Minutes of the Meeting of the HEALTH LIAISON PANEL held on 3 July 2018

PRESENT -

Councillor Richard Baker (Chairman); Councillor Tony Axelrod (as nominated substitute for Councillor Guy Robbins), Councillor Liz Frost, Councillor Jane Race, Councillor Humphrey Reynolds, Councillor Jean Steer MBE and Councillor Peter Webb.

In Attendance: Councillor Kate Chinn (Epsom and Ewell Borough Council); Councillor Rachel Turner (Reigate and Banstead Borough Council); Andrew Demetriades (Sutton, Merton and Surrey Downs Clinical Commissioning Groups) and Daniel Elkeles (Chief Executive, Epsom and St. Helier University Hospitals NHS Trust)

Absent: Councillor Guy Robbins

Officers present: Rod Brown (Head of Housing and Community) and Fiona Cotter (Democratic Services Manager)

1 DECLARATIONS OF INTEREST

Councillor Liz Frost (Epsom and Ewell Borough Council) declared an interest on the grounds of her employment with the NHS. Councillor Liz Frost had received a dispensation from Epsom & Ewell Borough Council's Standards Committee to speak and vote on matters related to health.

2 MINUTES OF PREVIOUS MEETING

The Minutes of the Meeting of the Health Liaison Panel held on 14 December 2017 and 3 March 2018 were agreed as a true record and signed by the Chairman.

3 IMPROVING HEALTHCARE TOGETHER 2020-30

Andrew Demetriades, Joint Acute Sustainability Programme Director (for Sutton, Merton and Surrey Downs Clinical Commissioning Groups), and Daniel Elkeles, Chief Executive, Epsom and St Helier University Hospitals NHS Trust (ESHUT) were in attendance to discuss recent developments in the exploration of addressing local health challenges.

Mr. Demetriades informed the Panel that Sutton, Merton and Surrey Downs Clinical Commissioning Groups continued to work together on the ambition to improve health care in a way that would be sustainable for years to come under the renamed programme title of Improving Healthcare Together 2020-30 (formerly known as the Acute Sustainability Programme). The Panel was reminded that ESHUT's catchment area covered the three CCGs areas in whole

or part. The CCGs were responsible for overseeing health care in their local areas, including hospital services, for a combined population of around 700,000 people across the three CCGs.

Mr. Demetriades spoke to the three key challenges the programme was seeking to address:

- **Improving the clinical quality of services:** clinical standards had been set out for six key acute services to facilitate the delivery of high quality care 24/7. ESHUT had undertaken a detailed self-assessment of the workforce challenge facing it in meeting the standards and was the only Trust that had openly stated that it could not meet those standards in two key areas of specialism in relation to the consultant work force for emergency departments and acute medicine;

- **Modernising buildings and care settings:** Many of the Trust's buildings had been built before the NHS had been founded, were rapidly ageing and were not designed for modern health care;

- **Achieving financial sustainability:** The Trust had an underlying financial deficit and the position would worsen unless changes were made.

Mr. Demetriades stated that, as Commissioners, the CCGs were very clear that clinicians had a central role in considering potential solutions to addressing these challenges. To that end, a Clinical Advisory Group had been convened earlier in 2018 to develop a clear vision about how services for the future might be shaped. The Group comprised representatives from the primary care providers, (the clinical chairs of the CCGs), and Trust clinical and medical directors. Mr. Demetriades stated that from the CCGs perspective they wished to drive not only improvements in hospital care but also preventative care and how these services might be intergrated. He also stated that the CCGs were clear on the need to retain all of the hospitals serving their local area, acknowledging the challenges that needed to be faced. In this context, the Advisory Group had been tasked with developing a clinical model for the combined geographies of the three CCGs based on clinical standards and evidence based best practice.

Turning to the clinical model for the future, there was a desire to retain access to the majority of district services, particularly bedded services for the frail elderly. However, it was recognised that given workforce challenges there was a potential need to bring together major acute services (emergency and acute medicine, critical care and emergency surgery) alongside women's and children's services (births, paediatric ED and inpatient paediatrics) and to potentially consolidate these onto one site.

A set of criteria or tests had been developed to assist in arriving at a shortlist of possible solutions. Following application of these criteria or tests, an emerging shortlist of solutions had just been published as follows:

- Locating major acute services at Epsom Hospital, and continuing to provide all district services at both Epsom and St Helier Hospitals;

- Locating major acute services at St Helier Hospital, and continuing to provide all district services at both Epsom and St Helier Hospitals;

- Locating major acute services at Sutton Hospital, and continuing to provide all district services at both Epsom & St Helier Hospitals

A lot of work had been distilled into the recently published issues paper but there was further work that needed to be done to understand how any potential changes might affect people living in the area:

- A multi-phased Equalities Impact Analysis: this was a public sector duty requirement around protected characteristics and phase 1 had been completed with further work to be undertaken over the summer and early autumn.

- A deprivation analysis – to understand how changes in location might impact on deprived communities

- A travel and impact analysis

- A provider impact analysis i.e. flow of patients and how this might be resourced by service providers

The provisional timeline on the programme had not significantly changed from when last presented to the Panel. The intention was still to go out to formal public consultation in January next year. In terms of pre-formal consultation engagement, the Issues Paper would form the basis of further engagement. In particular, the CCGs were keen to know whether the three challenges identified were the only challenges needing to be solved and whether people thought their vision for services in the area, based on greater prevention of disease and improved integration of services, was the right vision. They were also keen to listen to feedback regarding the tests and thinking around the solutions to date.

Panel members asked a number of questions in response to the presentation that reflected concern that they were troubled by the linkage to South West London and concerned that residents in the Surrey Downs area would be poorly served by a move of services over the County boundary, particularly in terms of the impact in relation to travel and transport.

Mr. Demetriades and Mr. Elkeles responded that, in the broadest terms, as a service provider to the CCGs, the Trust could not make any service change unless this was agreed by them. All three CCGs had an equal voice in terms of proposing a solution to the challenges faced. The CCGs had agreed that the current configuration of services was not sustainable and was now looking at what was in the best overall interest of the communities they served. However, if the CCGs could not agree on the pre-consultation business case for change, there would be no public consultation.

It was confirmed that it was the Trust's intention to sell land surplus to requirements on the Epsom site and to reinvest the capital receipt into its Epsom estate. The question of land use was a separate issue.

4 ANNUAL REPORT

A copy of the report would be circulated to members of the Panel for feedback.

The meeting began at 7.00 pm and ended at 8.51 pm

COUNCILLOR RICHARD BAKER (CHAIRMAN)