton; and
- Dr Rosena Allin-Khan MP (Labour Member of Parliament for Tooting), although we do not serve her constituency.
- **Siobhain McDonagh MP**, (Labour MP for Mitcham and Morden).

Stakeholders who do not think that this is the appropriate time to be undertaking this work

100. We received one letter to this effect, from Chris Grayling MP (Conservative MP for Epsom and Ewell).

Petitions

101. A number of local campaigns mobilised the public in opposition through a range of means, including a petition, with responses from:

- 1,573 people who stated they would like both *“the new hospital built at St Helier instead of Belmont or Epsom”* and are *“against the closure of any services at St Helier Hospital, including the closure of the consultant-led maternity unit and the A&E”*;
- 134 people who *“want the new hospital built at St Helier instead of Belmont or Epsom”* only; and
- 130 people who are *“against the closure of any services at St Helier Hospital, including the closure of the consultant-led maternity unit and the A&E”* only.

15 petitions from local groups (signed by 2,855 people) were received from local churches, community centres, mosques, campaign groups and political parties. The Trust also received seven petitions from Morden primary schools (signed by 55 people). These were focused on keeping services open at St Helier Hospital.

“The Council is committed to ensuring that the residents of Merton have access to a full range of NHS acute services on the St Helier Hospital site. Any attempt to relocate acute services away from an area of relative deprivation in favour of an affluent one would be plainly incompatible with the duty on the CCG under section 145T of the NHS Act to have regard to the need to tackle health inequalities.”

London Borough of Merton

“I understand that St. Helier Hospital is at risk of losing all acute services, including major

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accident and emergency as well as consultant led maternity services. As the Member of Parliament for Tooting, I am extremely concerned about the impact this closure would have on St. George's Hospital."

Dr Rosena Allin-Khan MP (Tooting)

"The CEO of Epsom and St Helier has today launched a public discussion about the two hospitals arguing that emergency and high end services like maternity need to be merged into a new building on one site... a debate we have had many times before. I do not believe it is helpful to have that debate again now."

Chris Grayling MP (Epsom and Ewell)

In a letter responding to Epsom and St Helier 2020-2030 the MP stated: "As I understand it, St Helier Hospital is at risk of losing all acute services including major accident and emergency as well as consultant led maternity services in two-thirds of your proposals. I am wholly against an engagement process that could leave St Helier Hospital's acute services at threat. I have undertaken a detailed analysis of a 1 mile radius surrounding each of the three proposed sites for the hospital catchment area's acute services (Rose Hill, Epsom and Belmont). The statistics are shockingly definitive in that the site requiring any investment is Rose Hill and that, most importantly, St Helier Hospital simply cannot afford to lose its acute services or put them at risk."

Siobhain McDonagh MP (Mitcham and Morden)

6.6. Key messages

102. Local people remain very passionate about their hospitals and a large number took time to share their views and ask questions.
103. Overall, the Trust believes that the public engagement has been supportive of the new clinical model based on the engagement undertaken to date and further consideration of how the Trust can achieve its aims for the next 10 years.
104. The majority of people who responded to the engagement (either via meetings or individual responses to the questions the Trust asked) agreed with the Trust's aim to provide as much care as possible locally by working with other local health and care providers from its existing hospital sites at St Helier and Epsom. The majority also agreed that patient care would be improved by bringing together services for the sickest or most at-risk patients in a new specialist acute facility on one site.
105. Though it was not the purpose or focus of the engagement, there were many views given on which site the single site acute facility should be located. The majority of those people who gave their views on the future of one of the hospitals without reference to the Trust's questions or Trust's materials focused on saving services and rebuilding St Helier Hospital or building the acute facility at St Helier Hospital.
106. Key themes that were raised throughout the engagement included:
 - **access**, travel times and the impact for patients, relatives and visitors

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- **deprivation**, healthcare needs and the location of acute hospitals
 - the need to understand **which services will be in the specialist acute site and what will be kept local**, and the evidence of why this change will improve outcomes for patients
 - concern over what will happen to the sites where the acute facility is not located in the **long term**
 - the need for assurance that this is for **NHS patients** not private patients
 - the impact of scenarios on **other hospitals**
 - **where the investment is going to come from** and how much it will cost to borrow the money
 - clarification around the **process** and next steps, including when decisions will be made
 - the **timescale to get permission to build a new facility** and what will happen to the sites and services in the short term.
107. The Trust believes these are key themes that will need to be addressed in any further development of this work.

7. Initial consideration of scenario viability

- 108. Analysis of scenarios has included an initial view of viability and further financial analysis of scenarios that appear to have greater potential.
- 109. This has been informed by the feedback from the public captured in Section 6.
- 110. The aim of this preliminary analysis has been to understand the broad scenarios that could be explored further in the future. No conclusions have been made about any preferred scenario; this requires further work at later stages.
- 111. This initial analysis is described further below. This finding also aligns with the feedback received during the Trust's engagement processes (see Section 6).

7.1. Do nothing scenario

- 112. This basic scenario requires an essential capital investment of c. £62 million in critical backlog maintenance (such as important building repairs, refurbishment and other vital maintenance work) on both sites.
- 113. This is the minimum level of investment likely to be required to avoid closure in the short term, but it does not address the medium and longer term functional and technical suitability of Trust buildings, and will result in a Trust that is not physically suitable to deliver twenty-first century healthcare.
- 114. As a result, the Trust would not be able to maintain itself at the level expected by regulators, which creates the risk of regulatory interventions by the Care Quality Commission or NHS Improvement and potential closures of key buildings at short notice (as some nearby trusts have experienced).
- 115. Given this risk, it is assumed that in reality, this do nothing scenario would mean that the Trust would not exist in its present form in ten years' time – it would be physically impossible to provide healthcare from the buildings due to the inability to meet basic Care Quality Commission, Health and Safety, NHS England and NHS Improvement standards. This scenario is therefore not considered further.

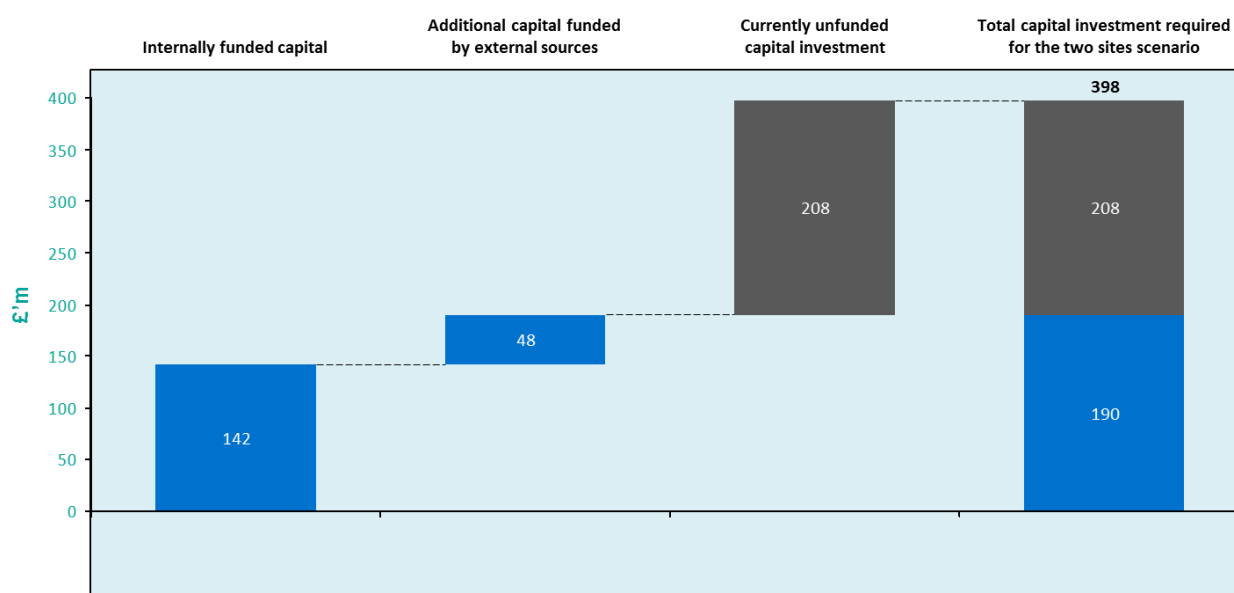
7.2. Continuing with two acute sites

116. A more significant investment in the two sites than in the do-nothing above could improve the estate at both Epsom and St Helier Hospitals. While this improves the estate in terms of helping the Trust to deliver great healthcare within its current configuration, and would meet all regulatory requirements and remove the risk of closure on these grounds, it does not address the key issues of clinical, workforce and financial viability described in Section 3. The Trust would be unable to deliver the required clinical model. It also means that the Trust will continue to incur a very significant annual financial loss and an ever-increasing cumulative deficit – the Trust is expected to still have a deficit of c. £40 million by 2025/26, meaning the scenario does not support financial sustainability.
117. However, some further analysis of this scenario has been undertaken in order to provide a point of comparison with other investment scenarios which can deliver the required clinical model.
118. In particular, the Trust estimates that £398 million of capital investment would be needed to address the most pressing estates issues at Epsom and St Helier hospitals. This investment is needed to improve the current estate and meet safety standards. In particular, it aims to address issues around maintaining the estate raised by the Care Quality Commission, statutory compliance, refurbishment work on the St Helier site, critical infrastructure works, and the purchase of essential equipment and technology. There are a number of large projects which would be required, particularly at St Helier Hospital where significant parts of the current estate would need to be demolished and rebuilt to modern standards, as it is technically impossible to refurbish them to meet current NHS standards. More specifically, this level of investment would result in:
- better bed spacing;
 - single rooms for patients;
 - improved emergency department layout;
 - ensuring that operating theatres are all in one place; and
 - ensuring better access to blood tests, X-rays and other tests for the sickest patients.
119. A lower level of investment than the £398 million would not enable the Trust to improve the functional suitability of its buildings to enable great healthcare for its patients.
120. Of the £398 million, £142 million would be funded through existing Trust cash which has been set aside. An additional £48 million would be funded through external sources, such as borrowing from the government. Funding has not been secured for

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the remaining £208 million (see Figure 14) – this investment is consistent with level of estates challenge the Trust has described over a number of years.¹⁵

Figure 14: Continuing with two acute sites capital investment (£m, 25/26)



121. This level of investment is used as the point of comparison for those scenarios that do deliver the clinical model, in order to capture the relative benefit of changing the way in which the Trust delivers healthcare.

7.3. Three single acute site scenarios

122. The Trust is clear that any scenario considered for the future of the Trust must meet four strategic criteria:

- it must meet the needs of the local population, as described by its commissioners
- it must be clinically viable
- it must ensure that the current and projected workforce supply – particularly medical and nursing – will be able to staff the hospital without anything but unavoidable and infrequent recourse to agency staff
- it must support financial sustainability.

123. The initial analysis included in this strategic outline case suggests that delivering acute services to the sickest patients on a single site would meet these objectives. However, there are several ways it could be delivered, using the three sites in different

¹⁵ In 2009, the local NHS recommended a limited rebuild of the existing hospital site at St Helier only. The Strategic Health Authority agreed that the outline business case – requiring £219m of additional investment – could go to the Department of Health for approval in 2010, but the plan was then put on hold pending a South West London-wide review of acute services. Two South West London reviews, Healthcare for South West London (2009-10) and more recently Better Services, Better Value (2011-13), explored different configurations of acute services (including whether there should be a reduction in the number of accident and emergency departments in South West London) but neither programme was able to address local population health needs. Therefore, the Trust continued to explore its options. In 2016, the Trust included an estimated capital requirement in the South West London sustainability and transformation partnership capital estimates to address its critical estates issues.

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configurations. The Trust has therefore undertaken an initial analysis to develop a set of metrics to support a comparison of scenarios. A full appraisal and evaluation across clinical, quality and financial criteria would be developed at the next stage should this strategic outline case progress, moving to a pre-consultation business case if consultation is required.

124. The development of single acute site scenarios has engaged local clinicians (including Trust clinicians, other provider clinicians, and local GPs) and a Clinical Board (with representation from the Trust and local clinical commissioning groups) to develop and agree viable scenarios. The Trust has also taken account of the feedback from the public engagement process. Important criteria for any new single acute site development would be:

- Local sites delivering a full range of non-acute care close to patients' homes and meeting the needs of the Epsom and Sutton/Merton localities. This requires a community-facing presence to be maintained at the Epsom and St Helier sites in all scenarios, delivering the full range of outpatient, diagnostic, day surgery, rehabilitation and community services. This would account for approximately 85% of all current patient episodes.
- A centralised site delivering a consolidated acute service for all acute requirements including major A&E, maternity, elective and non-elective surgery and inpatient medical services for the sickest patients. This would account for approximately 15% of the Trust's current patient episodes. This facility could be sited at any one of the Epsom, St Helier or Sutton sites – each of these sites has the physical space available to house a new, state of the art acute facility.

125. This results in three single-site scenarios:

- **Epsom as a primary site, with continued use of St Helier:** Epsom as the site delivering consolidated acute services and community-facing services, with community-facing services at St Helier.
- **St Helier as a primary site, with continued use of Epsom:** St Helier as the site delivering consolidated acute services and community-facing services, with community-facing services at Epsom.
- **Sutton as a primary site, with co-location with The Royal Marsden, and continued use of Epsom and St Helier:** Sutton co-located with The Royal Marsden (and with the addition of a RMP Cancer Treatment Centre) as the site delivering consolidated acute services, with community-facing services at St Helier and Epsom.

126. Two further scenarios were considered and dismissed:

Sutton as a primary site, without co-location with The Royal Marsden

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127. Though this scenario offers similar benefits – at a similar capital cost – to co-locating with The Royal Marsden, it appears less viable than co-locating due to:

- **Clinical quality:** Building a new acute hospital near to but not with The Royal Marsden on the Sutton site misses the opportunity to improve clinical care for both hospitals. Therefore, a stand-alone scenario would not deliver the same level of clinical quality as a co-located hospital.
- **Estates:** The available space on the Sutton site to build a standalone acute facility is limited, and co-locating with The Royal Marsden offers more flexible and efficient uses of space that will support local plans for the London Cancer Hub.
- **Financial:** Without co-location, the benefits of consolidating on the Sutton site are reduced as synergies with The Royal Marsden are not achieved (see Section 9.2). This means the stand-alone scenario is less financially beneficial than co-locating. This scenario would also comprise building new facilities which require more capital investment than refurbishing existing buildings, meaning the additional benefits associated with co-locating are important in supporting financial viability.

128. These constraints and the missed opportunity from a standalone development suggest that a standalone acute facility at Sutton without co-locating with The Royal Marsden would be significantly less attractive than a co-location, (but would cost about the same) and therefore should not be considered further.

No acute services scenario

129. No longer providing any acute services from the Trust would create significant pressure for other healthcare services in the rest of South West London, and would mean many people would need to travel further for acute services. Moreover, in the engagement to date, no public feedback has suggested that the Trust should stop providing acute services. On this basis, this scenario has been deemed non-viable, and as such, the Trust has discounted this scenario in this strategic outline case.

130. Four scenarios will therefore be considered in more detail in the next section in this strategic outline case:

- **continuing with two acute sites**, (for comparison purposes)
- **Epsom as a primary site**, with continued use of St Helier
- **St Helier as a primary site**, with continued use of Epsom
- **Sutton as a primary site, with co-location with The Royal Marsden** and continued use of Epsom and St Helier.

8. Scenario analysis

131. For each potentially viable scenario, the Trust has completed a preliminary analysis of its implications, including:
- the impact of any changes on access and activity at a high level
 - the space required to deliver the model of care, and the best way to configure the sites to deliver this
 - the capital investment which could be required across the three sites to deliver the new model
 - the financial impact, including Trust income and expenditure and the costs of borrowing
 - the potential impact of the location on patient flows to neighbouring hospitals
 - the alignment of the scenario with the broader system
 - the deliverability of the scenario.
132. The scenario analysis should be seen in the context of a number of important considerations, these include:
- The analysis is based on current data, and could change if new information becomes available. This could include changes to capital requirements and interest rates, the Trust's financial position, levels of demand, the benefits of the clinical model, and the initial impact on other parts of the system.
 - National planning assumptions and benchmarking have been used, where possible, to develop the analysis around efficiencies in particular. However, at this stage, detailed savings plans have not yet been identified, and as such there is a risk that not all efficiencies are delivered. More detailed plans will need to be developed as part of the next stage business cases.
 - The financial analysis assumes that the additional capital required for each scenario can be borrowed at a 3% loan rate from the government. This is a simplifying assumption and does not presume the availability or cost of capital.
 - A number of limited metrics have been estimated to support an initial comparison of scenarios. A broader set of metrics would need to be considered as part of further business cases.
 - The potential investment which could be required at neighbouring hospitals in particular is illustrative and has been developed based on Trust assumptions. Estimates have not been developed for individual hospitals and the analysis uses

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only Trust data rather than information from other providers. Further analysis will be required should this work progress to a next stage business case.

133. Non-financial considerations have not been analysed in detail. This would need to be addressed as part of any subsequent detailed work on the scenarios.
134. Assumptions have been aligned (where relevant and possible) with sustainability and transformation partnership and commissioner assumptions.
135. In each scenario which delivers the clinical model, local services continue to be provided at both Epsom and St Helier Hospitals, covering c. 85% of activity. Consolidated acute services are then located either at Epsom Hospital, St Helier Hospital or Sutton Hospital (co-located with The Royal Marsden).

8.1. Trust beds by scenario

136. Based on an analysis of activity and a set of locally agreed assumptions, The Trust has estimated the number of beds which could be required on each site for the three scenarios; as well as the requirement for any additional beds for patients who might be closer to another nearby hospital. Based on this initial work, the total number of beds across the local system does not significantly vary (c. 992-1,022, compared to 1,048 currently). Further work will be needed to refine these preliminary estimates, in particular greater detail around the underpinning assumptions.
137. The estimated bed requirement for each scenario is summarised in Figure 15.

Figure 15: Trust bed requirement by scenario (25/26)

(Beds)	Continuing with two acute sites	Epsom primary	St Helier primary	Sutton primary with RMH
Total beds	1,026	834	914	1,012
Total beds including other providers in South West London and Surrey	1,026	992	994	1,022

Source: Trust analysis

8.2. Financial benefits of clinical model

138. The financial benefits of the clinical model for each scenario reflect greater economies of scale and scope through delivering care to the sickest patients on a single (consolidated) acute site.
139. There are five components to the consolidation savings, linked to the implementation of the new clinical model. The greatest savings area relates to workforce, which reflects efficiencies in staffing and the reduction in the need for temporary/agency staff to staff rotas and meet quality standards. A range of other components drive further savings including utilising new technologies, improvements in the quality of buildings and Trust efficiency.
140. The level of consolidation savings which could be achieved varies by scenario. Where the Trust has more scale and a larger catchment, there are expected to be greater opportunities for economies of scale.
141. The consolidation savings are described in greater detail in Figure 16. The range of savings indicates the variation in estimated benefits by scenario.

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Figure 16: Consolidation benefits summary (£m, 2025/26)

Benefit	Description	Indicative financial benefits
Workforce	Treating the sickest patients on a single acute site will support the Trust to re-shape its workforce to deliver the required quality standards within the existing workforce, rather than take on additional staff. It will also help to reduce reliance on agency staff, and ensure rotas are efficient.	16 – 19
Technology	The new hospital facilities will include implementing digital technologies such as electronic patient records, which are already being used in many parts of the NHS. These allow patients and hospitals to view and update patient records electronically rather than relying on more traditional paper based systems.	6 – 8
Buildings that are fit for purpose	There are expected to be a number of benefits from having a fit for purpose set of buildings. These include: <ul style="list-style-type: none"> • Reduced adverse incidents such as patient falls; • Increased ability to achieve commissioner quality standards; • Reduced costs of maintaining and operating the estate, including efficiencies in energy utilisation, maintenance costs, lifts and cleaning; and • Avoiding a number of unplanned cost pressures which are currently incurred each year, particularly in relation to the Trust estate and current service delivery model. 	11 – 13
Efficiency	By redesigning the clinical model, improving patient flows and building new facilities, the Trust hopes to be able to drive further efficiencies by reducing patients' average length of stay, and helping to get patients home more quickly.	2 – 6
Cancer, complex and private services	Improving the throughput on complex / private work is expected to offer financial benefits. This could involve increasing the share of income from treating private patients from c. 2% currently to up to c. 3%.	4
TOTAL		39 – 49

Source: Trust analysis, figures may not sum exactly due to rounding

142. Given the two acute sites scenario does not deliver the clinical model, these financial benefits would not be achievable in this scenario. For example, in relation to workforce, the estimated financial savings would not be achievable, as care would be delivered to the Trust's sickest patients across two acute sites, meaning more doctors would be needed to meet standards, and additional nurses would be needed to oversee old-fashioned wards. In addition, the opportunity to implement new digital technologies in the two acute sites scenario is more limited. In particular, there are technical difficulties associated with introducing new IT and record systems within the existing site configuration, and any implementation would likely also be more costly as a result.
143. Co-location with The Royal Marsden would be expected to provide additional benefits, including maximising shared services and the potential for a RMP cancer treatment centre.

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144. These further benefits associated with the co-location are described in Figure 17 and are based on a range of benchmarks, which will need to be developed further should next stage business cases be developed.

Figure 17: Consolidation savings from The Royal Marsden co-location (£m, 2025/26)

Benefit	Description	Indicative financial benefits
Support services	Sharing support services – including facilities management – could reduce support costs beyond the financial benefits described above. Specific improvements included include: cleaning, laundry, energy costs and water usage.	4
Cancer services	Cancer services, other complex services and delivering private work and cancer services via RM Partners will provide the Trust with greater activity.	2
Clinical synergies	Clinical synergies will improve productivity by avoiding unnecessary tests and patient transfers.	1
Clinical support services	Sharing support services, including radiology, will improve utilisation and reduce wastage.	<1
RM Partners	Working with RM Partners to deliver a shared RMP cancer treatment centre will provide further efficiencies by increasing activity, improving utilisation and supporting better procurement.	<1
TOTAL		8

Source: Trust analysis, figures may not sum exactly due to rounding

145. The Trust expects to drive efficiencies of between £39 million and £57 million (depending on the scenario) by 2025/26 on the basis of the consolidation benefits and the potential further benefits associated with The Royal Marsden co-location.

8.3. Capital investment

146. The estimated capital investment required to deliver each scenario is summarised in Figure 18.
147. The methodology adopted is prescribed by the Department of Health and requires use of a specific model that ensures all aspects of building costs are included and allowances are made for optimism bias and contingency. The Trust has decided to use the standard framework for outline business cases to ensure that these potentially significant costs are understood as much as possible at this stage.
148. Around £190 million of capital investment is already secured but more is required to deliver the clinical model. Figure 18 shows the additional capital investment which would be required. In the two acute sites scenario, for example, £208 million (of the £398 million) is currently unfunded.

Figure 18: Currently unfunded capital investment requirement by scenario (£m, to 25/26)¹⁶

	Continuing with two acute sites	Epsom primary	St Helier primary	Sutton primary with RMH
Additional capital requirement – currently unfunded	208	291	356	416

Source: Trust analysis

149. The capital investment estimates do not include any further capital investment which would be required at neighbouring hospitals as a result of the Trust's planned changes.
150. The additional investment at neighbouring hospitals has been estimated based on the number of new beds which may need to be provided at these hospitals due to the Trust's service changes. The cost has been estimated based on applying a simple assumption of £0.5 million per additional bed required.¹⁷ Further work is required to refine these figures.
151. Figure 19 summarises these additional investments.

¹⁶ The total capital investment required for each scenario includes the cost of new buildings such as departmental costs, on-works, fees, as well as planning contingency and optimism bias as required by the national guidance. The total capital investment also includes additional costs such as backlog maintenance, equipment and IT, and planned expenditure for land purchases.

¹⁷ This assumption has been developed based on the Trust's implied capital investment cost per bed in this document. The £0.5m per bed reflects a combination of re-furbished facilities and new facilities which are typically more expensive to build.

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Figure 19: Capital investment which could be required at neighbouring hospitals by scenario (£m, to 25/26)

	Continuing with two acute sites	Epsom primary	St Helier primary	Sutton primary with RMH
Net Trust capital investment with no planned funding	208	291	356	416
(+) Additional capital investment which could be required at neighbouring hospitals	-	86 (c. 172 beds)	40 (c. 80 beds)	28 (c. 55 beds)
Total net capital investment with no planned funding (including both the Trust and neighbouring hospitals)	208	377	396	444

Source: Trust analysis

8.4. Outputs of scenario analysis

152. A summary of each of the three scenarios that support the clinical model, plus the continuing with two acute sites scenario, is included below. Included for each scenario is:

- A **graphic depicting the scenario** (except the continuing with two acute sites scenario, where the buildings remain as-is externally).
- A **map of the Trust's catchment population**, showing the population around the primary site where the accident and emergency centre is.
- A **summary of the services** provided on each site.
- The **estimated 2025-26 bed base** for the Trust and the additional bed demand which would need to be provided at neighbouring providers in South West London and Surrey, based on changes in demand driven by the Trust's service changes.¹⁸
- The **required net capital investment**, over and above capital expenditure which already has funding secured.
- The **in-year revenue position**, which is the difference between income and expenditure for the Trust in 2025/26 for the scenario.
- The **Trust's return on investment**, which measures the financial benefit of the scenario compared to the capital investment required. It is defined as the total financial benefit over and above the two acute sites scenario (i.e. the change in the 25/26 in year position compared to the two acute sites deficit of c. £40m) relative to the net capital investment required to deliver the scenario. A positive return on investment demonstrates an improvement compared to the two acute sites scenario. As the scenarios are measured relative to the two acute sites scenario, the two acute sites scenario itself does not have a return on investment, given it does not enable the clinical model and achieve the financial benefits. The

¹⁸ This *additional bed demand* is distinct from the *additional beds which may need to be built*, given the investment to build additional beds considers only the new capacity which may be required, rather than considering both a greater bed requirement in some areas and a smaller bed requirement in others.

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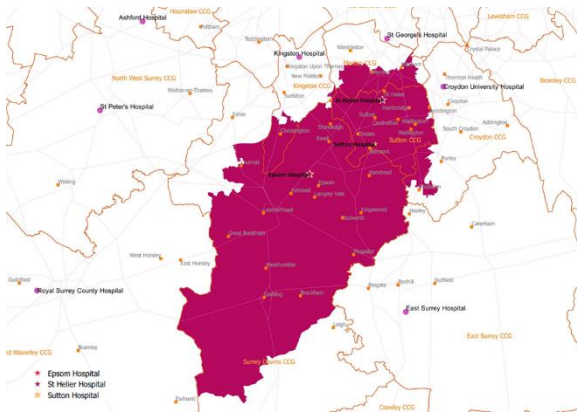
purpose of including this measure is to provide a preliminary indication of the benefits of the scenarios. Further work will be required to refine this analysis.

- The **wider system capital costs**, reflecting the potential additional investment at neighbouring hospitals, based on changes in demand (and therefore beds which may need to be built) driven by the Trust's service changes. The cost of this investment has been estimated based on applying a simplifying assumption of £0.5 million per additional bed required.
 - The **wider return on investment**, defined as the Trust's return on investment above, but also accounting for the potential additional investment at neighbouring hospitals (i.e. the wider system capital costs). The running costs associated with the additional demand have been estimated based on the Trust's cost and income structures rather than the other providers' data.
153. This analysis is based on preliminary work and further detailed analysis would be needed as part of any subsequent business case developments. However, the work would form a basis for this more detailed analysis.

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Figure 20: Continuing with two acute sites scenario

Catchment c. 490,000



Services provided

Epsom Hospital

- Retains all existing services

St Helier Hospital

- Retains all existing services

Sutton Hospital

- No services provided
- Site disposed

Total beds

Trust	Wider system change	TOTAL
1,026	-	1,026

Finances

Required net capital investment (£m)	(208)
In-year revenue position (2025/26) (£m)	(40)

Source: Trust analysis

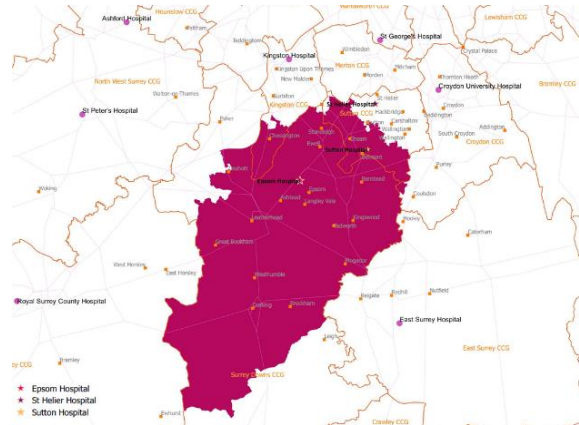
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Figure 21: Epsom primary scenario summary

Potential outline design of Epsom Hospital



Catchment c. 295,000



Services provided

Epsom Hospital

- Major A&E
- Critical care
- Emergency surgery
- Complex emergency medicine
- Inpatient paediatrics
- Births
- Outpatients
- Diagnostics
- Planned care procedures
- Elderly care rehabilitation
- SWLEOC

St Helier Hospital

- Local A&E (urgent treatment centre)
- Outpatients
- Diagnostics
- Non-complex planned care procedures
- Elderly care rehabilitation
- Eye care
- Chemotherapy

Sutton Hospital

- No services provided
- Site disposed

Total beds

Trust	Wider system change	TOTAL
834	158	992

Finances

In-year revenue position (2025/26) (£m)	(4)
Trust return on investment (%)	12%
Required net capital investment (£m)	(291)
Wider system capital costs (£m)	(86)
Wider return on investment (%)	7%

Source: Trust analysis

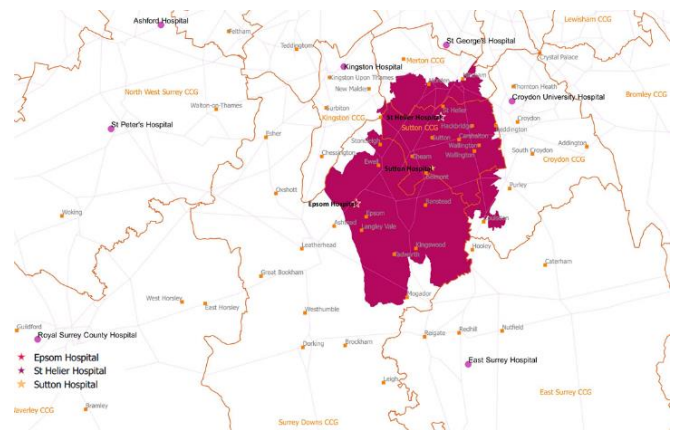
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Figure 22: St Helier primary scenario summary

Potential outline design of St Helier Hospital



Catchment c. 369,000



Services provided

Epsom Hospital	St Helier Hospital	Sutton Hospital
<ul style="list-style-type: none"> Local A&E (urgent treatment centre) Outpatients Diagnostics Non-complex planned care procedures Elderly care rehabilitation Eye care Chemotherapy SWLEOC 	<ul style="list-style-type: none"> Major A&E Critical care Emergency surgery Complex emergency medicine Inpatient paediatrics Births Outpatients Diagnostics Planned care procedures Elderly care rehabilitation 	<ul style="list-style-type: none"> No services provided Site disposed

Total beds

Trust	Wider system change	TOTAL
914	80	994

Finances

In-year revenue position (2025/26) (£m)	(4)
Trust return on investment (%)	10%
Required net capital investment (£m)	(356)
Wider system capital costs (£m)	(40)
Wider return on investment (%)	8%

Source: Trust analysis

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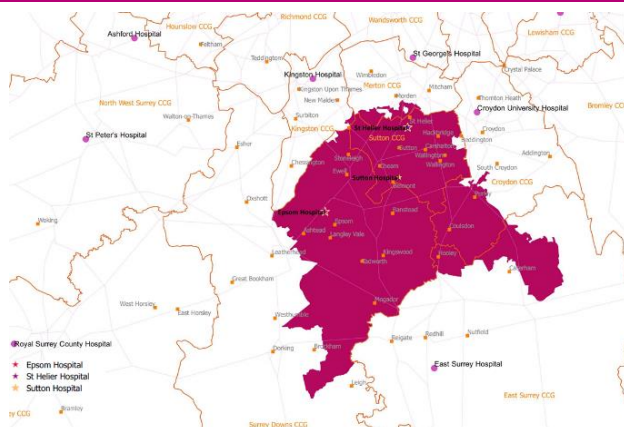
Figure 23: Sutton primary (with The Royal Marsden) scenario summary

Potential outline design of co-located Sutton Hospital

Catchment c. 418,000



Note: the red colour indicates Royal Marsden buildings



Services provided

Epsom Hospital	St Helier Hospital	Sutton Hospital
<ul style="list-style-type: none"> Local A&E (urgent treatment centre) Outpatients Diagnostics Non-complex planned care procedures Elderly care rehabilitation Eye care Chemotherapy SWLEOC 	<ul style="list-style-type: none"> Local A&E (urgent treatment centre) Outpatients Diagnostics Non-complex planned care procedures Elderly care rehabilitation Eye care Chemotherapy 	<ul style="list-style-type: none"> Major A&E Critical care Emergency surgery Complex emergency medicine Inpatient paediatrics Births RM Partners Cancer treatment centre (RMP CTC) Cancer diagnostics (RM Partners)

Total beds

Trust	Wider system change	TOTAL
1,012	10	1,022

Finances

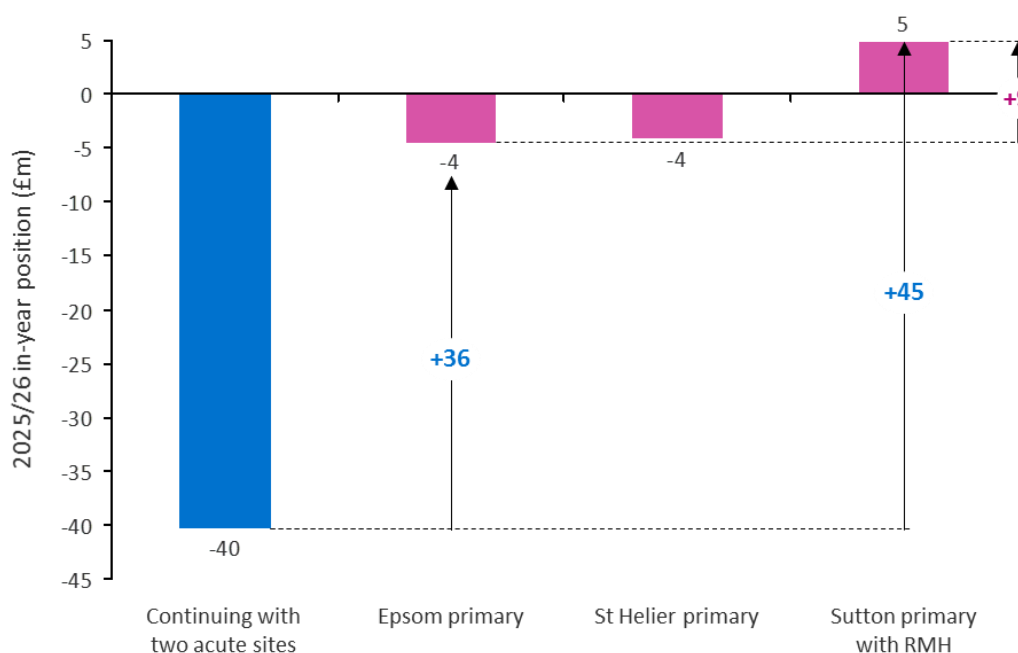
In-year revenue position (2025/26) (£m)	5
Trust return on investment (%)	11%
Required net capital investment (£m)	(416)
Wider system capital costs (£m)	(28)
Wider return on investment (%)	10%

Source: Trust analysis

8.5. Summary of scenarios

154. The Trust analysis suggests that all three scenarios where care for the sickest patients is consolidated on to a single acute site offer significant advantages over the two acute sites scenario (c. £36 – £45 million). On the basis of the initial analysis, the difference in total financial benefit between the three single-site scenarios is relatively small; there is up to a c. £9 million difference between them (or c. 2% of current Trust income). This is illustrated in Figure 24.

Figure 24: All three scenarios significantly improve the financial position (2025-26 in-year position, £m)



Source: Trust analysis

155. A significant capital investment is required to deliver each scenario. However, the Trust return on investment is c. 10–12% depending on the scenario.
156. Considering the wider return on investment to the system – including the investment that would be required at neighbouring hospitals – decreases the return on investment. Due to changes in catchment, the Epsom primary scenario decreases by more than the two other primary scenarios.
157. No preferred scenario can be identified at this stage. At this stage, only the initial viability of scenarios has been considered; none of the scenarios have been assessed against any formally agreed criteria.
158. Further work is needed with commissioners and the public to define broader criteria for assessment of different scenarios and further analysis is required to understand the performance of different scenarios against these.
159. However, the engagement process has suggested a number of themes for criteria that are important to local people, for example travel distances and variations in indices of

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deprivation between the immediate catchments of the various sites. The local commissioners will need to work with stakeholders and the public to determine the non-financial criteria that should be included when evaluating the scenarios in the future.

160. The Trust has also not completed an equalities impact assessment at this stage; this may be a requirement in a later stage.

8.6. Funding for scenarios

161. For each scenario there is a significant net capital investment required, where the full funding requirement has not currently been secured.
162. The financial analysis assumes that the additional capital required for each scenario can be borrowed at a 3% loan rate from the government. Financing may be available from a range of other routes including commercial borrowing, charitable donations and PF2 (the reformed private finance initiative).
163. As an example, an initial analysis has been undertaken on the potential scenario of funding part of the capital investment through an illustrative private financing funding scheme (based on PF2-type assumptions). At this stage this analysis has been limited to one scenario as an example to illustrate the potential impact based on a specific set of assumptions. The scenario with the greatest new build element has been selected – the Sutton with The Royal Marsden co-location scenario. This is intended to be illustrative, as a single scenario was needed, and does not imply a preferred scenario or preclude appraisal or evaluation of different scenarios; financing of all scenarios would be required as part of a full evaluation and comparison.
164. The initial analysis suggests that the 2025-26 in-year position of the scenario could decrease by c. £10 – £15 million in the PF2 option under the assumptions, driven mainly by the increased financing costs. The overall return on investment would also decrease.
165. This analysis is preliminary and the purpose is to provide an initial indication of the potential link between the strategic outline case scenarios and potential alternative funding models. There are many more factors which mean these options cannot be reliably compared at this stage, including risk transfer, availability of finance, and value for money analysis.
166. In addition, there is uncertainty around the future of overall funding for services, particularly after 2020/21. However, best estimates of funding projections suggest that across all the scenarios included in the strategic outline case, the share of funding available which is likely to be provided to the Trust either falls (or stays the same if overall funding growth is lower), suggesting the scenarios included in the strategic outline case are affordable. The overall analysis around funding and affordability, however, is based on broad assumptions at this stage and will require further work.

9. Conclusion

167. In the next ten years, the Trust faces a range of clinical, financial and estates challenges.
168. Based on the analysis in this strategic outline case, continuing with the current configuration of providing care to the sickest patients across two acute sites will mean the Trust will be increasingly unable to meet clinical standards, working from buildings that are unfit and financially unsustainable. In particular, it is clear that maintaining the current two acute site configuration will not enable the Trust to address these fundamental issues. Addressing these issues requires the Trust to consider both how it can deliver care differently in the future and the different ways it can organise itself to deliver this.
169. Therefore, the Trust needs to consider a clinical model. Specifically, it needs a model that supports local plans to help deliver more person-centred care locally and closer to patients' homes whilst consolidating specialist acute services on one of its sites.
170. Based on an initial analysis, such a clinical model appears to be clinically viable, potentially financially viable and supported by the public the Trust has engaged with.
171. This strategic outline case suggests that there are three scenarios that deliver the clinical model and that are worth further consideration as part of a further business case (potentially including a pre-consultation business case if consultation is required):
- Epsom as a primary site, with continued use of St Helier;
 - St Helier as a primary site, with continued use of Epsom; and
 - Sutton as a primary site, with co-location with The Royal Marsden and continued use of Epsom and St Helier.
172. A two acute site scenario will also need to be considered alongside these three scenarios, for comparison purposes; however, initial analysis suggests this is unlikely to be viable, as this cannot achieve any of the advantages – clinical, workforce and financial – of providing care to the sickest patients on a single acute site.
173. If acute services are not consolidated on a single site for the sickest patients and those most at risk of becoming acutely unwell, as described in its clinical model, then the Trust maintains its view that the wider NHS will need to develop a set of plans to ensure that high quality acute services are provided for the local population.
174. Based on this, the work undertaken by the Trust suggests that it should support the wider NHS to proceed with the further development of different scenarios to deliver clinical and financial viability. This may include the development of a pre-consultation business case, if consultation is required, and further business cases.

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175. An indicative timeline for next steps is included below. These are indicative; a programme plan would need to be developed by the relevant parties during the next stage.

Figure 25: Indicative timeline for next steps

Activity	Indicative timeline
Agreement to proceed	December 2017
Pre-consultation / outline business case completed (if required)	June 2018
Public consultation (if required)	Summer/autumn 2018
Decision on outcome of public consultation	Spring 2019

Source: Trust analysis based on discussions with the local system

176. If the Trust was to proceed with developing new facilities, it is initially envisaged that these could be open in 2024-26. This would be subject to an intense period of work including developing planning permissions and producing a full business case.

10. Recommendation

177. The Trust Board is asked to approve the content and conclusions of this strategic outline case.
178. The Trust Board is asked to approve the submission of the strategic outline case to NHS Improvement, the Trust's regulator.
179. The Trust Board is asked to approve the submission of the strategic outline case to the Sutton Local Transformation Board as the Trust's input into their component of the South West London sustainability and transformation partnership refresh due to be concluded at the end of November.
180. The Trust Board is asked to submit the strategic outline case to the Surrey Heartlands sustainability and transformation partnership and NHS England for their consideration.
181. The Trust Board is asked to approve sending the strategic outline case to every person and organisation who responded to the engagement.
182. The Trust Board is asked to approve that the Trust will support the wider NHS to:
 - Review the evidence presented in this strategic outline case for the Trust's proposed clinical model, which supports the Trust to be clinically and financially viable in the future. This includes the feedback from the engagement process that has supported the clinical model described in this strategic outline case.
 - Note that the Trust's analysis, including feedback from the engagement exercise, has not identified any alternative scenarios whereby the Trust can improve its clinical and financial viability to a greater extent than the scenarios presented in the strategic outline case.
 - Support the South West London and Surrey Heartlands sustainability and transformation partnerships to consider whether the Trust moving to a single site for its sickest and most at-risk patients would materially improve the clinical and financial viability of the Trust and the South West London and Surrey Heartlands healthcare economies.
 - Support further work to consider and assess the scenarios presented in this strategic outline case, meeting the regulatory requirements and due process. If it is decided that a formal public consultation is required, this is expected to include working with commissioners to support the commissioner-led development of a pre-consultation business case. This would build on the preliminary work included in this strategic outline case.
 - Based on this, establish relevant joint governance structures to oversee further work, including the three clinical commissioning groups most affected by the

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Trust's proposed clinical model (Sutton, Surrey Downs and Merton clinical commissioning groups).

- Support the work of commissioners to evaluate the relative merits of the different scenarios, building on the outputs from the Trust's previous engagement activities. Key outputs from the Trust's engagement, which it recommends commissioners consider in detail, include:
 - travel times and estimating travel time impacts for different groups of patients, relatives and visitors;
 - deprivation, healthcare needs and the location of acute hospitals;
 - an assessment of any equalities impact and other patient impacts; and
 - the impact of scenarios on other providers.
- Develop a timeline for the further work required that enables the local system to reach a shared view of the preferred scenario(s) that the public can be formally consulted on. In view of the Trust's conclusions about its clinical viability, it is important that this work is undertaken quickly. The Trust believes the NHS should aim to make its final determination by spring 2019 to enable new facilities to open from 2024 (given business case approval and building lead times).