Merton Council

South West London and Surrey JHOSC Sub Committee - Improving Healthcare Together 2020-2030 Agenda

Membership

Councillors:

Peter McCabe

Co-opted members:

Substitute Members:

Date: **Thursday 7 February 2019**

Time: **7.00 pm**

Venue: **Council chamber - Merton Civic Centre, London Road, Morden SM4 5DX**

This is a public meeting and attendance by the public is encouraged and welcomed. For more information about the agenda please contact or telephone .

All Press contacts: communications@merton.gov.uk, 020 8545 3181

South West London and Surrey JHOSC Sub Committee - Improving Healthcare Together 2020-2030 Agenda

7 February 2019

Note on declarations of interest

Members are advised to declare any Disclosable Pecuniary Interest in any matter to be considered at the meeting. If a pecuniary interest is declared they should withdraw from the meeting room during the whole of the consideration of that mater and must not participate in any vote on that matter. If members consider they should not participate because of a non-pecuniary interest which may give rise to a perception of bias, they should declare this, .withdraw and not participate in consideration of the item. For further advice please speak with the Assistant Director of Corporate Governance.

South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030

7 February 2019

7.30 pm at the

Merton Civic Offices, London Road, Morden, SM4 5DX

To all members of the South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030:-

Councillors: Colin Stears, Sutton Council
Peter McCabe, Merton Council
Zully Grant- Duff, Surrey County Council

This is a Council meeting held in public. Additional representations are at the invitation of the Chair of the Committee. If you are a relevant organisation and you wish to submit representations on a proposal contained within the reports to this agenda please submit a request via Committee Services three working days before the meeting date.

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Mary Morrissey
Chief Executive (Interim)
Date: 25 January 2019

Enquiries to: cathy.hayward@sutton.gov.uk
Copies of reports are available in large print on request

A G E N D A

1. Welcome and introductions

2. Apologies for absence

3. Declarations of interest

4. Minutes of the previous meeting

To approve as a correct record the minutes of the meeting held on 28 November 2018.

5. Improving Healthcare Together Programme Update 1 - 10

The Improving Healthcare Together programme office provides an update report on the various activities undertaken and outlines future plans.

6. A Report on the Options Consideration Process by Traverse 11 - 36

The report by Traverse covers the work they undertook and results from three workshops held on behalf of the Improving Healthcare Together (IHT) programme to consider the Options Development Process.

7. Response from Epsom & St Helier University Hospitals NHS Trust to the report on the Options Consideration Process by Traverse 37 - 40

The report provides a response from Epsom and St Helier Trust to the report by Traverse on the Options Development Process.

8. Reports from local Healthwatch on focus groups with protected characteristic groups 41 - 66

The three local Healthwatch organistions in scope to the Improving Healthcare Together programme, Merton, Surrey and Sutton held focus groups with people from protected characteristics groups. The suite of reports attached sets out their findings:

- Merton Healthwatch: BAME report; Carers report; Older people report.
- Surrey Healthwatch: Interviews with People with Learning Disabilities; Interviews with Carers; Interviews with Older People.
- Sutton Healthwatch: BAME report; Carers report; Older people report.
- Overall Summary Report

9. Improving Healthcare Together (IHT) programme Equalities responses to Healthwatch reports 67 - 114

The report provides the response from the IHT programme to the work undertaken by the three local Healthwatch organisations to look at the focus groups they held with people from protected characteristics groups.

10. Any urgent business

To consider any items which, in the view of the Chair, should be dealt with as a matter of urgency because of special circumstances (*in accordance with S100B(4) of the Local Government Act 1972*).

11. Date of Next meeting

To be confirmed.

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Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:** 7 February 2019	
Report title:	Improving Healthcare Together Programme Update		
Report from:	David Olney, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author(s)/Contact Number(s):	David Olney, Statutory Scrutiny Officer, 020 8770 5207		
Corporate Plan Priorities:	• Being Active • Making Informed Choices • Living Well Independently • Keeping People Safe		
Open/Exempt:	Open		
Signed:	David Olney	**Date:**	17 January 2019

1. Summary

1.1 The Improving Healthcare Together programme office provides an update report on the various activities undertaken and outlines future plans.

2. Recommendations

The Scrutiny Committee is recommended to:

2.1 Consider and comment on the report.

3. Background

3.1 The Improving Healthcare Together 2020-2030 programme uses an update report to provide committee members with a summary of the recent activity undertaken by the programme and to indicate future activity in the workplan.

4. Appendices and Background Documents

Appendix letter	Title
A	Improving Health Care Together 2020- 2030 - briefing Paper

Audit Trail		
Version	Final	Date: 23 January 2019

Background documents
None

Joint Health Overview Scrutiny Sub-Committee

Improving Healthcare Together 2020 – 2030

Briefing Paper

7th of February, 2019

1. Introduction

The following briefing paper has been prepared for the Improving Healthcare Together 2020 – 2030 JHOSC Sub-Committee. It includes updates as requested by the Sub-Committee on the:

- Improving Healthcare Together programme update (below), including a briefing on the Integrated Impact Assessment (Appendix 1)
- TRAVERSE independent report on the options consideration workshops (attachment 1)
- Improving Healthcare Together 2020 - 2030 - Equalities engagement report (attachment 2)

This briefing paper should be read in conjunction with the attachments 1 and 2.

2. Improving Healthcare Together update

a) Programme process and timelines

We have recently submitted a draft pre-consultation business case to our regulators, NHS Improvement (NHSI) and NHS England (NHSE), and the Joint Clinical Senates of London and South East to begin the assurance of all our work and evidence gathered to date to ensure that the proposed plans are financially and clinically viable for patients and the public.

The outputs of this pre-consultation business case are draft and any new options, new evidence and information will be considered by the three CCGs' Governing Bodies up to the point of the decision-making process after any public consultation.

Alongside this assurance process, the programme's work on a number of key areas will be progressed through 2019. These include exploring further evidence on the impact on providers, phase 2 of the Integrated Impact Assessment and the co- production of a draft consultation plan.

Any further evidence that will come out of this work, alongside the feedback from NHS regulators, and the Clinical Senate in conjunction with the JHOSC Sub-Committee and any new/additional information received, which may impact on the options, will be considered before determining our readiness to proceed to a public consultation on any proposals.

No preferred option(s) have been decided at this point or any decisions made. No decisions will be taken until after a public consultation.

b) Options consideration process

Following best practice advice from The Consultation Institute on options consideration, we have adopted its recommended process of working collaboratively with local people to evaluate the quality

of each of the options proposed via a series of workshops. The IHT programme commissioned TRAVERSE (an independent engagement and research organisation) to facilitate this process and produce an independent report.

The independent report on the options consideration workshops was published on the IHT website in December 2018, and outlines the process undertaken and the outputs of each workshop. This report will be further discussed at the next JHOSC Sub-Committee meeting on 7th February 2019.

The options consideration workshops are not a decision-making process. They are an evaluation process that forms part of a continued options consideration process. No decisions about the future of services at Epsom and St. Helier Hospitals have been made and no decisions will be taken until after a public consultation and all the available evidence has been considered.

c) Impact on other providers

We are continuing to work with all providers to understand the impact of each option. This work includes each provider undertaking further analysis around finance, estates, capital and workforce implications.

d) Finance, Activity and Estates

We are continuing to develop our financial analysis and this will be informed by feedback received as part of the assurance process.

The programme will need to determine the most appropriate financing route as well as secure in due course the capital investment needed prior to launching any formal public consultation.

e) Integrated Impact Assessment

We have commissioned independent specialists Mott Macdonald to undertake an Integrated Impact Assessment (IIA) to understand the full range of potential impacts that proposals could have on the local population. This work will be undertaken across three phases as detailed in Appendix 1 (IIA briefing paper).

With the first scoping phase of the IIA completed and its findings published on the IHT website, we are preparing to commence the second phase of this work.

Phase 2 of the IIA will commence in January 2019 and aims to:

- engage with different equality groups to further explore the perceived needs and impacts identified in phase 1 of this work and to determine any other potential unconsidered impacts (if any); and
- comprehensively assess any positive and negative impacts of the options across four areas: equality, health, travel and access, and sustainability.

This work will lead to the development on an IIA interim report.

An IIA Steering Group has been convened to oversee the delivery of this programme of work. This

group will be independently chaired and comprise of representation from across the combined geographies including CCGs, local authorities, public health, Healthwatch and voluntary sector representatives, as well as representation from the travel and access working group. The first IIA Steering Group will take place on the 23rd of January 2019.

f) Community outreach and engagement

Following the Consultation Institute's assurance process of our pre-consultation engagement phase Improving Healthcare Together have been awarded their certificate of good practice.

Building on the extensive programme of early engagement already undertaken, we are planning ongoing outreach work with community, voluntary, equality and seldom heard groups across Surrey Downs, Sutton and Merton. We aim to feedback to the public on the work we have done so far, continue to share the case for change and the new clinical model, ask people how they would like to be engaged during a public consultation.

Building relationships, encouraging dialogue and developing awareness will form an essential part of this activity, which will include mobile 'pop-up' sessions held at community focal points such as mosques and churches, on-site engagement (e.g. A&E units at Epsom and St Helier Hospital) and group discussions with service users, carers and local residents.

The IIA Steering Group will review and agree the engagement plan for phase 2 of this work, which will see further engagement with equality groups during February.

We will be further sharing a communications toolkit to support voluntary, community and interested groups to update their community about our work and implementing a social media plan that encourages people to visit our website to find out more about our planned activities.

Further information regarding Improving Healthcare Together 2020-2030 can be accessed via the website: https://improvinghealthcaretogether.org.uk/contact/.

MOTT MACDONALD

Appendix 1:

Integrated Impact Assessment

Improving Healthcare Together 2020-2030

Briefing

1. Context

The IHT programme have commissioned independent specialists Mott Macdonald to undertake an Integrated Impact Assessment (IIA).

Phase 1 of the IIA work has been completed and published. This includes:

- Stakeholder engagement with clinicians and community groups
- An initial equalities analysis
- A baseline travel analysis
- A deprivation impact analysis report
- Stakeholder engagement with protected characteristic and equalities groups

Prior to the IIA, the IHT programme commissioned PPL and the Nuffield Trust to produce an independent analysis of deprived communities in the Trusts' catchment and potential impacts of the options on those communities. This work identified 11 areas in Merton and Sutton which were in the most deprived 20% nationally, and a number of areas for the IIA to address in relation to these communities.

The IIA will pick up the following recommendations:

- Include an assessment of how the initial proposals resulting in possible changes to major acute services could potentially impact on people living in the LSOAs in the most deprived quintile considering:
- health inequalities and deprivation as part of the Health and Equality Impact Assessments
- health need through assessing potential links identified in national evidence; and
- health usage through analysis of patient flows and catchments for hospitals.
- Undertake travel time analyses to assess the impact on travel times for different communities to and from different service locations, by different means of transport ('blue light', public transport and car), to understand if there are material and disproportionate changes to those in deprived communities as a result of any changes of locations to major acute services. (this may include analysing the impacts on travel times for communities in areas of high deprivation who may typically have low levels of car ownership)

The Interim IIA report will identify, with reference to the PPL/Nuffield report, how each of the recommendations in relation to analysis of deprivation have been addressed.

2. What is an IIA

It is important that those involved in making decisions about future health service configuration understand the full range of potential impacts that proposals could have on the local population. It is particularly important to understand the potential impacts on groups and communities who will be the most sensitive to changes.

The aim of an IIA is to be used by decision- makers to maximise the positive impacts and minimise any negative impacts resulting from any potential service changes.

It is important to note that the purpose of impact assessments is not to determine the decision about which option might or might not be selected; rather they act to assist decision-makers by giving them better information on how they can promote and protect the well-being of the local communities they serve.

The IIA will bring together impacts across a number of different assessment areas. These include:

- An Equalities Impact Assessment (EqIA)

- Health Impact Assessment
- Travel and Access Impact Assessment
- Sustainability Impact Assessment

This will allow for a more balanced and inclusive assessment which recognises the linkages between the different assessment areas. It also allows the consideration of cumulative impacts.

3. The process

This IIA is designed to be an iterative process that can be revisited and take on board evidence over the course of the proposal development and consultation processes. Work has been structured around three phrases, as detailed in table 1.

Table 1: IIA Phases

Phase	Activities	Outputs	Status
	Phase 1: Baseline The work undertaken in phase one is to investigate the current situation (the baseline) and to identify what needs to be considered going forward.		
1.a	✓ Initial equalities analysis to identify which protected characteristic groups may have a disproportionate need for services. ▪ It identifies and separates differing profiles of people and their experiences, including equality characteristics, those from areas with health inequalities and, by implication, low income households and others that suffer deprivation. ▪ As part of this process strategic stakeholder engagement with clinicians and community groups took place. ▪ The purpose of this engagement was to gather evidence on the need for acute services and any potential impacts. ✓ Baseline travel analysis presenting the current travel times to hospitals for car, public transport and blue light ambulance	✓ Initial equalities analysis ✓ Baseline travel analysis	✓ The reports have been published on the IHT website.
1.b	✓ Deprivation impact analysis ▪ This includes a baseline study of where there is health inequality, why it exists and with whom. ✓ Stakeholder engagement with protected characteristic groups was undertaken by Traverse, Healthwatch and IHT programme	✓ Deprivation impact analysis ✓ Summary of all equalities engagement report	✓ The reports have been published on the IHT website.
	Phase 2: Interim IIA report Phase 2 is an exploration with (i) people that need to travel to services, (ii) people from areas where health inequality has been identified or is suspected, and (iii) people with protected characteristics and their representatives as identified through the pre-engagement phase to identify what they think should be considered by those undertaking option development and appraisal.		
2.a	▪ Further engagement through focus groups and interviews with local people to understand potential impacts. ○ To sense check the perceived needs and impacts from phase one and to determine any unconsidered impacts or potential impacts. ○ Full impact assessments produced for equality, health, travel and sustainability.	▪ Interim IIA report which brings together the evidence collated in phases 1.a and 1.b and 2.a.	▪ Work to commence in January 2019. ▪ Stakeholders to review the IIA report in spring 2019. ▪ Report to be published before the public consultation.
	Phase 3: Final IIA report This final report takes into consideration all of the evidence from phases one and two and the public consultation. It presents a comprehensive assessment of the positive and negative impacts and provides suggested mitigation and enhancement measures.		
3.a	▪ Review public consultation outputs.	▪ Final IIA report.	▪ Work to commence once the public consultation has closed. ▪ Stakeholders to review the IIA report in Autumn 2019. ▪ Report to be published afterward stakeholder feedback.

4. Detail of each assessment areas

Each assessment area is detailed below:

Equality impact assessment (EqIA)

Undertake an EqIA, critical in supporting the CCGs in meeting their obligations under the Equality Act 2010[1] to:

- Understand the impacts on protected characteristic groups across the CCG populations through programme of stakeholder engagement.
- Identify which (if any) of the protected characteristic groups are more likely to be affected by the proposals due to their propensity to require different types of health services and what these impacts will be.
- Identify where (if any) of the protected characteristic groups are more likely to be experience unlawful discrimination, harassment and victimisation and what these impacts will be.
- Help foster good relations between people who share a characteristic and those who don't.
- Where impacts are disproportionate for certain groups, consider opportunities for mitigating negative impacts and enhancing positive impacts.

Health impact assessment

- Identifies health impacts and recommends mitigation actions. These are usually grouped within three sub sections; health outcomes, service impacts and workforce impacts.
- Health outcomes will appraise; individual health outcomes for patients [inc. safety, effectiveness of care and patient experience] and individual choice for patients
- Service impacts will appraise; capacity of service, clinical inter-dependencies and ambulance service capacity.
- Workforce impacts will appraise; workforce standards, workforce sustainability and workforce turnover.

Travel and access impact assessment:

- Identifies travel and access impacts which could potentially be experienced as a consequence of implementing the proposals.
- It will include quantitative and qualitative analysis of impacts to consider increases and decreases in journey times and changes in journey patterns for the overall impacts.
- Quantitatively the analysis will be undertaken for four time periods (AM peak, PM peak, inter-peak and off-peak) for three modes of transport (blue light ambulance, car and public transport). The quantitative assessment is modelled using TRACC software which is the industry leading accessibility modelling software package. The quantitative assessment will present changes to the baseline (current situation) of travel times and % of population who can reach a hospital within certain time bands.
- Qualitative assessment will be undertaken using information from stakeholder engagement activities and review of literature on travel and access impacts in healthcare. It is likely this will be split into the following sub-categories; impacts on ambulance service journey times and capacity, travel impacts for patients and travel impacts for family, carers and visitors. This will include impacts such as cost of longer travel, car parking and accessibility for those with limited mobility.

Sustainability impact assessment:

- Assesses greenhouse gas (GHG) emissions under each of the shortlisted proposals. This is considered across three areas; building energy use, travel and goods and services.
- Building energy use will consider available data for the consumption of gas and electricity for each of the proposals, for all of the buildings after any potential change is implemented.
- Travel will consider how long it will take patients to travel under any new configuration and then assess carbon impacts of longer travel.
- Goods and services will consider available data for the change in delivery of goods and services and asses carbon impacts.

[1] Equality Act 2010 (Commencement No.3) Order 2010.

5. Governance

This work will be overseen by a newly convened IIA Steering Group (IIASG) which will have oversight of delivery of this programme of work. The Steering Group will meet in January 2019.

6. Contact details

If you require any further information on the IIA work please contact:

Brian Niven: Brian.Niven@mottmac.com
Frances Parrott: Frances.Parrott@mottmac.com

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Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030		**Date: 7 February 2019**
Report title:	Report on the Options Consideration Process by Traverse		
Report from:	David Olney, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author(s)/Contact Number(s):	David Olney, Statutory Scrutiny Officer, 020 8770 5207		
Corporate Plan Priorities:	• Being Active • Making Informed Choices • Living Well Independently • Keeping People Safe		
Open/Exempt:	Open		
Signed:	David Olney	**Date:**	17 January 2019

1. Summary

1.1 The report by Traverse covers the work they undertook and results from three workshops held on behalf of the Improving Healthcare Together (IHT) programme to consider the Options Development Process.

2. Recommendations

The Scrutiny Committee is recommended to:

2.1 Consider and comment on the report.

3. Background

3.1 As part of the work of the Improving Healthcare Together 2020-2030 programme an independent organisation, Traverse, was commissioned by IHT to deliver three workshops to inform the Options Development Process.

3.2 Attached is the independent report from Traverse on the outcomes from the (1) criteria (2) weighting and (3) evaluation workshops held in November 2018.

4. Appendices and Background Documents

Appendix letter	Title
A	Cover report - Traverse options considerations report
B	Traverse - Options Consideration Process

Audit Trail		
Version	Final	Date: 23 January 2019

Background documents
None

Improving Healthcare Together 2020-2030
NHS Surrey Downs, Sutton and Merton CCGs

JHOSC Sub-Committee Cover Sheet
Attachment: 1
7 February 2019

Title of Document: Traverse options considerations report	**Purpose of Report:** For noting
Report Authors: Traverse	**Lead Director:** Andrew Demetriades

Executive Summary:

Following best practice advice from The Consultation Institute on options consideration, Improving Healthcare Together adopted its recommended process of working collaboratively with local people to evaluate the quality of each of the options proposed via a series of workshops. The IHT programme commissioned TRAVERSE (an independent engagement and research organisation) to facilitate this process and produce an independent report.

The independent report attached on the options consideration workshops was published on the IHT website in December 2018, and outlines the process undertaken and the outputs of each workshop.

Key issues to note are:

- Our work around the options consideration process to date has been developed in conjunction with The Consultation Institute and follows best practice.
- The options consideration workshops are not a decision-making process. They are part of an evaluation process that forms part of a continued options consideration process. Additional feedback and evidence alongside any other information received will be considered by the three CCGs up to the point of the decision-making after any public consultation has taken place.

Recommendation:
The JHOSC Sub-Committee is asked to note the Traverse options consideration report.

Financial Implications:
None

Equality Impact Assessment:
An Equality Impact Assessment will be conducted as part of the Integrated Impact Assessment.

Information Privacy Issues:
None

Communication Plan:
A communications and engagement plan for the Improving Healthcare Together 2020-2030 has been developed.

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TRAVERSE

Options consideration process

Improving Healthcare Together 2020-2030

November 2018

Client	Improving Healthcare Together 2020-2030
Title	Options consideration process
Subtitle	Improving Healthcare Together 2020-2030
Dates	last published 06/12/2018 last revised 20/12/2018
Status	Final
Classification	Published
Author(s)	Lucy Farrow, Duncan Grimes
Quality Assurance by	Lucy Farrow
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Contents

1. About this report

Traverse is an employee-owned engagement and research organisation that was commissioned by the Improving Healthcare Together 2020-2030 (IHT) programme to act as an independent facilitator for the options consideration process in October and November 2018. This independent report, prepared by Traverse, describes the process that was undertaken and the outputs of each workshop.

1.1. Background

NHS Merton, Surrey Downs and Sutton Clinical Commissioning Groups (CCGs) are the organisations responsible for making decisions about how healthcare services should be provided in their local areas.

The three CCGs have come together to develop the IHT 2020-2030 programme which aims to address long-standing challenges at Epsom and St Helier Hospitals. In Summer 2018 the programme published an issues paper setting out the challenges, a vision for addressing them, and some potential solutions. By October 2018 the programme had collected feedback from over 800 people in the local area, as well as evidence on a range of potential impacts. As part of the process, the IHT programme wanted to work together with local residents and healthcare professionals to assess this evidence and evaluate each option.

1.2. *The Process*

Following best practice advice from The Consultation Institute, the IHT programme developed a process for working collaboratively with local people and professionals. The overall objective of the process was to inform the Governing Bodies decision making process with information about how the community and professionals assessed the options.

The aims of each workshop were to:

1) Decide the criteria to test the potential solutions
2) Decide the weighting for each criteria in terms of importance
3) Apply the criteria to score the options

Each workshop included a different group of stakeholders to represent a range of perspectives (see the participation section below for more detail).

Each workshop was guided by an independent facilitator to consider information presented by clinicians and other professionals. This information included feedback from the engagement reports, information from the programme issues paper, NHS and mayoral assurance tests, the deprivation impact analysis, the equalities scoping report and evidence prepared by the IHT team about the likely impacts of the projects.

The workshop process focused on evaluating the quality of each option, it did not consider their financial merits. The IHT programme chose to consider

the financial criteria separately to the quality criteria, recognising the difficulty of developing financial metrics within the workshop process.

The process for the workshops, and a draft Terms of Reference which set out how participants would be asked to work together were approved by the Stakeholder Reference Group. The terms of reference is in Appendix 1, and everyone attending the workshops was asked to sign a copy.

The workshops took place over the space of three weeks across three separate locations:

- Tuesday 30th October 13.00-17.00, Bourne Hall, Ewell
- Tuesday 6th November 13.00-17.00, The Sutton Life Centre
- Wednesday 14th November 13.00-19.30, Everyday Church, Wimbledon

Community members were compensated for their time, with a payment of £50 per session. Additional costs were covered upon request such as childcare for participants who would not otherwise have been able to attend.

1.3. Facilitator notes on the process

In each of the workshops participants discussed the case for change and the clinical model as well as the potential solutions proposed. Participants had a range of views on the need to relocate services, on the engagement process and on the suitability of the options. Facilitators confirmed that taking part in this process would not preclude participants from expressing these views during any future consultation. All participants who attended a workshop agreed to take part on this basis and in line with the terms of reference.

2. Participation

2.1. Types of participant

Each workshop involved three groups of people with distinct roles.

- **Participants:** Workshop participants were the decision makers, they weighed and discussed the evidence and issues presented, and made decisions on the criteria, weighting and scoring.
  - Each workshop was made up of around 60% community members and 40% professionals involved in the programme
- **Advisors:** Each workshop also had a smaller number of professional staff who provided evidence to inform the participants. Advisors did not have a decision-making role in the workshops.
  - Each workshop had appropriate advisors for the topics under discussion, drawn from the technical and clinical professionals supporting the programme
- **Observers:** In order to ensure that the process was fair and transparent a range of observers were invited to attend each workshop and oversee the process. Observers did not have a decision-making role in the workshop.
  - Observers were drawn from the programmes Stakeholder Reference Group, local Healthwatch groups and JHOSC officers.

A full list of participants is detailed in the appendix. The table below indicates the number of each type of participant in each workshop:

	Community participants	Professional participants	Observers	Advisers
Criteria workshop	11	8	4	5
Weighting workshop	13	3	5	5
Scoring workshop	14	10	5	10

2.2. Recruitment of community members

Members of local communities were key participants in this process. Decisions about recruitment were made by Traverse without involvement of the IHT programme team, and were made based on demographic criteria described below. The aim was to ensure participants represented a cross-section of the community, and residents of each of the three CCG areas.

Traverse used two methods to identify local residents who were interested in attending:

1) **Re-contacting previous participants in engagement events**. Traverse contacted local community members who had previously participated in IHT engagement events run by Traverse. This guaranteed the participation of certain key demographics; residents in deprived areas, users of paediatrics and maternity services as well as LGBTQ+ residents. This was either done directly by Traverse, sub-contracted to professional recruitment agency Plus4 if the participants had not agreed to Traverse holding their contact details or by members of the IHT team at events they were conducting with local groups of people with protected characteristics.
2) **Open advertisement** through community groups, social media and newsletters. Local community members responded to open advertisements to attend the workshops. A public advert (see appendix A) was disseminated through the IHT engagement lead and residents were asked to contact Traverse for further details. The advert was shared with a number of local community groups to raise awareness of the events e.g. Action for Carers. As part of the programme's work across the three CCG areas to involve equality groups, the opportunity to participate in these workshops was also shared with the service users engaged (this process reached 122 service users and 18 local support groups).

Once a local community member expressed interest in attending (either through re-contact or open advert) a member of the Traverse team conducted a screening interview. This interview aimed to obtain basic demographic and protected characteristic information to ensure that the workshops were attended by a broad cross-section of the community.

Observer participation was managed by the stakeholder reference group (SRG). As the SRG had a specific role in scrutinising the process they were invited to attend as observers rather than as participants.

Traverse also advised local participants in advance what was expected from them during the workshop in terms of decision-making and participation. Relevant background reading materials were shared with all participants in advance of the session.

For further information on the demographic breakdown of community participants see appendix A. In total there were 38 community and 21 professional participants, which met the 60/40 ratio of voting participants as agreed by CCG Governing Bodies.

Across the three workshops there was a good mix of participants from each of the three areas, and of most demographic characteristics. There were more participants in the older age groups than younger. There was a good mix of participants with disabilities and carers, groups which had been identified as potentially being affected most by any proposed changes in

services.

3. Criteria workshop results

In the criteria workshop participants were provided with information on:

- Evidence from engagement activities
- case for change,
- clinical model
- and potential solutions, as well as an overview of the feedback provided in the engagement to date.

While this information was familiar to many participants it was important that everyone taking part had a shared understanding of the background and context. The same information was presented in each of the three workshops, with time for discussion and clarification questions.

In order to develop criteria participants started by discussing the question 'if the proposed changes went ahead, how would we know that they were working?'.

This generated a large number of ideas for potential criteria. Participants were then asked to consider whether any of the evaluation criteria suggested by the programme board should be included and suggestions made by one of the technical advisors about how criteria should be formulated to be effective (e.g. they should be measurable, and differentiate the options). This generated a long list of over 30 criteria which participants were asked to consider before allocating green or red markers to the criteria they thought were most and least appropriate. Each criteria was then discussed with the full group and either included or excluded, to leave a final list of 16 criteria.

As the criteria identified in the workshop were often made up of several initial ideas grouped together on multiple post-its, the version below was developed following some drafting to clarify the definitions. This drafting was carried out jointly by the independent facilitators and technical advisors from PA Consulting, with the aim of capturing as clearly as possible the criteria agreed in the workshop.

Criteria	Definition
Accessibility	The extent to which the option allows patients, staff and visitors to access the site whether using public or private transport, in terms of travel time and cost
Availability of beds	The extent to which the option allows for an appropriate number of beds to meet the needs of the population
Delivering urgent and	The extent to which the option allows patients to access urgent and emergency care when needed

emergency care	
Staff availability	The option can be staffed appropriately, meeting rota requirements
Workforce safety, recruitment and retention	The extent to which the option retains a sustainable level of staffing with good staff experience and reduced sickness and absence rates
Alignment with wider health plans	The extent to which this option supports local, regional and national healthcare goals
Integration of care	The extent to which this option improves patient journeys through the health and social care systems via effective discharge planning, better communication between professionals and patients, and clarity about pathways
Complexity of build	How challenging is the build of the option, considering the impact on existing services and the local community
Impact on other providers	Impact on finance and workforce for other health and social care providers
Time to build	Length of time taken to build the option
Deprivation	The extent to which this option affects the most deprived communities in the area
Health inequalities	The extent to which this option helps to reduce health inequalities
Older people	How well this option meets the needs of the aging population
Clinical quality	The extent to which the option prevents people from dying prematurely, enhances quality of life and helps people recover from episodes of ill-health
Patient experience	The extent to which the option ensures patients are confident they are being treated by the right staff and are empowered in decision-making about their treatment and care, are treated with dignity and respect in an environment that is welcoming
Safety	The extent to which the option ensures patients are treated safely, with fewer serious incidents and lower excess mortality

There were a few factors which participants in the criteria workshop identified as being important considerations without necessarily being useful criteria to differentiate the options. This included

- the importance of any chosen option having adequate parking arrangements, and
- mental healthcare provision being considered.

In other cases, like patient safety, participants felt that criteria might not differentiate between options, but were too important not to include in the consideration process.

4. Weighting workshop results

In the weighting workshop participants had the same introduction to the case for change, clinical model and potential solutions as in each of the other two sessions. Then participants were introduced to the criteria and had a chance to indicate the level of priority they would assign to each criteria (high/medium/low) with coloured markers. As with the criteria workshops technical advisors from PA Consulting provided advice about weighting and examples from other healthcare programmes. Participants went on to assign individual weightings to the options, which were collated, and an average weighting calculated and presented back to the group. A further discussion was held, where participants decided that there was not enough consensus on the weightings to agree them as a group and they preferred to revise their individual scores and use the average. The weightings below are the average of all participants' individual scores.

Criteria	Weighting
Accessibility	8.4%
Availability of beds	5.0%
Delivering urgent and emergency care	8.6%
Staff availability	7.1%
Workforce safety, recruitment and retention	6.9%
Alignment with wider health plans	3.9%
Integration of care	6.8%
Complexity of build	5.0%
Impact on other providers	5.3%
Time to build	3.0%
Deprivation	6.3%
Health inequalities	6.0%
Older people	6.0%
Clinical quality	7.8%
Patient experience	6.6%
Safety	7.3%
Total	100.0%

5. Scoring workshop results

In the scoring workshop participants had the same introduction to the case for change, clinical model and potential solutions as in the other two sessions. After this the group worked through each criteria in turn. One of the professionals gave a five-minute presentation of the best available evidence on each criterion, followed by ten minutes of discussion and clarification questions at tables before participants recorded their scores. Participants were asked to score each of the three options (major acute services at Epsom, Sutton and St Helier) and for the 'no change' scenario for comparison. It is important to note that the CCG's do not believe the 'no change' scenario is possible, and this was explained in the workshop, it is presented purely for comparison.

The table below shows the average scores for each criterion and each option. You can see the full criteria descriptions in chapter 4, and you can review the evidence presented for each criterion in the appendices. To calculate the average score, we added up each participant's scores and divided the total by the number of scores[1].

	Epsom	Sutton	St Helier	No change
Accessibility	5.39	6.17	5.26	6.70
Availability of beds	6.57	7.48	7.39	5.65
Delivering urgent and emergency care	5.86	7.00	6.23	6.36
Staff availability	7.48	7.83	7.91	3.22
Workforce safety, recruitment and retention	6.52	6.91	6.74	4.00
Alignment with wider health plans	6.91	7.17	6.74	2.74
Integration of care	6.17	6.74	6.17	5.30
Complexity of build	5.91	8.04	5.00	4.61
Impact on other providers	3.52	6.70	6.48	5.59
Time to build	5.70	7.57	4.61	4.87

[1] For all criteria except 'Delivering urgent and emergency care' and the 'impact on other providers' for the no change option, this is the average of all 23 participant scores. One participant did not provide scores for all 'delivering urgent and emergency care' and the no change option for 'impact on other providers' and so the average is of the remaining 22.

Deprivation	4.13	5.57	5.30	4.87
Health inequalities	3.70	4.13	3.87	3.52
Older people	6.35	5.91	5.57	5.43
Clinical quality	6.48	6.35	6.91	3.74
Patient experience	6.04	6.26	6.65	4.30
Safety	7.04	7.43	7.39	4.61
TOTAL	**93.78**	**107.26**	**98.23**	**75.52**

6. Combined outputs

The final step of the process, which did not take place during the workshop, was to combine the scores and weighting for each criterion to produce a weighted score, as shown in the table below. These figures have been scaled to give scores out of ten, so they are directly comparable with the unweighted scores.

Criteria	Weighting	Epsom	Sutton	St Helier	No change
Accessibility	8.4%	0.45	0.52	0.44	0.56
Availability of beds	5.0%	0.33	0.37	0.37	0.28
Delivering urgent and emergency care	8.6%	0.50	0.60	0.54	0.55
Staff availability	7.1%	0.53	0.55	0.56	0.23
Workforce safety, recruitment and retention	6.9%	0.45	0.48	0.47	0.28
Alignment with wider health plans	3.9%	0.27	0.28	0.26	0.11
Integration of care	6.8%	0.42	0.46	0.42	0.36
Complexity of build	5.0%	0.30	0.40	0.25	0.23
Impact on other providers	5.3%	0.19	0.35	0.34	0.29
Time to build	3.0%	0.17	0.23	0.14	0.15
Deprivation	6.3%	0.26	0.35	0.33	0.31
Health inequalities	6.0%	0.22	0.25	0.23	0.21
Older people	6.0%	0.38	0.36	0.33	0.33
Clinical quality	7.8%	0.50	0.49	0.54	0.29
Patient experience	6.6%	0.40	0.42	0.44	0.29
Safety	7.3%	0.51	0.54	0.54	0.34
Total	**100.0%**	**5.89**	**6.65**	**6.21**	**4.79**

Appendix A: Workshop participation

A.1 Names of professional participants and observers

The criteria workshop was attended by 11 community members and:

Advisors (5)	Professional participants (8)	Observers (4)
Dr John Clarke, ESHT	James Blythe, Managing Director Merton CCG	David Clayton-Smith, independent chair IHT programme board
Andrew Demetriades, IHT programme	Michelle Rahman, Managing Director, Sutton CCG	David Williams, Healthwatch Sutton
Charlotte Keeble, IHT programme	Jeff Croucher, Clinical Chair Sutton CCG	Pete Flavell, Healthwatch Merton
PA Consulting (x2 colleagues)	Karen Worthington, GP Clinical Governing Body Member Merton	Nigel Colin, IHT Stakeholder Reference Group and College Ward RA Committee
	Susan Gibbins, Lay member Sutton CCG	
	Jacky Oliver, Lay member Surrey Downs CCG	
	Clare Gummett, Lay member Merton CCG	
	Simon Williams, Clinical Director Surrey Downs CCG	

The weighting workshop was attended by 13 community members and:

Advisors (5)	Professional participants (3)	Observers (5)
Dr John Clarke, ESHT	Dr Douglas Hing, Clinical Director Merton CCG	David Williams, Healthwatch Sutton
Andrew Demetriades, IHT programme	Sue Tresman, Lay member Surrey Downs CCG	Saffron Pineger, Freshwater communications
PA Consulting (x3 colleagues)	Pippa Barber, Lay member Sutton CCG	Melanie Martin, Sutton CCG
		James Blythe, Managing Director Merton CCG
		Simon Williams, Clinical Director Surrey Downs CCG

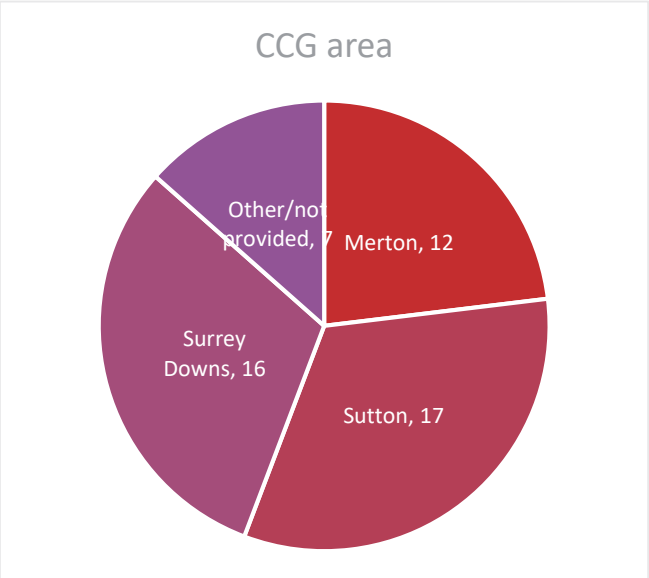
The scoring workshop was also attended by 14 community members. The

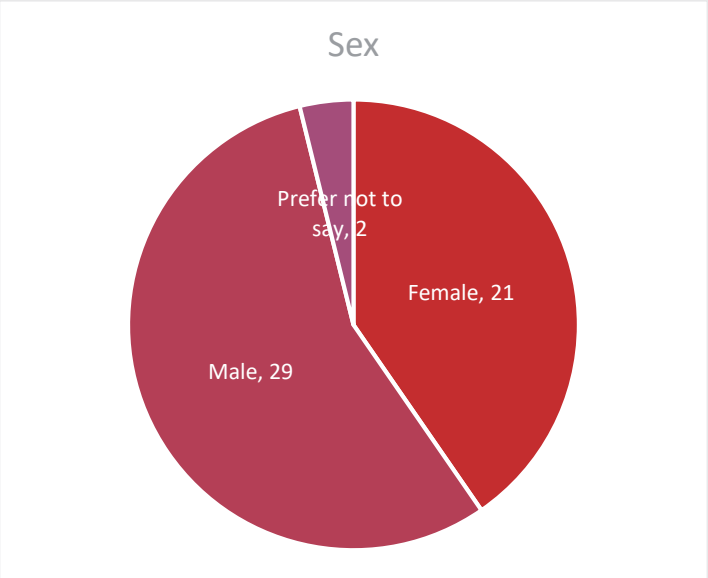
scoring workshop had a larger number of advisors than the previous workshops in order to present evidence on particular criteria, for example the consultants who prepared the deprivation and travel time analysis.

Advisors (10)	Professional participants (10)	Observers (5)
Andrew Demetriades, IHT Programme	Jonathan Perkins, Lay member Surrey Downs CCG	Pete Flavell, Healthwatch Sutton
James Marsh, Medical Director ESHT	Andrew Leigh, Lay member Merton CCG	David Clayton-Smith, Independent Chair IHT Programme Board
Trevor Fitzgerald, Director of Estates, ESHT	Les Ross, Lay member Sutton CCG	Saffron Pineger & John Underwood, Freshwater Communications
Frances Parrott & Neil Hurst, Mott McDonald	Dr Russell Hills, Clinical Chair Surrey Downs CCG	Barry Creasy, the Consultation Institute
Tim Pope & Toby Irving, PPL	Dr Jeff Croucher, Clinical Chair Sutton CCG	Suzi Shettle, Communications Lead Surrey Downs CCG
PA Consulting (x3 colleagues)	Dr Andrew Murray, Clinical Chair Merton CCG	
	Matthew Tait, Accountable Officer Surrey Heartlands	
	Sarah Blow, Accountable Officer SW London Alliance	
	James Murray, Chief Finance Officer SW London Alliance	
	Karen McDowell Chief Finance Officer Surrey Downs CCG	

A.2 Participant demographics

The data below outlines the key demographic information for community and professional participants across the three workshops. This information was gathered voluntarily through equalities monitoring forms, with 52 of the 59 participants completing the forms.


CCG area
Other/not provided, 7
Merton, 12
Surrey Downs, 16
Sutton, 17


Sex
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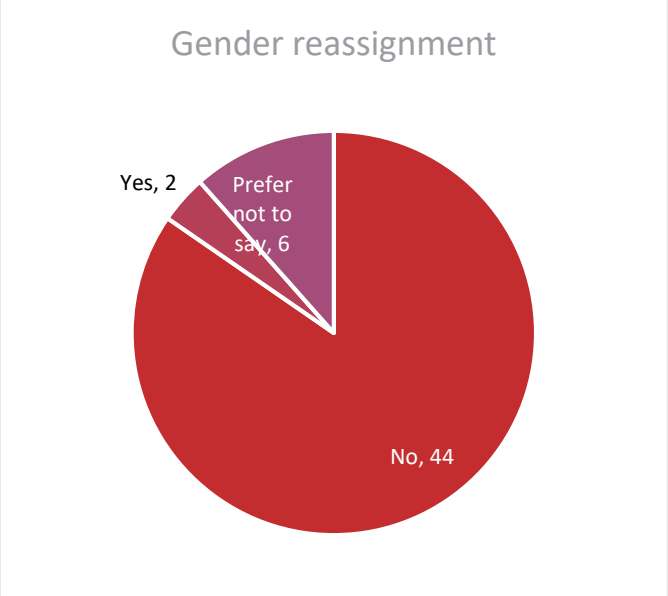
Male, 29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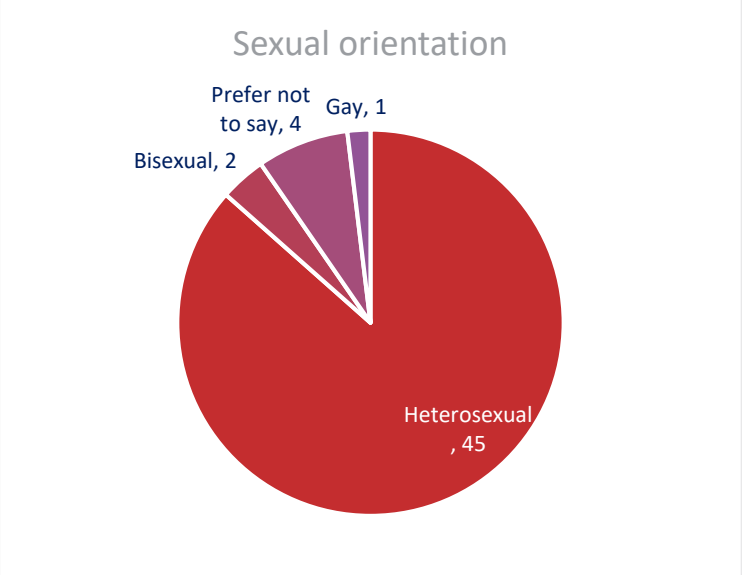
No, 44


Sexual orientation
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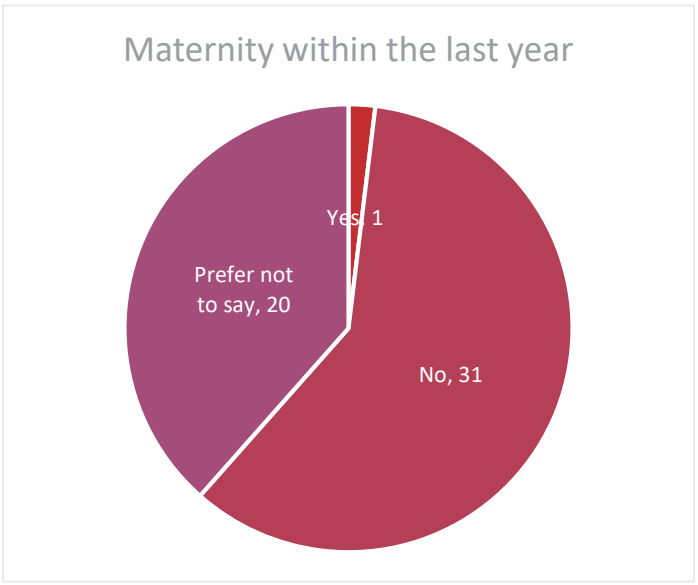
Gay, 1
Bisexual, 2
Heterosexual, 45


Maternity within the last year
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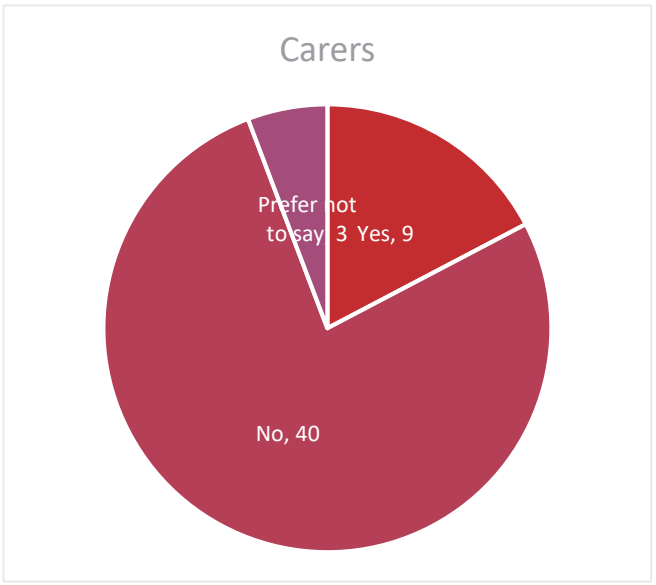
Carers
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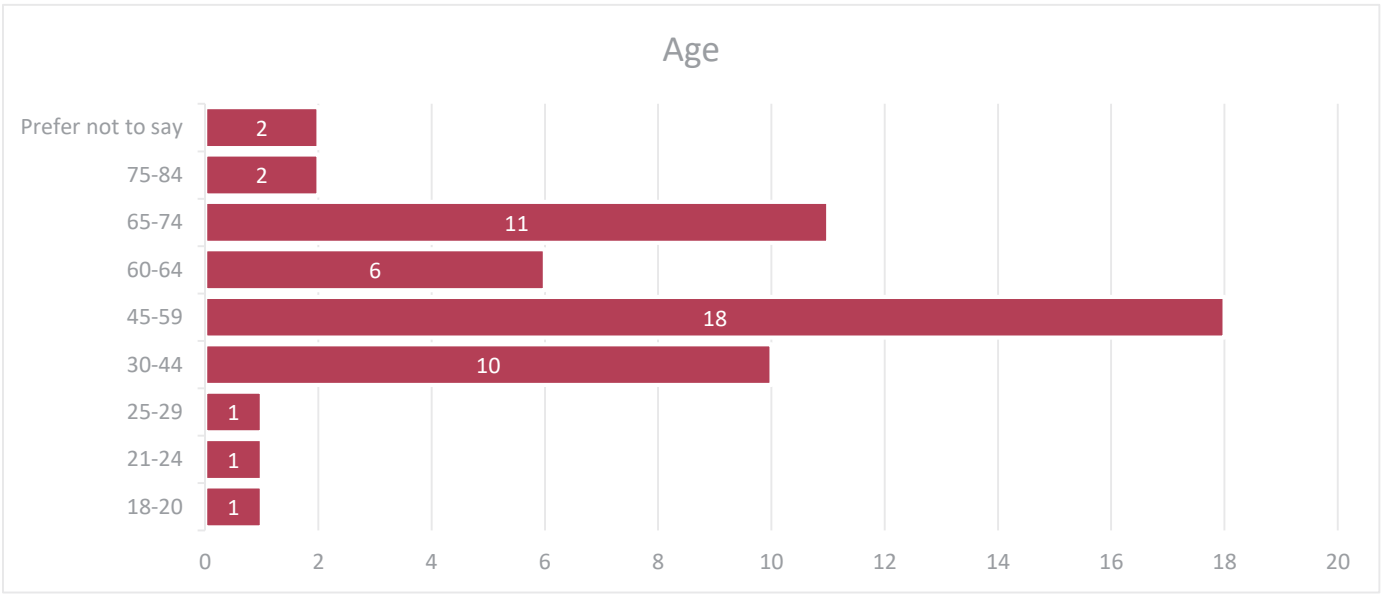
Yes, 9
No, 40


Age
Prefer not to say
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60-64
45-59
30-44
25-29
21-24
18-20
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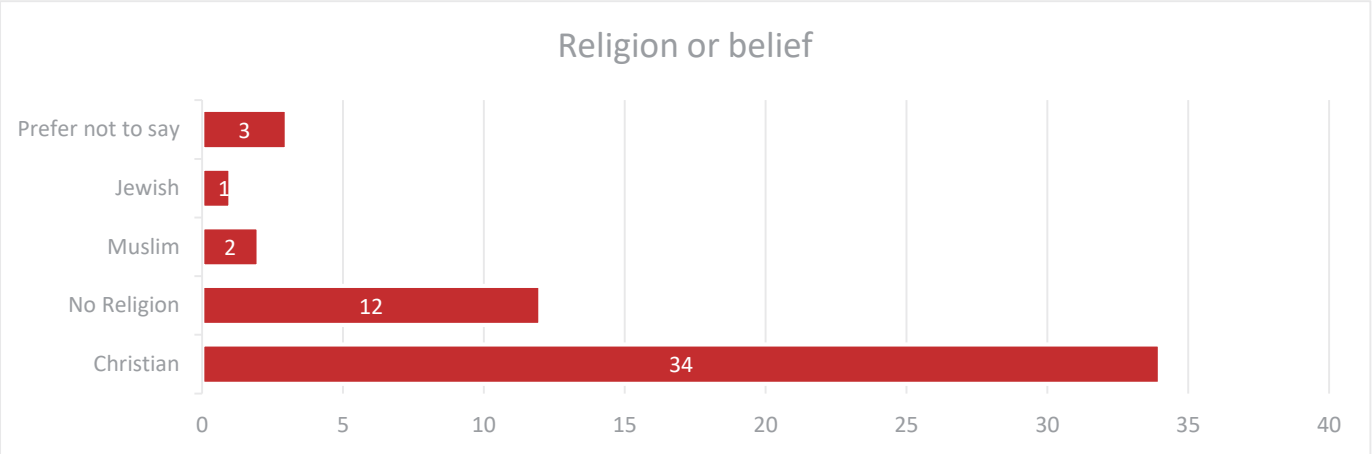
16
18
20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Muslim
2
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Christian
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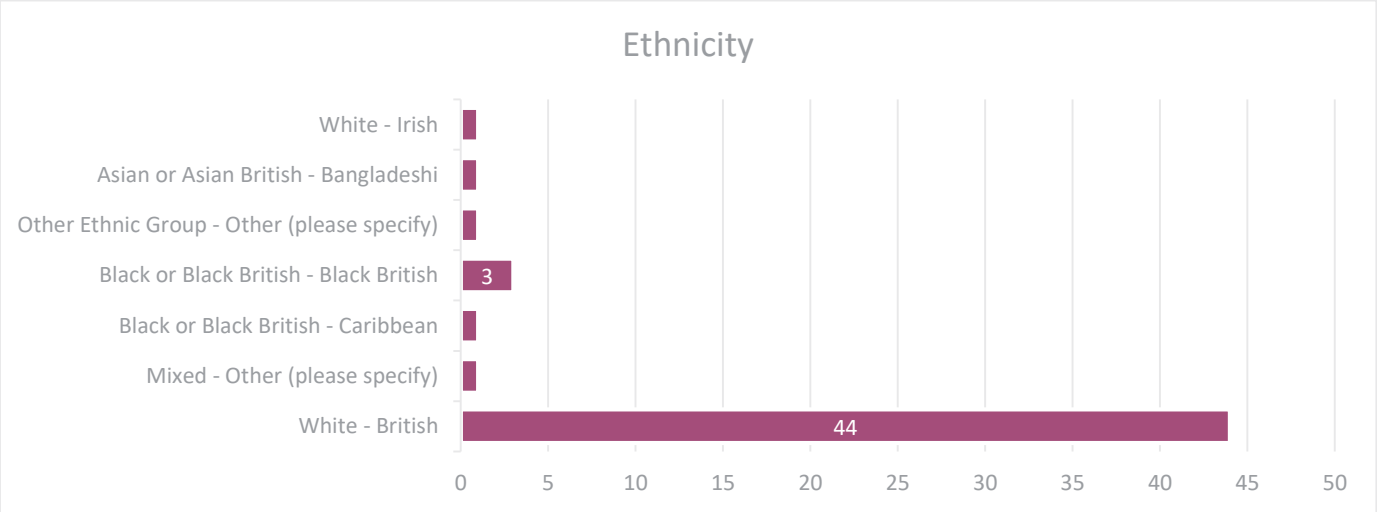
5
10
15
20
25
30
35
40


Ethnicity
White - Irish
Asian or Asian British - Bangladeshi
Other Ethnic Group - Other (please specify)
Black or Black British - Black British
3
Black or Black British - Caribbean
Mixed - Other (please specify)
White - British
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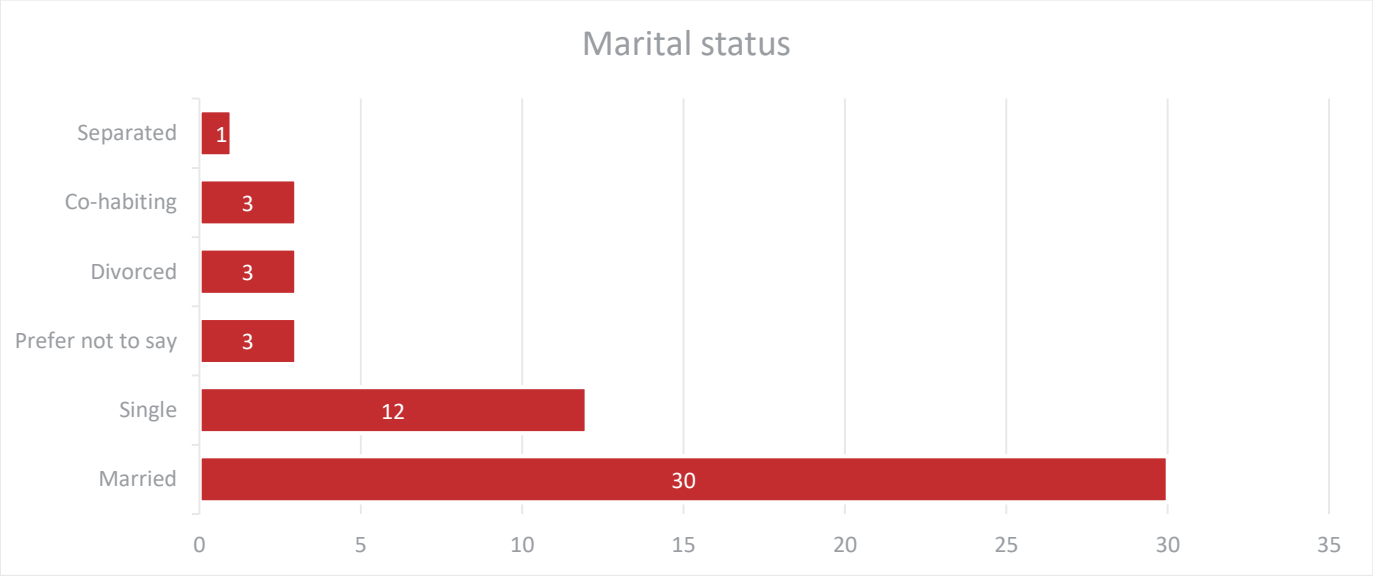
0
5
10
15
20
25
30
35
40
45
50


Marital status
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Co-habiting
3
Divorced
3
Prefer not to say
3
Single
12
Married
30
0
5
10
15
20
25
30
35

A.3 Recruitment materials

The advert used to promote the events to local community members:

Improving Healthcare Together 2020-2030
NHS Surrey Downs, Sutton and Merton CCGs

NHS

Epsom and St Helier Hospitals – get involved in the future of your local hospitals

We face many challenges at Epsom and St Helier hospital around the staff, buildings and finances.

Sutton, Surrey Downs and Merton Clinical Commissioning Groups are looking at these challenges and trying to decide the best way to solve them. We have some potential options and we want local people to have a genuine say in how the best option is chosen.

An independent research company called Traverse (https://traverse.ltd/) will be running workshops on behalf of the NHS to **develop a recommendation about the options.**

You will be given information, to help you to give your opinion about how you think the NHS should make this decision.

Who do we want to speak to?

We'd like to hear from **residents who have used either Epsom or St Helier hospital in the last twelve months.**

We'd also like to hear from **local residents with disabilities and carers that use these hospitals.**

When do we want to speak to you?

There are three half-day workshops. You only need to attend one workshop, so please look at the following dates and see if you are available:

- Monday 29th October, 13.00-17.00, Bourne Hall, Ewell
- Tuesday 6th November, 13.00-17.00, The Sutton Life Centre

- Wednesday 14th November, 13.00-19.30, Wimbledon (exact location TBC)

Why should I take part?

The main reason to participate **is to be involved in this important decision** that impacts your area. So most of all we want people who take that responsibility seriously. We do recognise that we are asking you to give up your time, so we are offering **£50 to each participant**. If you incur additional costs such as childcare, we may be able to reimburse that as well. We can discuss that with you and make a decision on a case by case basis.

How do I take part?

If you are available on these days and would like to be involved. Please contact, Duncan Grimes, one of the independent researchers who will be running the discussion at:

Email: Duncan.grimes@traverse.ltd

Mobile phone: [removed for publication]

Thank you!

Your views are important and will help us to deliver better health care for local residents.

Sutton

Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:** 7 February 2019	
Report title:	Response from Epsom & St Helier University Hospitals NHS Trust to the report on the Options Consideration Process by Traverse		
Report from:	David Olney, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author /Contact Number:	David Olney, Statutory Scrutiny Officer, 020 8770 5207		
Corporate Plan Priorities:	• Being Active • Making Informed Choices • Living Well Independently • Keeping People Safe		
Open/Exempt:	Open		
Signed:	David Olney	**Date:**	17 January 2019

1. Summary

1.1 The report attached provides a response from Epsom and St Helier Trust to the report by Traverse on the Options Development Process.

2. Recommendations

The Scrutiny Committee is recommended to:

2.1 Consider and comment on the report.

3. Background

3.1 In order to provide the Improving Healthcare Together, Joint Health Sub-Committee with a wider view of the work conducted for the Options Development Process Epsom and St Helier Trust was asked to provide their observations and comments on the Traverse report.

4. Appendices and Background Documents

Appendix letter	Title
A	Independent Report on the Options Considerations Workshops

Audit Trail		
Version	Final	Date: 23 January 2019

Background documents
None

Epsom and St Helier University Hospitals NHS Trust

Joint Health Scrutiny Committee Meeting

Report Title	Independent report on options consideration workshops - Epsom and St Helier University Hospitals NHS Trust
Meeting Date	7 February 2019
Lead Executive	Daniel Elkeles, Chief Executive
Summary	Epsom and St Helier University Hospitals NHS Trust was pleased to see that Merton, Surrey Downs and Sutton clinical commissioning groups (CCGs) had come together to develop the Improving Healthcare Together (IHT) 2020-2030 programme which aims to address long-standing challenges at Epsom and St Helier hospitals. This follows on from the engagement work the Trust undertook the summer and autumn of 2017. Following best practice advice from The Consultation Institute, the IHT programme developed a process for working collaboratively with local people and professionals. Part of this work was undertaken by Traverse, an employee-owned engagement and research organisation, commissioned by the IHT programme to act as an independent facilitator for the options consideration process in October and November 2018. As a Trust we are very supportive of the approach to engage local communities and professionals in shaping any options and decisions about the long-term future of healthcare and particularly local hospitals. Gaining a wide range of perspectives is vital to inform any future decisions. The workshops undertaken are only part of the process to inform any proposals which will of course be subject to a full public consultation. What was clear from theses workshops is that the participants agreed that there was a need for change and that 'no change' is not an option for the future. It also showed that when the participants reviewed the case for change, the clinical model and the potential solutions, applying 16 different criteria developed by the workshop participants, the option of locating the new acute hospital facility on the Sutton site scored highest overall. This information will be used alongside all of the

	feedback the CCGs have received, and continue to receive, to inform any decisions they take. The Epsom and St Helier Trust Board has been clear that it does not have a preferred option and it maintains this position. It is evident that change needs to occur and the Trust wants to provide the highest quality care for the people it services for generations to come. The issues facing the Trust are significant. Over the next 10 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 21st century buildings; and • **Achieving a financially sustainable** position. 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. The Trust is fully committed to supporting the CCGs in their bid to attract c.£500m to build a new acute hospital facility on one of our sites and to continue to provide the majority of care locally.

Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:** 7 February 2019	
Report title:	Reports from local Healthwatch on focus groups with protected characteristic groups		
Report from:	David Olney, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author(s)/Contact Number(s):	David Olney, Statutory Scrutiny Officer, 020 8770 5207		
Corporate Plan Priorities:	• Being Active • Making Informed Choices • Living Well Independently • Keeping People Safe		
Open/Exempt:	Open		
Signed:	David Olney	**Date:**	4 January 2019

1. Summary

1.1 The three local Healthwatch organistions in scope to the Improving Healthcare Together programme, Merton, Surrey and Sutton held focus groups with people from protected characteristics groups. The suite of reports attached sets out their findings :

- Merton Healthwatch : BAME report; Carers report; Older people report.
- Surrey Healthwatch : Interviews with People with Learning Disabilities; Interviews with Carers; Interviews with Older People.
- Sutton Healthwatch : BAME report; Carers report; Older people report.
- Overall Summary Report

2. Recommendations

The Scrutiny Committee is recommended to:

2.1 Consider and comment on the reports.

3. Background

3.1 The Improving Healthcare Together 2020-2030 programme has commissioned a range of supporting work for its programme including independent reports by the local Healthwatch bodies on the possible effects on people from protected characteristics groups.

3.2 The Improving Healthcare Together (IHT) JHSC sub committee will consider and review these reports and the IHT Equalities responding report (also included as a seperate item on this agenda) as part of their ongoing scrutiny oversight of the programme.

4. Appendices and Background Documents

Appendix letter	Title
A 1-3	Healthwatch Merton reports
B 1-3	Healthwatch Surrey reports
C 1-3	Healthwatch Sutton reports
D 1	Healthwatch overall summary

Audit Trail		
Version	Final	Date: 23 January 2019

Background documents
None

Improving Healthcare Together – Group discussion with BAME residents in Merton

Introduction

Healthwatch Merton engaged with:

- A group of five BAME residents, aged between 45 – 62. Three were of Asian British background, and one each of African and Caribbean heritage. Four were female, one was male. The session was held on Friday 19th October at the Vestry Hall, London Road, Mitcham, CR4 3UD.

Priorities / Main Criteria for 'Good Healthcare'

Participants felt they were well served with hospitals locally – thanks in part to the area being very densely populated and diverse. Linked to that, accessibility is a priority (as it is in other groups), and St George's Tooting especially was deemed easy to get to (although it had expensive parking). There is a 'blessing and curse' element however; St George's is a major trauma centre on people's doorstep – but with such a wide catchment area for emergency cases, its more routine appointments can sometimes be cancelled or delayed.

Staff attitude was important, and most were seen to be doing their best in 'difficult circumstances'. Mental health was cited as one example; people attending A&E with mental health problems caused greater stress for both those patients and the staff who are not necessarily specially trained. On the positive side, local hospitals are familiar with Sickle Cell Anaemia and other conditions associated with specific ethnic groups.

A quick, efficient and pragmatic booking system has helped people be seen for appointments more quickly than at first expected.

What Needs Improving Most?

The system was generally felt to be 'creaking' and the discharge system especially.

'Attitude of the staff is great, but the discharge system is dreadful – I've had it at St Helier, St George's and Kingston. You get told 'you're ready to go', they take your bed and you can wait for hours waiting for a consultant sign-off or for medication. It's so inefficient.'

As noted, capacity was generally seen as an issue, with overcrowding and long queues in A&E and a system operating at full capacity.

'We're blessed with good specialisms and trauma services at St George's, but that has knock-on effects as your operation might be postponed if a new emergency arrives.'

Also, there are specific mentions that special needs (Learning Disabilities and Autism) or elderly residents are not prioritised.

The Principle of Integrated and Site-Focussed Acute Services (prefaced by overview of safety / modernity / funding issue)

As found with other participants, the need for change was generally understood and generally the priorities were the right ones - focussing on patients, staff and quality of service delivery.

The infrastructure was generally considered in need of updating.

'There is not a great deal of leverage on the St Helier site, but it is an old building and in need of updating. But there are transport and access issues with the site more generally.'

Participants already thought that Sutton Hospital had closed many of its services, and although most wouldn't necessarily use it, it was an under-used asset.

Potential Solutions – Acute Services only at Epsom, St Helier or Sutton Hospitals

Because participants felt they were already quite well served with local health services, they felt any of the proposed changes wouldn't really affect them – although there was concern that it may impact on capacity.

'If you do move acute services from St Helier, people would probably just switch to St George's, Kingston or [Croydon University] *Mayday.'*

However, they acknowledged it would affect a considerable number of people and had to be managed carefully.

'It's only around 5 miles or so from St Helier to the next hospital with acute services - but think of the number of people in those 5 miles. You want somewhere local and accessible for these services. It's also an emotive issue locally.'

Concern around Epsom in part reflects the less diverse demographics that it caters for.

'I would be concerned that Epsom Hospital would be able to meet my cultural needs in terms of food, language and cultural sensitivity.'

'Epsom is not a London Borough so it's not even in the psyche. It appears further than it might actually be. I think it would be the fifth choice if asked.'

****

HWM Associates – 24th October 2018

Improving Healthcare Together – Group discussion with Carers in Merton

Introduction

Healthwatch Merton engaged with:

- A group of four carers. Two were female and two male – two White British and one each Indian and Pakistani. None had long-term conditions themselves. Precise ages were not recorded, but participants were middle-aged or elderly. The session was held on Monday 15th October at the Vestry Hall, London Road, Mitcham, CR4 3UD.

Priorities / Main Criteria for 'Good Healthcare'

Good integrated communication was emphasised – for example the requirement that GPs keep a list of carers. Is this happening, and does the public know about it (even if the CCGs do) ?

SMI (Severely Mentally Ill) registers were also noted as important to keep up to date.

'Is Healthwatch keeping a beady eye on the 26 local GP practices in this area?'

What Needs Improving Most?

One plea was for healthcare statistics (*'they already exist'*) to be fully used to give an overall picture of, and so improve, local healthcare provision.

On the resourcing front, a severe shortage of beds was highlighted – with the result that patients are transferred to places such as Roehampton *'..which people have no connection with'*, and carers too are inconvenienced. Another incident involved a carer (who needed to stay with her brother with LD overnight) having only a sofa to sleep on. The LD Nurse was not present – so the problem went unresolved - but in fact help could have been rendered by several other people, but for their job title not 'fitting' the situation.

So-called 'open appointments' were also unpopular; people being told to arrive early am for eg a minor procedure at an eye clinic, but then having to wait several hours for the process to run its course. It also causes uncertainty of the cost for paying for people to attend with the person.

Geographically, Merton has some particular challenges. It has no hospital of its own, so residents (depending on their exact location) might be referred to St Helier or St George's, or to Kingston / Croydon University Hospitals if they are towards the edge of Merton's boundary. Roehampton is also sometimes in the frame.

For those who drive, high parking charges are criticised. *'It's a headache'*.

The Principle of Integrated and Site-Focussed Acute Services (prefaced by overview of safety / modernity / funding issue)

'Uproar' was the initial reaction of one person to St Helier *'being touched'* or of acute services being concentrated at one site. However others were less vociferous - in part because St George's (which would be unaffected by the acute changes) is a familiar and convenient backstop if St Helier is for some reason not available.

The need for change in principle was neither expressly supported or opposed – though we should note that this was a small sample of people so not necessarily representative. The priorities of patient care quality, improved integration and modernisation had all been embraced. Furthermore, the familiar themes of staff 'doing their best' and reported shortages of basics (eg pillows and clothes hooks) highlighted a perceived lack of resources (even if this was not expressed in terms of money alone).

Reactions to staff shortages vary: patients and visitors can judge very quickly whether a shortage of nurses (or sufficiently qualified / specialised nurses) exists. If it does, it impacts on the quality and safety of care. However, any shortage of *consultants* is not self-evident, and people do not always make the link between such a shortage and with their own care being jeopardised. Indeed, it is sometimes viewed as *'your [*NHS] *problem'* not *'our* [patient] *problem'*.

Potential Solutions – Acute Services only at Epsom, St Helier or Sutton Hospitals

The three-way Epsom vs St Helier vs Sutton choice seems not wholly applicable to this group – partly as St George's is so often the first or second port-of-call, and because Sutton Hospital is not really on the radar screen. By contrast, Croydon University and Kingston Hospitals are (to some extent) 'in play'. St George's hand is also strengthened by the well-respected and on-site Moorfields Eye Centre.

Overall though, St Helier is the first choice of the three sites proposed; despite its poor state of repair, it enjoys the *'loyalty'* of local people – albeit that the 'Save St Helier' campaign has perhaps outlasted its ability to mobilise general opinion.

Epsom has its well-regarded knee and hip replacement service, but the layout and signage need considerable improvement. It is also *'another world'* for Merton residents in terms of the demographics it serves, and would be difficult to get to by bus or car. On a related note, would higher house prices in Epsom rule out staff being able to relocate from their current homes ?

Sutton Hospital is seen as *'at best a rump of some old buildings'* with very few services. This group had no sense that the partly-demolished site therefore had *potential* to be redeveloped from scratch.

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HWM Associates – 24th October 2018

Improving Healthcare Together – Discussion group with Older People in Merton

Introduction

Healthwatch Merton engaged with:

- A group of six older residents aged 58-82. The group comprised four male and two female participants. Four of the group had a long-term condition or disability and participants were of Pakistani, Indian, Black British and Caribbean heritage - and one of a mixed ethnic background. The session was held on Wednesday 17th October 2018, at the Vestry Hall, London Road, Mitcham, CR4 3UD.

- People used several different hospitals – St Helier was the closest (and most used) but many also used St George's Tooting as well as occasional historical visits to Epsom and Sutton (although Sutton is not used recently as the specific treatments [eg ophthalmology] were reportedly no longer offered there).

Priorities / Main Criteria for 'Good Healthcare'

The key criteria were those commonly found elsewhere – convenience of access (via bus) was paramount overall – somewhat more so than a close location per se. Friendly staff, quick appointments and cleanliness were also valued.

There are 3 or 4 different buses that go to St George's from around my house, so I go there – it's the easiest.'

'Epsom hospital is difficult to get to from me and St George's has expensive parking'

Reputation also mattered, with St George's felt to have the best overall.

What Needs Improving Most?

As with other groups, participants felt staff did their best in difficult circumstances and that the estate was aging – and often unsuitable for modern healthcare.

'St Helier is difficult to navigate your way through – it's all bits and pieces'

There were concerns that some hospitals were closing important departments and some services were being lost – with some becoming more difficult to access.

'I used to go to Sutton for my eye care, but the department closed and I now have to go to Moorfields at St George's.'

Perceptions were that ‘the system’ was not being run as it could be - and one questioned whether it was actually working with the patient as the main priority in regards the shortage / allocation of consultants.

‘I asked [at a meeting]: *are you working for the patient or for the consultant?’*

The Principle of Integrated and Site-Focussed Acute Services (prefaced by overview of safety / modernity / funding issue)

Some participants had previously heard of potential changes being planned locally and of a promised modernisation programme. They generally agreed that change was needed in some form to bring about the necessary improvements.

‘St Helier’s definitely needs upgrading and urgently needs money being spent on it – it’s falling down.’

‘The local press has been saying for ages that St Helier is inappropriate for modern medicine and it should be knocked down. They’ve been talking about change for years.’

Potential Solutions – Acute Services only at Epsom, St Helier or Sutton Hospitals

There were concerns here – mainly the need for emergency services to remain close and easily accessible.

‘My condition meant I had to get to A&E quickly, so proximity is a major factor. I could have been dead in 10 minutes.’

Changes at Sutton or Epsom would not really affect the group much as they were rarely used and not particularly convenient to get to - but there was an understanding that any changes would affect communities local to each site.

St Helier was the preferred choice overall. As in other discussions the view was that its unpromising exterior disguised good quality services and staff – and relativelu good public transport links.. The Renal Unit was singled out for praise by one person. Participants all felt it was necessary to develop the St Helier site, and as a stop-gap they would use St George’s (as they presently do).

Importantly too, participants felt the modernisation of St Helier would bring significant benefits to the community more widely. The regeneration project would have far greater implications than just more modern healthcare facilities; the work would help the poorer communities presently situated close to the hospital. (In that regard a contrast was made with the more affluent catchment area of Epsom).

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HWM Associates – 24th October 2018

Improving Healthcare Together

Interviews with People with Learning Disabilities (LD)

1) Introduction

Healthwatch Surrey has engaged with the following people with LD:

- Three depth interviews with people with LD (2 female, 1 male, aged between 21 - 53, all White British. One depth interview with the Father of a daughter with LD (63 years old, White British). The interviews were held on Thursday 27th September 2018 in Epsom.
- One group session of 7 people with LD (5 female, 2 male, aged between 20 - 48, 6 White British and 1 mixed ethnic background). Two senior members of staff from The Grange Centre for People with Learning Disabilities also took part in this group session. The group was held on Monday 1st October 2018 in Little Bookham.

2) Priorities / Main Criteria for 'Good Healthcare'

"We need the best care and the shortest journey"

The people interviewed lived either at home with their parents or in specialist Residential Care with a fair degree of autonomy. Some have local work placements, and most have their own bedrooms within a small sub block with shared living room, dining room and kitchen. Regardless of circumstance, people's **parents** are usually their central focus in terms of who cares for them (in the broadest sense). Anything which jeopardises that causes uncertainty and fear.

Against this backdrop, some with LD are not *directly* affected by some of the day-to-day logistics of accessing services. They are taken or accompanied there either by a parent, by their community-based carer, or by their care home's own transport. However, they all adhere to the basic principle that – for acute situations – short journeys are better than long journeys.

"If you had a heart attack, you'd have to drive further. That's improving the service is it?"

LD are often accompanied by a myriad of other health conditions – so for those making their own way to multiple appointments, consistency is a great advantage.

"I go [to hospital] *for four things: bones, ears, epilepsy and diabetes. Always to Epsom"*

3) What Needs Improving Most?

For LD respondents, the emphasis is often more on maintaining the status quo than on making improvements. Improvements mean change, and change means uncertainty. However, comments on the relative performance of A&E versus in-hospital services do echo those of carers:

"The first responders were very good, very understanding of the [residential care] *environment they were in. But once you're in hospital it's not so good; hospital passports get lost or returned and there are misdiagnoses"*

Information is also important: *"How do they make people better if they're feeling poorly?"* The hospital food comes in for some criticism from one: *"It was crap"*

Staffing shortages are seen by carers for LD as less pertinent than the training which staff receive. Ideally, there would be a specialist LD liaison nurse at every hospital (whether for district or acute situations).

4) The Principle of Integrated and Site-Focussed Acute Services (prefaced by overview of safety / modernity / funding issue)

Many LD participants have multiple health conditions, and they are patients not only at local Surrey and South London hospitals (e.g. St. George's Tooting and St. Peter's Chertsey), but also at the major London teaching hospitals such as Guy's, St. Thomas' and the National ENT Hospital at UCLH – where they receive more specialist care from audiologists and bone specialists. Respondents understand that any amalgam of *local* acute services would not affect those provided in the capital. That said, there is concern at any potential change:

"There are quite a few ambulances. If they all go to one hospital it might be a bit overcrowded"

"The car park might be a bit crowded. People with LD might find it a bit hard and challenging; they don't like crowded places. Prefer to be quiet. Also all the nurses would be running around"

Staff shortages were raised as a concern by those with LD – but no link was made between easing this and a one-site approach:

"We're 40,000 nurses short [nationally] *and that won't get any better if we start banning EU nationals coming here – or even sending them home. If you can't attract new staff now, how will you if there's only one site?"*

5) Potential Solutions – Acute Services focussed at Epsom, St Helier or Sutton Hospitals

People with LD and those caring for them raise the two familiar concerns about a one-site solution – that it risks danger to patients and severe (if not impossible) disruption for visitors. Epsom is the best-known hospital and generally well-regarded:

"It's convenient to get to, we get good treatment when we're there, we get seen (not always on time) and we see the right doctors. We're also lucky as we have bus passes"

St Helier is not so familiar and few were able to comment on it for good or bad. Sutton is again surrounded by uncertainty - *"I think I've heard of it"* – and doubt that it could be a contender as the primary acute site.

Improving Healthcare Together

Interviews with Carers

1) Introduction

Healthwatch Surrey engaged with the following Carers:

- One depth interview in Leatherhead [57 yr old female White British, carer of Mother-in-Law]. The interview took place on Tuesday 18th September 2018 in Leatherhead.
- One group of 8 people in Banstead [7 female, 1 male, aged 52 - 90, all White British – and 2 with long-term conditions / disabilities. Carers for their spouse or children]. The group was held on Thursday 27th September 2018 in Banstead.

2) Priorities / Main Criteria for 'Good Healthcare'

Participants highlighted 'Joined-Up' care delivery as a priority:

- between staff on a ward
- between different wards
- different shifts (especially between weekdays and weekends)
- different hospitals and;
- between the health and care sectors

Furthermore, being listened to and seeing action taken within an individual service or in relation to a specific condition (e.g. Dementia) is crucial. Similarly, easy transport access for carers / family / visitors was important. Barriers to such access are (for drivers) traffic jams and car park fees and (for non-drivers) the presence /convenience of buses. The distance to hospital is crucial in discussing the site for acute services.

"It would be nice if there was one person who knew his case – so they could give me a proper update. You end up repeating things over and over again when he moves ward".

"My daughter has three big files, and the notes don't keep up with her if she's moved"

"The logistics of trying to take someone with advanced Alzheimer's on a long car journey to hospital are just unbelievable. So I'm grateful it's Epsom"

3) What Needs Improving Most?

Co-ordination between social care and everyday care. Individual staff are generally very well-regarded (and trying their best in difficult circumstances) but the system is not considered to be working well. Staffing levels of nurses is a concern. In general, A&E is well-regarded but "the system falls apart" when patients are admitted.

*"[My husband] had cancer and was in B5 Ward in St Helier. He needed the toilet but they said 's*** the bed' as they didn't have anyone to accompany him"*

"They transferred me from Epsom to St Helier. I was nil by mouth all over the weekend, and on Monday the consultant said 'I'm sorry – we thought you were discharged on Friday'"

"He had a UTI and was taken to St Helier. I can't fault A&E; excellent nurses and doctors telling you what was happening. But the further up the hospital you go the worse the care gets"

4) **The Principle of Integrated and Site-Focussed Acute Services (prefaced by overview of safety / modernity / funding issue)**

Many of the carers' concerns – the need for integration, co-ordination, continuity and effective communication of patient information – might, in theory, support a move to single-site acute services.

"With a financial background I appreciate the need to not over-duplicate and to have efficient and fit-for-purpose services. But there is a balance to be struck with serving local communities"

The 'Case for Change' – sufficient staffing at all levels, modern buildings and financial sustainability – is broadly accepted, but as noted some asked why not improve the existing multi-site arrangement. Buildings' physical condition is less cited than the need for *cleanliness* – and the idea that staff shortages will be tackled by concentrating services was not wholly accepted: '[individual staff members] *already work at both sites'*.

The 'Clinical Vision' was deemed about right – but crucially the need for 'integration' was taken by carers as improving co-ordination *between existing sites*, not closing down or moving them. The 'fairness' of any solution was difficult to judge – or just not felt possible if some have to travel further.

"I could probably afford a cab [if I didn't drive], *but a lot of people couldn't"*

"As carers, we just want to be able to get to the nearest place"

"We all have different expectations – and some drive, some don't – so you'll never please all"

5) **Potential Solutions – Acute Services only at Epsom, St Helier or Sutton Hospitals**

Carers could not agree on what *actual* change might be best. The appeal of better co-ordinated / integrated services could not trump the view that moving any acute services would mean greater journey times (for ambulances and visitors), risk and inconvenience. St Helier has a generally solid reputation, but is seen as slightly 'cold' and difficult to access by car. Epsom is if anything better-regarded, due to its location and less austere feel. Uncertainty surrounds the Sutton Hospital site.

"[Sutton Hospital] *has been basically closed. Blood tests are done there, and land was sold off."*

Improving Healthcare Together

Interviews with Older People

1) Introduction

Healthwatch Surrey engaged with the following Older People:

- A group of 16 participants aged between 68 – 86yrs with an average age of 78yrs. Four participants were male and twelve females, with fifteen White British and one mixed ethnic background. Four had long term disabilities. The group was held on Thursday 27th September 2018 in Esher.

2) Priorities / Main Criteria for 'Good Healthcare'

Overwhelmingly, participants stressed the importance of joined-up healthcare – GPs 'on the ground' in touch with social care providers and hospital staff.

It is important to walk in somewhere and feel it was clean and organised – somewhere you would feel 'safe in' – medically and generally. Staff were generally perceived as very caring – and 'doing their best in difficult circumstances'.

Ease of access was vital for these participants – whilst not necessarily a core component of healthcare as such, it was raised as an important aspect of the overall experience for this group. Ease of access encompassed affordability (use of bus passes and avoiding parking charges), frequency of the service and importantly how direct the service was. Many chose to use Kingston hospital as it was so easily accessible via public transport – even though it was not necessarily the nearest:

"We're spoilt here as we can get a bus direct to Kingston Hospital every 15 minutes – and use our bus passes. Buses don't go directly to the other hospitals around here and parking costs a fortune so most of us choose to go to Kingston – it's the easiest to use. That's a great advantage"

Reputation counts too – some of the participants would reluctantly use St Helier hospital as it had had historical MRSA problems. Word of mouth was the main source of these reports.

"St Helier has a rather dicey reputation as it was one of the first hospitals where MRSA was out of control. The protective wards were full so infected patients were put on open wards making the situation worse"

3) What Needs Improving Most?

The issue they thought most important was the need for a joined-up service. There was frustration that there was no central record of a patient's medical requirements ensuring the 'left arm could see what the right arm was doing'. The links that exist with social care are now perceived to be much weaker putting further pressure on the system. There was a

recognition that this is now being prioritised – though needs more money and focus. It was generally felt that the system was creaking – or not really working as it should be. The staff did their best (as stated earlier) but there were frequent mentions, too, of perceived inefficiencies.

4) **The Principle of Integrated and Site-Focussed Acute Services (prefaced by overview of safety / modernity / funding issue)**

Participants largely understood the case for change – it wasn't a case of just 'throwing more money at the problems'. Financial responsibility was deemed a necessity for a sustainable service, although how the funding works in practice is found to be rather confusing. What happens if a Trust does overspend/Do they need to recoup that money in the following years/Who pays for an overspend were some of the more commonly asked questions.

They appreciated that some of the infrastructure is old and unsuitable and needs updating, and staff could perhaps be better used in fewer locations to create 'centres of excellence'.

It was thought that the clinical vision was about right with the improved integration of care the most pressing issue to them.

5) **Potential Solutions – Acute Services focussed at Epsom, St Helier or Sutton Hospitals**

Despite understanding the case for change – and agreeing with the clinical vision – participants couldn't agree on the need for *actual* change. They all felt that moving any acute services would mean longer journey times in case of emergency and therefore greater danger. Revisiting thoughts on inefficiencies, they thought that if the system was run better – and there was less 'bed blocking' – then these changes wouldn't be necessary.

"The thought of closing down [some acute services] specifically at any hospital absolutely horrifies me. If you need A&E for anything you need to get there fast and don't want to have to go 12-15 miles, possibly through traffic. It could be too late by the time you get there."

"If you go to A&E on a Friday night, it's already too busy – standing room only. How would it help closing any down? Closing down maternity units too would cause issues"

"Not closing (or running down) the cottage hospitals would help – these could alleviate pressures on the bigger hospitals"

A huge amount of reassurance would be needed to convince participants that these changes would not result in greater journey times in the event of an emergency and if they did, then safety would not be compromised. Even though many did not presently use their nearest hospital, they still felt reassured knowing the acute services were close by if needed. Saying that, one of the vital considerations in any change would be accessibility – how easy the hospital would be to actually get to.

Healthwatch Sutton

Improving Healthcare Together – Discussion Group with BAME Groups in Sutton

1) Introduction

Healthwatch Sutton engaged with the following Black, Asian and minority ethnic (BAME) groups:

- African & Caribbean Heritage Association (ACHA), Sutton. A group of 14 older people (aged 62 - 82). 12 were female and 2 male. 5 were of Caribbean background, 4 Black British, 2 Other Black, 1 Arab, 1 White British and 1 Other Mixed/Multiple Background. 8 had a long-term disability, 5 did not, and 1 preferred not to say. Location: St. Nicholas Way , Surrey. SM1 1EA - 20/9/18, 1pm -3pm

- Sangam. A session with 39 older people (aged 62 - 90). 28 were female, 11 were male. 27 were of Indian background, 10 Asian British, 1 African and 1 Pakistani. 22 had a long-term disability, 14 did not and 3 preferred not to say. Granfers Community Centre, 73-79 Oakhill Road, SM1 3AA - 24/9/18, 12pm – 12.30pm

2) Priorities / Main Criteria for 'Good Healthcare'

The main themes here are familiar from other groups: the speed of response to emergencies, the time and distance to hospital from a person's home (both for ambulances and visitors); the availability of sufficient and knowledgeable, caring, respectful and honest healthcare staff – and of beds; the convenience (or lack) of public transport; being listened to and having the correct equipment / technology on site.

"*You'd die before you get there* [Epsom Hospital]*"*

"[Staff] *should be respectful and* [patients] *should have a chance to speak"*

Many respondents were elderly – so they emphasised the need for good (non-emergency) access for them and their families / carers. Car parking charges were a familiar bugbear.

3) What Needs Improving Most?

Again, the main points echo those from other respondents – including effective communications between hospital staff and the waiting time to be seen. There was also a strong emphasis on improving the condition of St Helier Hospital – which is the main / nearest / preferred hospital for many of these respondents.

"St Helier would be good, but the hospital building needs rebuilding instead of continuing the patching-up that has been going on for the past 40 years"

4) **The Principle of Integrated and Site-Focussed Acute Services (prefaced by overview of safety / modernity / funding issue)**

The idea causes anxiety for some – would a longer journey to A&E put them in danger? – and the alternative to using their regular hospital (in most cases St Helier) would not be Sutton or Epsom, but St. George's in Tooting.

"Centralising is not necessarily best; it's better to have local A&Es"

Once again, people often do not distinguish between 'acute' services and A&E – or the latter is the one that *really* matters to them. Maternity services, for example, are not top-of-mind for older people (even if they may be for their children or grandchildren). The consideration is 1) for the person themselves, 2) their spouse, carer or chaperone / escort and 3) their other visitors.

This shows a key challenge of local perception: there is more to acute services than A&E alone.

5) **Potential Solutions – Acute Services focussed at Epsom, St Helier or Sutton Hospitals**

St Helier

Overall, St Helier is the clear favourite by virtue of its proximity, and that for many people it has been their first port of call for 40+ years. However, familiarity breeds concern – in particular, over the buildings' state of repair. One referred to it as 'terrible' and 'scary'. Nevertheless, it is accessible to Sutton, Merton and Wallington residents – and it has good public transport links.

Epsom Hospital

Epsom is marked down mainly due to its location, being further afield than is St Helier. At least one person reports having received better care at Epsom than at St Helier – and another that it has 'more options than Sutton' - but overall it is not a popular choice.

Sutton Hospital

Most groups in this research project have viewed Sutton as being either in the process of demolition, or of its land being sold off for housing. It is thought to offer a few routine services such as blood tests – but is not a viable option for any kind of front-line acute role.

Among the BAME respondents from ACHA, however, the picture is far more positive. The 'space' available at the site is a boon to its future expansion, car and public transport access are good - and parking not so expensive. The (few) current facilities are modern and hi-tech.

"The possibility for Sutton Hospital in the future is good"

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David Craig & John Leaman - 10th October 2018

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Healthwatch Sutton

Improving Healthcare Together – Discussion Group with Sutton Carers.

1) Introduction

Healthwatch Sutton engaged with the following groups of Carers:

- A group of 6 younger carers (aged 11 - 17). Four participants were female and two male, all White British and one participant had a long-term disability themself. Location: Sutton Carers Centre, Benhill house, 12-14 Benhill Ave, Sutton SM1 4DA - 28/9/18, 4pm - 4.45pm.

- A group of 9 older carers (aged 39 - 86) . Four participants were female, four were male and one preferred not to say. Six had long-term disabilities and the group comprised five White British participants, three Asian British and one Caribbean participant. Location: Sutton Carers Forum, St Nicholas Way, Sutton SM1 1EA - 12/9/18, 1pm – 2pm.

2) Priorities / Main Criteria for 'Good Healthcare'

When asking what good care 'looks like', some of the main points were: Proper diagnosis and appropriate medication; short waiting lists; good communication; empathy, support and good advice; close to home; well-trained staff; having a chance to have your say and feeling listened to; enough beds; appropriate staffing levels; right equipment; disabled waiting area; easily accessible/good transport; emergency cases given priority; clean hospital.

"*Listening to the people who need help. The doctor kept giving my Mum the same treatment when she told them it didn't work. Good communication is important".*

3) What Needs Improving Most?

The main points were being listened to, waiting lists (too long) and communications.

4) The Principle of Integrated and Site-Focussed Acute Services (prefaced by overview of safety / modernity / funding issue)

As found with other participants in this project, carers understood the case for change. Additionally, the clinical vision generally aligned with their own views. However, they urged that any change not restrict their access to services any further.

At this stage, any potential change is not really seen as a 'step' to the better healthcare vision they had discussed earlier.

5) Potential Solutions – Acute Services focussed at Epsom, St Helier or Sutton Hospitals

Carers' worries echoed participants elsewhere. Any changes must not make their experiences more inconvenient – easy transport access to services had to remain, and they were keen to ensure no one community was disadvantaged. There had to be equal geographical coverage.

There were also concerns at the cost of reconfiguring services and the ensuing disruption: as commonly feared with big projects, would the process become 'bogged-down' – would it go over-budget and end up being subject to political wrangling? Generally, there was not much confidence that even if one plan was agreed, it would be successfully implemented.

Epsom Hospital

The carers felt that it would take them longer to get to Epsom, and it would cost them more for them and their families, in time and money.

Epsom is outside my Oyster card Zone and would take too long to get to. This would affect my studies too."

However, Epsom was perceived as better-equipped than Sutton Hospital, had more specialists and had a better quality of care.

St Helier

St Helier was most carers' local hospital, and so was an easier choice over the other schemes; any improvements would be close-by. It has good transport links, so if something happened it was easily and quickly accessible. It was familiar to carers and perceived to have good quality staff and ambulance services. However, participants recognised the building was tired and in need of improvement, so change was needed. Parking was also seen as an issue.

Sutton Hospital

Generally, people thought it was a small hospital and associated (as often by other groups) with 'blood tests'. There was a lack of knowledge about this hospital. Some people felt that it was not central whereas others felt it had good transport links (train and bus nearby). Lack of parking facilities were noted by some.

Which one solution / site is preferred? Why?

Although seen as needing improving, St Helier was the preferred option as it was the closest to participants and therefore offered the most familiar and accessible service.

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David Craig & John Leaman - 10th October 2018

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Healthwatch Sutton

Improving Healthcare Together – Discussion Group with Older People in Sutton.

1) **Introduction**

Healthwatch Sutton engaged with the following groups of older people:

- Sutton South Hello, Sutton. A group session of 32 older people (aged 53 - 90). 26 participants were female and 6 male. 20 were White British, 7 Indian, 1 Asian British, 1 Other White, 1 Other Asian and 2 preferred not to say. 16 had a long-term disability themselves, 13 did not and 3 preferred not to say. Location: Christchurch Hall, Christchurch Park, Sutton SM2 5TN, 12/9/18, 3pm – 4pm.

2) **Priorities / Main Criteria for 'Good Healthcare'**

The familiar list of issues here reflects the older age group of respondents – so the emphasis is on convenience and comfort (short waiting times for appointments, for ambulances, and for being seen on arrival at A&E; multiple appointments should be co-ordinated at the same place on the same day; easy access by public transport and car; easy and cheap parking - and good food). The physical appearance and cleanliness of hospitals is noted. St Helier is 'not in a good state of repair', and memories linger of its MRSA problems – as they did among older people in the Epsom research. People also want well-trained and more staff (one person urged a recruitment drive into medicine among school-leavers). There was even a rare mention of NHS finances.

"The long-term financial overspend is not ultimately sustainable"

"[Good healthcare is] *that I feel confident that assistance is available when needed at a convenient distance"*

3) **What Needs Improving Most?**

This group focusses on staffing levels, which intertwine with the speed of being seen and the quality of care. As noted, St Helier is criticised for its condition – though improvement and modernisation work are acknowledged. The ever-present desire for 'joined-up' healthcare centres around being able to have multiple appointments at the same hospital on the same day – 'to help complete them with less stress and time'

4) **The Principle of Integrated and Site-Focussed Acute Services (prefaced by overview of safety / modernity / funding issue)**

"Any A&E hospital is better than a non-A&E hospital"

"A&E must be large and appended to a large, well-staffed hospital"

There are few advocates for the proposed amalgamation of acute services – though again the

focus is mainly on A&E, so misperception is an issue.

5) **Potential Solutions – Acute Services focussed at Epsom, St Helier or Sutton Hospitals**

Both Epsom and St Helier garner good and poor reviews. Word-of-mouth plays an important role, and location is perhaps slightly less the *sole* factor in determining people's preference.

Epsom Hospital

Though not the primary hospital for this group, it does have a good reputation for care quality and, specifically, for its knee and hip replacements. The small A&E counts against it – but few people are expressly critical of the whole hospital. Insofar as it is judged on location, opinions are mixed on the local bus services' convenience).

"I have limited experience [of Epsom], *but it seems clean and better organised than St Helier"*

"My daughter has had excellent care there"

"It's too far for me to get there: two buses"

St Helier

While not winning any beauty prizes, St Helier reportedly has a lot to recommend it. It has a large and efficient A&E, the staff are well-regarded (albeit in short supply), cleanliness is much-improved, the restaurant / canteen is liked, and there is a general impression that the place functions a lot better than it looks.

"The staff are very caring; nothing is too much trouble, and I'm always seen on time"

"It has established A&E, Maternity and Paediatric services"

"I am happy with the service all the time"

Sutton Hospital

Once again the also-ran in people's minds, little is known about Sutton. It has relatively few services and is regarded almost as a transit camp for those being referred on to St Helier.

"*Once you go to Sutton you get sent to St Helier. It's an inconvenience. Why consider Sutton Hospital for the future?"*

****

David Craig & John Leaman - 10th October 2018

Healthwatch Merton
Healthwatch Sutton
Healthwatch Surrey

Improving Healthcare Together – Summary Report

1) Introduction

This is the Summary Report for Healthwatch's independent engagement with residents in Epsom, Sutton and Merton (within the boundaries of Sutton, Merton and Surrey Downs CCGs) in September and October 2018.

Over a hundred participants from specific parts of the community were consulted:

- Epsom – One group with carers, one with older people and one with those with Learning Disabilities (LD). Conducted between 18/09/18 – 1/10/18

- Sutton – Two groups with carers (one of younger carers, one of older carers), one group with older people and two BAME groups (one with members of the African & Caribbean Heritage Association [ACHA], and one with an African and Asian group called Sangam). 12/9/18 – 28/9/18

- Merton – one group with carers, one group with older people and one group with BAME residents. 15/10/18 – 19/10/18

Participants were a broad mix of age, ethnicity and had a variety of long- and short-term health needs.

2) Priorities / Main Criteria for 'Good Healthcare'

The main criteria for healthcare looked the same across all groups. Participants wanted quick referrals, short waiting times and to be treated with respect by medical staff (including any cultural sensitivities being accounted for).

The reputation of the hospital was important and hard won (and easily lost). Previous issues were hard to shake off (such as St Helier's problems with MRSA) and participants took them into account when choosing where to go - even though any issues may have happened years previously. The hospital also had to look and feel clean and suitable for treatment.

Accessibility was key too, especially to older people and those reliant on public transport (almost exclusively buses rather than trains). For those using a car, hospital parking was thought very expensive.

3) What Needs Improving Most?

Staff were generally praised and felt to be doing their best in difficult circumstances. It was

strongly felt that 'the system' itself was creaking (or broken in parts) and could be run far more efficiently. In fact, when considering service reconfiguration later, it was felt that many of the issues that needed addressing could be solved by better management (inefficient discharge process, medical care not 'joined-up' with social care etc).
Capacity was a key concern too; many had stories of very long waits in A&E departments – again though, it was felt some of the capacity could be freed up by better system management.

4) **The Principle of Integrated and Site-Focussed Acute Services (prefaced by overview of safety / modernity / funding issue)**

Participants generally understood and agreed *in principle* with the case for change. Improving patient safety and providing healthcare from modern buildings were key although achieving long-term financial stability was a greyer area. Participants didn't really understand the funding models (although they recognised the need for financial responsibility and operating within budgets). Surely if there was an overspend, as it was a National Health Service, then that overspend would be cleared? Staff shortages were much more apparent (and of greater concern) in regards to nurses than consultants.

The clinical vision and model both seemed to be prioritising the right areas. The issue of fairness was sometimes raised (especially in regards more deprived people / areas not losing out) – but people felt any re-configuration would inevitably be a boon to some but a burden to others.

5) **Potential Solutions – Acute Services focussed at Epsom, St Helier or Sutton Hospitals**

Participants did not think along the CCG lines when choosing their preferred hospitals. As previously mentioned, accessibility, reputation and convenience were all the main factors, so St George's Tooting, Kingston, Croydon and Guildford were all potential (and actual) alternatives or backstops to St Helier and Epsom. Sutton Hospital is for many an unknown quantity – beyond the general observation that it provides few (and district only) services such as blood tests. Some of those more familiar did rate it as not particularly accessible, but again this was based on very few people.

Reactions to re-configuration tended to depend most on location and distance from hospital. There were real concerns that closing *any* A&E would increase journey times, especially in the more rural parts of the CCG area. Those in more urban areas (Mitcham for instance) were less concerned and just thought they would go elsewhere – being 'well served' locally. However, in all areas there were concerns that closing any department would put greater pressure on overwhelmed services elsewhere. (St George's Tooting was often cited here).

St Helier is seen as in need of repair and development to make it more appropriate for modern medicine. It does though benefit from familiarity and loyalty; many have used it for 40+ years. So while many participants feel change is necessary, it would have to be very carefully managed and communicated. All would need reassurance that any closures locally would not negatively impact their safety, convenience or community. Any new units would need to be accessible and well-served by public transport, and they would need to have good levels of nursing staff.

Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:** 7 February 2019	
Report title:	Improving Healthcare Together (IHT) programme Equalities responses to Healthwatch reports		
Report from:	David Olney, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author(s)/Contact Number(s):	David Olney, Statutory Scrutiny Officer, 020 8770 5207		
Corporate Plan Priorities:	• Being Active • Making Informed Choices • Living Well Independently • Keeping People Safe		
Open/Exempt:	Open		
Signed:	David Olney	**Date:**	17 January 2019

1. Summary

1.1 The report attached provides the response from the IHT programme to the work undertaken by the three local Healthwatch organisations to look at the focus groups they held with people from protected characteristics groups.

2. Recommendations

The Scrutiny Committee is recommended to:

2.1 Consider and comment on the report.

3. Background

3.1 This report should be looked at alongside the reports from the local Healthwatch organisations also on this agenda. The attached report provides the response and actions arising by the IHT programme to the Healthwatch work.

4. Appendices and Background Documents

Appendix letter	Title
A	IHT Equalities Programme Report - Cover
B	IHT Equalities Programme Report

Audit Trail		
Version	Final	Date: 23 January 2019

Background documents
None

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JHOSC Sub-Committee Cover Sheet
Attachment: 2
7 February 2019

Title of Document: IHT Programme equalities engagement report	**Purpose of Report:** For noting
Report Author: Jaishree Dholakia – Head of Patient and Public Engagement	**Lead Director:** Andrew Demetriades

Executive Summary:
Throughout October 2018, further patient and public engagement took place through local support groups across Sutton, Merton and Surrey Downs to reach potentially impacted equality communities.

This work was undertaken by the Improving Healthcare Together Patient and Public Engagement Lead. The findings of this work are included in the Equalities engagement report attached.

Additional engagement with equality groups, deprived communities and impacted service users was undertaken by local Healthwatch bodies and an external engagement consultancy.

Key issues to note are:
Please see the Improving Healthcare Together 2020 - 2030 - Equalities engagement report attached.

Recommendation:
The JHOSC Sub-Committee is asked to note the findings of this equality engagement report.

Financial Implications:
None

Equality Impact Assessment:
A full Equality Impact Assessment will be undertaken as part of the Integrated Impact Assessment.

Information Privacy Issues:
None

Communication Plan:
A communications and engagement plan for the Improving Healthcare Together 2020-2030 has been developed.

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Improving Healthcare Together 2020 - 2030
Equalities report

1. Introduction

This report details the impact of options for future critical care at Epsom and St Helier on different equality groups gathered by the Improving Healthcare Together 2020 – 2030 programme team.

This evidence was gathered by working through local support groups across Sutton, Merton and Surrey Downs to reach potentially impacted equality communities.

An Easy Read version of the Issues Paper and animation video was used to engage service users in small group discussions plus one-to-one interviews. This generated detailed, in-depth feedback concerning the service proposals. This information was supplemented by invaluable feedback also provided by carers and group co-ordinators present during discussions. The appendices to this report capture the detailed feedback gathered by the programme team.

In addition to the engagement undertaken by the programme team, Healthwatch and an independent engagement consultancy (Traverse) were also commissioned to secure the views of equality groups and deprived communities.

2. Key themes

a) People with physical and sensory impairments:

- **Travel** – the new hospital should be local i.e. located nearby for quick treatment if you are seriously ill with a heart attack or stroke. There is traffic impact at all locations.
- **Transport** – is vital. Some people with physical and sensory impairments have to rely on patient transport, do not drive (licence taken away, frailty), do not have a driver and cannot use public transport. Others rely on family. Need to keep service local because the cost of transport is a key issue for people with physical impairments e.g. taxi fares. The new hospital needs to be easily accessible by local buses. Familiarity with the hospital and known transport routes are also key issues for people with physical and sensory impairments. The availability of parking cropped up time and time again.
- **Family and friends** – people who are critically ill are vulnerable and need help with making decisions. If friends and family cannot visit because of the distance this has a serious, isolating, significant impact on the patient. Social contact / network is vital to recovery and information-sharing. Visitors and carers also have needs of their own e.g. some are older or use a wheel-chair – cost of transport, distance and lack of available transport are key inhibitors.
- **Centre of excellence** – concentrating staff and services in one place is a good idea as need to be seen by expert – someone who knows what they are talking about. Patients should not be transferred from one hospital to another.

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Mitigations:

- **Information** – should be provided in the proper format in compliance with the NHS Accessibility Information Standard – make pathway easy for everyone.
- **Disability-friendly** – the new hospital should have adaptable equipment, changing places, disabled toilets, step-free access, space for wheelchair transfer, hand-rails, proper signage (blue lines), ramps, disability parking bays, manual handling training, trained volunteers, staff awareness of impairment, good hoisting and free blue badge spaces.
- **Transport** – provide bus service, hospital transport, dedicated bus lane and wheelchair accessible taxis. Transport should stop outside the hospital. Buses are better for some than trains – stations do not have level platforms.
- **Join up care** – between A&E and specialist services eg stroke unit**.**
- **Tests** – review population density, accident-prone zones and incidence of illness present locally (breathing, blood, neurological).

b) Children and Young People [CYP]:

- **Travel** – the time and difficulty of getting to the hospital are key issues for CYP who may be less patient to travel far and wait to be seen. Familiarity with the hospital is a key issue. There are more buses around St Helier.
- **Transport** – the cost of transport is a key issue for CYP.
- **Population** – There are more schools and CYP in Carshalton and Rosehill so the new service should be located at St Helier.

Mitigations:

- **Transport** – introduce a shuttle service, increase the number of ambulances, introduce more transport links which are free – especially buses. Parents cannot always afford to pay parking and/or transport costs. Need to consider recipients of welfare benefits.
- **Visitors** – do not have set visiting hours for vulnerable people eg CYP who need parents to be around.
- **Accommodation** – have specific accommodation for young people who are placed on adult wards as soon as they turn 16 which is a shock to the system.
- **Respect** – CYP need to be taken seriously by nurses and doctors: in a dignified way. Ease fear of hospitals which are claustrophobic – receptionists can be intimidating.
- **Tests**: work out how many people could become seriously and where they live and use that as a measure – who uses what where? If the new hospital is placed in the middle will

there be an extra strain on ambulances? If ambulance has to travel further patients are more at risk.

- **Raise awareness**: there is a need to tell people about the Sutton Hospital site.

c) People with mental health needs:

- **Transport** – distance and proximity to the hospital is a key issue for people with mental health needs. Some struggle with anxiety and cannot get on a bus or train, drive (licence revoked, on medication) or travel alone. Some do not leave the house (agrophobia), leave the house alone or travel if they do not know where they are going. Familiarity with the hospital and travel route plus access to transport links eg buses are also key issues.
- **Family and friends** – people who struggle with mental health rely on visitors and the extra cost of transport incurred because the hospital is further away is a barrier. Visits are curtailed if you have to travel after working hours.

Mitigations:

- **Visitors** – do not have set visiting hours for vulnerable people with mental health needs. Discharge begins on admission and family is an important part of recovery.
- **Raise awareness of mental health** – to reduce discrimination. Introduce staff training and police training.
- **Transport** – the new hospital should be accessible by public transport. There should be more car parking.
- **Join up care** – with mental health services and expertise on site eg psychiatric wards and mental health liaison nurse. Reduce waiting time to see a psychiatrist, offer single rooms and link up with GP to work out care plan.
- **Parking** – parking should be free and there should be long-term visiting concessions.

d) Adults, children and young people with learning impairments:

- **Distance** – the hospital should be local and not far away because the journey builds up anxiety. Lack of familiarity with the hospital and hospital staff induces panic and challenges sensory needs. Children with additional needs should not be shipped between hospitals – this is terrifying. Parents without a network or support also struggle eg managing the school run - leaving child alone in hospital and isolated.
- **Transport** – many people with learning impairments have a fixed income, do not drive, do not travel alone and/or are transported – this must be taken into account. People with learning impairments are trained to travel by bus not rail because buses are easier to understand and have a ramp – this must also be taken into account.

- **Specialist support** – there is a need for trained staff, individual support and joined up care on site eg hospital passport, CAMHS, learning disability nurse, mental health nurse and duty psychiatrist. Young people with learning impairments should be fast-tracked through the hospital to avoid distress and delay. There must be enough beds. There is a need to train the police around how to deal with young people with learning impairments.

- **Environment** – hospital should be user-friendly for people with learning impairments eg more and better signage, volunteers and ambassadors, reception desks which are staff, separate A&E for children.

- **Parking** – introduce concessions for parents and carers who struggle with long-term parking which is very expensive.

- **Transport** – make staff shuttle bus available and introduce a bus service

Please review the Surrey Healthwatch report attached to this Evidence Pack for the views of people with learning impairments in Surrey Downs.

e) Black and minority ethnic communities:

Please review the Sutton and Merton Healthwatch reports attached to this Evidence Pack for the views of members of black and minority ethnic communities in these localities.

f) Older people over the age of 65:

Please review the Surrey, Merton and Sutton Healthwatch reports for this cohort plus summary of key themes attached.

g) Carers:

Please review the Surrey, Merton and Sutton Healthwath reports for carers attached.

h) Residents who experience deprivation and poor health outcomes:

Please review the Traverse reports attached to this Evidence Pack for the views of people who experience higher health inequalities and deprivation in Surrey Downs, Merton and Sutton.

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Appendix A: Physical Impairments

CCG area:	**Surrey Downs**
Group:	Surrey Coalition for Disabled People – specially convened workshop
Date:	19.10.18
Profile:	Three participants attended: all female and of White-UK origin, one 65 plus. One used a wheel-chair, had a visual impairment and mental health needs. Another walked with a limp, used a crutch and had been critically ill (long term condition and visual impairment). The third participant was a carer (mother of attendee who used crutch).

Epsom Hospital:

- Not familiar with Epsom Hospital – can't you work with existing sites and facilities – see how they can change rather than spending a load of money? Cost comparison.
- Positive – nearby – on site – to be treated. If have heart attack odds on you will survive. Need quick treatment for stroke. Same with any hospital nearby.
- Lived next door to Queens Square – neurology. Very helpful to have one stop shop – most people have complex issues – see 10 different doctors. Seen as "illness" not a whole person. All providers of healthcare should see everyone on the same day.

St Helier Hospital:

- If you have a road traffic accident or heart attack you need to get there quickly but there is a one way system and traffic. No helicopters to treat us.
- Impact of traffic – transport for people is vital – getting there – many do not have people who can drive us – can't use public transport – or fit around the constraints of patient transport. If working and need to get to hospital in middle of the day quickest to take taxi as allows me to work full time and attend hospital appointments. If wait for patient transport does not work.
- Taxi cost to my hospital - £25 each way. To another hospital it is £30 each way. A lot of my own expenditure – if reduce this by keeping it local – great.
- Not been
- If you are in dire straits and you have a heart attack expect local hospital – to be seen as quickly as possible. If Wales – go to hospital in Wales to get attention – prevent you from having further problems. Discharge must be in one place – a mess – stuff that goes around medical treatment.

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- When I was critically ill I was away from home – went to nearest hospital that was best place for me. Impact on family significant because it was more than a month before I could be transferred home for rehab care. Could not release me. Mum had to give up work and move to be my side – significant impact.
- System failing big time due to cuts. People becoming more and more reliant on friends and family for support – they are getting older and can't do it themselves. My mother is not well – sees I do not have support because of budget cuts – strain on her health after having a serious operation in the summer to make sure I'm OK – not fair – system aware I am unwell. Other family is abroad.
- When you are critically ill you are very vulnerable – nursing staff not the same as family – cannot help with decisions about your care – operations but no sounding board – pushed in one direction – isolating experience if no one to talk to.

Sutton Hospital:

- Not happy if live in Epsom and have to go to Sutton. Brother took me to see ? in hospital because too much of a cost.
- Sutton hospital is very old – layout terrible at the moment higgledy-piggledy – developed over time.
- Road to Marsden – A217 – really busy dual carriageway with lots of crashes – 'mad mile'. Too much traffic – at peak times this is fairly constant – very, very busy route.
- Easier than St Helier if you have a car [but congestion is issue] but not by public transport [three buses to St Helier, two buses to Sutton]
- Stations – old – not accessible by wheelchair – no bus to connect.

Other:

- Need to match with need in community where accidents happen – critical car crash, high density, where illnesses live – match against proposal.
- If acute want it in three places – baby in Epsom – not transported to hub.
- All three sites will have noise problems, problems with bad smells, impact on environment.
- Less concerned about cost of traffic and more concerned about specialist – have someone who knows what they're talking about. Great if local – no hesitation in going if London.
- Had to go to Cranleigh – why could they not come to me – specialist travel down from London?

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- Feel very alone even though I am not. When I am critically ill I am not thinking straight – can't read leaflet – need guidance to break it down into small chunks – to climb obstacle. Many cannot process information quickly.
- St Helier and Sutton are considered 'dirty' hospitals – have this reputation - come out ill afterwards. Hard to shift. Both known for MRSA infections. If you have a visual impairment you will be touching everything to get from one place to another including signage so have higher rate of catching something.
- Ambulance staff – poor service – impacts on how treated and long-term health. Reassuring to know if call 999 someone will help but if wait for four hours on floor degrading as well as risk to health.
- Look at who is more likely to have breathing, blood or neurological problem: ABC: airway, breathing ….. Triage stuff. Most have heart and blood problem so put effort there – save most people in quickest time. Is it a time-dependent problem? Eg bleeding on brain, stroke, asthma or heart attack – road traffic accident too but not in same way.
- Very concerned about people who can't get to [ ] Do not go to hospital because generational

<u>Mitigations:</u>

- Ensure compliance with NHS Accessibility Information Standard – vital – law – still not happening – surprised as legislation – over-sight. Have information in proper format that people need – make pathway easy for everyone.
- Cut down on admin – too much – not enough money for care and provision.
- Make sure all equipment needed is provided eg for scan – adapt for wheelchair user because not all wheelchair users have someone with them constantly (cuts).
- Need space for wheelchair user to transfer safely – have things to hold on to – MRI – assistant puts leg on to MRI machine.
- Manual handling training for staff – can scanner be lowered. We do not all have good sitting balance – need chair with arms. Eye clinic stressful – equipment not at my level and cannot transfer onto office chair.
- Larger person cannot fit into chairs. Equipment must be versatile – more early obesity.
- Changing places and toilets
- Bank of wheelchairs and scooters for people to use
- Transport - provide bus from Epsom for visitors
- Need proper signage people can read – so confusing. Blue lines are best. Some hospitals have separated spaces and signage suddenly disappears.

- Dedicated bus lane so get there quickly because of gridlock from Epsom to Sutton. If you have a heart attack you do not want to be in ambulance waiting – roads quite narrow – cars stacked both directions – verge not big enough for ambulance – need to re-design geography which is a greater cost.
- Need wheelchair accessible taxi to take electrical wheelchair
- Parking at all three sites
- Need to consider safety of site and safety of people travelling at night

CCG area:	**Sutton**
Group:	Oaks Way Centre – service users
Date:	19.10.18
Profile:	Six participants: all 65 plus, four of White-UK origin, one user of East Asian origin. One user had polio and one user had advanced Parkinson and scoliosis – this service user was wheel-chair bound with no movement from the neck down. Other users relied on crutch, wheelchairs and a modified shopping trolley.

Epsom Hospital:

- Too far
- When my husband was alive had to go to GP to arrange ambulance to pick him up by wheelchair – when the ambulance arrived the wheel-chair was in the ambulance. When my husband was alive he was well-treated at St Helier – could not fault them. Had blood test at St Helier. Depends on where you live.
- Getting there – have to get two buses or paying money – inconvenient. If husband still alive.
- Too far away – should be St Helier because large number of people live in the area.
- Can get bus / public transport to St Helier.
- Sutton would be a disaster because of transport – there is a main road plus two – three side roads – not enough room for ambulance.
- Depends on area – away away if no transport. I still drive – could drive but would not like to. Just drive locally. Cost of parking.
- I would need ambulance – do not drive – drove until broke hip.
- Need more staff
- You will have more staff if two hospitals come together

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- Not enough beds in big hospitals – left in corridors – no space.
- Should not be transferred from one hospital to another – not good for patient.
- No poor areas in Sutton compared to inner London – not rich.
- Could do with it – have St Helier
- Going anywhere on my own is a problem – only go if my daughter takes me. Could not come here today if did not have club bus. All difficult – St Helier and Epsom. If I could walk St Helier would be 15 minutes. When I have to go somewhere my daughter takes me. Knees replaced in Epsom – very good to me.
- How long will it take to build? Then have to refurbish it.

<u>1:2:1 interview with service user with advanced Parkinson's disease:</u>

- Access into the hospital is key – is there parking available? Is it exorbitant? Should have profit-making facilities
- Prefer St Helier because there is big ground - near to where I live – very familiar with hospital. Children born there – wife a nurse there for donkey years – good care.
- With Epsom Hospital transport is the problem. DVLA has taken my licence away – can still drive. Now, if I go to St George's – my consultant is there – was at St Helier. In St George's – when I make an appointment – they organise transport for me – usually an ambulance – feels like a waste of resources.
- When you are that ill you will go anywhere.
- Must be wheel-chair friendly inside the hospital.
- Sutton is quite good – live near there.
- When you are seriously ill you need to get there as quickly as possible so transport system is key.
- With paramedic services and hospital if you are will and you live in Mitcham you are taken to St George's.
- Consultant staff are critical – if you go to A&E you end up waiting for doctors.
- Important to be seen by the right person at the right time. I used to be an oil engineer. Colleague had heart attack – took him to hospital and triage nurse said "wait" – angry – wasting a man's life. It was a mistake for me to have taken him – should have gone by ambulance as would have been seen quicker.
- Distance to hospital and specialist skills are equally important – should get there quickly.

- Specialist staff should be separated from medical staff. Roehampton and Queen Mary have different wards – very open format – like it.
- Hospital transport is important – very important – St George's do this but quite a high cost. I get taken by ambulance because of my wheelchair. When study economics of NHS ambulance is very high cost.
- Must be quick and efficient transport. Go to St George's and St Helier quite often – Epsom not so often. Every time go to St George's for consultant appointment at 12 they pick me up at 9.00am so I get there for 9.30am / 9.45am and wait until 12am for a 15 minute consultation – then wait for transport to go back which takes six hours – 10 hours for the day. Fantastic waiting lounge – like an airport – have food – M&S inside, Tesco, Sainsbury's – can buy lunch.

CCG area:	**Sutton**
Group:	Sutton Lodge – Day Centre
Date:	30.10.18
Profile:	Eight participants: all female of White-UK origin. Over 60, one 95 year old, some over 80. Wheelchair user, crutches and sticks.

- Parking – major issue at any hospital with cost – very, very prohibitive. Have hospital half-way. If two people are arguing meet in the middle.
- As you get older it is more difficult to get to hospitals

Epsom Hospital:

- Too far
- Too far – nearly dying!
- Quite a way to go, can't walk properly, hard work
- Can't get there, too difficult

St Helier Hospital:

- Nearer than St George's
- Doing up St Helier
- Better bus service to St Helier
- Know St Helier
- S4 goes right outside Helier
- Outside my house bus goes to St Helier
- Easier to get to – not such a long walk

- Always been there
- Well known – as long as lifts work

Sutton Hospital:

- Big area – near the Marsden

Mitigations:

- Have ambulance to pick you up
- Fell and broke pelvis – placed on dementia ward because over 75 but had all my faculties – no one to talk to all day until husband visited. Could be improved.
- Supply transport
- Transport key – how you get there
- Visitors are important – makes you think of someone else other than yourself, stops negative thoughts

CCG area:	**Merton**
Group:	Merton Vision
Date:	09.10.18
Profile:	Eight participants: five female, two male, two of BAME origin, two with hearing impairments, all with visual impairments, all 60 plus.

Epsom Hospital:

- Epsom Hospital is way too far for me – live five minutes' drive from St George's in Merton.
- Too far – my sister was there for three weeks – too far away. Had to pay £50 in cab-fare to go and see her.
- I go to St George's
- Little bit far
- I am happy at St Thomas Hospital – do not want to change – had my babies there.
- At our age and given our disability transport is a problem. Taxis are expensive – difficulty getting on and off buses, from practical view no-go area. Can't always get hospital treatment.
- By the time you get there what will you be like!!

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- In my experience – when you ring for an ambulance, no matter how urgent it is, there is too much demand. Had an occasion one week ago – last Friday – taken to A&E at St George's: very difficult conditions, I was there from 7.30pm – 2.00am – staff are overworked – abused. Won't solve problem unless persuade people to be less selfish. Worked in the health service for 10 years.
- Epsom has a very good reputation for joint replacement. Must factor in especially at our age that people have difficulty getting there. You are isolated in terms of visitors and this is very important. When you turn on the TV the greatest threat to health is loneliness – either for young people or people our age.

St Helier Hospital:

- Good because it's close – can get transport.
- Depends on where people live
- Would have an impact on me if taken away – a bus ride (94). My nearest hospital we are fighting to keep it open – Siobhan [MP] doing enough
- Under St Helier for my eyes – fine because I have a taxi-card, can get there. It's a good hospital – taken there when fell and cut head open – looked after me well.
- St Helier's is central – want something in the middle – Epsom is too far – OK if you live there.
- My views are complex. Had appointment at St George's two – three weeks ago but did not send transport. No one called me. Bringing together services in one place is a very good idea – concentrate staff in one place. If you have a heart attack it does not matter where you go to as long as you are seen to – prefer to be looked at by expert. Want to be rushed to hospital and seen quickly. Seen people wait a long time.

Sutton Hospital:

- Can the transport take you there quickly?
- Depends on traffic
- Wouldn't matter really – difficult to say – only used it as eye hospital
- Sutton is OK but a little far away

<u>Other:</u>

- Look at how many people live in each catchment area – would have thought fairest to assess where densest population is to uses services – should put it in the centre there irrespective of location. Doesn't apply to me – I go to St George's – they have an encyclopaedia on me and my husband.

<u>Mitigations:</u>

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- If you have a visual impairment volunteers should be aware you may need help moving about – even while waiting.
- Most manage despite visual impairment
- When I want to contact someone at St Helier Hospital it's automated – there is no one there – tell you to come back 24 hours later. So waiting for phone call – happened to me when I needed hearing aid checked. Need someone to answer the phone – once had answer – leave them alone.
- Transport is especially important if you are visually impaired.
- For people who are seriously ill try and solve contact with people they know – in terms of someone going with them if need in-patient treatment. If you are from St Helier but have to go to Epsom friends and neighbours cannot visit – so totally isolated. People recover best when they have social contact, do not feel isolated and are kept informed of what is going on. Treated me like an adult with a brain at St George's – important – "does she take sugar?" does not work with me.

<u>Service Manager at Merton Vision (also with a visual impairment):</u>

- If you have a stroke there is an 80% chance of visual loss – important staff are aware they are dealing with a patient who cannot see someone standing to their left or right – they will hear people talking and then the person suddenly appears.
- Any patient attending A&E has the potential to have a visual impairment – can't do anything if you don't know – once identified through a family member of friend need to be aware you are dealing with a patient with a visual impairment - staff should be trained to deal with this – must be 'whole awareness'.
- Visual impairment and poverty goes together – large number of unemployed visually impaired – benefits related. Especially in older age – has impact on life – costs more to do things. If don't know route confident only way is taxi which costs more money. Can't just jump on a bus. Getting from A to B involves combination of finance and independent travel: will not go unless of paramount importance – impacts on decision.
- Visually impaired with significant sight loss will be concerned about what is going on when they are ill and so feel less confident.
- Need large sign-posting, colour co-ordination in building – not white seats on white floor – very difficult for people to see and contrast – door frames.

Not knowing where you are and not knowing how to get to where you are going to key for visually impaired. Receptionist saying "down the left past yellow statue" is no good to visually impaired. Need awareness all the way through – very important otherwise you will have difficulty accessing

anything. Tactile identification is also helpful eg signage – some could be in Braille. Flooring can be used as a guide – if flooring is tactile visually impaired person will know they are approaching at T-junction eg bottom and top of steps and tactile paving can help them to identify this hazard – include identifying facto where possible eg audible clues.

CCG area:	**Surrey Downs**
Group:	Swail House [supported housing for blind and partially sighted people in Epsom run by RNIB]
Date:	15.10.18
Profile:	15 residents all with varying degrees of visual impairments – six female. One resident was accompanied by a guide dog. One carer.

Epsom Hospital:

- Prefer Epsom Hospital geographically – far easier to get visits and local means local - St Helier is far – both good hospitals.
- Use hospital transport to get to either
- Epsom on doorstep – if elsewhere difficult if do not have hospital transport: bus / train – have to work out how to get from A to B. Know Epsom to Swail House.
- Better care at St Helier when had kidney stones – on intensive care – HDU in Epsom. Care better at St Helier (specialist).
- Standard deteriorated over 50 years – shocking. Went to A&E four times before admitted.
- Geographically amazing but need standard of care with access to right specialist quickly – hard on tap.
- If have acute in Epsom right staff there. If seriously ill get there as quickly as possible.
- Outside Epsom: too expensive.
- If you are involved in a road traffic accident you need a quick MRI – have machine at Epsom – so do not have to travel to another hospital for MRI – on tap at Epsom.

St Helier Hospital:

- Prefer St Helier – my view
- For kidney problem have to go to St Helier – do not stay in one place. Big problem for visually impaired.
- Better experience, staff. More outstanding, disability awareness. Better treated – disability transport lounge.

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- Replace or add on to? St Helier is ancient. Major problems – long corridors, lost – cold – Victorian – very bad experience. Needs to be completely replaced.
- A long way to see me – could not get parking near entrance.
- Parking appalling – not enough disabled parking – and charge.
- Too far away – not visited so easily. Two weeks in St Helier hospital – skint. Wife a wheel-chair user – has to have a carer and take taxi to see me.
- Had good experience at St Helier hospital – if seriously ill doesn't matter where. Prefer Epsom but Epsom more convenient for family.

Sutton Hospital:

- In middle so probably best
- Easy to get to for visitors – two buses – not as easy as others as have to change transport
- In favour of Sutton because of size of site – do not infringe on other buildings. Good site. As patient having heart attack do not care if get correct care quickly enough so Epsom because of traffic. If had to be Sutton – as long as get there quickly enough – golden hour for heart attacks – visiting: more difficult.
- Never been there.

Mitigations:

- More training / awareness – staff awareness of visual impairment – have anxieties.
- Disabled-friendly, step-free, have to use wheelchair, bigger signs. At Epsom lift out of action – had to be carried. Hand rails, ramps, signage.
- Friend in Epsom – blind person on ward – no sign above bed to say blind – given food – did not even know.
- Had same experience – asked them to put sign above bed – good for all – so visitors and carers know.
- When my husband was in hospital if he was not treated correctly we would contact PALS [Patient Advice and Liaison Service] – very good.
- Need disabled toilets on ground floor accessible by wheel-chair with door which can shut.
- Raise awareness of hospital transport available for use – must be reliable, available. Volunteer drivers are in short supply. Waited all day to go home when booked in – all down to communication – so busy do not tell you what is going on – infuriating.
- In and around hospital should be accessible from street to building with no obstacles.
- Holes in ground in Epsom – nearly went down a hole – has to be addressed.

- Building – do not make it like a maze.
- Look at accessibility of sites especially for wheelchairs.
- Please take peoples' relatives into account especially if patient has visual impairments because of their needs – went to hospital when husband was very unwell – extremely isolated. Brilliant at other times. Could not go unless have carer and safe to go there [carer and wheelchair user].
- When I was in hospital – on the ward – my wife was treated disgustingly
- More well-trained volunteers made huge difference – gave my dog water, connections. When you can't see and do not know – feel even more isolated
- Make staff hopper bus available to public – really useful to get on bus if have to go without carer – feel safe on bus with nurses and GPs – seats available.

CCG area	**Merton**
Group:	All Saints Community Resource Centre
Date:	09.10.18
Profile:	Nine participants: seven wheel-chair users, three female, one user of BAME origin. Group also included two carers, stroke survivors and service user with a learning impairment.

Epsom Hospital:

- A long way – if I had a heart attack – called 999 - middle of rush hour. How long does it take to get to Epsom? Dead by the time I got there.
- Had bad experience there
- Depends on how long it takes to get there. Would go to Kingston Hospital really. Used to have free blue badge and parking – not now. Even if have blue badge have to pay for parking.
- A&E is not joined up with stroke – spent five hours in A&E and was then discharged – told to go to GP for referral to be examined at hospital! A&E doctors send you home without examining you. Good if works right from A&E upwards.
- Need learning / physical disability support in hospital.
- Not been to Epsom: need good hoisting, people who understand my needs, free parking.
- Carer: parking is key – distance is too great. Roads to Epsom from here are not major roads but A-roads which are choc-a-bloc. One hour to Epsom. Epsom fine for people over in Epsom.

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- By time get to Epsom dead.
- Epsom needs new building.
- Needs to be local hospital.
- Population density is a problem – one unit cannot deal – too many people – very dense here – St Helier estate for a start. Epsom has single households next to one another. Here there are flats – lots of people in one place.
- Work out where middle is between three sites and build new hospital there.

St Helier Hospital:

- At St Helier three year ago – nearly died – have to go if ill. Distance and right staff equally important. Need enough staff. No point in having nice big hospital if not enough staff to run it – had to wait 5-6 hours in A&E – then in stroke department. Good once get past A&E on to ward – not so bad.
- Is St Helier closing?
- Needs to be local hospital
- Ambulance will ask you "which hospital?" – give choice – say St George's or St Helier – St George's best because biggest and best – no hesitation about saying St George's – no way go to St Helier – run down for years. With St Helier – if you have a stroke – no facilities – taken straight to St George's. St Helier OK if has good department for stroke – if expertise there no problem.

Sutton Hospital:

- Never been to Sutton – could not say
- Hard to get to
- Sutton nearer to me
- Would never touch Sutton
- Never been there – people go for eyes, can't imagine using it as local hospital.

<u>Other:</u>

- Should be local hospitals everywhere
- Do not mind St Helier or Epsom
- As wheelchair user if seriously ill get ambulance

<u>Mitigations:</u>

- When had anaesthetic could not press button so need to have someone to sit with me

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- Carer: need nice new building with huge underground car park. No good saying come by bus – if go by bus would never get there – would have to lift my wife in wheelchair. I can't walk so use a scooter – cannot get myself and my wife (wheelchair-user) on the bus as bus does not allow scooters. My wife (wheel-chair user) could never go on her own.
- Knowing about people's disabilities – no good going in and have extra needs too
- Hoisting – learning important
- Parking – need free blue badge space

Co-ordinator:

- Travel by train difficult – only possible if platforms are at the same level.

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Appendix B: Children and Young People:

CCG area:	**Merton**
Group:	Hearts and Minds
Date:	16.10.18
Profile:	Young people with mental health needs: Five participants aged 16 – 24: one used a mobility scooter. Co-ordinator in attendance with mental health needs also attended.

Epsom Hospital:

- What is Surrey Downs?
- Live in Merton – far
- My nearest hospital is St George's
- Mine is St Helier
- If you struggle with mental health you are reliant on people visiting – add extra barrier cost-wise – especially if you can't drive [co-ordinator]
- 293 from Morden
- Nuisance of getting there
- The time
- Easy for me because I live in north Cheam – but if live in Sutton – more difficult
- Wimbledon to Morden is 30 minutes – further hour to Epsom – finish work at 6.00pm – visit up to 8.00pm – only half an hour – wasted trip.
- If child goes to paediatrics – as young adults still need a lot of support from family – friends can't drive – end up on adult wards.
- Some struggle with travel anxiety – some struggle to get to Hearts and Minds – if have to visit family at Epsom – a struggle.
- When first came to Hearts and Minds could not get on bus – OK now because know route. Do not know route to Epsom – so someone needs to drive me there.

- Don't travel by myself – get quite nervous – work here – going to Epsom – will not go myself – feel bad asking someone to take me every week.
- Comfortable going to St George's because bus goes inside hospital – 493. Difficult to get bus into St Helier.

St Helier Hospital:

- Not much space on site – built double car park for staff.
- Don't know where it is –
- Still far
- From here easier to get to than Epsom
- Two people there in main corridor – accessibility people
- Hear St Helier has bad reputation – if new building reassuring – not forgotten hospital with bad reputation.
- If you struggle with anxiety – mental health – struggle to use trains – so buses are important.
- Really cramped, very industrial, people rushing around

Sutton Hospital:

- Don't know where it is
- No objections as don't know site. If in Belmont – in the middle
- Only heard of Tooting and Kingston
- Merton – less keen on locations – if new transport links made – easier
- Transport is problem rather than location
- Big hill – Sutton hospital

<u>Mitigations</u>**:**

- Shuttle service a good idea
- Extension of 293
- In St Helier there are two people who help people with additional needs – visit if know about this
- Specific accommodation for young people – as soon as you turn 16 you go straight to adults – scary – should move you in slowly – just get chucked in.
- CAMHS takes you up to 18 – adult wards start at 16. Once hit 16 on adult wards – shock to system.

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- Look at which service is used the most currently – more people can get there than one used the least
- Basic accessibility – if lots of hills more difficult for disabled people
- Not have set time for visiting – stay overnight – helpful for me.
- Should be special measure for vulnerable people – eg mental health needs or young adults – for example – make exception for relatives.
- Make it colourful and light – St Helier is white – if new building like Nelson – colourful - makes feel when go in.
- Enough space – St George's A&E: no space for visitors. Not ideal – especially if serious.

CCG area:	**Surrey Downs**
Group:	Bfree – North Leatherhead Youth Council
Date:	27th September 2018
Profile:	Eight children aged 12 – 17

- Surprised it was a personalised study to the local area.

Epsom Hospital:

- Epsom is quite a bit older than other options. Would be a disadvantage if you put the critical services there. A lot of people that use Epsom. Epsom is a well-known hospital so good for people to go to.
- Hard to get to Epsom hospital. Open up a smaller place closer to home for people that find it hard to get to Epsom.
- Could be too crowded if people go to Epsom. Could be a surge of people coming to a knew service.
- Would need more workers if critical services are at Epsom – Epsom already struggling with staff.
- An area that helps 16 – 24 year old young people

St Helier Hospital:

- Quite far to get to from Leatherhead. Young people would be less patient to travel that far and wait around to be seen.

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- Some people might not have money to get on a bus/train. If someone was hurt then would be uncomfortable getting into a random hospital drivers' car. Increase amount of ambulances to help people get there. Would be good to have a direct route for people on bus. Getting the right care quickly. Difficult to think of a solution because the problem needs everything to be working in order first. Making sure everyone has the care for basics things is a good start.

Sutton Hospital:

- Better than St Helier as it's closer. Don't really know the area well or know of the Sutton hospital.

Anything else?

- Important to be taken seriously by nurses/doctors.

What else should we think about to try and reach the right decision?

- Economics – depends on what people can afford to get to these services.
- Someone who doesn't care about the way they live – if they needed surgery and someone else needed surgery who actually cared about how they lived then would find it hard to think how fair it is for those to get treatment - someone who is incapable of the repercussions that they put their health through. Healthy people should have more priority over people who don't look after themselves. Need more beds and space for hospitals.

CCG area:	**Sutton**
Group:	Children in Care Council
Date:	25th September 2018
Profile:	Two participants – both female – one aged 21 with a young son

St Helier:

What is your experience of care in St Helier?

- Some staff rude
- Service good
- Reception and A&E services are not well placed
- Son had accident on bus, when waiting on line, people cut in front
- Distance is OK - good public links, buses that stop right outside

What does good care look like for you?

- Experience of scolding hand service was excellent in A&E
- Staff were compassionate

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- Waiting times in A&E too long, need to be kept informed
- Frequent updates
- Good vision
- Possible changes:

Epsom Hospital:

- Getting there will be an issue
- Distance is an issue
- St Helier closer, but if it is a better service
- Cost to travel travelling to and back from home

How can we make it easier?

- More local transport links, not just trains but buses
- Better transport link that is for no charge
- Epsom now more accessible, more parking easy for visitors

St Helier Hospital:

- Very local
- More young people in Carshalton, especially children and young people in care
- Also high schools primary and secondary are in this area
- Lots of buses around this area
- Hospital big

Disadvantages:

- Can't think of disadvantage
- See people who may know you

Sutton Hospital:

- Closer than Epsom
- Not as well-known as St Helier and Epsom good as a new venture
- More nervous if not well or have an emergency not knowing where it is
- Seems isolated due to location
- Only one bus goes there S4-long bus ride
- Train stations too far from hospital
- Costs of public transport going up affects young people

What can we do to make it ok and easy for you to use this service at Sutton Hospital - to overcome barriers?

- Able to get a shuttle bus from St Helier or Epsom Hospital to go to Sutton Hospital as well as awareness where Sutton Hospital is located

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Are there other tests or criteria (apart from location) we should be thinking about to show we are being fair and respectful of everyone?

- Work out how many people might need treatment for their eyes, for example and in Epsom might be higher and use that as measure - ie serious illnesses, work out who could be seriously ill or affected ie Hackbridge building new homes affecting people with asthma
- In which area who uses what service and which area has the highest % of usage? Iehhave a heart attack, extra strain on ambulances if services are placed in the middle? Ambulances will have to travel further, patients more at risk till they get to hospital
- Getting the right treatment is important

What would tell you whether the solution is working or not?

- Consultation- send out surveys to all asking people to rate and monitor response
- Once service is up and running, run the surveys frequently to see if responses have changed
- How people have shared their experience- do they feel their experience is ok

CCG area	**Sutton**
Group:	Sutton Young Commissioners
Date:	19.10.18
Profile:	Five participants aged 16 – 20: co-ordinator also in attendance.

Epsom Hospital:

- Depends on where you are in Sutton
- Transport not best in Sutton
- OK if ambulance
- St Helier is closer than Epsom
- Went to St Helier for blood test
- In emergency time is key: crucial minutes – early intervention – heart attack – chance of surviving is greater – also need CPR at scene.
- Don’t know Epsom – not knowing is hard.

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- My school is in Banstead – fear knocked down
- Not in London travel zone – can't use Oyster card – parents – strikes.
- Easier to get to London than other places
- Time is key – have to wait – a long time for anything
- If live in north Sutton getting to Epsom can be difficult

St Helier Hospital:

- Got lost in hospital – really hard
- Parking is bad
- Mum has blue badge – would have to have a lot of disabled bays
- Biased – yes – easy to get to – more convenient for us
- St Helier estate nearby – big community around there – born there – average income is low so need more.
- Big fight to save it
- Comfort an issue – small corridors – sitting on floor – not a very good experience
- Is it disabled-friendly?

Sutton Hospital:

- Building school – is there space?
- One bus – so, compared to other two – not so accessible
- Only one bus to Royal Marsden – un-reliable
- If you are from Epsom or Leatherhead – how will you get to the site easily? Quite difficult.

<u>Mitigations:</u>

- Must be treated in dignified way
- Children's Unit – take you up to 18
- In CAMHS there is a sudden transition – straight from child and adolescent service to adult service. Hard transition from child to adult unit.
- In Somerset there is an intermediate stage in CAMHS [cousin works there]
- Getting to right department – lost for 15 minutes in St Helier – not many signs – no direction.
- Should be a question about whether the system is smooth [efficient] enough in the first place.
- Travel time vs right care depends on circumstances. If have heart attack need to get there as soon as possible. Other cases – can delay. Specialist definitely important.
- Would expect doctors to do basics – stabilise.

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- When call ambulance if can describe symptoms and inform which hospital you want to go to beforehand.
- How many people does Epsom serve already? Divert people.
- Young people want parents around – can't afford to pay parking / transport. Need to solve cost of transport – funding. Transport should not cost money if you are saving lives.
- Solve accessibility issue
- How will you decide where hospitals are placed? Make it equi - distant?
- Think about people on benefits – quality of care, specialists, facilities
- Ease fear of hospital – very claustrophobic. Receptionists should not be so intimidating – patients in agony interrogated at A&E.
- Mental being of patient not well cared for
- Build from scratch so not lost

CCG area:	**Sutton**
Group:	'Street Doctors': community and victim reparation scheme run by YOT
Date:	25.10.18
Profile:	12 year old service user: female

Epsom Hospital:

- No – St Helier because most accidents happen around here – don't hear about it in Epsom. Other day – heard about man driving into tree – mate's dad – died.

- High Street's on main road
- Don't know about Epsom that much – not too keen on Epsom
- Old people walking around – not as busy as Rosehill

St Helier Hospital:

- Born in St Helier – went back when I broke my leg a couple of weeks ago – had cast and boot

- A lot of kids around Rosehill – young boys on motorbikes think they're big. Also, school nearby.

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- In Rosehill – so many fights – stabbings. Stabbings in Mitcham – closers. Everyone meets at Rosehill.

- With St Helier – always packed
- When people think of Rosehill – they think of St Helier

Sutton Hospital:

- Cars can't go up high street – have to go round

- Hidden away – not a lot of people know where it is. No point being near Royal Marsden – never even mentioned

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Appendix C: Mental Health

CCG area:	**Merton**
Group:	Imagine Independence
Date:	03.10.18
Profile:	Three participants – all female with mental health needs, two of White-UK origin, one of BAME origin. Eight participants were invited but did not attend so a further session was arranged.

St Helier Hospital:

- Used St Helier before but not recently. Also used St George's. Had good and bad care there. Depends on treatment. When we had mixed wards it was awful. Went from emergency to being kept in to having an operation – surgeon did an amazing job. However, didn't like being in mixed wards. Challenge seems to be, feel, that more admin is going on and ticking boxes rather than investment in medical staff. They are not getting the wages they deserve, astronomical if kick football around but not nurses who work socks off. Other countries work in our NHS industry – those from here go to work privately because they are paid a lot more than in the NHS. Sister-in-law in nursing – went agency while children were small – private nursing homes and hospitals.

  There are more mental health issues than ever these days: stress, expectations, perfection and dump-down. Now have five methods of communication, 140 emails before lunchtime – can't ask someone to change a light-bulb without having to find a manager, send an email. How we function these days.

  Not very pleasant in St Helier – casualty heaving. Don't know. Chelsea & Westminster Hospital amazing. St Helier Mental Health team is scary I can tell you. If emergency just carted off – no discussion – that's it. Treatment at Royal Marsden amazing, phenomenal, wonderful service.

- St Helier is OK – not too bad, not too good. If St Helier is struggling as it is not a good idea to put serious care there. Good because closer to home but probably wouldn't use it because know other hospitals are better eg Kingston.

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- Good because I can get there easily from Mitcham and direct bus routes from Sutton – don't know about train.

- Good because seems to be community hospital used by community
- Should have more parking

Epsom Hospital:

- Would not travel there – logistically, parking – have problems getting anywhere I am not familiar with – been to St George's for bits and pieces on the train.
- Too far – hospitals which are closer to me eg Kingston, St Helier, St George's. Some people with mental health problems do not leave the house, will not leave the house alone or if they do not know where they are going.
- Yes – I was supposed to go to a meeting yesterday but did not know the venue – different venue – so did not go. If you have a heart attack you do not have a say! If patient is a young child it is important to have a facility for the parent to stay with the child. My mother left me when I was 3 ½ in hospital – still remember this. When my daughter was 18 months I was allowed to stay with her – rushed to hospital – better experience for her because her mother was there all the time. Do not need whole family at bedside. In old days hygiene was better – matron fierce -did not allow anyone to sit on the bed in outdoor clothes. You do not want to be ill in this country.
- Don't know Epsom or Sutton – had scan at St Helier on second floor
- Initial impact on mental health: if I have to find somewhere new I get scared – anxious – have to take taxi – need repeated instructions.
- Transportation – I don't drive so must be accessible from transport point of view and I don't have a freedom pass
- Difficult to understand but if you panic you think about how you are going to get there – what directions I have to take
- Worry about distance from Mitcham. Always on news – not enough ambulances and technical staff – have to wait for emergency vehicles – shortage of medics.

Sutton Hospital:

- Never been to Sutton – never felt a part of Sutton. Funny – where you start your life is where you feel you fit in.

- Definitely don't know Sutton Hospital – have to look it up on the map
- Will the natives become restless? Accept ambulances? Transport issue.

Other:

- If you have sufficient nursing staff in pristine building that is what counts – all gone so horribly wrong. With diversity of people communicating on different levels with different forms of communication – impacts on what works and does not work for the individual. Brought up to appreciate, please, say thank you – lacking today.
- Problem starts way back at GP because hospitals do not share information well. Scan in one place – when go for follow-up / exploration not furnished with information so whole package is there. Someone told me it took 20 years for their family member to get a diagnosis. Do not feel listened to, no continuity because of overload of people on books for doctors surgeries and hospital. Outside agencies do CT scans. Marched out and marched out.

Mitigations:

- Could advertise – send letters out with maps – explain how to get there
- Won't know whether the solution is working until seen on the ward
- Yes – needs to be tried and tested – may look good on paper
- Depends on what's on the site – if get there and throw a wobbly – how will they look after you? Not that I would do that – some people would.
- Been to hospital and patients are shouting – can staff cope with people with mental health issues? Will there be training?
- Have staff awareness of certain mental health issues
- Discrimination – do not want to discriminate just because you have mental health need – should be accessible to all – staff aware how to cope with anyone with overt reaction.
- In acute trauma situation – person in life or death situation – concern is about physical health.
- If staff know you have a mental health issue they make you wait until you are the last person to be seen – wont' happen if trauma situation. Happens at GP and hospital – my family had to speak to people about this – still there at for 11.00am appointment at 6.00pm.

- Wherever you put it you need staff awareness / training – not call security as soon as something happens but being aware of the person and dealing with them as humans

- How does the community interact with the hospital? Hospitals have community awareness teams – is it a community hospital?

- Think about transport

CCG area:	**Sutton**
Group	Sutton Mental Health Foundation
Date:	12.10.18
Profile:	Five participants – two female – all of White-UK origin. Some also had a long term condition and / or physical impairment. Co-ordinator also participated.

Epsom Hospital:

- Too far.
- Transport not so good as St Helier and Sutton
- Can't walk far – took one hour to walk from car park to hospital.
- Difference between Epsom and Springfield? Is bus from Sutton to Epsom – do not know area.
- Don't know it
- If have breakdown – very ill – no say where you go – no choice.
- Visiting – next of kin – family – kept in – rather than travelling to west country for 100 miles
- No psychiatric ward at St Helier
- Relationship between GP and hospital – know something is being done rather than dishing out tablets – did scan.

St Helier:

- Rather keep St Helier because nearer
- My family is in south London – St Helier is the limit rather than Epsom
- £12 for parking at St George's – disgrace any hospital should charge
- So if transport not good to Epsom pay parking.
- More buses to St Helier

- Easy access, transport, know people in area
- St Helier: so much transport, different buses, not far. Nice to know transport system close by.
- Good because of travel not just for patient but visitors – more accessible. Can't fault care – excellent.
- Parking too expensive – a problem.

Sutton Hospital:

- Love it – St Helier best option all round – more accessible. Here – schools – not all transport comes up here. Number 80 comes up here from St Helier – more transport and more buses.
- Good for people nearby but traffic – new school, Royal Marsden – big impact.
- Had eye hospital – developed. Sutton Hospital – 1275 pupils – plus hospital – plus cancer hub – residential parking – narrow road, small roads here. Banstead – South Road – numbers of people – commute to school – afternoon – dangerous for children. Narrow paths – infrastructure barriers – two steps into the road.

Other:

- What are the other nearest major acute hospitals in relation to St Helier and St George? Had difficulty last year – assessed me if I could walk – could not – in pain. Double questionnaire – 999 – asked if acute – say no – referred to clinician – asked same questions – then told me no ambulances available. Had to get cab – went to Farnborough from Mottingham – someone said do not go to Lewisham. So, serious acute accident – heart attack – travelling long distances – some have helicopters – can't have next acute 50 miles away – proportionate to number of population.

Mitigations:

- Have hospital buses going there – told what buses go there – none go at the moment. St George's have 1 -2 buses go to front.
- How does ambulance service work? Longer journey for them. Have more ambulance / depots around – coming a long way to collect you. More ambulance units get you quickly to that site.
- Use feedback to measure whether solution works – audit / impact on statistics now – usage – what facilities used in other hospitals – same number of beds and wards? What happens in other hospitals? Have all specialists in one area is good – but impact – independent assessment on impact on catchment areas of Sutton, St Helier and Sutton.

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- Merging two hospitals together – impact on amount of staff? Working long hours, no facilities or accommodation. Allow for build-up of extra patients.
- Does Espom cater for mental health – now you can walk into St Helier and see a psychiatrist.
- Wherever it goes must have enough staff to cope with number of patients.
- At weekend cost of bed £1,000 – all wrong. 18 wards – manager for each ward.
- Speed up time it takes for psychiatrist to see you wherever you are – make you wait and wait. With friend who self-harmed – in end walked out. Really bad, patient causes disturbance because having to wait.
- Put new hospital in middle - central to all three sites.
- Impact already there. Loneliness causes premature deaths, cost of housing means more flatshare, we have the longest working hours in Europe, more people work from home so do not meet other people, on-going austerity means there is no money for mental health "cinderella" services – murders, violence and suicides up. Politicians are only concerned about the economy [Sunday Politics: 14.10.18].

CCG area:	**Surrey Downs**
Group:	The Old Moat Garden Centre [support for people with mental health needs sponsored by The Richmond Fellowship]
Date:	15.10.18
Profile:	Six participants – three service users, one volunteer with two children [twins] with mental health needs and two co-ordinators.

Epsom Hospital:

- Time is crucial – life and death – get to what you need quickly – how go to St Helier's through traffic in Epsom?
- I would go to closest A&E
- Three sites – ambulance service under-funded. If brilliant does not matter where acute it – pump money in, possibly airlift. Transportation – most reassuring.
- Good because easy to get to – St Helier is a terrible journey – traffic is ridiculous.
- On door-step – ideal
- It put it around back of Epsom OK to get to. If in front of hospital – more traffic.

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- Need car parking – just adequate. Taking this away? Not enough car parking: park on estate.
- Not everyone has a car – public transport important. Visitors important to recovery. Belmont a nightmare.
- I was told to wait in a room with someone vomiting – already distressed
- Mental health patients do not have transport – not organised – lost licence and on medication – benefits – when have appointment need to arrange transport – harder if mind is not functioning.
- If building is near public transport – more buses to Epsom.
- Epsom central to train station – can walk

St Helier Hospital:

- Too far away – traffic ridiculous. Public transport very difficult – is there a station?
- Very, very hard to get there – especially if head is messed – won't look at timetable. Need to look at three timetables.
- Big site – need to find out where to get to
- A lot of effort to get there. Pain in a*r*e if physically disabled.
- If you are in a blurry state – unable to make decisions – make journey – anxious – distressed – no support – live on own – no friend to come with you – won't get there. Some unable to leave house – would not go to that hospital.
- If live in Epsom – know area – familiar – feel more comfortable – know it.
- Different area – s*i*
- Epsom: better train links than bus services?

Sutton Hospital:

- Better than St Helier – can walk up from station
- Sutton Hospital is way out
- Rose Hill is weird – Belmont is calmer
- Transport slightly harder

Other:

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NHS

- Go in middle – everyone happy
- Do not build if no staff
- Need to be holistic – can't separate mental health and physical health
- What are back up services?
- Look at radius, how long it takes to get through traffic, is it easy to get to?
- Comes down to cost of three sites, some win, some lose, never win re: access.
- Let public know actual figures – save money, how? Employed staff – change contract – still need huge amount of doctors.
- Need enough beds – right number? Make sure enough beds.
- Identify mental health need at A&E – liaise with GP – work out care plan
- Have centre of excellence linked to university so inspire – accommodation for doctors and nurses – London weighting guaranteed.
- Many would travel further if know good quality – save life – want to know it's there – ready, waiting for you – right quality of care.

Mitigations:

- Knowing whether, at acute service, there is a mental health liaison nurse qualified to give clinical advice and support – need to be receptive to mental health problems. Panic attack is serious – when you are very unwell you will go to A&E.
- Treated like a dog [by the police?] – need proper mental health nurse there all the time. Do not say you will offer a service and then do not offer it. If you say "we will see you in two hours" stick to it. Mental health liaison nurse – only role is to liaise between patient and clinicians – mental health training. Some will not tolerate wait – kill themselves or not come.
- Need staff, training – do it
- If you are in rehab daily visitors are important – funded transport to get people to hospital.
- Bus route – guaranteed, easy access
- Cannot rehab without family – discharge begins on admission. Accessibility of family to visit important part of recovery.
- Need car parking – accessibility
- In 2012 I cut myself – big crisis – bled – no rapport with police – agitated, distressed. Cut myself at 1.30 – did not get ambulance until 3.50 – had heart attack because lost so much blood – taken to Southend – transferred to Basildon – prevented if more ambulances. Did not want blood on uniform.

- If there is a crisis GP calls the police out but they are not trained.
- No mixed wards – difficult.
- When you are very ill – unfamiliar – do not know – has an impact. To be aware. Better in single ward.
- Single sex – very small dorms – single rooms – if you have been a recluse for five years you will not tolerate hospital environment for very long
- Mental health expertise in all three sites
- 111 Service, Epsom mental health line and drop-in centre: should use these services more, advertise, promote.
- People know where to go
- Very important to educate so people understand

CCG area:	**Surrey Downs**
Group:	Mary Frances Trust [charity which supports people with mental health needs in Epsom, Ewell and Mole Valley]
Date:	18.10.18
Profile:	Six participants – three female. Some with physical impairments and long term conditions.

Epsom Hospital:

- Why was Leatherhead Hospital not considered?
- Doesn't have A&E – small cottage hospital.
- Considerable advantages – here, on fringe of your area, area you impact on spreads out to Sussex border. If St Helier – Sutton not quite as bad because accessible by train. St Helier not very accessible. Transport – get acute patient there but also needs visitors.
- Length of time to hospital for acute case crucial – too far – how long it takes you to get there – lose lives.
- Do not allow enough time to get to St Helier – longer than you think.
- Equally covered by Epsom and East Surrey – are you looking at services provided by adjoining authorities? If move acute to St Helier and leave East Surrey / Redhill – long distance between them.

- If suffer anxiety journey out of the question – daunting. Must plan how to get there. If have to go to St Helier by public transport never get there. Transport not reliable – being treated for agrophobia – do not want to go out never mind St Helier – if have to rely on transport do not turn up.
- Treatment at Epsom better than St Helier
- Broke ankle – elected Epsom – looking at fully comprehensive service. Needs to cover everything.
- Need to reach it easily – not much problem – more countrified – out of the way – do not like busy – too much traffic.
- What is happening to the rest of the site?
- Ideally, provide more money for what is there, get / pay permanent staff.
- In construction terms – more cost effective to build
- Plenty of room at back to re-build – better use of facilities you have – take a long time

St Helier Hospital:

- Very big – stressful when go there because it takes awhile to get there – stressed out anyway – get there – can't find your way around. Went to pain clinic for back – told it had been moved – if had not told me would have wasted time walking there and back – not very well organised like Epsom.
- Difficult for family to get there once acute dealt with – most important is visiting if suffering.
- Angina and asthma can be acute – must get there quick – not dragged all the way to St Helier.
- Not easy to get to – OK if drive
- Even then – anxiety provoking – anxious anyway
- If very ill do not want to be taken a long way – when going through it – do not want to feel dragged miles away when nearest down the road – very difficult if in strange place never been to before.

Sutton Hospital:

- Difficult – bus from Sutton Railway station to Royal Marsden – spend small fortune on bus-fare visiting person – can't afford his – can only use pass at certain time – visiting every evening.
- Better than St Helier

- Not that far from St Helier
- Don't know Sutton
- Do not know where located

Mitigations:

- More funds – not everyone has to have a mobile
- If want family to visit acute - go to hospital car park – charge a lot - £9 – cannot afford this prices – especially us on benefits – can't work.
- Long-term visiting concession
- Reasonable amount of family accommodation for visitors – children as well as adults.
- Transport scheme similar to dial-a-ride locally organised by surgeries who know us
- Look at positioning of acute trusts in adjoining areas
- Look at Surrey map – densities of population and major roads
- If big area and there is only one hospital how cope with numbers coming in?
- If St Helier will be channelled to Brighton! Right on Surrey / Sussex border
- Need to look at critical pathways for ambulance transport
- Need more ambulances
- On the news you hear that ambulances are not getting there – another anxiety – will they turn up?

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Appendix D: Learning Impairments

CCG area:	**Merton**
Group:	Merton Mencap
Date:	06.10.18
Profile:	17 participants – six female – primarily White-OK origin.

Feedback obtained from the group was limited by learning impairments. The group did not wish to complete the equality monitoring form. An Easy Read version of the Issues Paper was distributed.

The following feedback was provided:

- Will there be enough beds?
- I go to St George's
- Not heard of St Helier
- Make it bigger
- New doctors and nurses
- St Helier is good. Make signs bigger – need to know where it is
- Yes – St Helier – I live in Wimbledon
- Local – for me.
- Epsom OK if it will make me better. Mum had hip replacement.
- Epsom is too far out – St Helier very close.
- Too far – don't know where it is – need someone to come with me – what buses?
- They should look into your eyes
- Too many people at St George's

- Building important
- Don't leave old people waiting too long in beds in hallway
- Smoking is bad for you

Group Co-Ordinator:

- Some people like to be alone in a ward but many need individual care and support. Difficult for parents / carers who struggle with long-term parking at hospital which is very expensive
- Service users do not have an income – fixed every week. Most do not drive – they are taken or use public transport.
- Car / taxi would be nice - distance and time is important.
- We struggle to understand our service users as some can express themselves and some cannot. If that is so how can doctors cope? Need specialist trained support staff to ask right questions so get right result quickly.
- Adult over 18 without capacity still has to give consent to operation even when accompanied by parent or carer. Operation cancelled in one case because patient did not understand – this issue should be sorted out beforehand.

CCG area:	**Sutton**
Group:	Sutton Mencap
Date:	06.10.18
Profile:	11 participants – three female – one wheelchair user – one user of BAME origin.

Group discussion – learning impairments limited feedback obtained. An Easy Read version of the Issues Paper was distributed.

The following comments were provided:

- Signed petition to keep St Helier open – three times – both against it. Not a good idea – rather go to St Helier – signed petition. What will they use St Helier for? Don't want it smaller – keep the same.
- Medicine – injections – blood test.
- Travel to St Helier by taxi
- Epsom too far – have bus pass – do use it – have to travel with mum – get bus or taxi.

- Been to Epsom and Sutton Hospital – nice
- Ambulance – takes longer to get to further hospital.
- Will there be enough beds?
- No straightforward route to see mum and dad at Epsom Hospital
- Want friends and family to visit
- Sutton hospital – would go there
- Not allowed to travel on train by myself – mother would worry – get lost – could go further distance than bus – Victoria!

Co-ordinators feedback:

- Would patients be seen independently?
- Transport if further out?
- Like Sutton – more control, in-between, more inclusive, better to travel to Sutton – one straight bus from Epsom to Sutton and St Helier to Sutton.
- Service users are trained to travel by bus – easier to understand – stops are easy to access – longer distance between train stations so greater impact if get on wrong train. Always ramp on a bus.
- Trains – will not allow you to embark if you have not called beforehand for a ramp.

CCG area:	**Sutton**
Group:	Sutton Parents Forum
Date:	18.10.18
Profile:	Four female parent-carers of children with a range of complex learning, physical and mental health needs: autism, ADHD, global development delay, depression, anxiety, insomnia, Aspergers, hyper mobility syndrome, chronic fatigue, visual impairment, dyspraxia, OCD and Dyscalculia.

Epsom Hospital:

- Location – journey to get there – build up problems because half an hour – parking problems – build up anxiety, longer travel if further away. Some at St Helier – major – different building – if do not recognise staff makes son panic.

- Access – getting there – no train.
- What buses go there? Hospital is 15 minutes from town centre. If do not drive that is difficult especially if you do not have a car – some children do not like public transport – have school transport.
- Overcrowding and changing of route – challenges sensory needs.
- Young adults and children do not have attention span – St Helier on door step.
- Grand-daughter taken to St Helier – did not have bed to operate anywhere else – no bed in St George's – ended up in intensive care in St Helier – no staff – said St George's will do it.
- Son in accident taken to St Helier – then taken to St George's.
- Do not ship children between hospitals if have additional needs – parents upset, children with special needs in accident will be anxious, in pain, crumbling on floor – lack of familiarity.
- Most know children's hospital at St Helier and Queen Mary's - wonderful.
- St Helier's cannot plaster after 8.00pm – care fantastic but no funding.
- Epsom: slightly more modern that St Helier but still dated
- Get to Epsom a nightmare – two buses – 293 from north Cheam – fair walk to hospital or bus. If have physical impairment or autism very difficult.
- Difficult for parents with other children and no car – how would they manage the school run? Child in school and hospital – no network or support – stuck – child left alone or isolated because parent cannot be there. 45 minutes in rush hour. Carshalton to Epsom – double.

St Helier Hospital:

- Good transport links
- Serves huge area – St Helier estate – hundreds of families – biggest in Europe at one point – if thousands to go to Epsom – no money – on benefits – could not afford bus journey.
- Very central – in middle of areas – close to mental health and special units.
- Has children's hospital
- Have Queen Mary's
- Excellent staff
- But quality of equipment?
- Money wasted elsewhere
- Acute should have everything – ease of access, signage improved, footsteps.

Sutton Hospital:

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- Not a bad idea– prefer St Helier. Geographically closer than Epsom – Number 80 bus, three buses go to Belmont. Least disruption – site already blocked off – building anyway.
- Where would you park cars? Residents complaining – yellow lines. Easer at St Helier to park.
- Carshalton to Sutton Hospital a longer distance – site is at top of Sutton and further on.
- St Helier in centre of Sutton borough

Mitigations:

- Police need training on autism and how to deal with young people with this condition in order to keep the situation under control and be flexible about the approach they take for someone with a learning disability.
- There needs to be a learning disability nurse in hospital, and duty psychiatrist needs to have a learning disability specialism.
- Young people with learning disabilities need to be fast tracked through hospital in order to avoid even more distress and delay.
- Should be easy route inside hospital – St Helier – not enough signage, should be user-friendly, some have hearing impairments, someone you can go to 24 24 hours a day, some reception desks not manned. At St Helier's volunteers signpost – have ambassador to support parent or child.
- When arrive at A&E with child with ASD they are terrified – people everywhere – terrifying.
- Waiting room at A&E too busy so anxiety levels increase – need to walk child around outside – can exit double doors for fresh air – can't sit son in waiting room.
- Lighting, smells and overcrowding – what child sees in A&E frightening.
- Separate children's A&E very important. After initial event – follow up happens elsewhere.
- Hospital passport: has all information, what child likes, does not like – when son had operation in Epsom hospital consultant knew nothing. Doctors and staff to know about system. If parent is not with young person with additional needs staff should have this passport: "does not like to be touched at X".
- No transport – consider staff shuttle bus which runs from Epsom to St Helier – parent on benefits, no car, could they use this? No extra cost.
- Have bus, mental health nurse, chaperone. Depends on child's needs – make sure this is provided eg if have epilepsy. Daughter will bolt if does not like environment – terrified as parents – security issues.

- Familiarity important for children and children with special needs – know route – “am I going to the teddy bear hospital?” – got son to St Helier. Wouldn’t get him in the car if it was Sutton – no familiarity – does not know doctors.
- Is there space?
- Transfer from minor A&E to major A&E is terrifying – acute should have all facilities. If child is very ill taken to one hospital – if trauma go straight to St George’s.
- Bring CAMHS and Springfield under one unit – adults and children.
- Mum very, very poorly – taken to three different buildings – no notes – no idea in critical condition – notes in another hospital. If all under one roof – notes there, would know disabled, on crutches – under five hospital departments at the moment.
- One stop shop – everything in it.
- Son suicidal - told to go to A&E – St Helier referred me to CAMHS but I am already at CAMHS – waste of time.
- Look at data of children with needs at St Helier and compare with other locations – needs are higher at St Helier.
- Friend’s husband suicidal – told to go home – committed suicide.

South West London & Surrey JHSC sub-committee - Healthcare Together 2020-2030

Improving Sutton

Thursday, 7 February 2019

7.30 pm at the

Merton Civic Offices, London Road, Morden, SM4 5DX

SECOND DISPATCH

To all members of South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030:-

The following papers, which were not available for dispatch with the agenda, are attached. Please bring them with you to the meeting:-

4. MINUTES OF THE PREVIOUS MEETING (Pages 1 - 6)

To approve as a correct record the minutes of the meeting held on 28 November 2018.

Mary Morrissey
Chief Executive (Interim)
Date: 29 January 2019

Enquiries to: Cathy Hayward committeeservices@sutton.gov.uk, 020 8770 4990

Copies of reports are available in large print on request

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SOUTH WEST LONDON & SURREY JHSC SUB-COMMITTEE - IMPROVING HEALTHCARE TOGETHER 2020-2030
28 November 2018 at 7.30 pm

MEMBERS: Councillors Zully Grant-Duff, Peter McCabe and Colin Stears

11. WELCOME AND INTRODUCTIONS

The Chair, Councillor Colin Stears, welcomed those present.

Councillor Peter McCabe was disappointed no representative of the Merton CCG was present at the meeting.

12. APOLOGIES FOR ABSENCE

There were no apologies for absence.

13. DECLARATIONS OF INTEREST

Councillor Colin Stears declared that his wife is employed by the Epsom and St Helier Trust.

14. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

that the minutes of the meeting held on 16 October 2018 be agreed as an accurate record subject to the following amendment: Item 4 to now read: Councillor Peter McCabe reported that the London Borough of Merton reserve the right to refer this matter directly to the Secretary of State. It was noted that both the London Borough of Sutton and Surrey County Council are yet to decide their approach.

15. OVERALL BRIEFING REPORT AND VERBAL UPDATE ON ENGAGEMENT

Andrew Demitriades, Programme Director, Improving Health Care Together (IHT), presented the report.

The Programme Director informed Members that the attendees of the three workshops which were held recently to look at the options consideration process had included 60% community and 40% staff attendees, the attendees included a range of demographic including the protected characteristics.

A terms of reference for the workshops had been developed, which covered the rules of engagement for both community and professionals, attendees were asked to sign this voluntarily. The Programme Director clarified that the terms of reference for the workshops did not mention that attendees are not allowed to discuss items or documents presented at the meetings. At the workshops attendees were asked to respect that documentation provided at the meeting was in a draft form.

In discussion Members were of the view that the workshops could have been held at a later date, and that the Programme was being moved forward more quickly than expected and in particular that holding the workshops at a later date would have allowed attendees to view and comment on more complete documentation.

The Programme Director did not agree the programme was being sped up. He also reported that the Programme team will consult with the Local Authorities more fully about how future engagement and communications can be improved. He also explained that work to date had been shared with the Regulator.

The Programme Director committed to publishing the outcome of the quality scoring as a report after the three governing bodies have met.

It was noted that additional work is required, the governing bodies can review the work completed to date and the further work required.

In discussion Members considered how the Integrated Impact Assessment (IIA) will be used to identify the positive and negative impacts on groups by each suggested option. It was noted that groups shown as being impacted by any changes will be identified but this will not lead any preferred option, but will be used to inform of any issues and mitigations for any of the possible options.

Information about the output from the workshops will be available after 12 December following consideration and approval by the three CCGs' Governing Bodies.

Deprivation will be considered as part of the scoring within the equalities impact assessment.

Before the end of December an advert will be placed for an independent Chair of the Integrated Impact Assessment steering group and, representation will be sought from all the bodies

It was noted that agenda item 5, appendix B item 2 mentions the Joint Health Overview and Scrutiny Committees, and that this should read Committee.

16. DEPRIVATION IMPACT ANALYSIS

Toby Irving, Principal Consultant, PPL presented the report.

It was noted that the data collected will provide oversight, and can be used to assess and monitor effects of each of the options on the population. Research suggests that access to acute care services does not impact health care outcomes. Members suggested that access to acute care services should be considered for aging populations in the more rural areas of the geographies.

Members noted that the recommendations in the report state that more work is needed. Programme Manager, IHT stated that the recommendations will be completed and added to the work plan, which will be provided to Committee Members.

Councillor Peter McCabe stated that in November 2017 Merton Council agreed not to carry out their own independent deeper deprivation analysis, as the Council was informed that as part of partnership working between the Council and the IHT programme, the IHT programme would complete this work. The Councillor expressed disappointment this work has not been completed and that the Leader of Merton Council had written to the IHT programme about this failure to deliver on the original agreement.

Concern was raised by the Members that work was being completed too quickly. This resulted in the data not being developed and reviewed in sufficient detail, not showing variations of levels of deprivation within the boroughs and particularly within individual wards meaning that pockets of deprivation may be overlooked. The work completed shows a moment in time, Members suggested the data should be projected forward to show future predicted demographic changes, such as aging populations.

The Programme Manager reported that the work completed is reported openly, and acknowledged that there is further work to be completed. Advice will be taken from the Local Authorities and their Directors of Public Health, to agree the data sets and methodologies for future work.

Dr Simon Williams, Clinical Director for Urgent Care and Integration, Surrey Downs suggested the evidence gathered shows that any changes to acute services would only impact a small proportion of the population within the geographies and the current health needs of the population would be met by any of the options. Out patients appointments would not be affected by the options but that a robust and sustainable acute care services model is required.

Dr Russell Hills, Clinical Chair, Surrey Downs CCG reported that the engagement sessions had helped the Programme understand the impacts on communities within the geographies of the suggested options, and what is important to the populations.

A member of the public, Councillor Andy Stranack, London Borough of Croydon asked if the impact on other hospitals in the area would be considered, it was noted this would be included within the IIA.

17. PROVIDER IMPACT ANALYSIS

Andrew Demetriades, Programme Director, Improving Health Care Together presented the report.

The Programme Director clarified the figures provided in the report including the range of impacts on other hospitals in the area, particularly St George's hospital who have written to express concerns about the impacts of the options being considered. This letter was

responded to by the Programme Director and a copy of that response would be provided be to the Members of this Committee.

Discussion included that some pockets of deprivation may create more impact on the hospitals listed than is reported in the figures.

Members asked why the workshops had been carried out even though it is acknowledged that there is more work to complete, and suggested they felt the workshops had been completed too soon and that several of the reports presented suggested more work is required. The Programme Manager, reported that the workshops show information at a point in time, and it was felt that the work completed had meant that it had been appropriate to hold the workshops.

RESOLVED: that report was commented upon and noted.

18. INDEPENDENT REVIEW BY THE CAMPAIGN COMPANY INTO IMPROVING HEALTHCARE TOGETHER ENGAGEMENT

Dr Jeffrey Croucher, Clinical Chair, Sutton CCG presented the report.

Members commented that the report showed that there is a contrast between what experts are reporting and what the public are saying. The Clinical Chair, Sutton CCG noted that the engagement sessions had been a listening exercise for the Programme and that this will continue as good conversations and understanding were produced. It was recognised that a good communications programme needs to be developed to help overcome suspicions amongst the public.

Engagement will continue and will include service users of maternity services. Members expressed concerns that the views of vulnerable users, such as teenage mothers are not included. Dr Russell Hills, Clinical Chair Surrey Downs CCG confirmed that antenatal care would remain at a local level.

19. ANY URGENT ITEMS BROUGHT FORWARD AT THE DIRECTION OF THE CHAIR

There was no urgent business.

20. DATE OF NEXT MEETING

The next meeting will be held on Thursday 7 February 2019.

South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030

28 November 2018

The meeting ended at 9.45 pm

Chair: .....

Date: .....

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