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: **Wednesday 28 November 2018**

Time: **7.00 pm**

Venue: **Sutton Civic Offices, St Nicholas Way, Sutton, SM1 1EA**

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

28 November 2018

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

28 November 2018

7.30 pm at the

Sutton Civic Offices, St Nicholas Way, Sutton, SM1 1EA

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

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

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Niall Bolger
Chief Executive
16 November 2018

Enquiries to: Cathy Hayward,Committee Services Officer Tel.: 020 8770 4990, Email: committeeservices@sutton.gov.uk

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A G E N D A

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	Overall briefing report and verbal update on engagement.	
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	The deprivation impact analysis prepared for the Improving Healthcare Together programme by Cobic, the Nuffield Trust and PPL.	
7.	**Provider Impact Analysis**	79 - 86
	A report on the current work to understand the provider impact analysis prepared for the Improving Healthcare Together programme.	
8.	**Independent review by the Campaign Company into Improving Healthcare Together Engagement**	87 - 150
	A report prepared by the Campaign Company on the engagement work undertaken to date by the Improving Healthcare Together programme.	
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SOUTH WEST LONDON & SURREY JHSC SUB-COMMITTEE - IMPROVING HEALTHCARE TOGETHER 2020-2030

16 October 2018 at 7.30 pm

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

ABSENT None

1. WELCOME

Councillor Colin Stears will remain as the interim chair, until a Chair can be elected.

It was agreed that the items will be taken in the order: items 2 to 8, followed by items 1,2 and 9.

2. APOLOGIES FOR ABSENCE

There were no apologies for absence

3. DECLARATIONS OF INTEREST

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

4. TERMS OF REFERENCE AND RULES OF PROCEDURE FOR THE STANDING AND SUB-COMMITTEE

Councillor McCabe reported that The London Borough of Merton reserve the right not to delegate the power of referral to the Secretary of State to this Committee. It was noted that both London Borough of Sutton and Surrey County Council are yet to decide on their approach.

Resolved that:

The terms of reference for the South West London and Surrey Joint Health Sub Committee be noted.

5. SCRUTINY ISSUES : THE APPROACH OF THE IMPROVING HEALTHCARE TOGETHER SUB-COMMITTEE

David Olney, Commissioning & Business Insight Manager, London Borough of Sutton presented the report.

There were no further questions from members of the Committee.

RESOLVED that:

The committee consider the approach to its work as outlined in agenda item 6 appendix A and listed below:

During the programme's engagement phase the sub-committee will undertake the following kind of work, this is not an exhaustive list of what the committee may choose to do.

- The sub-committee will prepare a workplan, using the Programme's timeline, to set out a timetable for its meetings and the relevant business content for those meetings
- Hold public committee meetings to hear about and provide comment on the progress of the programme
- Receive and comment on reports on progress and actions from the programme director
- Participate in engagement activities to understand and contribute to the development of the programme.

If and when the programme moves into a formal public consultation the sub-committee will undertake its statutory responsibilities to consider whether the consultation is adequate and whether the proposals being put forward are in the interest of the local population.

6. IMPROVING HEALTHCARE TOGETHER 2020 -2030 PROGRESS UPDATE

James Blythe, Managing Director Merton CCG presented the report.

In discussion members of the Committee requested that all relevant papers, data and reports, which have been referenced in the agendas are available to members in a timely fashion. In the case that the information is not available for publication that a summary or draft information be provided.

The Managing Director Merton CCG presented the section of the report - Impact on other providers.

A member of the public, Councillor Sean Fitzsimmons (LB Croydon) asked why only the three boroughs, Sutton, Merton and Surrey County Council have been included in this part of the work as the options being considered would impact both residents in LB Croydon and acute health services in LB Croydon. It was noted that potential impacts on other boroughs is included within the data and reports provided and is being considered. Additional borough could be asked to join the Committee in the future if necessary.

Brian Niven, Technical Principal, Mott MacDonald presented the section of the report - Travel Impact Assessment.

It was outlined that the data collated showed how the nine protected characteristics and an additional category of deprivation would be impacted by the options, (with the data overlaid on each other). This data and its analysis will be included within the final report which will be available in Spring 2019 prior to the consultation.

The earliest date which could be considered for the consultation to take place is January 2019, although in order that full regulatory assurance can be provided and issues of local elections considered it is more likely the consultation will take place in Spring 2019.

Charlotte Keeble, Senior Programme Manager, Improving Healthcare Together Programme and Dr Jeffrey Croucher, Clinical Chair Sutton CCG presented the section of the report - Engagement.

Councillor Zully Grant Duff joined the meeting at 8.05pm.

In discussion it was explained that patients who currently use services had been included in the engagement sessions, information about how to become involved in engagement sessions has been displayed at GP surgeries in the geographies. Six of the focus groups had included current users of services, and their views of impacts of the options reported. The findings of the engagement sessions which have been held will be used to provide focus for future sessions.

Members of the Committee asked for assurance that the Engagement events provide transparency and evidence based options. Residents have expressed concerns to the members of the committee about the long history of and amount of money spent on consultations.

It was requested that a report on the findings from the engagement work is provided to this group and made available to the public.

The managing Director, Merton CCG explained that the specialism of maternity care is being considered within the options outlined. It was requested that a recommendations session is held which includes clinical staff from this specialism.

Land searches have been commissioned to ensure that there is no other site in addition to the three options outlined which could be considered.

Dr Russell Hills, Clinical Chair Surrey Downs CCG presented the section of the report - Equalities.

The data collected has been benchmarked against national data sets, no unexpected results have been reported. The Joint Strategic Needs Assessment (JSNA) was considered when collating data sets, the aging population in the Surrey Downs area has been noted, this will be included within the Integrated Impact Assessment report.

The options being considered would not create any changes to district level services. The impact of changes to acute services on the deprived sections of the population will be considered within the Equalities work. The impact on the population with protected characteristics and to include deprivation caused by each of the options, and mitigations which could be taken, will be outlined in the report.

The Impact report will provide data and analysis linking travel, access to services, the nine protected characteristics plus deprivation for each of the options.

It was noted that communications to residents is important at all stages throughout this work

7. Q&A / DISCUSSION OF PROGRESS UPDATE

There were no further questions.

8. ELECTION OF CHAIR

Councillor Zully Grant - Duff motioned that Councillor Colin Stears be elected as Chair, this was seconded by Councillor Peter McCabe.

RESOLVED: that Councillor Colin Stears be elected Chair of the Sub-Committee.

9. ELECTION OF VICE CHAIR

Councillor Colin Stears motioned that Councillor Zully Grant - Duff be elected as Vice Chair, this was seconded by Councillor Peter McCabe.

RESOLVED: that Councillor Zully Grant - Duff be elected Vice Chair of the Sub-Committee.

10. DATES FOR FUTURE MEETINGS OF SUB-COMMITTEE

Dates of future meetings are being planned.

The meeting ended at 8.55 pm

Chair: .....

Date: .....

Joint Health Overview Scrutiny Sub-Committee

Improving Healthcare Together 2020 – 2030

Briefing Paper

November 28th 2018

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:

- Deprivation Impact Analysis (attachment 1)
- Provider impact analysis (attachment 2)
- Independent analysis of feedback from public engagement by The Campaign Company (attachment 3)
- Improving Healthcare Together programme process and timelines (below)

This briefing paper should be read in conjunction with the following attachments: 1- 3.

2. Improving Healthcare Together process and timelines

The evidence we have gathered on the clinical models, baseline travel, deprivation study, equalities scoping, engagement outputs and the provisional likely impact on other providers, plus feedback from staff and the public feeding into the options consideration process.

The options consideration process consists of three separate workshops, independently facilitated and attended by a mixture of the public and professionals.

The options consideration workshops review the evidence we have collected and:

- Workshop 1: decides the criteria we should use to test the potential solutions
- Workshop 2: decides how we should weight these criteria in terms of importance
- Workshop 3: applies the criteria and weighting to score the options

The three local CCGs will then consider the quality criteria, along with a comprehensive financial assessment of the potential solutions. In December we will submit the outputs of this work along with our case for change, plans and processes and all of the evidence to our regulators for assurance. This will form part of a draft Pre-Consultation Business Case.

No preferred option(s) will be decided at this point or any decisions made. The options consideration process is not a decision-making process, it is an evaluation process and forms part of a continued process we are following.

During early 2019 NHS England, NHS Improvement, the London and South East Clinical Senates and the Joint Health Overview and Scrutiny Committees assess all our plans to make sure they stack up financially, clinically and for patients and the public.

Alongside this assurance process we will run phase two and three of the Integrated Impact Assessment. The first scoping phase has already been completed (the Initial Equalities Analysis). The second phase of the work, which comprehensively assesses positive and negative impacts of the options, can only be undertaken when the details of the options have been confirmed.

All options will be subject to the same level of assessment, regardless if one has been stated as preferred by the programme board.

The IIA will integrate assessments on equality, travel, health and sustainability under each of the options. This work will seek to incorporate, where relevant, the findings of the earlier work undertaken.

This work starts in late November and oversight of this work will be through an independently chaired Steering Group with representation from CCGs, local authorities and other key stakeholders.

Following assurance, the three CCGs will then consider, the provider impact analysis, any outputs from the assurance process and the phase two IIA before determining whether they wish to proceed to public consultation on any proposals.

Following a public consultation, the CCGs will reflect and deliberate on the evidence gathered, the views of the public and expert clinical advice.

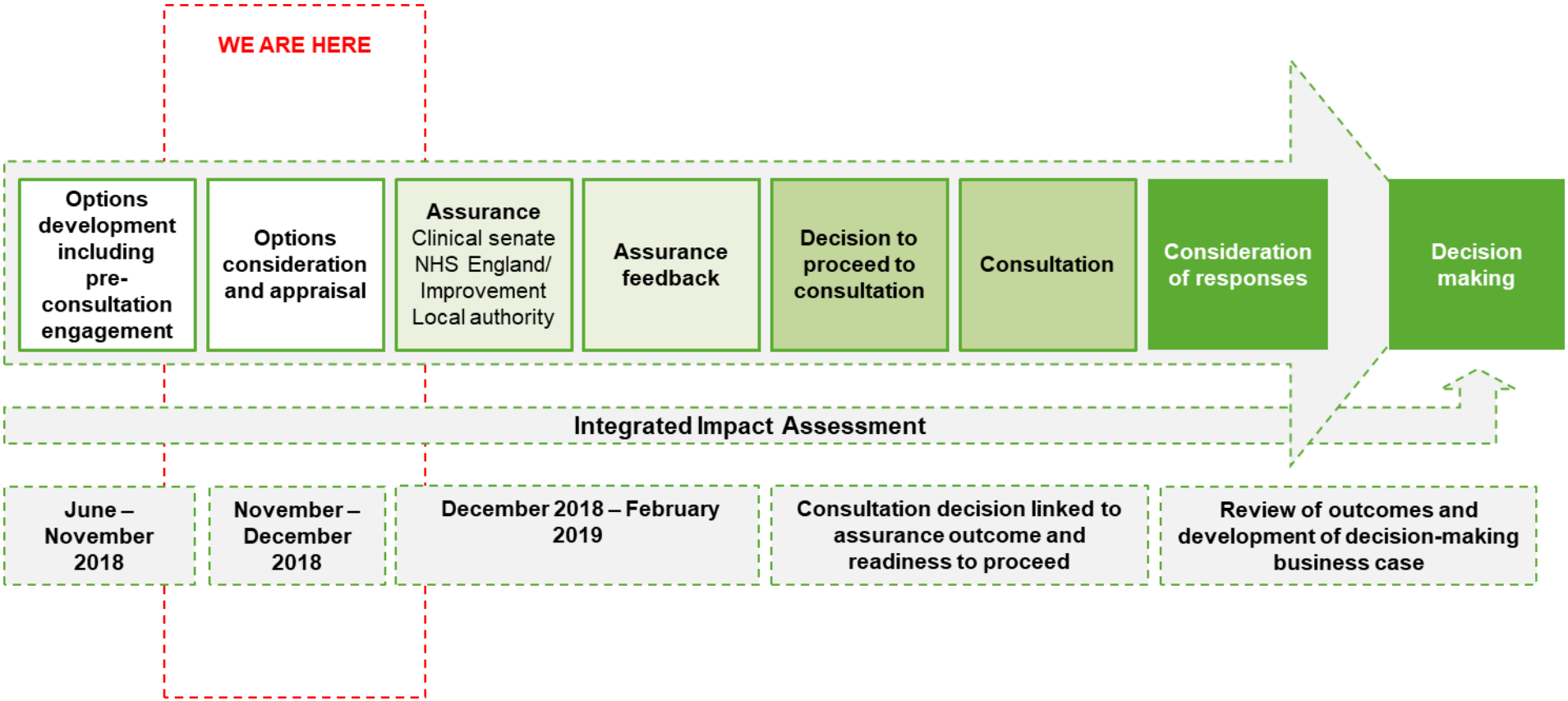
No decisions are made until after a consultation and all the evidence and feedback has been assessed.

The process and indicative timelines are attached in Appendix 1.

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

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

Appendix 1: Process and indicative timeline



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Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:**	28 November 2018
Report title:	Improving Healthcare Together 2020-2030 - Deprivation Impact Analysis		
Report from:	Tom Alexander, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author(s)/Contact Number(s):	David Olney, Commissioning & Business Insight Manager - 020 8770 5207		
Open/Exempt:	Open		
Signed:		**Date:**	14 November 2018

1. Summary

1.1 The deprivation impact analysis prepared for the Improving Healthcare Together programme by Cobic, the Nuffield Trust and PPL.

2. Recommendations

The Sub Committee is recommended to:

2.1 Consider and comment on the report.

3. Background

3.1 The Improving Healthcare Together 2020-2030 programme has commissioned a range of supporting work for its programme including this deprivation analysis.

3.2 The Improving Healthcare Together JHSC sub committee will consider and review this report as part of their scrutiny oversight of the programme.

4. Appendices and Background Documents

Appendix letter	Title
A	Cover Sheet Deprivation Impact Analysis
B	Deprivation Impact Analysis report

Audit Trail		
Version	Final	Date: 14 November 2018

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

JHOSC Sub-Committee Cover Sheet
Attachment:1
28th November 2018

Title of Document: Deprivation Impact Analysis	**Purpose of Report:** For noting
Report Authors: PPL, COBIC and The Nuffield Trust	**Lead Director:** Andrew Demetriades

Executive Summary:

Following a best practice approach, Improving Healthcare Together commissioned The Nuffield Trust, PPL and COBIC to undertake a deprivation impact analysis.

The scope of this work addressed the following questions:

a) What are the main health needs?
b) Do deprived communities have an increased need and usage for acute hospital services and do geographical factors influence this?
c) Which services are critical to retain?
d) How should any proposed clinical options be tested?
e) Are there any mitigations and balancing considerations?
f) Are there areas where further analysis be undertaken?

The key findings show:

- There is a wealth of evidence that deprived communities have worse health outcomes than non-deprived communities; however, there is less evidence linking deprivation with the need/usage of the specific major acute areas being considered as part of the Programme;
- Within the combined geographies, deprivation is relatively limited when compared nationally at the average level, driven by pockets of deprivation;
- These pockets of deprivation are dispersed in several locations, in Sutton and Merton;
- The area of Sutton and Merton containing the pockets of deprivation is a concentrated area. Given the current relative ease of access to major acute services within this area, and given the three current proposed locations for major acute services, any changes to locations of major acute services are likely to have relatively marginal impacts.
- The report understands these three proposed locations are the current proposed solutions, and that the Programme is open to other possible solutions for major acute service locations;
- Health inequality is an important factor, but that will not be solved or addressed specially by the decision about major acute service locations. Instead it will need be solved by wider partners.

Appendix 2 will include the deprivation impact analysis report.

Key issues to note are:
These findings provide important information which has been used in the evidence packs for the options consideration process and will be used to inform the continued work on deprivation and equalities through the Integrated Impact Assessment (IIA)

Recommendation:
The JHOSC Sub-Committee is asked to note the findings of the Deprivation Impact Study

Financial Implications:
None

Equality Impact Assessment:
An initial equalities scoping has been conducted as part of the IHT programme.

Information Privacy Issues:
None

Communication Plan:

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

JHOSC Sub-Committee Cover Sheet
Attachment:1
28th November 2018

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

Deprivation impact analysis

As part of Merton, Sutton and Surrey Downs CCGs Improving Healthcare Together: 2020-2030 programme

31 August 2018

An independent report prepared by:

cobic nuffieldtrust PPL

1 Executive summary

1.1 Aims and objectives of the deprivation impact analysis

The footprints of the three CCGs of Surrey Downs, Sutton and Merton, together known as the "combined geographies", cover a population of approximately 720,000 residents and a number of health care providers. Across this combined geography there is a need to address long term issues of sustainability, particularly for acute hospital services.

Within the combined geography this is a particular challenge for Epsom & St Helier University Hospitals NHS Trust ("the Trust"), where there has been a long standing concern about the ability to provide care sustainably. The three CCGs, and the Trust, recognise that they need to address three main challenges relating to clinical quality, providing healthcare from modern buildings and achieving financial sustainability if they are to provide high quality healthcare into the future. They recognise that in addressing these challenges any solutions will have additional considerations, including understanding any impact on deprived communities.

To support understanding of this issue the three CCGs commissioned COBIC, the Nuffield Trust and PPL to undertake an independent analysis to assess the impact of any proposed changes to major acute services for deprived communities within the combined geographies.

The approach adopted has sought to review evidence of links between overall health and deprivation, drill into the specific aspects that relate to the local context and develop initial considerations in relation to emerging proposals for major acute services. We also consider the potential for addressing any impacts found and recommend further areas for the Improving Healthcare Together 2020-2030 programme ("the IHT Programme") to consider as it develops proposals for consultation.

1.2 Improving Healthcare Together 2020-2030

Our work has been undertaken in the context of the Merton, Surrey Downs and Sutton CCGs' 'Improving Healthcare Together: 2020-2030 programme', which aims to make informed decisions on how to resolve the long-standing healthcare challenges relating to major acute services at the Trust within the combined geographies.

This review is one strand contributing to the complex change programme which is considering a wider range of issues and impacts. Public engagement on the issues commenced during Summer 2018 and there will be a further period of review, engagement and consultation before any decisions are made on any service change next year.

An Integrated Impact Assessment ("IIA") has been commissioned by the IHT Programme Board. The findings from this report and some areas of proposed further analysis are expected to inform the IIA, so we briefly explain the purpose of the IIA.

IIAs are a key component of policy-making and help guide and appraise investment. They have long been identified as a mechanism by which potential effects on health outcomes and health inequalities can be identified and redressed prior to implementation. According to the World Health Organisation (WHO), impact assessments (including IIAs) provide "*a combination of procedures, methods and tools by which a policy, programme or project may*

be judged as to its potential effects on the health of a population, and the distribution of those effects within the population".[1]

The aim of the IIA is to explore the positive and negative consequences of different proposals and produce a set of evidence-based, practical recommendations, which can then be used by decision-makers to maximise the positive impacts and minimise any negative impacts. It is important to note that the purpose of the impact assessment is not to determine the decision; rather they act to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve.

It is regarded as best practice to assess impacts for the whole population and highlight the sections of the population which will be differently or disproportionately affected by the impacts. These might be geographical communities or certain socio-economic or 'equality' groups.

A health impact assessment (HIA), a travel and access impact assessment, an equality impact assessment (EqIA) (in which the impacts of the proposals on protected characteristic groups and deprived communities are assessed) and a sustainability impact assessment will be conducted as part of the IIA.

1.3 Health needs of the combined geographies

An analysis of the health needs in each of the CCG areas is provided in Section 4 illustrating the specific characteristics in each area. Across the combined geography a number of common issues are apparent and relevant to this analysis, including:

- Populations across the combined geographies are ageing which is, and will continue to be, the single largest driver of health and care usage and costs;
- The main causes of premature death are cancer, circulatory disease, and respiratory disease;
- Prevalence rates across the most common long-term conditions (LTCs) in the combined geographies are lower, or comparable to those rates seen nationally, with the exception of heart failure in Surrey Downs, which is marginally higher;
- Prevalence rates of depression are lower in the combined geographies (11.7% in Merton, 14.1% in Surrey Downs, and 13.7% in Sutton) than the national average (15.0%). However, this is just one measure of mental health, and other measures such as adolescent mental health should be examined; and
- There tends to be a higher prevalence of LTCs in more deprived communities;
- Age is also a significant driver of LTCs, Surrey Downs typically has higher prevalence rates than Sutton and Merton, primarily due to its significant older population;
- Within the combined geographies, the proportion of those from Black, Asian, and Minority Ethnic ("BAME") backgrounds is 30%, which is lower than in London (55%), but higher than the national average (20%). It is varied within the combined geographies: 52% of the Merton population are from BAME backgrounds, 29% in Sutton, and 16% in Surrey Downs.

[1] Source: World Health Organisation (2017): '*Health Impact Assessment*'.

1.4 Deprived communities and health factors

People in Sutton, Merton and, particularly, Surrey Downs are not significantly deprived when compared to the rest of England. However, there is local variation within the combined geography and areas which are more deprived (which we examine further in Section 5).

Grouping areas into quintiles according to the level of deprivation within a larger geography is a way of identifying localities that are in greater need of services. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The country is split into small geographical areas called Lower Super Output Areas (LSOAs) which are then ranked according to the Index of Multiple Deprivation – an overall measure of multiple deprivation experienced by people living in an area.

Ranked nationally, Merton ranks 160 out of 209 CCGs in the overall Index of Multiple Deprivation ("IMD"), Sutton ranks 167 and Surrey Downs ranks 207 where 1 is the most deprived and 209 is the least deprived. In Merton and Sutton it is the living environment and crime domains that are driving the overall ranking, while in Surrey Downs barriers to housing is the main issue. In relation to the health domain, Merton ranks 175, Sutton ranks 164 and Surrey Downs ranks 203 out of 209.

There is however significant local deprivation within the combined geographies, particularly within Merton and Sutton where there are larger concentrations in specific lower super output areas (LSOAs) within the wards shown in Table 1-1 identifying the eleven LSOAs (totalling 17,500 people) within the combined geographies which are in the top quintile of deprivation in the country, as measured by IMD.

Note: the England wide distribution of IMD is 0.48 to 92.6, where a higher IMD value indicates more deprivation. In England, the mean IMD value is 21.67, and the upper quintile is any area with an IMD of higher than 33.93. In the combined geographies, the average score is 11.94.

Of the 11 LSOAs in the top quintile, none are in Surrey Downs, four are in Merton, and seven are in Sutton. Sutton also has the LSOA with the most deprived population as measured by IMD, with a value of 51.26 (in Beddington South). In terms of health deprivation and disability, the LSOAs range from being in the most deprived decile, to the 5th most deprived decile. Individual domains within the IMD are examined in more detail in Section 5.

Table 1-1: LSOAs in the combined geographies in the most deprived quintile in England

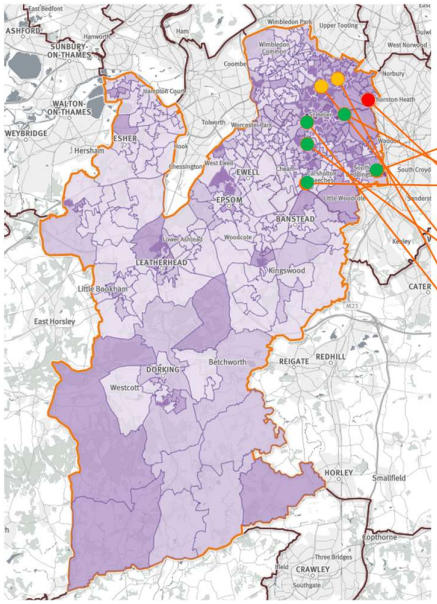
CCG	Ward	LSOA code	IMD score (higher = more deprived)	Health Deprivation and Disability decile (where 1 is most deprived 10%)
Sutton	Beddington South	019c	51.26	2
Sutton	Belmont	021a	42.3	1
Sutton	Wandle Valley	001d	41.83	3
Sutton	Beddington South	019a	40.49	3
Merton	Pollards Hill	019d	39.85	5
Sutton	Sutton Central	012b	39.7	1
Merton	Cricket Green	018a	36.42	3
Sutton	St Helier	002e	35.05	3
Merton	Cricket Green	012c	34.58	4
Sutton	Beddington South	019d	34.27	3
Merton	Figge's Marsh	018d	34.22	3

Source: DCLG, English indices of deprivation 2015

Note: DCLG guidance is that for the Health Deprivation and Disability domain, decile (or rank) is a better measure than score

Of the LSOAs in the most deprived IMD quintile, the seven Sutton LSOAs are all within the Trust catchment area (as shown in Figure 1-1 below, and defined in Section 2.5). Of the Merton LSOAs, Pollards Hill is not in the Trust's catchment area. Figge's Marsh and the two LSOAs in Cricket Green are on the border of the catchment area. It is noted that further work is being undertaken around the catchment of the Trust and this should be considered at a later stage.

Figure 1-1: LSOAs in most deprived quintile in the combined geographies and the Trust's catchment area



Ward	LSOA	IMD
Beddington South	Sutton 019C Sutton 019A Sutton 019D	51.26 40.49 34.27
Belmont	Sutton 021A	42.3
Wandle Valley	Sutton 001D	41.83
Pollards Hill	Merton 019D	39.85
Sutton Central	Sutton 012B	39.7
Cricket Green	Merton 018A Merton 012C	36.42 34.58
St Helier	Sutton 002E	35.05
Figge's Marsh	Merton 018D	34.22

Source: Trust catchment area sourced from Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups (June 2018), "Issues Paper". LSOA IMD data from Table 1-1.

Whilst there are no LSOAs in Surrey Downs CCG in the top quintile for deprivation, the CCG has a significant GRT (Gypsy Roma Traveller) population, who typically have poorer health outcomes than those from non GRT communities.

There is a strong body of evidence about deprived communities having worse health outcomes. We tested a number of hypothesis to understand this further in relation to the major acute services relevant to the IHT Programme confirming:

1) People in deprived communities have increased acute healthcare need;
2) Acute health need is driven by age and other social factors, as well as deprivation, but these factors are linked;
3) Deprivation is correlated with poor mental health which can lead to difficulties in negotiating the welfare/health system, as well as impact negatively on physical LTCs;
4) People in deprived communities have increased acute healthcare usage;
5) Acute health usage is driven by age and other social factors, as well as deprivation, but these factors are linked;
6) Geographical factors are important – the closer to a hospital, the higher usage of acute hospital services by patients than those who live further away; and
7) Some of deprived communities' usage of acute hospital services could be dealt with in primary/community care.

1.5 Health care within deprived communities

National evidence suggests that an inverse care law can apply within deprived communities, where those who need most medical care, typically are often least likely to receive it. In particular:

- In elective care the high number of LTCs within deprived communities would suggest that there would be more elective procedures, whereas the data suggests this is not the case;
- Less access to primary care with lower levels of GP registration, greater difficulty in getting a GP appointment and poorer perception of the quality of primary care;
- Wealthier older people, despite being in better health, make more use of GPs, outpatient visits and dentists, and hospital admissions;
- There is evidence that more deprived communities have worse maternal outcomes, particularly in the fourth and fifth quintiles. Babies whose mothers live in poverty have a 57% higher risk of perinatal mortality; and
- Certain ethnic minorities have a higher requirement for certain condition specific services.

There is good access to hospitals within the combined geographies, particularly in Merton and Sutton. 49.3% of households within the combined geographies have access to hospitals within 30 minutes by public transport or walking, compared to an England wide average of 38.6%. In Merton the level is 64.4%, Sutton it is 56.5% and in Surrey Downs it is 33.8%.

1.6 Relevant considerations for emerging clinical models

The purpose of this report was not to assess potential solutions but to identify the issues and considerations that should be considered as the IHT Programme develops. For this report, and the IHT Programme, which are specifically looking at major acute services, the new model of care **should not materially disadvantage deprived communities in terms of access to major acute services**. This should be for both patients, and their families and friends:

- **Patient access for using major acute services** should be analysed through the travel times modelling through conveyance by ambulance to emergency departments. Expected response and conveyance times should fall within appropriately agreed local thresholds; and
- **Family and friend access to visiting patients using major acute services** should be analysed through travel times modelling through travel times by public transport or walking. Travel times should fall within an appropriately agreed local thresholds. This should include consideration of evening, weekend, and bank holiday services.

More generally, the accountable CCGs, and their local partners, may want to consider activities to tackle deprivation and health inequalities within the combined geographies. These actions were not specifically part of the scope of this work, which has focused on the major acute services covered by the IHT Programme, and measures are likely to include community and primary care services, as well as those of partner organisations, which appear to have greater scope for impacting outcomes. Much of this work may already be being considered as part of the CCGs' and Local Authorities' local plans to improve the overall model of care for their populations.

1.7 Conclusions and areas for further analysis

From the evidence reviewed, our conclusions are that:

1) There is a wealth of evidence that health outcomes decline with increasing deprivation;
2) However, there is less evidence linking deprivation with the need/usage of the specific major acute services being considered as part of the IHT Programme;
3) In addition, within the combined geographies, overall deprivation is comparatively limited when compared nationally. There are, however, individual LSOA areas within the most deprived quintile nationally which is a helpful indicator of the areas of greatest need;
4) These pockets of the most deprived LSOAs are dispersed in several locations, in Sutton and Merton;
5) The geographical area of Sutton and Merton, which contains the pockets of deprivation, is fairly concentrated resulting in a relative ease of access to major acute services (see Section 1.5). Initial proposals (see Section 3.5), for any changes to locations of major acute services are likely to have relatively marginal impact on access. However this report understands that the IHT Programme is open to other possible solutions on top of these initial proposals; and
6) Addressing health inequality is an important goal for those accountable for population health, but decisions about the major acute service locations within the combined geographies are likely to only have marginal impacts on this. A greater impact on health outcomes for deprived communities within the combined geographies would be more likely to come from concerted effort earlier in the health and care service pathways prior to need for major acute services. It is also likely to require involvement of wider partners on the wider social determinants of health.

Notwithstanding the points above, additional work could be carried out by the IHT programme to inform decision making about any changes of locations of major acute services.

These could be covered in the IIA which will consider the current (or baseline) situation and then assess positive and negative impacts of a shortlist of options when compared to the baseline. In relation to deprivation, the IIA could:

- 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.

Health outcomes are worse for more deprived communities but mitigating the impact is more likely to come from interventions earlier in the health and care pathways than at the major acute service level. Outside of the IHT Programme, the individual responsible CCGs as part of their wider responsibilities for population health management may wish to consider, for people living in the LSOAs in the most deprived quintile:

- Further research into what works in relation to the needs of these people in relation to managing demand and improving health outcomes;
- Creating an evidence-based plan targeting the specific needs of these people; and
- Formative evaluation to understand and monitor health outcomes.

2 Introduction

2.1 Project overview

Within the footprint of Merton, Surrey Downs, and Sutton CCGs (an area known as the 'combined geographies') there is a particular challenge for the Trust with regard to a long standing concern about the ability to provide care sustainably.

The three CCGs and the Trust recognise that they need to address three main challenges relating to clinical quality, providing healthcare from modern buildings and achieving financial sustainability if they are to provide high quality healthcare into the future. They equally recognise that in addressing these challenges any solutions will have additional considerations, including understanding any impact on deprived communities.

To support understanding of this issue the three CCGs commissioned COBIC, the Nuffield Trust and PPL to undertake an independent analysis to assess the impact of any proposed changes to major acute services for deprived communities within the combined geographies.

2.2 Who we are

This independent review has been undertaken in partnership by three organisations:

- **COBIC** are the pioneers of Outcomes Based Incentivised Contracting in the UK. COBIC and PPL have been working together since 2012. COBIC were involved in the development of the very early outcomes-based contracts in Bedfordshire and Milton Keynes, and since then, have worked to support areas across the UK to successfully implement new approaches to commissioning and contracting.
- **The Nuffield Trust** is an independent health charity focused on health and social care policy and how service delivery models are adapting and changing and the workforce, technological and other factors. The Nuffield Trust provide evidence based research and policy analysis for informing and generating debate.
- **PPL** is a full-service consultancy specialising in supporting commissioners and providers of health and care services across the UK. Founded in 2007, PPL has a permanent team of 30 consultants based in South London, supported by our specialist advisory group, and have past and current programmes supporting transformation and change within the local health economy.

Working together, our three organisations bring together complementary skills and experience to provide a robust and thorough analysis of the deprivation impact any proposed acute clinical changes.

2.3 National context

With the 70th anniversary of the NHS there have been a number of reviews and reflections on its successes and pressures, with a clear recognition that health and social care are systems under serious strain (Darzi review).

In June 2018 the Government announced the NHS would receive an average 3.4 per cent a year real terms increase in funding over the next five years, supported by a new 10-year long term plan to help the NHS tackle waste and improve services. The priorities for this plan will include:

- Getting back on the path to delivering agreed performance standards – locking in and further building on the recent progress made in the safety and quality of care;
- Transforming cancer care so that patient outcomes move towards the very best in Europe
- Better access to mental health services, to help achieve the government's commitment to parity of esteem between mental and physical health
- Better integration of health and social care, so that care does not suffer when patients are moved between systems
- Focusing on the prevention of ill-health, so people live longer, healthier lives

The increased investment will be set against five financial tests to put the NHS on a sustainable footing including improving productivity and efficiency, eliminating provider deficits, reducing unwarranted variation, getting better at managing demand effectively and making better use of capital investment.

Underpinning the government agenda are drivers relating to:

- An increasing burden of healthcare demand resulting from an increasing population and in particular an increasingly old population, with pressures on funding as a result;
- Recognition that the status quo will not do as expectations increase and advances in standards of care mean that standing still is perceived as going backwards;
- A need for system wide reform with areas are looking at new models of care – care being delivered closer to home; being seen by the right person, first time;
- Difficulties in recruiting and retaining workforce (e.g. 45% of consultant posts in 2017 went unfilled due to lack of suitable applicants);[2]
- Evidence reinforcing the theory that populations who need healthcare the most tend not to get it (inverse care law) both in support and ability to demand or access care.

All of the above reinforce the need for any proposed solution to consider the specific needs, demands and outcomes for disadvantaged communities

2.4 Local context: Improving Healthcare Together 2020-2030 programme

Our work has been undertaken in the context of the Merton, Surrey Downs and Sutton CCGs' (together "the combined geographies") 'Improving Healthcare Together: 2020-2030' programme, which aims to resolve the long-standing healthcare challenges in the combined geographies.

This work feeds into the programme, which has a potential timeline as set out below.

[2] Source: Royal College of Physicians (2018), '*Focus on physicians Census of consultant physicians and higher specialty trainees 2017–18*'.

Figure 2-1: Potential timeline for any potential service change as part of the Improving Healthcare Together: 2020-2030 programme

Source: Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups (June 2018), "Issues Paper".

More details on the programme and the local context is covered in more detail in Section 3.

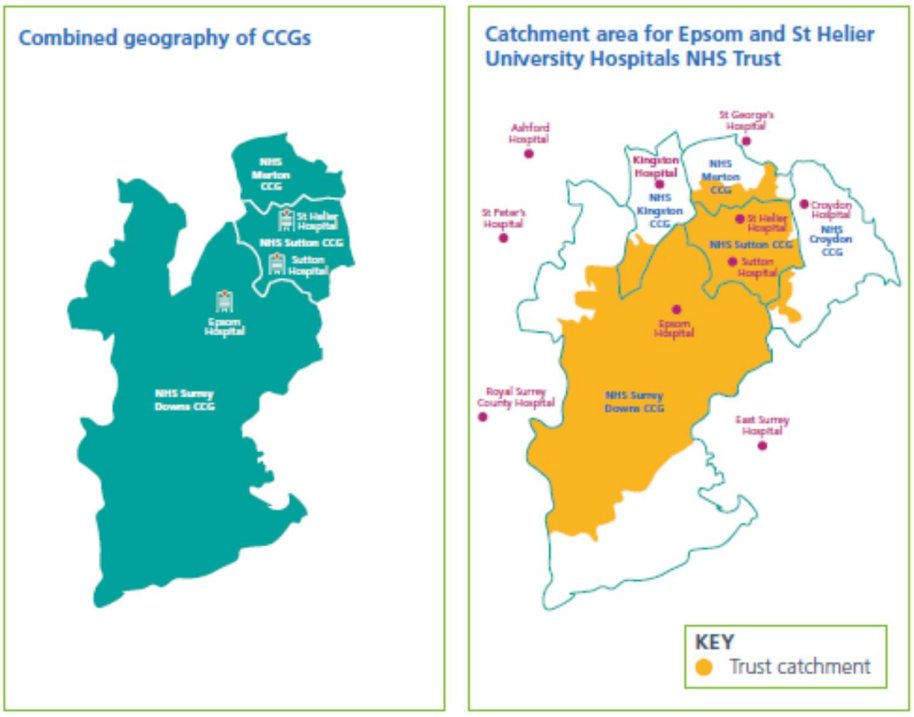
2.5 Key terms and definitions

For the purposes of this report, the following key terms will be used and their definitions are set out below.

Combined geographies – The combined geographies are made up of the three CCGs Merton, Sutton and Surrey Downs. There are approximately 720,000 residents in the combined geographies and the healthcare providers based there are shown in Figure 2-2.

Trust catchment area – The Trust catchment area is the area served by Epsom and St. Helier University Hospitals NHS Trust. Figure 2-2 shows this area.

Figure 2-2 – Combined geographies and Catchment area for Epsom and St. Helier University Hospitals NHS Trust



Source: Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups (June 2018), "Issues Paper".

Study area – The study area of this work focuses on the combined geographies. However, we still acknowledge that the Trust catchment area does not cover the entirety of the combined geographies, and that there are other hospitals relevant to the populations of the combined geographies – for example St George's, just to the north of Merton and Croydon Hospital to the east.

Healthcare need – Health needs are deficiencies in health that require health care services, from promotion to palliation, as defined by the WHO.

Healthcare usage – Healthcare usage is the use of healthcare services. This is driven by both perceived health needs and professionally defined health needs and behaviour. Perceived health needs are the need for health services as experienced by the individual and which they are prepared to acknowledge and professionally defined health needs are the need for health services as recognised by health professionals from the point of view of the benefit obtainable from advice, preventive measures, management or specific therapy, as defined by the WHO.

Major acute services – There are six major acute services in the scope of this work. These are emergency departments, acute medicine, critical care, emergency surgery, obstetrician-led births and paediatrics. These services all depend on the use of intensive care services and specialist input for patients who are the highest risk and sickest.

Deprived communities – groups of people who are damaged as a result of lack of something. The seven domains of deprivation according to the widely used Index of Multiple Deprivation

(IMD) are: income, employment, education, skills, training, health, crime, barriers to housing, and living environment.

2.6 Evaluation questions

We have been asked to respond to the following research questions:

1) What are the **main health needs** of the people who live in the combined geographies? This is covered in Section 4.
2) Based on evidence published to date, do **deprived communities** have an increased need and usage for acute hospital services? This is covered in Section 5.
3) Do **geographical factors** influence deprived communities in their uptake of both acute and out of hospital facilities? This is covered in Section 5.
4) Of the services provided by the Trust, and referencing the needs of local populations evidenced by the Joint Strategic Needs Assessments ("JSNAs"), which services are therefore critical to maintain on a very local basis and for which specific populations? This is covered in Section 6.
5) In the proposed **clinical model options** (as they emerge), do the services which will be retained in local hospitals, align with the services which are critical to remain locally as identified in the analysis specified above? This is covered in Section 7.
6) If there are areas in the proposed clinical model options which mean that some services which are critical to retain locally might move further away, is there a mitigation within the wider strategy of the relevant CCG or a way that other services could be adapted to address the potential gap? This is covered in Section 7.
7) If there are areas in the proposed clinical model options which mean that some services that are critical to remain locally might move further away, are there **balancing considerations** in terms of improved quality and outcomes from services operating at greater scale? This is covered in Section 7.
8) Are there areas **where further analysis and work should be undertaken** potentially as part of a wider future equalities impact assessment? This is covered in Section 8.

2.7 Evaluation approach

The key principle underpinning our evaluation is to **provide an independent analysis underpinned by facts and evidence**.

Our approach followed broadly the following steps:

- **Research and review of evidence base relevant to the research questions**. We have considered a range of sources including medical journals, academic papers, independent research institutes, and public data sources. This enables us to demonstrate what the prevailing evidence says about the key issues facing the combined geographies.
- **Interviews with key local stakeholders to understand local context, and the issues which are important to local people**. This piece of work is not a comprehensive public engagement, but we spoke with representatives from CCGs and Local Government for each of Merton, Surrey Downs, and Sutton, many of whom are aware of the needs and concerns of local populations, and the history of proposed acute clinical changes in the combined geographies. Those we spoke with are listed in Appendix 2

- **Test national evidence, and key themes at the local level.** Where data allows, we have tested some of the theories and hypotheses from the first two stages, with local data
- **Playing back findings with local stakeholders.** We ran a workshop with representatives from Merton, Surrey Downs and Sutton CCGs and local authorities, and the Trust to test emerging findings and ensure there was appropriate challenge from local viewpoints
- **Draft final report.** Final report summarising our findings and recommendations
- **Further work:** It is natural that as you move from the national level to the local level and to specific services, there will be less evidence on the links between deprivation and health outcomes. There are a number of areas where we propose more detailed testing at the local level, in order to further validate some of the findings. There were also some areas needing further testing which were brought out during the interviews and workshop with local stakeholders.

Key themes which emerged during our conversations with local stakeholders were:

- The move to community/primary care away from acute should be the direction of travel;
- Services shouldn't be built around acute services for young people and adults, they should be focusing on wrapping care around the frailest people so they don't need hospitalisation which will improve health outcomes;
- Key consideration for Surrey Downs is how their ageing population (and their carers) can access services;
- Public opinion stated access to health services is a key issue (for both deprived, and non-deprived areas);
- Important to contextualise distance from hospitals in terms of how close other areas are;
- In any proposed site change, it is very important for the NHS to take responsibility for accessibility of local sites;
- Want to test the argument that hospitals are needed to deal with young families
- There is a need to commission to reflect inequalities (for example high levels of deprivation in East Merton);
- Need to consider travel times to different hospital sites;
- Is there evidence on young people (16-24) using disproportionately more health services?;
- There is a perception that high usage of emergency departments by deprived communities is a good thing. Need to differentiate what usage is by department, and therefore what could be delivered in the community;
- Want to understand the requirements of the local populations in terms of health needs
- Need to understand how to best support the most deprived communities access to good health outcomes. This is likely to be by being able to access local care, close to home, with access to Emergency Departments ("ED") if really necessary; and

- Need to understand objectively how deprivation leads to service need, and what that need is.

We have considered these key themes when pursuing key lines of enquiry within this research. It is important to reiterate that our recommendations are based upon evidence and that stakeholder views were useful in framing areas to explore.

2.8 Aims and scope of this report

The aim of this report is to:

- Independently answer the research questions set out in Section 2.6;
- Provide recommendations to the Improving Healthcare Together: 2020-2030 programme, which focuses on possible changes to six major acute services (defined in Section 2.5). However, we acknowledge these cannot be considered in isolation, so where appropriate, we provide recommendations to other parts of the health system (e.g. primary and community care). For example for other relevant programmes which are being taken forward independently within the combined geographies e.g. Integrated Care System development programmes in Sutton;
- Inform and help guide the IIA which is being undertaken subsequent to this report;
- Inform Merton, Surrey Downs and Sutton CCGs' evaluation of potential solutions; and
- Contribute to the development of a Pre-Consultation Business Case.

This report **does not**:

- **assess specific acute clinical models proposed in the combined geographies**. Rather, it provides a set of tests and frameworks which should be considered when making a decision about whether a clinical model is suitable for the populations of the combined geographies;
- **aim to provide comprehensive public/stakeholder engagement**. It has relied on a smaller number of interviews and engagement to gain local context, and to test emerging findings with. Additional consultation will be required, which is expected as part of the Improving Healthcare Together: 2020-2030 programme; and
- **repeat the analysis done within the high level case for change.** It does not challenge the need, within the combined geographies, to make changes to certain major acute services in order to: 1) deliver clinical quality; 2) provide healthcare from modern buildings; and 3) achieve financial sustainability.

3 Improving Healthcare Together: 2020 – 2030 programme

3.1 Overview

It is important to position this work in some local context in terms of some of the potential changes being discussed, and why they are being suggested. However, as set out in Section 2.8, this report does not repeat the analysis done within the high level case for change to make changes to certain major acute services.

The 'Improving Healthcare Together: 2020-2030' programme is an initiative led by Merton, Surrey Downs, and Sutton CCGS, which aims to resolve the long-standing healthcare challenges in the combined geographies. It focuses on how healthcare needs to be delivered in the 2020s and beyond, with the 'burning platform' of if current issues are not resolved, it will not be possible to maintain all the services which are currently being provided locally and which populations need.[3] This programme focuses on potential changes to major acute services.

3.2 Case for change

The current situation is not a viable one, with three key issues affecting the need for change:[4]

1) **Improving clinical quality**: Clear clinical standards defined by the three commissioners in line with national best practice in 2017 for six acute services set out, amongst other things, expected senior staffing levels. All local providers of acute patient care in the said they believed they could meet these quality standards, with the exception of the Trust. Based on the agreed standards, there is a shortage of consultants in emergency departments, acute medicine and intensive care. The Trust is not meeting the Royal College of Emergency Medicine guidance for consultant cover and this is something recently identified by the Care Quality Commission (CQC) the regulator of services, when it inspected acute services. Additionally, there is also a shortage of middle grade doctors and nursing staff;
2) **Providing healthcare from modern buildings** Many of the Trust's buildings were built before the NHS was founded and are rapidly ageing. They are not designed for modern healthcare, an issue repeatedly highlighted by the CQC, including in its latest report (May 2018). The Trust has a very significant and critical backlog of maintenance and the deterioration of the estate is affecting the day-to-day running of clinical services and patients' experience; and
3) **Achieving financial sustainability:** The Trust has an underlying financial deficit which is getting worse each year. In 2013/14 it was around £7million and in 2017/18 it has increased to around £37m. This growing deficit is driven by unavoidable increases in costs for clinical workforce including temporary staff, increasing costs for estates maintenance and decreasing opportunities for changing ways of working. The financial position will continue to worsen unless changes are made.

[3] Source*:* Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups (June 2018), "*Issues Paper*".
[4] Source*:* Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups (June 2018), "*Issues Paper*".

3.3 What needs to change

In the context of the national move towards moving appropriate care closer to people's homes, whilst still having properly staffed, accessible emergency care available. Local issues mentioned in Section 3.2 show that the current situation in the combined geographies is unsustainable, and there needs to be changes. The three CCGs believe that it is major acute services which may need to change. Namely: emergency department; acute medicine; critical care; emergency surgery; births; and paediatric ED and inpatient paediatrics.

3.4 What will not change

Most health services will not change as a result of Improving Healthcare Together: 2020-2030. Primary, community, and district acute services (including urgent treatment services, outpatients day case surgery, low-risk antenatal and postnatal care, imaging and diagnostics, and district beds) can continue to be developed through local strategies, which includes looking at delivering care in a more integrated way. District services, and how they relate to other services are shown in the Figure 3-1 below.

Figure 3-1: District services and how they relate to other services

Source: Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups (June 2018), "Issues Paper".

3.5 Proposed setting of care locations

The current potential solutions from the provisional shortlist developed by the Programme are:[5]

1) Locating major acute services (as defined in Section 2.5) at Epsom Hospital, and continuing to provide all district services (as set out in Figure 3-1) at both Epsom and St Helier Hospitals.
2) Locating major acute services at St Helier Hospital, and continuing to provide all district hospital services at both Epsom and St Helier Hospitals.
3) Locating major acute services at Sutton Hospital, and continuing to provide all district services at both Epsom and St Helier Hospitals.

However this report understands these three proposed locations are merely the initial proposals, and that the Programme is open to other possible solutions for major acute service locations.

3.6 What happens next – Integrated Impact Assessment

This review is one strand contributing to a complex change programme which is considering a wider range of issues and impacts. Public engagement on the issues commenced during Summer 2018 and there will be a further period of review, engagement and consultation before any decisions are made on any service change next year.

An IIA has been commissioned by the Programme Board. The findings from this report and some areas of proposed further analysis are expected to feed into this IIA, so we briefly explain the purpose of the IIA. IIAs are a key component of policy-making and help guide and appraise investment.[6] They have long been identified as a mechanism by which potential effects on health outcomes and health inequalities can be identified and redressed prior to implementation. According to the World Health Organisation (WHO), impact assessments (including IIAs) provide "*a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population*".[7]

The aim is to explore the positive and negative consequences of different proposals and produce a set of evidence-based, practical recommendations, which can then be used by decision-makers to maximise the positive impacts and minimise any negative impacts.[8] It is important to note that the purpose of impact assessments is not to determine the decision about which option would be selected; rather they act to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve. This is the purpose of the IIA process.

It is regarded as best practice to assess impacts for the whole population and highlight the sections of the population which will be differently or disproportionately affected by the

[5] Source*:* Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups (June 2018), "*Issues Paper*".
[6] Source: HM Government (2011) 'Impact Assessment Overview'
[7] Source: World Heath Organisation (2017): 'Health Impact Assessment. Available at: http://www.who.int/topics/health_impact_assessment/en/
[8] Source: Herriott, N, and Williams, C (2010) 'Health Impact Assessment of Government Policy' .

impacts. These might be geographical communities or certain socio-economic or 'equality' groups.

A health impact assessment (HIA), a travel and access impact assessment, an equality impact assessment (EqIA) (in which the impacts of the proposals on protected characteristic groups and deprived communities are assessed) and a sustainability impact assessment will be conducted as part of the IIA.

3.7 Recommendations

- For the IHT Programme:
  - Any communications and engagement should position the IHT Programme in the context of the wider health agenda in the area around new models of care, which is likely to include the strengthening of community and primary care, asset based approaches, social prescribing, and support for self-care. Otherwise, there is a risk that that changes are being made in isolation (e.g. major acute services only)

4 Health needs of the combined geographies

4.1 Overview

The combined geographies have many health needs similar to the rest of the country, but have key local variations which are important to consider.

4.2 Merton summary

4.2.1 Population profile

Merton has 209,421 residents (2018), projected to rise to over 252,000 by 2030. As with the rest of the UK, the population is expected to age. As shown in Tables 4-1 and 4-2 below, the number of people over the age of 65 is expected to increase by 28.1% and the number of people over the age of 85 expected to increase by 33.3%.

Table 4-1: Merton over 65 age profile

Area	Current population	Current >65	Projected >65 (2030)	% change
Merton	209,421	26,000	33,300	+28.1%

Source: ONS custom age tool

Table 4-2: Merton over 85 age profile

Area	Current population	Current >85	Projected >85 (2030)	% change
Merton	209,421	3,600	4,800	+33.3%

Source: ONS custom age tool

4.2.2 Health profile

The average life expectancy for residents in Merton is 80.4 years for males and 84.2 years for females. This is higher than the national average but as shown in Table 4-3, there is variation within Merton, with life the expectancy in East Merton being lower than the national average and West Merton being higher than the national average.

Table 4-3: Merton Life Expectancy

Area	Life Expectancy	
	Male	Female
England	79.3	83
Merton	80.4	84.2
West Merton	81.9	85.1
East Merton	78.9	83.3

Source: London Borough of Merton (2018), 'The Merton Story 2018'

Merton has an avoidable mortality rate of 194.9 per 100,000 population which is higher than the rate in England of 178.4 per 100,000 population, as shown in Table 4-4 below. The main causes of premature death in Merton, as shown in Table 4-5 below, are cancer, circulatory disease and respiratory disease which matches the pattern across the country.

Table 4-4: Mortality rates from causes considered avoidable

Area	Mortality rate from causes considered avoidable (per 100,000 population)
England	178.4
Merton	194.9

Source: ONS (2018), Avoidable mortality by Clinical Commissioning Groups in England and Health Boards in Wales, 2016.
Note: Deaths that are classified as avoidable are those from causes that are considered avoidable in the presence of timely and effective healthcare or public health interventions.

Table 4-5: Main causes of premature deaths per 100,000

Condition	Merton
Circulatory disease	70.7
Cancer	124.1
Respiratory disease	26.3

Source: PHE Fingertips (2014-2016)

Table 4-6 below shows the prevalence of common conditions in Merton compared to the prevalence nationally. Merton has lower prevalence rates for all the LTCs shown in the table below.

Table 4-6: Prevalence of common conditions

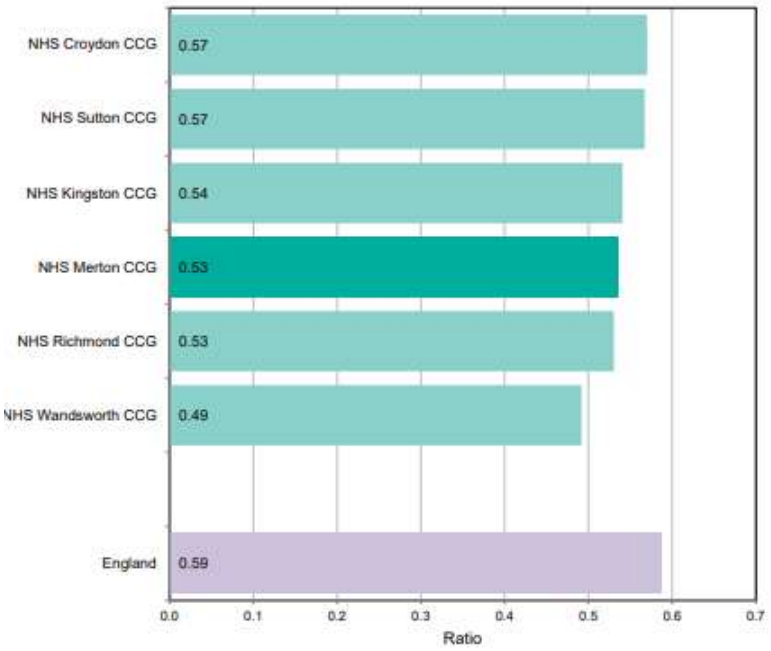
Indicator (estimated prevalence 2015)	Merton rate	Merton total number	England rate
Hypertension	17.7%	39,898	20.8%
Depression	11.7%	26,286	15.0%
CHD	7.4%	16,582	7.9%
Stroke	3.4%	7,723	3.7%
Peripheral arterial disease (PAD)	0.9%	2,009	1.2%
Heart Failure	1.0%	2,205	1.4%
COPD	1.5%	3,308	3.0%
Cancer	1.1%	2,541	2.6%

Source: The Merton rate is calculated as a weighted average prevalence for all Merton GP practices (Source: PHE Fingertips). The Merton total number is calculated as applying the weighted average prevalence to the total number registered to Merton GP practices (in 2015 this was 225,219, source NHS Business Services Authority) The England rate was taken from PHE Fingertips

As shown in Table 4-5, Circulatory disease is a major cause of premature death in Merton. Hypertension is a major risk factor for circulatory disease and as shown in Table 4-6, Merton has almost 40,000 individuals estimated to have hypertension.

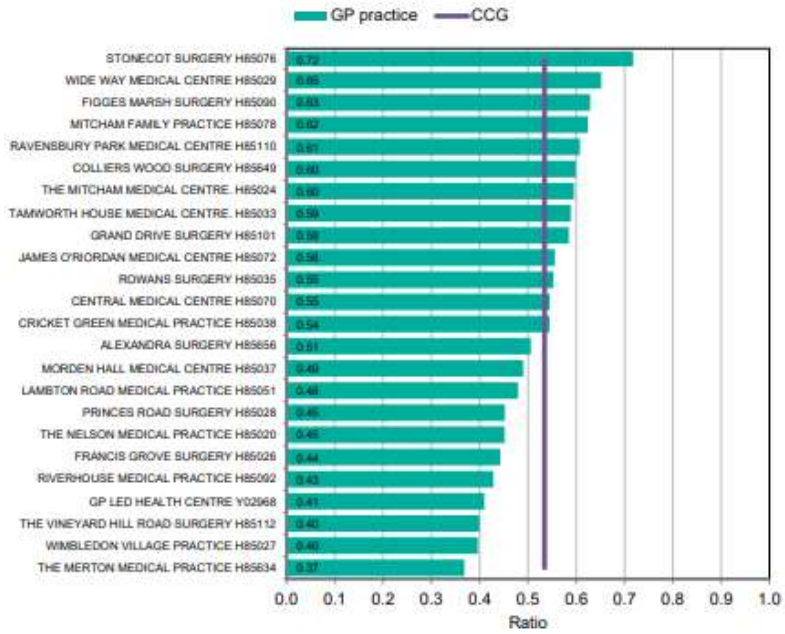
As shown in Figure 4-1, the ratio of those diagnosed with hypertension versus those expected to have hypertension is 0.53. This suggests that only 53% of the people with hypertension in Merton have been diagnosed. In addition to this, there is significant local variation, as shown in Figure 4-2, with the GP practice ratio of observed to expected hypertension prevalence range from 0.37 to 0.72.

Figure 4-1: Hypertension observed prevalence compared with expected prevalence by CCG, comparison with CCGs in the STP.



Source: Public Health England Primary Care Intelligence Packs (CVD) – NHS Merton CCG, June 2017

Figure 4-2: Hypertension observed prevalence compared with expected prevalence by GP practice.

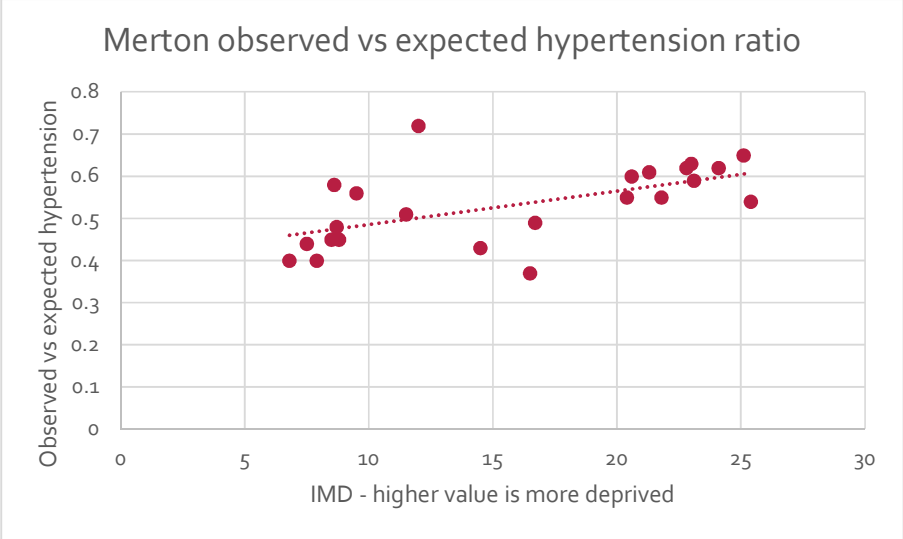


Source: Public Health England Primary Care Intelligence Packs (CVD) – NHS Merton CCG, June 2017

It can be helpful to assess how deprivation affects diagnosis rates. In Merton, as shown in Figure 4-3 below, there are higher rates of diagnosis of hypertension for GP practices in more deprived

communities. This broadly indicates that health needs are being identified in more deprived communities.

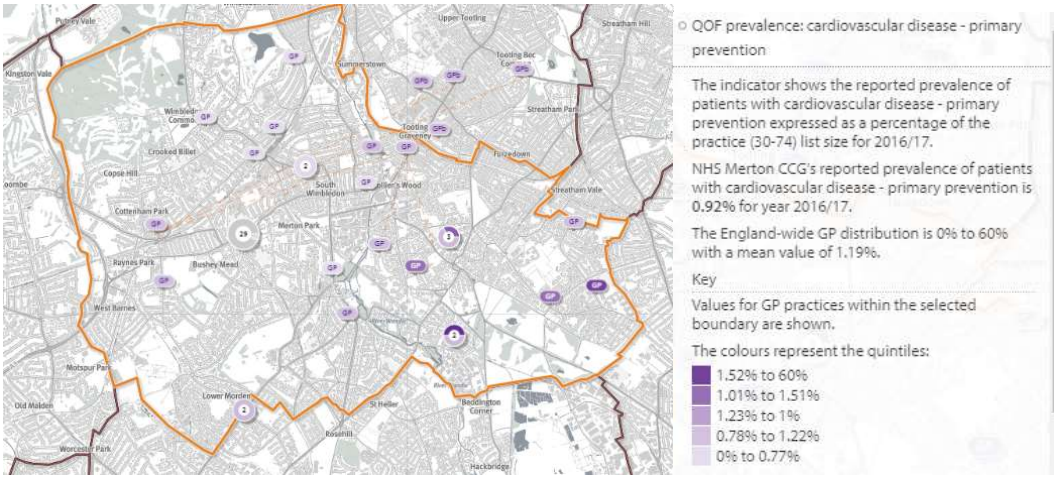
Figure 4-3: Merton observed vs expected hypertension ratio by deprivation of GP population



Source: Data on observed vs expected hypertension taken from: Public Health England Primary Care Intelligence Packs (CVD) – NHS Merton CCG, June 2017; data on IMD by GP practice taken from DCLG English indices of deprivation 2015

As the map in Figure 4-4 below shows, there is a higher prevalence of CVD in the GP practices in East Merton when compared to West Merton, further indicating local variation. This broadly supports the theory that there are higher LTC prevalence rates in areas of higher deprivation (see map of deprivation by LSOA for Merton, in Section 5).

Figure 4-4: CVD prevalence by GP practice – Merton



Source: *Public Health England SHAPE tool – CVD prevalence by quintile by GP practice*

Merton ranks 160 out of 209 CCGs in overall IMD deprivation (where 1 is the most deprived and 209 is the least deprived). More on deprivation in Merton will be covered in Section 5.2.1.

4.3 Surrey Downs summary

4.3.1 Population profile

Surrey Downs has 300,967 residents (2015), projected to rise to over 314,000 by 2030. As with the rest of the UK, the population is expected to age. As shown in Tables 4-7 and 4-8 below, the number of people over the age of 65 is expected to increase by 31.2% and the number of people over the age of 85 expected to increase by 42.8%.

Table 4-7: Surrey Downs over 65 age profile

Area	Current population	Current >65	Projected >65 (2030)	% change
Surrey Downs	300,967	59,600	78,249	+31.2%

Source: Surrey-i

Table 4-8: Surrey Downs over 85 age profile

Area	Current population	Current >85	Projected >85 (2030)	% change
Surrey Downs	300,967	7,123	13,000	+42.8%

Source: Surrey-i

4.3.2 Health profile

The average life expectancy for residents in Surrey Downs is 81.8 years for males and 85.1 years for females which is higher than the national average.

Table 4-9: Surrey Downs Life Expectancy

Area	Life Expectancy	
	Male	**Female**
England	79.3	83
Surrey Downs	81.8	85.1

Source: Surrey Downs CCG Health Profile 2015

Surrey Downs has an avoidable mortality rate of 165.1 per 100,000 population which is lower than the rate in England of 178.4 per 100,000 population, as shown in Table 4-10. The main causes of premature death in Surrey Downs, as shown in Table 4-11, are cancer, circulatory disease and respiratory disease which matches the pattern across the country.

Table 4-10: Mortality rates from causes considered avoidable

Area	Mortality rate from causes considered avoidable (per 100,000 population)
England	178.4
Surrey Downs	165.1

Source: ONS (2018), Avoidable mortality by Clinical Commissioning Groups in England and Health Boards in Wales, 2016.
Note: Deaths that are classified as avoidable are those from causes that are considered avoidable in the presence of timely and effective healthcare or public health interventions.

Table 4-11: Main causes of premature deaths per 100,000

Condition	Surrey Downs
Circulatory disease	60.5
Cancer	106.1
Respiratory disease	20.3

Source: Surrey Downs: NHS Digital (CCG OIS Indicator 1.6 2009-2015)

Table 4-12 below shows the prevalence of common conditions in Surrey Downs compared to the prevalence nationally. Surrey Downs has lower prevalence rates for all the conditions listed below compared to the rest of the country, with the exception of heart failure.

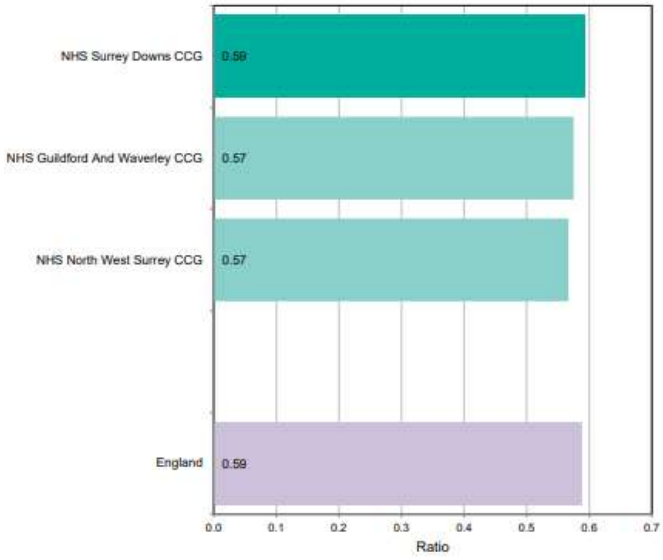
Table 4-12: Prevalence of common conditions

Indicator (estimated prevalence 2015)	Surrey Downs rate	Surrey Downs total number	England rate
Hypertension	20.4%	62,698	20.8%
Depression	14.1%	43,148	15.0%
CHD	6.8%	20,758	7.9%
Stroke	3.6%	10,941	3.7%
Peripheral arterial disease (PAD)	0.9%	2,828	1.2%
Heart Failure	1.5%	4,714	1.4%
COPD	1.9%	5,889	3.0%
Cancer	1.6%	4.888	2.6%

Source: The Surrey Downs rate is calculated as a weighted average prevalence for all Surrey Downs GP practices (Source: PHE Fingertips). The Surrey Downs total number is calculated as applying the weighted average prevalence to the total number registered to Surrey Downs GP practices (in 2015 this was 306,691, source NHS Business Services Authority) The England rate was taken from PHE Fingertips

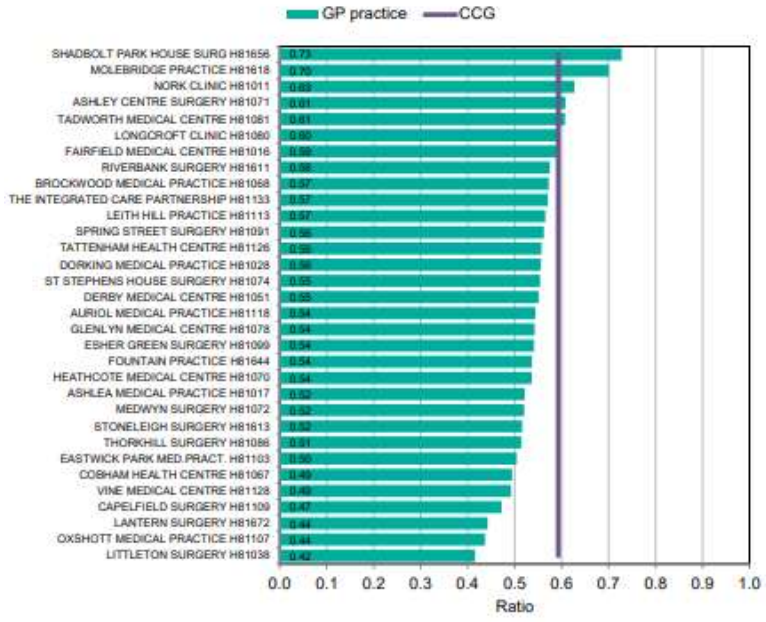
As shown in Table 4-11, circulatory disease is a major cause of premature death in Surrey Downs. Hypertension is a major risk factor for circulatory disease and as shown in Table 4-12, Surrey Downs has a prevalence rate of 20.4%. As shown in Figure 4-5, the ratio of those diagnosed with hypertension versus those expected to have hypertension is 0.59. This suggests that 59% of the people with hypertension in Surrey Downs have been diagnosed. In addition to this, there is significant local variation, as shown in Figure 4-6, with the GP practice ratio of observed to expected hypertension prevalence range from 0.37 to 0.72.

Figure 4-5: Hypertension observed prevalence compared with expected prevalence by CCG, comparison with CCGs in the STP.



Source: Public Health England Primary Care Intelligence Packs (CVD) – NHS Surrey Downs CCG, June 2017

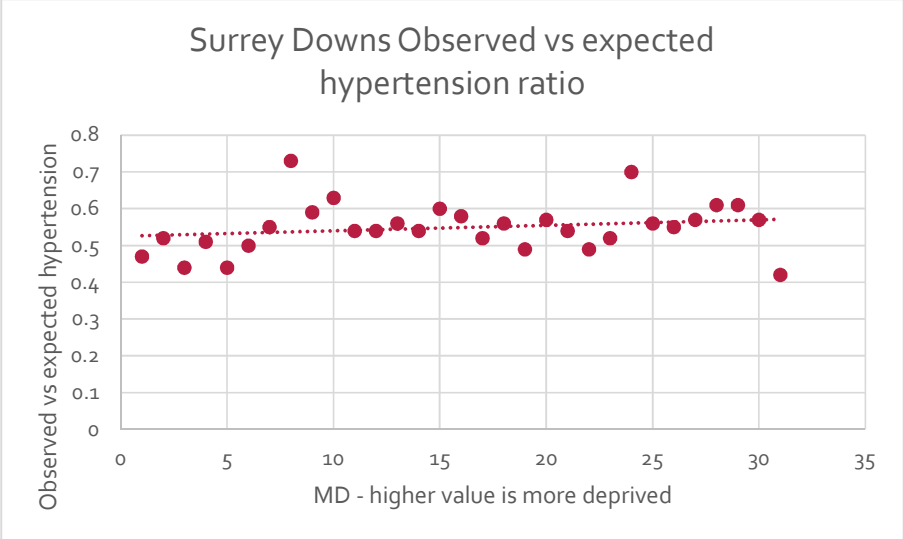
Figure 4-6: Hypertension observed prevalence compared with expected prevalence by GP practice.



Source: Public Health England Primary Care Intelligence Packs (CVD) – NHS Surrey Downs CCG, June 2017

It can be helpful to assess how deprivation affects diagnosis rates. In Surrey Downs, as shown in Figure 4-7 below, there is relatively little difference in rates of diagnosis for hypertension between GP practices looking after less versus more deprived populations.

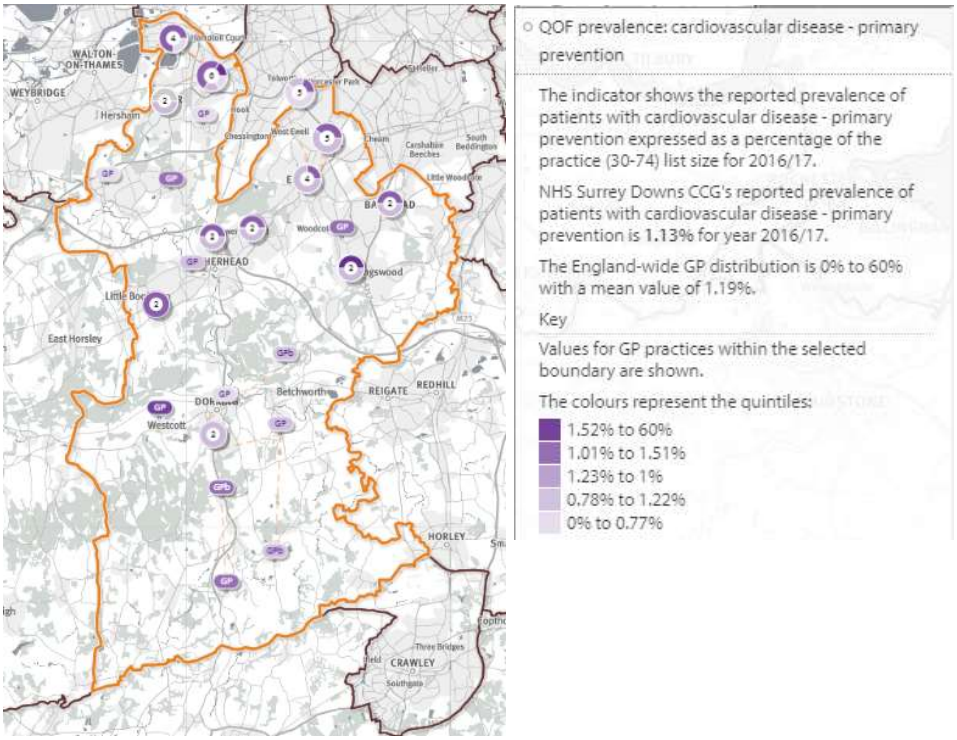
Figure 4-7: Surrey Downs observed vs expected hypertension ratio by deprivation of GP population



Source: Data on observed vs expected hypertension taken from: Public Health England Primary Care Intelligence Packs (CVD) – NHS Surrey Downs CCG, June 2017; data on IMD by GP practice taken from DCLG English indices of deprivation 2015

As the map in Figure 4-8 below shows, there is not a clear pattern between prevalence rates of CVD in GP practices in Surrey Downs.

Figure 4-8: CVD prevalence by GP practice – Surrey Downs



Source: Public Health England SHAPE tool – CVD prevalence by quintile by GP practice

Surrey Downs ranks 207 out of 209 CCGs in overall IMD deprivation (where 1 is the most deprived and 209 is the least deprived). More on deprivation in Surrey Downs will be covered in Section 5.2.2.

4.4 Sutton summary

4.4.1 Population profile

Sutton has 201,900 residents (2015), projected to rise to 225,800 by 2030. As with the rest of the UK, the population is expected to age. As shown in Tables 4-13 and 4-14 below, the number of people over the age of 65 is expected to increase by 28.4% and the number of people over the age of 85 expected to increase by 34.8%.

Table 4-13: Sutton over 65 age profile

Area	Current population	Current >65	Projected >65 (2030)	% change
Sutton	201,900	31,300	40,200	+28.4%

Source: ONS Custom age tool

Table 4-14: Sutton over 85 age profile

Area	Current population	Current >85	Projected >85 (2030)	% change
Sutton	201,900	4,600	6,200	+34.8%

Source: ONS Custom age tool

4.4.2 Health profile

The average life expectancy for residents in Sutton is 80.5 years for males and 84 years for females which is higher than the national average.

Table 4-15: Sutton Life Expectancy

Area	Life Expectancy	
	Male	Female
England	79.3	83
Sutton	80.5	84

Source: Sutton JSNA

Sutton has an avoidable mortality rate of 169.4 per 100,000 population which is lower than the rate in England of 178.4 per 100,000 population, as shown in Table 4-16. The main causes of premature death in Sutton, as shown in Table 5, are cancer, circulatory disease and respiratory disease which matches the pattern across the country.

Table 4-16: Mortality rates from causes considered avoidable

Area	Mortality rate from causes considered avoidable (per 100,000 population)
England	178.4
Sutton	169.4

Source: ONS (2018), Avoidable mortality by Clinical Commissioning Groups in England and Health Boards in Wales, 2016.
Note: Deaths that are classified as avoidable are those from causes that are considered avoidable in the presence of timely and effective healthcare or public health interventions.

Table 4-17: Main causes of premature deaths per 100,000

Condition	Sutton
Circulatory disease	63.6
Cancer	198.8
Respiratory disease	32.9

Source: PHE Fingertips (2014-2016)

Table 4-18 shows the prevalence of common conditions in Sutton compared to the prevalence nationally. Sutton has lower prevalence rates for all the conditions listed below compared to the rest of the country.

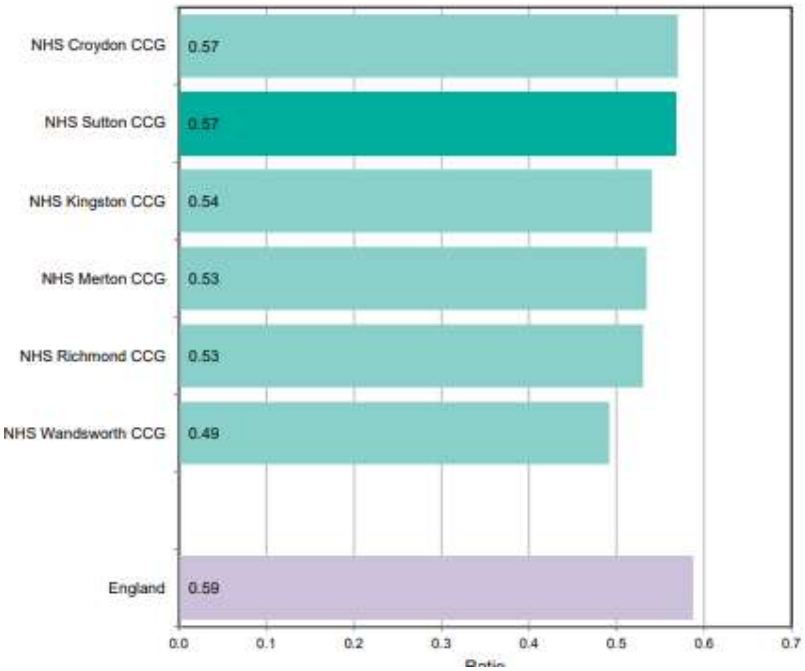
Table 4-18: Prevalence of common conditions

Indicator (estimated prevalence 2015)	Sutton rate	Sutton total number	England rate
Hypertension	11.6%	22,566	20.8%
Depression	13.7%	26,680	15.0%
CHD	7.3%	14,167	7.9%
Stroke	3.5%	6,847	3.7%
Peripheral arterial disease (PAD)	1.0%	1,880	1.2%
Heart Failure	1.2%	2,461	1.4%
COPD	1.9%	3,516	3.0%
Cancer	1.4%	2,634	2.6%

Source: The Sutton rate is calculated as a weighted average prevalence for all Sutton GP practices (Source: PHE Fingertips). The Sutton total number is calculated as applying the weighted average prevalence to the total number registered to Sutton GP practices (in 2015 this was 194,305, source NHS Business Services Authority) The England rate was taken from PHE Fingertips

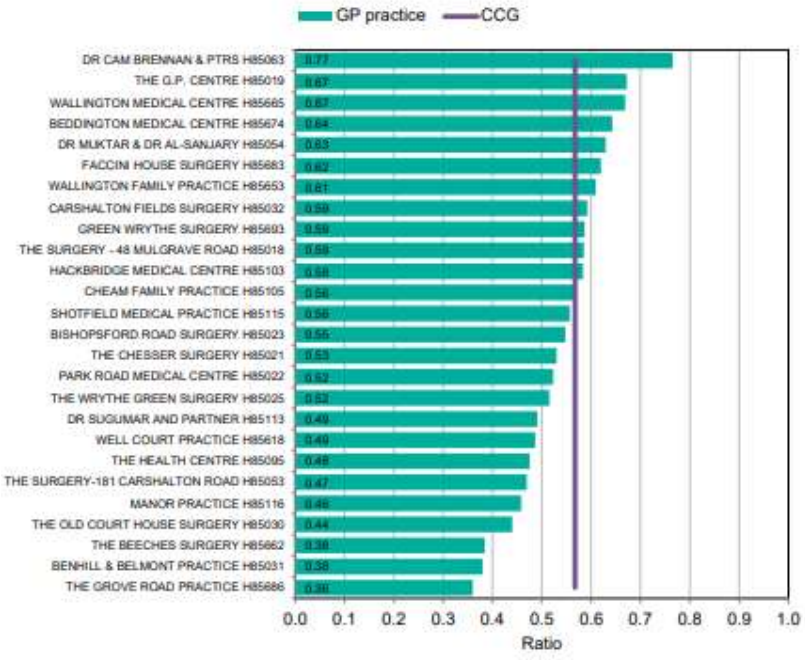
As shown in Table 4-17, Circulatory disease is a major cause of premature death in Sutton. Hypertension is a major risk factor for circulatory disease and as shown in Table 4-18, Sutton has a prevalence rate of 12.3%. As shown in Figure 4-9, the ratio of those diagnosed with hypertension versus those expected to have hypertension is 0.57. This suggests that 57% of the people with hypertension in Sutton have been diagnosed. In addition to this, there is significant local variation, as shown in Figure 4-10, with the GP practice ratio of observed to expected hypertension prevalence range from 0.33 to 0.77.

Figure 4-9: Hypertension observed prevalence compared with expected prevalence by CCG, comparison with CCGs in the STP.



Source: Public Health England Primary Care Intelligence Packs (CVD) – NHS Sutton CCG, June 2017

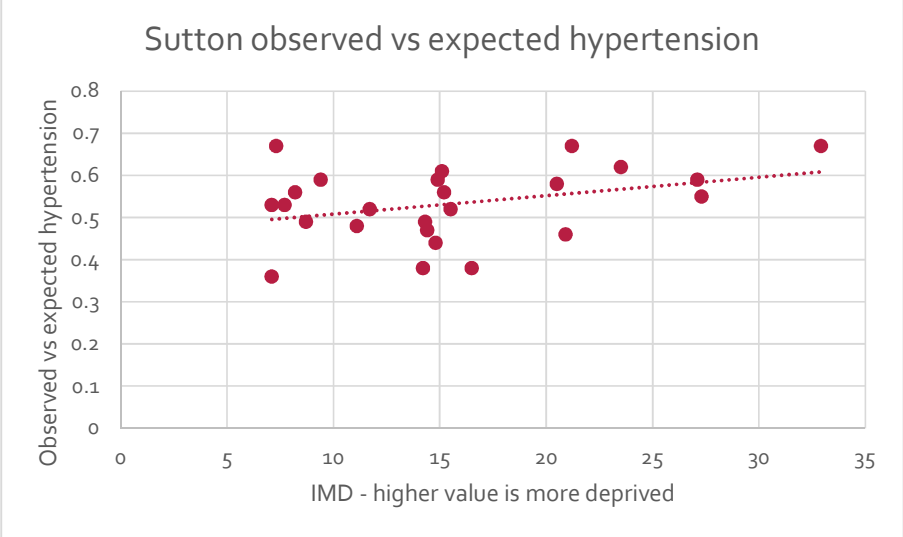
Figure 4-10: Hypertension observed prevalence compared with expected prevalence by GP practice.



Source: Public Health England Primary Care Intelligence Packs (CVD) – NHS Sutton CCG, June 2017

It can be helpful to assess how deprivation affects diagnosis rates. In Sutton, as shown in Figure 4-11 below, there are higher rates of diagnosis of hypertension for GP practices in more deprived communities

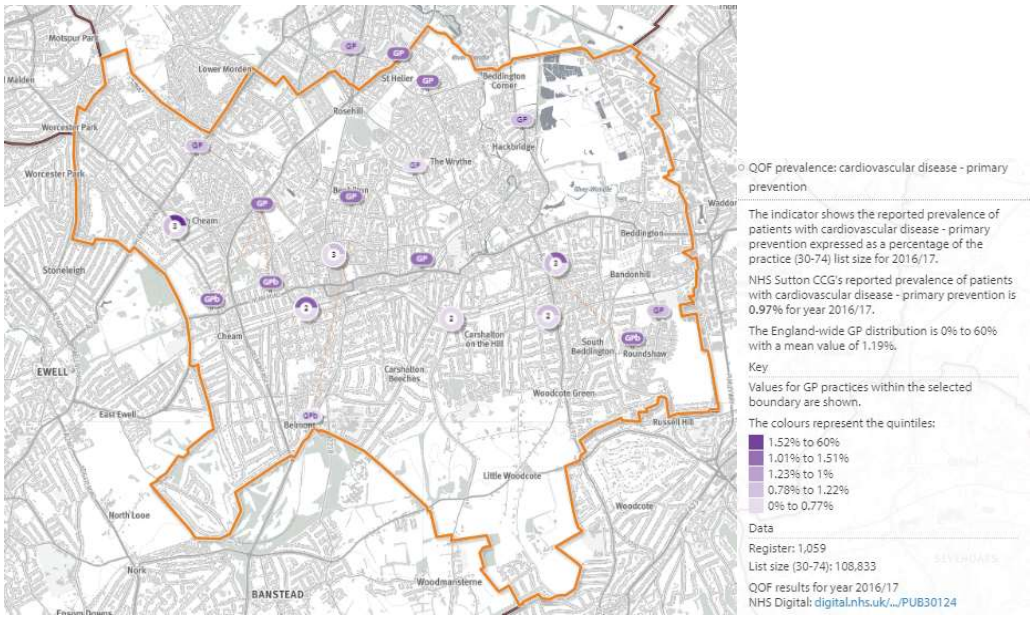
Figure 4-11: Sutton observed vs expected hypertension ratio by deprivation of GP population size



Source: Data on observed vs expected hypertension taken from: Public Health England Primary Care Intelligence Packs (CVD) – NHS Sutton CCG, June 2017; data on IMD by GP practice taken from DCLG English indices of deprivation 2015

As the map in Figure 4-12 below shows, there is generally higher prevalence of CVD in the GP practices in north and west. To some extent, this matches the areas of higher deprivation in Sutton (shown in more detail in Section 5).

Figure 4-12: CVD prevalence by GP practice – Sutton



Source: Public Health England SHAPE tool – CVD prevalence by quintile by GP practice

Sutton ranks 167 out of 209 CCGs in overall IMD deprivation (where 1 is the most deprived and 209 is the least deprived). More on deprivation in Sutton will be covered in Section 5.2.3.

4.5 What are the key distinctive features (and main variations from national) of the combined geographies

From the evidence shown in Section 4:

- People in Sutton, Merton and Surrey Downs are generally less deprived than the rest of England, however there is significant local variation (which we examine further in Section 5);
- Populations across the combined geographies are ageing which is, and will continue to be, the single largest driver of health and care usage and costs (see Figure 4-13 below);
- The main causes of premature death are cancer, circulatory disease, and respiratory disease (see Figure 4-14 below);
- Prevalence rates across the most common LTCs in the combined geographies are lower, or comparable to those rates seen nationally, with the exception of heart failure in Surrey Downs, which is marginally higher (see Figure 4-15 below)
- There tends to be a higher prevalence of LTCs in more deprived communities;
- Age is also a significant driver of LTCs – Surrey Downs typically has higher prevalence rates than Sutton and Merton, primarily due to its significant older population;
- Prevalence rates of depression are lower in the combined geographies (11.7% in Merton, 14.1% in Surrey Downs, and 13.7% in Sutton) than the national average

(15.0%). However this is just one measure of mental health, and other measures such as adolescent mental health should be examined; and

- Diagnosis rates of hypertension are higher in more deprived areas, than less deprived areas.
- Within the combined geographies, the proportion of those from Black, Asian, and Minority Ethnic ("BAME") backgrounds is 30%, which is lower than in London (55%), but higher than the national average (20%). It is varied within the combined geographies: 52% of the Merton population are from BAME backgrounds, 29% in Sutton, and 16% in Surrey Downs.[9]

Figure 4-13: Summary population profile of the combined geographies

	Merton	Surrey Downs	Sutton	England
Current population	209,421	300,967	201,900	55,268,100
Current >65	26,000	59,600	31,300	9,882,800
Projected >65 (2030)	33,300	78,249	40,200	12,897,300
% change	+28.1%	+31.2%	+28.4%	+30.5%
Current >85	3,600	7,123	4,600	1,328,000
Projected >85 (2030)	4,800	13,000	6,200	1,930,300
% change	+33.3%	+42.8%	+34.8%	+45.4%
Life expectancy (male)	80.2	81.8	80.5	79.3
Life expectancy (female)	84	85.1	84	83

Source: Sections 4.2 – 4.4; 2016-based population projections, ONS

Figure 4-14: Main causes of premature death per 100.000 in the combined geographies

	Merton	Surrey Downs	Sutton
Circulatory disease	70.7	60.5	63.6
Cancer	124.1	106.1	198.8
Respiratory disease	26.3	20.3	32.9

Source: Sections 4.2 – 4.4.

Figure 4-15: Prevalence rates in combined geographies

	Merton	Surrey Downs	Sutton	England
Hypertension	17.7%	20.4%	11.6%	20.8%
Depression	11.7%	14.1%	13.7%	15.0%
CHD	7.4%	6.8%	7.3%	7.9%
Stroke	3.4%	3.6%	3.5%	3.7%
Peripheral arterial disease (PAD)	0.9%	0.9%	1.0%	1.2%
Heart Failure	1.0%	1.5%	1.2%	1.4%
COPD	1.5%	1.9%	1.9%	3.0%
Cancer	1.1%	1.6%	1.4%	2.6%

Source: Sections 4.2 – 4.4.

[9] Source: ONS, 2011 Census.

4.7 Recommendations

- For the IIA:
    - The local population characteristics described in this section, and summarised in Section 4.5 should be considered (for example ethnicity), and investigated further where more granular information is needed (for example at the LSOA level for the most deprived communities) to assess the impacts of any service changes on health needs. This will be included in the Equality Impact Assessment.
- Outside of the IHT Programme, the individual responsible CCGs as part of their wider responsibilities for population health management may wish to consider – for people living in the LSOAs in the most deprived quintile – further research into what works in relation to the needs of these people in relation to managing demand and improving health outcomes

5 Deprived communities and health outcomes

5.1 Overview

We have tested a number of hypothesis in this area:

1) *People in deprived communities have increased acute healthcare need*
2) *Acute health need is driven by age and other social factors, as well as deprivation, but these factors are linked*
3) *Deprivation is correlated with poor mental health which can lead to difficulties in negotiating the welfare/health system, as well as impact negatively on physical LTCs*
4) *People in deprived communities have increased acute healthcare usage*
5) *Acute health usage is driven by age and other social factors, as well as deprivation, but these factors are linked*
6) *Geographical factors are important – the closer to a hospital, the higher usage of acute hospital services by patients than those who live further away*
7) *Some of deprived communities' usage of acute hospital services could be dealt with in primary/community care*

Before presenting the evidence testing each of these hypothesis, we first review the levels of deprivation in each of Merton, Surrey Downs, and Sutton CCGs. Generally speaking, people in Merton, Sutton, and (in particular) Surrey Downs, are less deprived than the rest of England. Nevertheless there is significant local deprivation, particularly in Merton and Sutton.

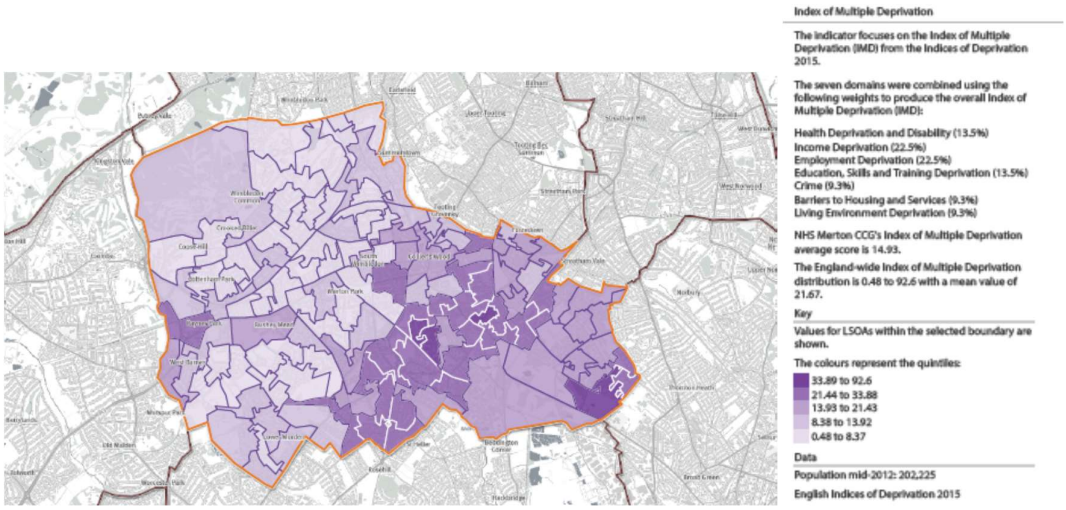
As set out in the scope of this report (Section 2.8), the focus is on possible changes to six major acute services (defined in Section 2.5). Therefore we primarily examine need and usage for these services. However, we acknowledge these cannot (and should not) be considered in isolation, so where appropriate, we mention other parts of the health system.

5.2 Deprivation in the combined geographies

5.2.1 Merton

Merton ranks 160 out of 209 CCGs in overall IMD deprivation, where 1 is the most deprived and 209 is the least deprived. Whilst this ranking indicates that Merton as a whole is in the least deprived quartile of the country, there is local variation, as show in Figure 5-1 below.

Figure 5-1: Merton CCG IMD by quintile



Source: Public Health England SHAPE tool – IMD by quintile

When the IMD deprivation breakdown is explored (see Table 5-1 below), variation can be seen again, within the domains of deprivation, with the living environment and crime being particularly notable.

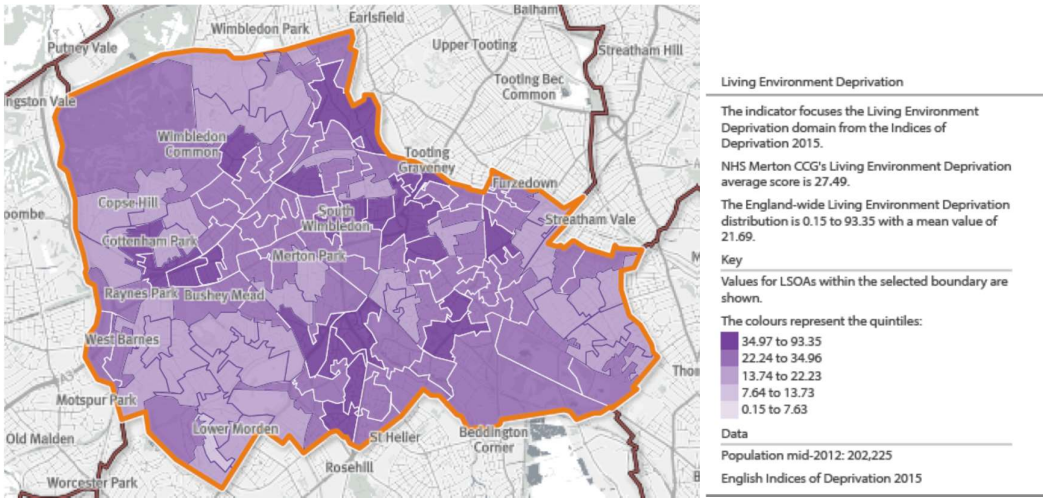
Table 5-1: IMD breakdown of Merton by rank

IMD Domain	Merton rank (out of 209, where 1 is most deprived, 209 is least deprived)
IMD	160
Income	140
Employment	178
Education, skills, training	190
Health	175
Crime	69
Barriers to housing	123
Living environment	44

Source: *DCLG, English indices of deprivation 2015*

When the living environment is looked at closely, as shown in Figure 5-2 below, variation across Merton can be seen.

Figure 5-2: Living environment deprivation in Merton

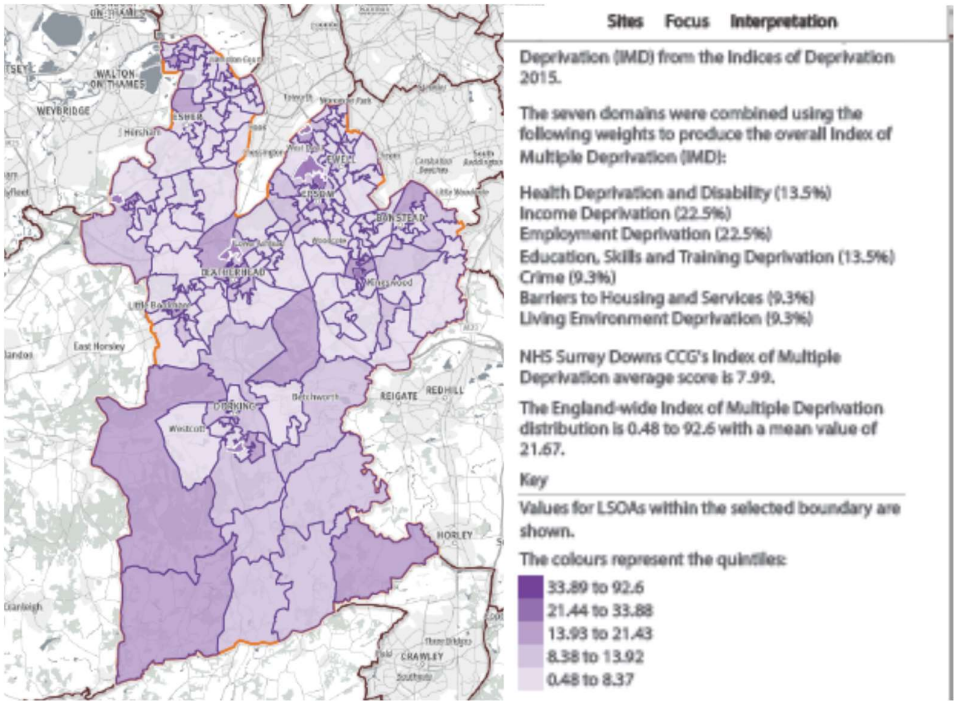


Source: Public Health England SHAPE tool – Living environment deprivation by quintile

5.2.2 Surrey Downs

Surrey Downs ranks 207 out of 209 in overall IMD deprivation, where 209 is the least deprived. As shown in Figure 5-3 below, there is some variation across the CCG but not a significant amount.

Figure 5-3: Surrey Downs CCG IMD by quintile



Source: Public Health England SHAPE tool – IMD by quintile

When the IMD deprivation breakdown is explored (see Table 5-2 below), there is again little variation, with the exception of barriers to housing.

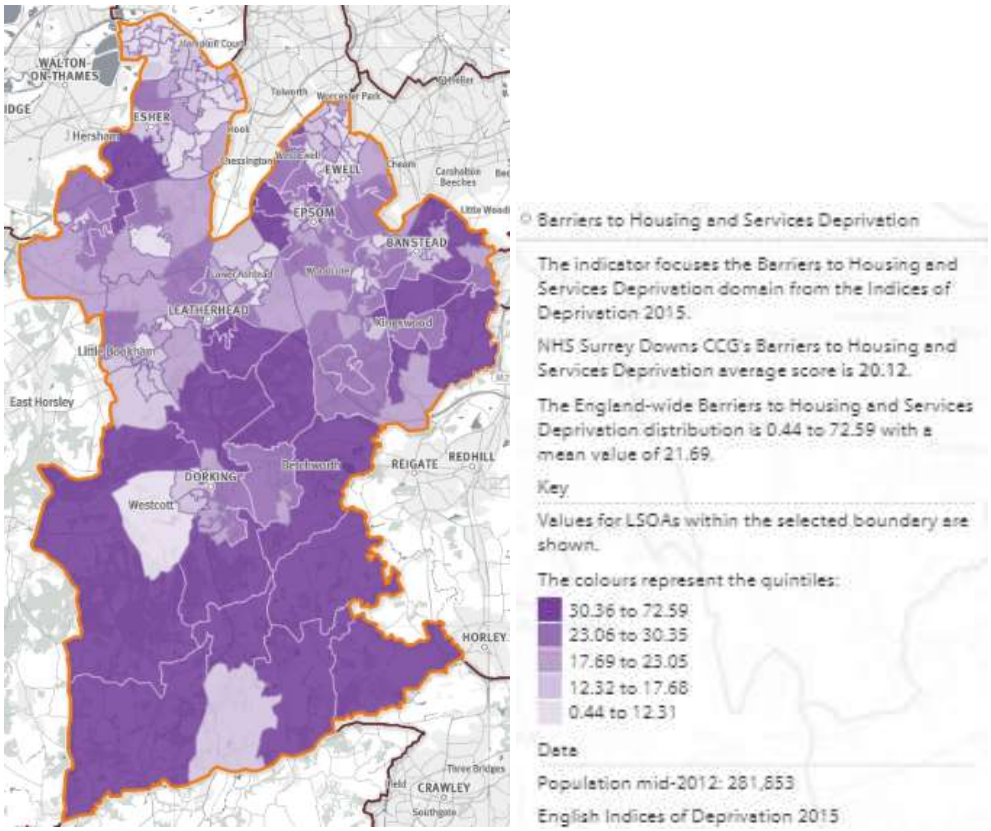
Table 5-2: IMD breakdown of Surrey Downs by rank

IMD Domain	Surrey Downs Rank(out of 209, where 1 is most deprived, 209 is least deprived)
IMD	207
Income	208
Employment	208
Education, skills, training	203
Health	203
Crime	189
Barriers to housing	121
Living environment	154

Source: *DCLG, English indices of deprivation 2015*

When the barriers to housing domain is looked at more closely, there is significant variation in the area, as shown in Figure 5-4 below.

Figure 5-4: Barriers to housing and services deprivation in Surrey Downs



Source: Public Health England SHAPE tool – Barriers to housing and services deprivation by quintile

In addition to the deprivation profile described above, Surrey Downs has a significant GRT (Gypsy Roma Traveller) population. The exact GRT population is unknown, but, for example, the ONS count of traveller caravans[10] shows that rates of traveller caravans are more than twice as high in the Elmbridge Local Authority within Surrey Downs CCG when compared to the national

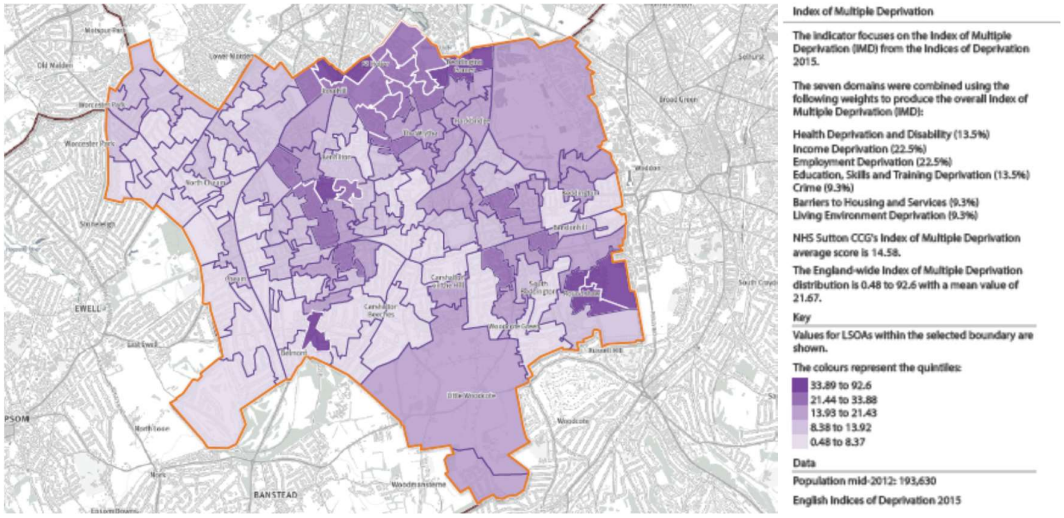
[10] Source: Department for Communities and Local Government (2015), Traveller caravan count, July 2015. Count applied to ONS population projections (2018) by Local Authority.

average. National research has shown that GRT populations perform on average worse than nationally across a range of health outcomes (including life expectancy, mental ill-health, and vaccination rates) and other outcomes including education and attainment, and social inequalities.[11]

5.2.3 Sutton

Sutton ranks 167 out of 209 in overall IMD deprivation, where 209 is the least deprived. As shown in Figure 5-5 below there is some variation across the CCG.

Figure 5-5: Sutton CCG IMD by quintile



Source: Public Health England SHAPE tool – IMD by quintile

When the IMD deprivation breakdown is explored (see Table 5-3 below), variation can be seen within the domains, with crime and living environment being particularly notable.

Table 5-3: IMD breakdown of Sutton by rank

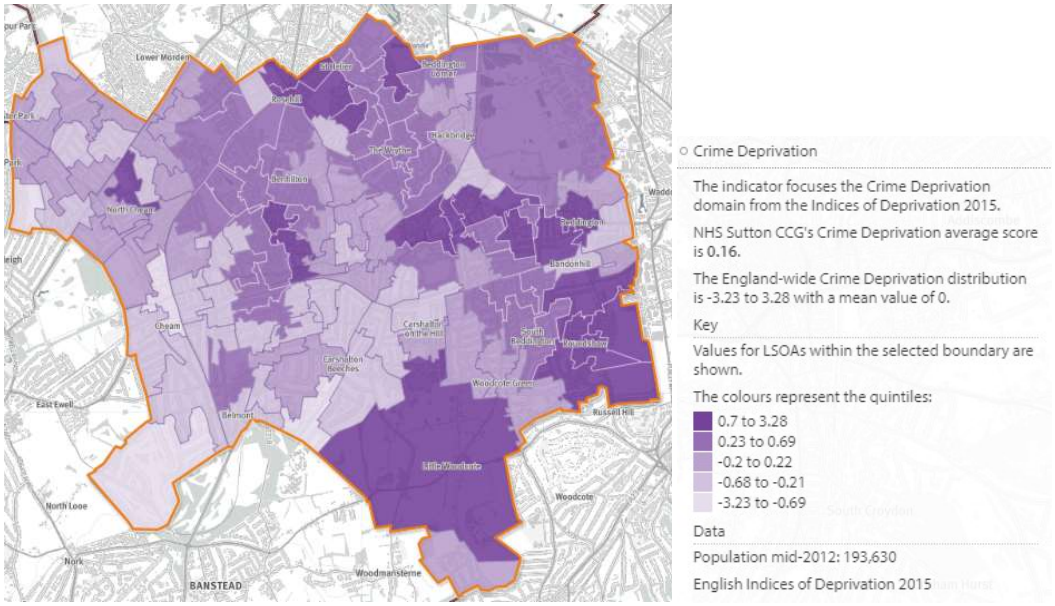
IMD Domain	Sutton Rank(out of 209, where 1 is most deprived, 209 is least deprived)
IMD	167
Income	151
Employment	169
Education, skills, training	183
Health	164
Crime	77
Barriers to housing	114
Living environment	99

Source: DCLG, English indices of deprivation 2015

[11] Source: Surrey County Council (2013): Needs analysis for Surrey's Gypsy Roma and Traveller children and young people 2013.

When the crime domain is looked at more closely, there is significant variation in the Sutton area, as shown in Figure 5-6 below.

Figure 5-6: Crime deprivation domain in Sutton



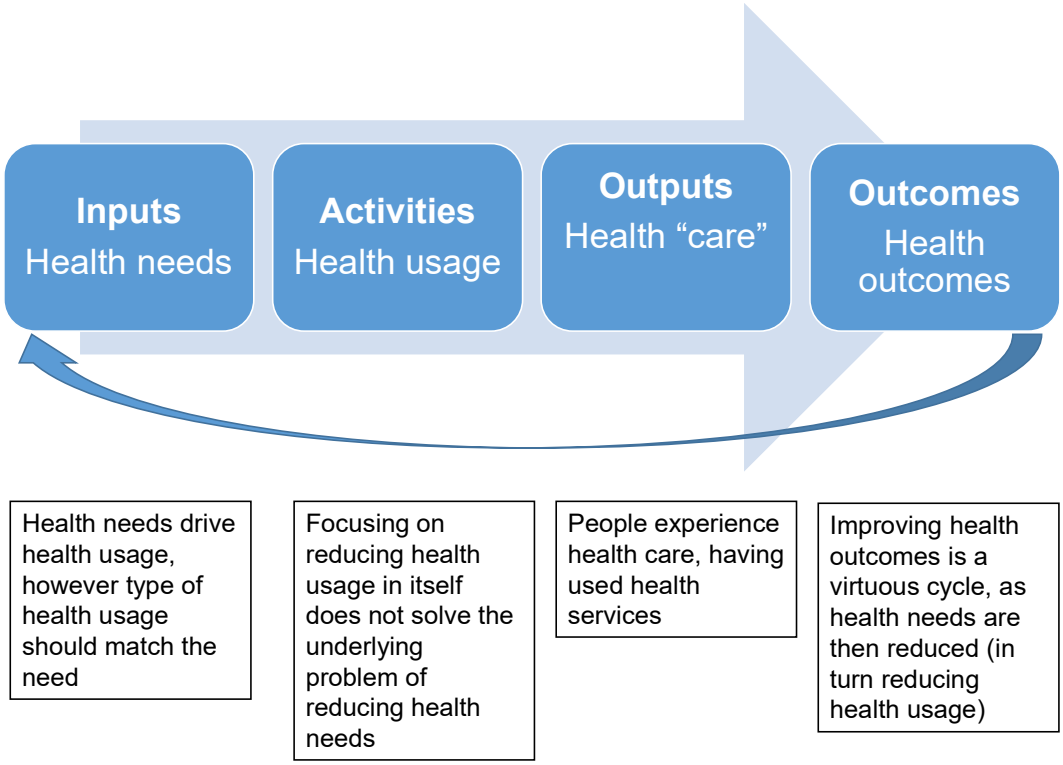
Source: Public Health England SHAPE tool – Crime deprivation by quintile

5.3 Health need, usage, and outcomes

We have been asked to assess how deprivation impacts on healthcare need and health usage (which the remainder of Section 5 examines). It is key to distinguish between need and usage. These are both defined in Section 2.5. Thinking about the two in terms of a logic model, where inputs lead to activities, outputs, and outcomes (see Figure 5-7 below), health needs are the inputs, which drive health usage.

However it is important to have the correct health usage to meet the need, or health outcomes can suffer. For example, turning up at a local GP in the middle of a heart attack is not an appropriate usage of health services. The overarching aim from any change should be to improve health outcomes, as this reduces health needs, and in turn, health usage. Focusing on reducing health usage in itself does not solve the underlying problem of reducing health needs.

Figure 5-7: Logic model of health needs, usage, care and outcomes



In the sections that follow, we test various hypotheses around deprivation and its links to health needs (Section 5.4), health usage (Section 5.5), and the matching of health needs and usage (Section 5.6).

5.4 Drivers of health needs

5.4.1 Hypothesis 1

People in deprived communities have increased acute healthcare need

5.4.2 Evidence

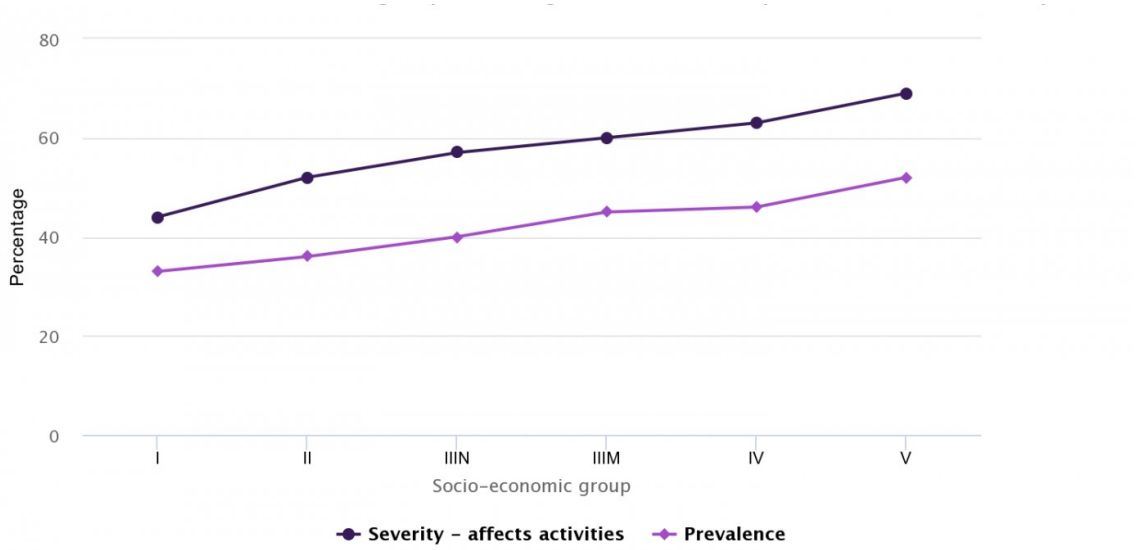
There is a large body of long standing evidence that shows that deprived communities have greater acute healthcare need, for example in the Marmot Review, 2010.

Key driver of acute healthcare need is illness requiring acute intervention, for which strong proxies are the number of long-term conditions (LTCs) and the standardised mortality rates. For example:

- Multi-morbidity is more common among deprived populations and there is evidence that the number of conditions can be a greater determinant of a patient's use of health service resources than the specific diseases. (Barnett K et al, 2012)
- "The population burden of multi-morbidity is the strongest predictor of ED attendance, which is independently associated with social deprivation." (Hull et al, 2018)

Figure 5-8 below shows that there are higher numbers of LTCs for individuals in lower socio-economic groups. Prevalence of LTCs is over 50% for those in the lowest socio-economic group, and approximately 34% for those in the highest socio-economic group.

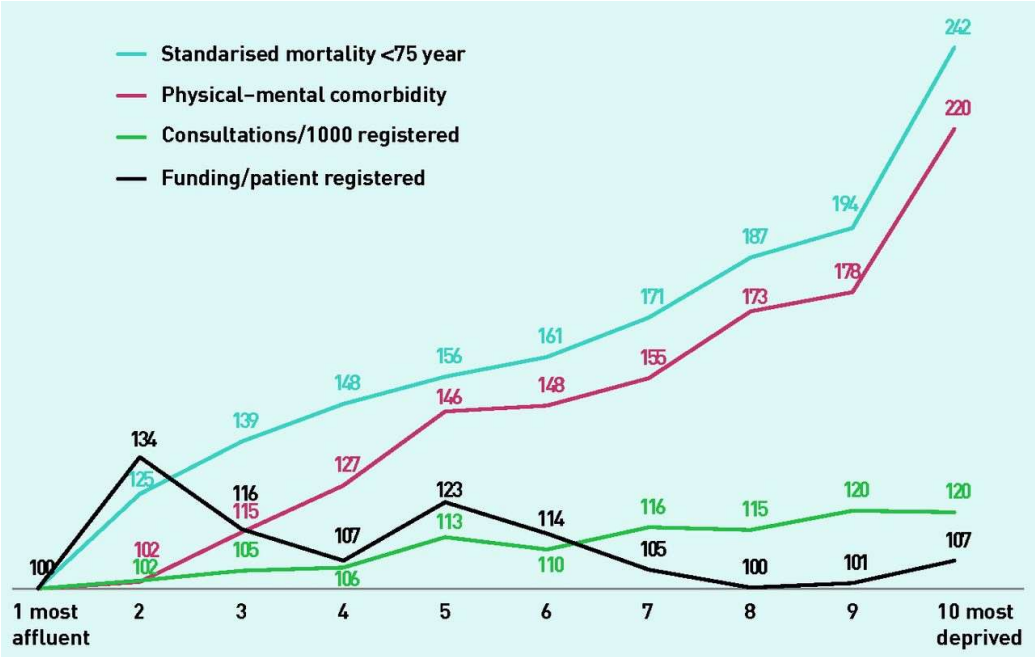
Figure 5-8: Link between socio-economic group and long term conditions prevalence and severity



Source: Department of Health (2006) in The King's Fund (2012/2013)

Standardised mortality ratios are significantly higher in more deprived areas, as shown in Figure 5-9 below. If standardised mortality for those under 75 years are benchmarked at 100 in the most affluent areas, they increase steadily as individuals are more deprived, rising to 262 for the most deprived decile.

Figure 5-9: Standardised mortality by deprivation decile



Source: G McLean, B Guthrie, S Mercer, G Watt (2015) 'General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland', British Journal of General Practice

5.4.3 Hypothesis 2

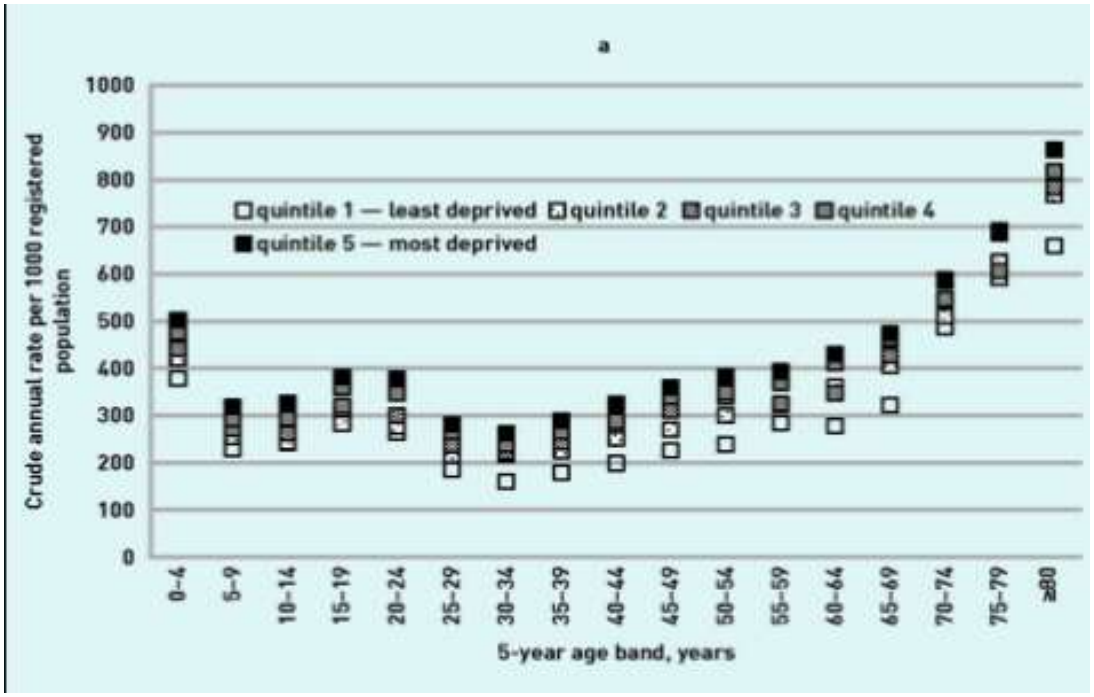
Acute health need is driven by age and other social factors, as well as deprivation, but these factors are linked

5.4.4 Evidence

Acute health need is driven by a range of factors, but primarily by number of long term conditions, or multi-morbidity, which in turn are typically driven by age: For example:

- "The population burden of multi-morbidity is the strongest predictor of ED attendance, explaining much of the association with social deprivation." (Hull et al, 2018)
- Age and social deprivation are significantly associated with emergency admission to hospital. For patients under 65, age and social deprivation have similar risks for emergency admission; in patients over 65, age has a much greater effect on the risk of admissions than social deprivation (BMJ, Gray et al, 2017)
- Multi-morbidity (and by extension acute health usage) is driven by both age and deprivation, but compared to deprivation, age appears to be the larger driver of ED attendance, in particular after the age of 65. It is the least deprived communities which see the largest impact in terms of fewest ED attendances (British Journal of General Practice, 2018 – Figure 5-10 below).

Figure 5-10: Age profile of ED attendance rates per 1000 population stratified by internal IMD 2015 quintiles



Source: S Hull, K Homer, K Boomla, J Robson, M Ashworth, (2018), 'Population and patient factors affecting emergency department attendance in London: retrospective cohort analysis of linked primary and secondary care records', British Journal of General Practice

5.4.5 Hypothesis 3

Deprivation is correlated with poor mental health which can lead to difficulties in negotiating the welfare/health system, as well as impact negatively on physical LTCs

5.4.6 Evidence

A large body of research has consistently shown that mental health problems are more common in areas of deprivation and poor mental health is consistently associated with unemployment, less education and low income or material standard of living, in addition to poor physical health. (Melzer et al, 2004, Jenkins et al, 2008, Butterworth et al, 2009)

Socio-economic deprivation also exacerbates the relationship between having multiple long-term conditions and experiencing psychological distress:

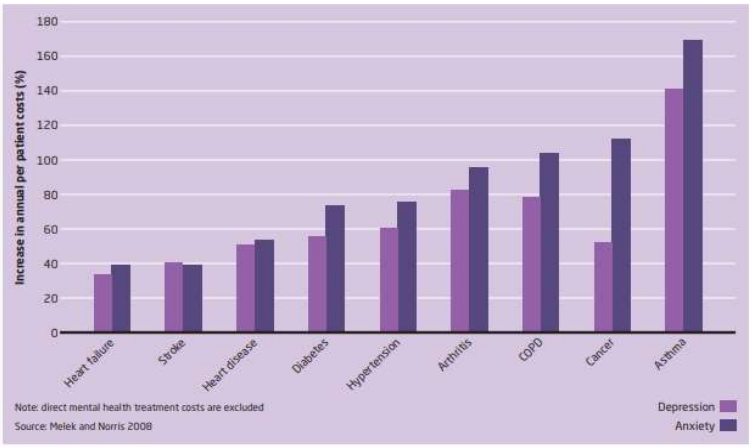
- A larger proportion of people in deprived areas have multiple long term conditions
- The effect of multiple morbidity on mental health is stronger when deprivation is present (Mercer and Watt, 2007)

The impacts of physical and mental co-morbidity for the person include significantly poorer clinical outcomes and prognosis, adverse health behaviors, poorer self-care, including difficulty in navigating the health system, decreased adherence to rehabilitation regimes and reduced quality of life.

There are also significant increases in costs of healthcare for individuals having either depression or anxiety, as well as a LTC. This can range from a 30% to 160% increase in per

patient healthcare costs, according to a study reviewed which looked at US claims data – see Figure 5-11 below.

Figure 5-11: Proportionate increase in per patient medical costs associated with depression and anxiety relative to people without a mental health problem



Source: C Naylor et al, (2012),"Long-term conditions and mental health: the cost of co-morbidities", The King's Fund.

For the health and social care system, the impacts include increased service use (such as hospital admissions and readmissions, and GP consultations) and higher health service costs, such as outpatient clinic attendance, pharmaceutical use and inpatient stays. (The King's Fund, 2012)

5.5 Drivers of health usage

5.5.1 Hypothesis 4

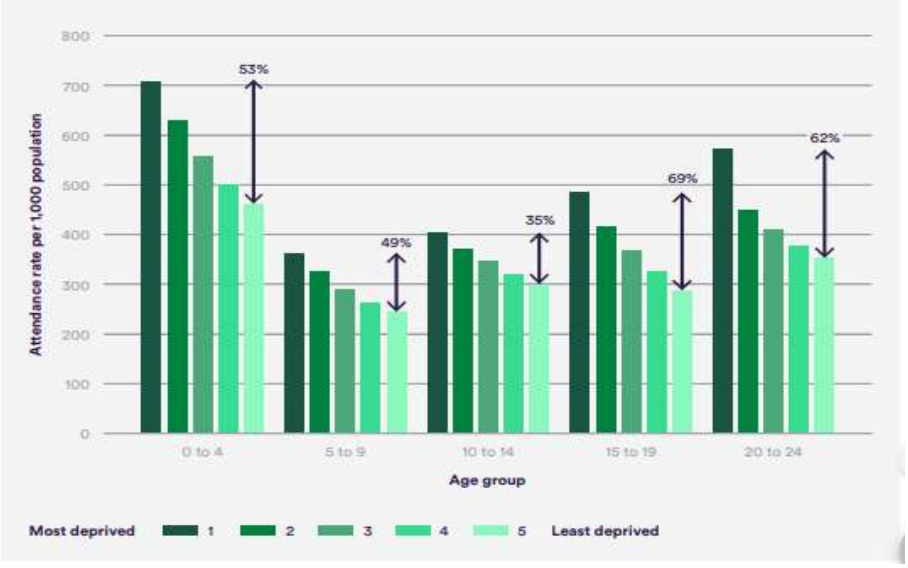
People in deprived communities have increased acute healthcare usage

5.5.2 Evidence

There is a large body of long standing, well documented evidence that shows that deprived communities have greater health usage. Evidence includes:

- More deprived areas had more emergency inpatient admissions per head than less deprived areas – Decile 10 had more than twice as many as decile 1, across all age and all sex groups. (McCormick, 2012)
- Children and young people from the most deprived areas experienced higher A&E attendance rates per 1,000 population than those in the least deprived areas. (Nuffield Trust, 2017)
- Social deprivation - 52% increase in crude attendance rates when comparing the most deprived population quintile to the least deprived (British Journal of General Practice, 2018)
- However putting into context, age and illness are more significant drivers of acute service usage than deprivation, although both are exacerbated by deprivaton (see Section 5.4.4)

Figure 5-12: Crude A&E attendance rate per 1,000 population in 2015/16 by age band and deprivation quintile, with percentage difference between most and least deprived



Source: L Kossarova, R Cheung, D Hargreaves, E Keeble (2017), Admissions of inequality: emergency hospital use for children and young people (CYP), Nuffield Trust.

5.5.3 Hypothesis 5

Acute health usage is driven by age and other social factors, as well as deprivation, but these factors are linked

5.5.4 Evidence

There is more limited evidence on the drivers of **increased acute health usage** by deprived communities, but indications that these are a combination of health, social, and other factors. For example, a 2008 study in the Journal of Public Health, suggested:

- casualty use was higher for individuals living in rented accommodation or without car access, lower income groups, unskilled manual workers, current smokers and for individuals with limiting illness)

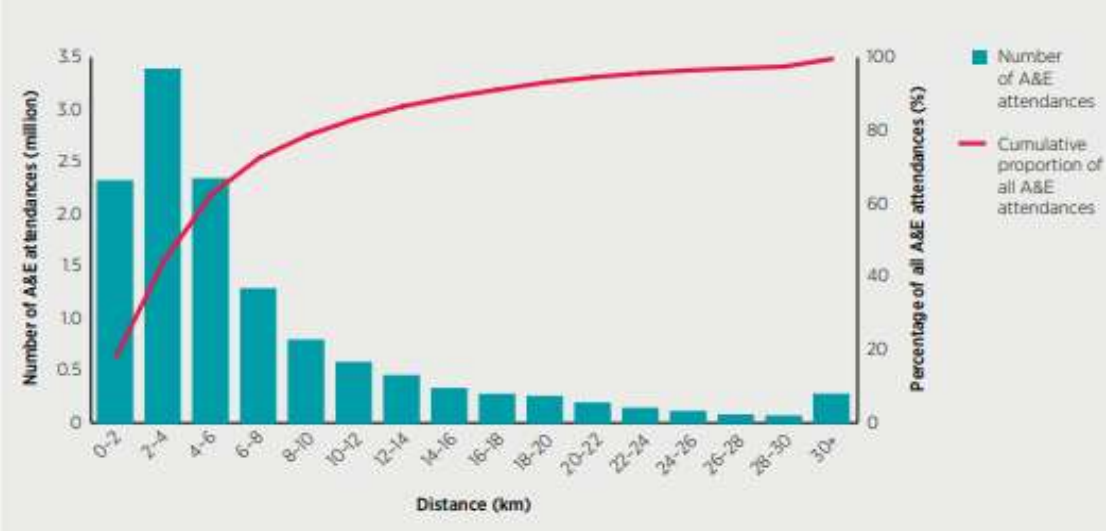
5.5.5 Hypothesis 6

Geographical factors are important – the closer to a hospital, the higher usage of acute hospital services by patients than those who live further away

5.5.6 Evidence

Existing literature demonstrates that patients show a strong preference for shorter distances (Beckert et al, 2012). Hospitals' A&E attendances are much more likely to come from individuals who live nearby. A study by the Nuffield Trust and the Health Foundation showed that approximately 70% of A&E attendances are from individuals living within 6km from the hospital (see Figure 5-13 below).

Figure 5-13: Distribution of distances between a person's home and the A&E department that they attended between April 2011 and March 2012



Source: A Roberts, I Blunt, M Bardsley (2014), Focus On: Distance from home to emergency care, The Health Foundation, Nuffield Trust.

The same study finds the mean distance between a person's home and the A&E department that they attended was 7.2 km, with a median of 4.2 km.

5.6 The link between acute health need and usage – how people access care

5.6.1 Hypothesis 7

Some of deprived communities' usage of acute hospital services could be dealt with in primary/community care

5.6.2 Evidence

Disease prevalence in deprived areas explains part but not all of the extra emergency care usage. Instead, the need for admission may also reflect inadequate community management of illness – factors which have their roots in both the quality and accessibility of services. For example:

- A tendency to access hospital care via emergency channels is implied by the finding that patients in deprived areas are more likely to present at A&E with symptoms more appropriate for a GP consultation. (McCormick, 2012)
- There are 2.2 times as many emergency ACSC (ambulatory care sensitive conditions – for which hospital admission could be prevented by interventions in primary care) episodes in decile 10 (most deprived) than in decile 1 (McCormick, 2012)

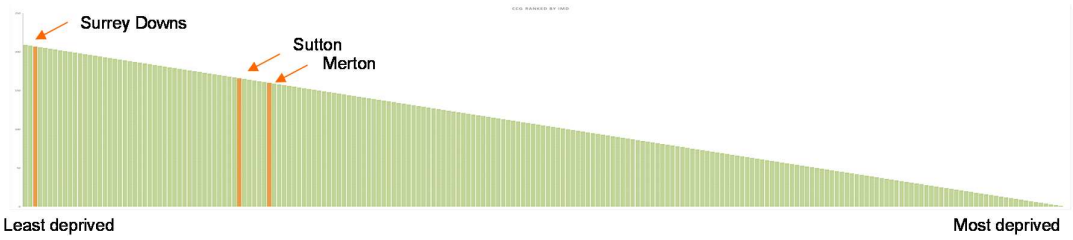
5.7 Key deprivation characteristics of the combined geographies

From the evidence shown in Section 5:

- People in Sutton, Merton and, particularly, Surrey Downs are not significantly deprived in relation to the rest of England. Merton ranks 160 out of 209 CCGs in overall IMD deprivation, Sutton ranks 167 and Surrey Downs ranks 207, where 1 is the most deprived and 209 is the least deprived (see Figure 5-14 below).

- In Merton and Sutton it is the living environment and crime domains that are driving the overall ranking, while in Surrey Downs barriers to housing are the main issue (see Table 5-4 below). In relation to the health domain, Merton ranks 175, Sutton ranks 164 and Surrey Downs ranks 203 out of 209 (where 209 is least deprived).
- There is however, variation within each CCG, with some pockets of deprivation, dispersed in several locations in Sutton and Merton. Of the 11 Lower Super Output Areas (LSOAs) in the top quintile for deprivation in the combined geographies, none are in Surrey Downs, four are in Merton, and seven are in Sutton (see Figure 5-15 below).
- Of the aforementioned LSOAs in the most deprived IMD quintile, the seven Sutton LSOAs are all within the Trust catchment area (as shown in Figure 5-15 below)
- Of the Merton LSOAs, Pollards Hill is not in the Trust's catchment area. Figge's Marsh and the two LSOAs in Cricket Green are on the border of the catchment area
- Whilst there are no LSOAs in Surrey Downs CCG in the top quintile for deprivation, the CCG has a significant population from the GRT community, who are proven to encounter worse health outcomes than those from non GRT communities.

Figure 5-14: CCGs in England ranked by Index of Multiple Deprivation



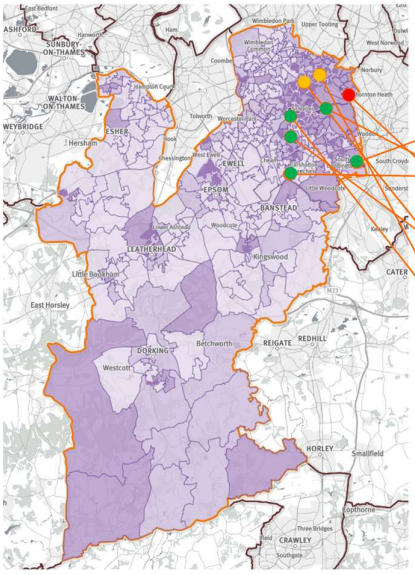
Source: DCLG, English indices of deprivation 2015

Table 5-4: Deprivation rank for combined geographies: 1 is most deprived, 209 is least deprived

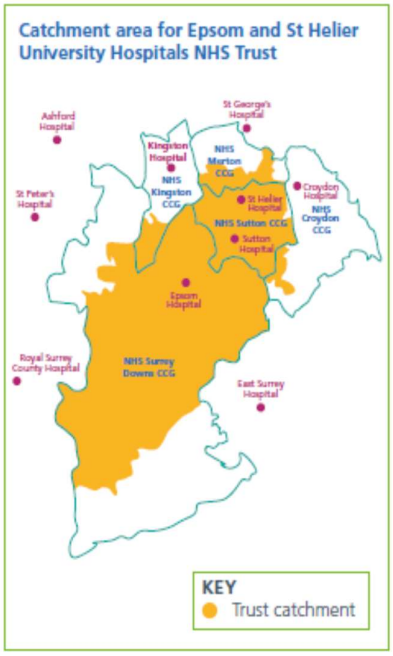
IMD Domain	Merton rank	Sutton Rank	Surrey Downs rank
IMD	**160**	**167**	**207**
Income	140	151	208
Employment	178	169	208
Education, skills, training	190	183	203
Health	175	164	203
Crime	69	77	189
Barriers to housing	123	114	121
Living environment	44	99	154

Source: DCLG, English indices of deprivation 2015

Figure 5-15: LSOAs in most deprived quintile in the combined geographies and the Trust's catchment area



Ward	LSOA	IMD
Beddington South	Sutton 019C Sutton 019A Sutton 019D	51.26 40.49 34.27
Belmont	Sutton 021A	42.3
Wandle Valley	Sutton 001D	41.83
Pollards Hill	Merton 019D	39.85
Sutton Central	Sutton 012B	39.7
Cricket Green	Merton 018A Merton 012C	36.42 34.58
St Helier	Sutton 002E	35.05
Figge's Marsh	Merton 018D	34.22

- 

Source: Trust catchment area sourced from Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups (June 2018), "Issues Paper". LSOA IMD data from Table 1-1.

5.8 Recommendations

- For the IIA:
  - Assess how the initial proposals resulting in possible changes to major acute services could potentially impact on the health usage of people living in the LSOAs in the most deprived quintile, through analysis of patient flows and catchments for hospitals:
- For the IHT Programme:
  - If there is to be a move in major acute service location, this may impact on certain populations' distance to a major acute centre. However these distances should be considered in the context of how far others in the country are from a major acute centre (given the relative proximity of all options).
- For the wider health leadership:
  - With evidence showing age is the largest contributor to acute health need, any future model of care needs to consider the older population as a key component (as well as deprivation).
  - With evidence showing strong links between mental health problems, deprivation, impact of physical LTCs, and ease of accessing the health system, any future model of care may wish to consider overcoming barriers to accessing the relevant healthcare support.
  - Deprivation and its impact on acute health services needs to be tackled not solely by the acute healthcare system but as part of a system response to also address causes, drivers and access to primary care.
  - Further work to be done to test national trends at the local level in order to better understand where local initiatives can be most effective:
    - investigate what evidence there is of higher standard mortality rates (SMRs) in more deprived areas in the combined geographies.
    - investigate what evidence there is around the breakdown of mental health condition prevalence for the combined geographies.
  - investigate what local evidence there is around the extent to which major acute usage could be dealt with in other care settings. Furthermore, the extent to which this changes relative to deprivation levels.
- For the wider system
  - Deprivation and its impact on acute health services need to be tackled not solely by the healthcare system, but by the wider system, including the living environment, housing, education, transport etc.

6 Major acute health services needed within deprived communities

6.1 Overview

We have tested a number of hypotheses in relation to the major acute health services:

1) *It is important to provide for the health needs of deprived communities, as the inverse care law says that those who need medical care are least likely to receive it*
2) *Major emergency departments do not need to be located right next to the people who use them, compared with primary, community, and some district services*
3) *Maternity services: evidence that deprived areas have higher rates of maternal obesity, which is linked to a greater need and use of obstetrics*
4) *Certain ethnic minorities have higher requirement for certain condition specific services*

In these areas detailed non-identifiable patient level data is required to assess the local application of the findings and we have suggested this is considered as further work.

The evidence suggests that deprived communities can find it more difficult to medical care but that proximity is not the key factor.

6.2 Inverse care law

6.2.1 Hypothesis

It is important to provide for the health needs of deprived communities, as the inverse care law says that those who need medical care are least likely to receive it

6.2.2 Evidence

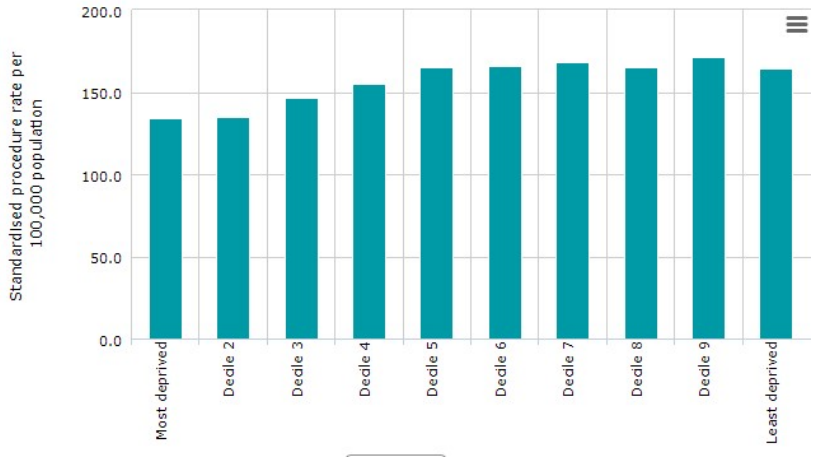
The inverse care law, first hypothesised nearly fifty years ago by Julian Tudor Hart, describes an inverse relationship between the need for health care and its actual utilisation – "*the availability of good medical care tends to vary inversely with the need for it in the population served*".[12] There are various sources of evidence which point to the truth of this law at a national level. For example

- This appears particularly true for elective care. Due to higher number of LTCs for deprived communities, one might expect them to have more elective procedures, however the evidence supports the opposite in a number of cases: for example with hip replacements, as shown in Figure 6-1 below.
- Deprived populations are less likely to access primary care. For instance deprivation has been associated with lower level of GP registration, greater difficulty in getting a GP appointment and poorer perception of the quality of primary care (Nuffield Trust, 2017)
- Despite being in better health (in terms of the number of health problems, self-reported health status, and activity limitations), wealthier older people are significantly more likely to see a doctor, have an outpatient visit and see a dentist,

[12] Source: J Tudor Hart (1971), '*The Inverse Care Law*', The Lancet, Volume 297 Issue 7696.

with a similar although non-significant trend seen in hospital admission (LSE Health, 2006)

Figure 6-1: NHS hip replacement operations by deprivation decile



Source: Quality Watch, Deprivation and access to planned surgery, The Health Foundation, Nuffield Trust

6.3 Major acute services

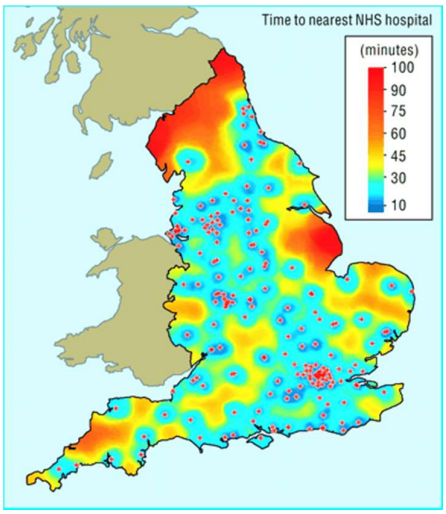
6.3.1 Hypothesis 1

Major emergency departments do not need to be located right next to the people who use them, compared with primary, community, and some district services

6.3.2 Evidence

The accessibility of hospital emergency services is often seen by the public as a critical marker of the level of investment in healthcare. There has been limited research into this issue. A review in 2005 found:

- For most areas of England, an acute NHS trust was accessible within 100 minutes' travel time
- For large parts of the country a NHS trust was accessible within 30 minutes.
- Overall, 25% of the population had one hospital within 15 minutes' travel time and 41% had up to two hospitals.
- Fifteen per cent had no hospital within 30 minutes' travel time, but 98% had one hospital and 92% had two hospitals within 60 minutes' travel time.



Source: M Damiani, C Propper, J Dixon (2005), 'Mapping Choice in the NHS: cross sectional study of routinely collected data', British Medical Journal

A more recent review in 2014 by Quality Watch considered the distance people travelled to received emergency care and how this had changed over ten years. They found: [13]

- An estimated reduction of 8 in major A&E sites, to around 200 in England, since 2001/02;
- A mean distance between a person's home and the A&E department that they attended of 7.2 kilometres and median of 4.2km based on analysis of 13 million attendances in 2011/12. 84% of attendances being from people living within 12km;
- The mean distance from hospital to home for an emergency admission was 8.7km with a median of 5.5km, based on 5 million emergency admissions in 2011/12, with 70% being within 10km
- A slight but not statistically significant increase in the distance travelled for emergency admission in the 10-year period between 2001/02 and 2011/12 from 8.3km to 8.7km, with the biggest increase due to distance travelled for emergency admissions following a stroke (from 7.9km to 8.9km).

Locally, for the combined geographies, there is good access to hospitals particularly in Merton and Sutton:[14]

- **49.3% of households within the combined geographies have access to hospitals within 30 minutes by public transport or walking, compared to an England wide average of 38.6%;**
- In Merton the level is 64.4%, Sutton it is 56.5% and in Surrey Downs it is below the average at 33.8%;
- In the most deprived quintile LSOAs within the combined geography, 100% of households within Merton and Sutton are within 45 minutes (the England average is 71.9%), and 100% within 60 minutes (the England average is 87.6%).

6.3.3 Hypothesis 2

Maternity services: evidence that deprived areas have higher rates of maternal obesity, which is linked to a greater need and use of obstetrics

6.3.4 Evidence

The national review of maternity services, Better Births,[15] found that the quality of maternity services has been improving but not all are provided to a consistent, high level of quality. There is significant variation in safety, effectiveness and outcomes between providers that cannot be explained on the basis of differences in demography, deprivation or clinical complexity.

There is evidence which links maternal obesity to adverse pregnancy outcomes (Heslehurst et al, 2010). Maternal obesity is therefore likely to lead to a great need and use of obstetrics. There is evidence that more deprived communities have worse maternal outcomes, particularly in the

[13] Source: A Roberts, I Blunt, M Bardsley (2014), '*Focus On: Distance from home to emergency care, Quality Watch'*, The Health Foundation, The Nuffield Trust,

[14] Source: analysis using Public Health England's SHAPE tool travel time function.

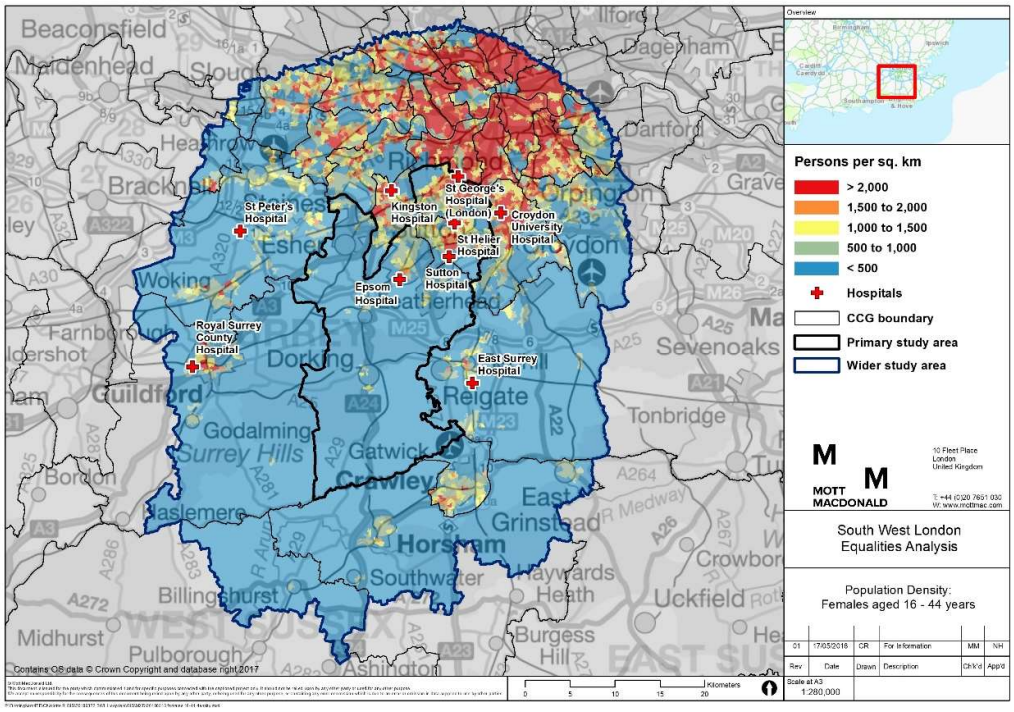
[15] Source: NHS England (2016), '*National Maternity Review: Better Births – Improving outcomes of maternity services in England, A Five Year Forward View for maternity care*'

fourth and fifth quintiles[16]. For example, babies whose mothers live in poverty have a 57% higher risk of perinatal mortality[17].

Number of women aged 16-44 provides an indication of the levels of pregnancy and maternity in the combined geographies. Within the study area, the number of women aged 16-44 (19%) is in line with the national average (19%)[18]

Figure 6-2 below shows that the highest density of females aged 16-44 in the combined geographies is clustered in Merton, nearest to St George's hospital

Figure 6-2: Population of females aged 16-44



Source: LSOA population estimates 2016, ONS – in Mott MacDonald (2018) 'Improving Healthcare Together 2020-2030: Initial equalities analysis of major acute services', (Figure 11)

At present, there is no strong evidence on the impact of distance/travel time to maternity services on birth outcomes (Public Health Wales Observatory, 2015)

6.3.5 Hypothesis 3

Certain ethnic minorities have higher requirement for certain condition specific services

6.3.6 Evidence

There is evidence showing that certain ethnic minorities have a higher requirement for certain condition specific services. For example:

[16] Source: MBRRACE UK (June 2018), *Perinatal Mortality Surveillance Report for 2016*

[17] Source: NHS England (2016), *National Maternity Review: Better Births – Improving outcomes of maternity services in England, A Five Year Forward View for maternity care*

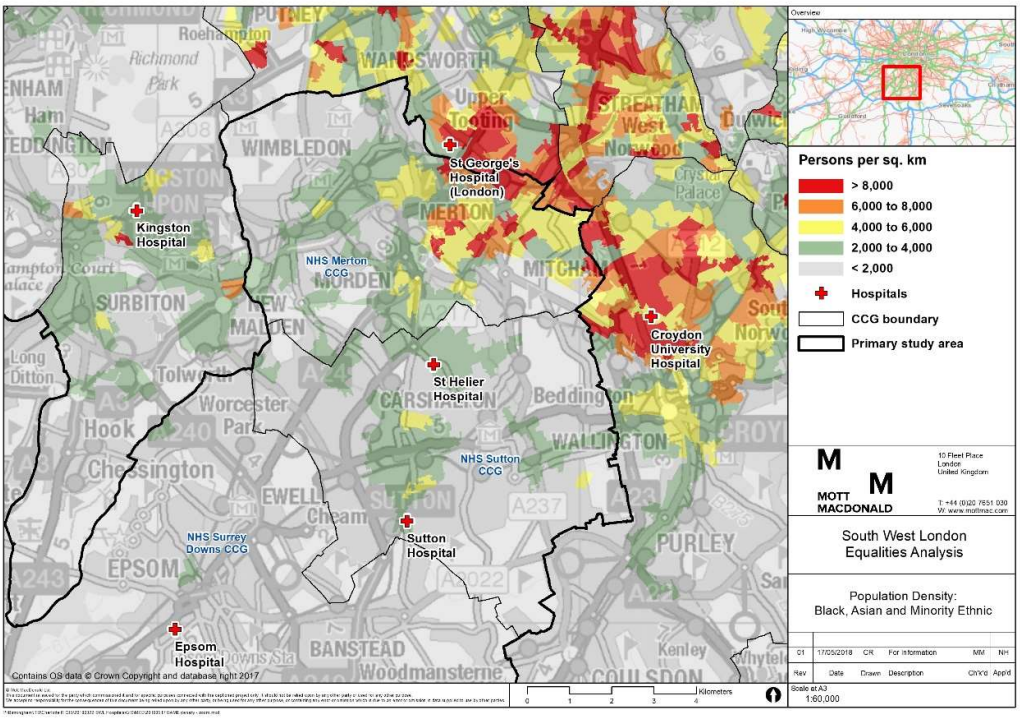
[18] Source: LSOA population estimates 2016, ONS – in Mott MacDonald report (Table 11)

- People of South Asian background have the highest rate of coronary heart disease; people from an African Caribbean background have a higher risk of developing high blood pressure; and the prevalence of type-2 diabetes (which may cause complications to acute medical care) for both people of African Caribbean and South Asian ethnicity is much higher than in the rest of the population; (British Heart Foundation)

It is likely that some of these requirements could be better served in outpatient appointments, and new models of specialist support to general practice rather than inpatient care, however further work is required to test this.

Figure 6-3 below shows the population of people from BAME backgrounds. There are low densities throughout Surrey Downs, and Sutton, but with a couple of higher density areas in Merton.

Figure 6-3: Population of people from BAME backgrounds – higher density areas



Source: *Census 2011, ONS –in Mott MacDonald (2018) 'Improving Healthcare Together 2020-2030: Initial equalities analysis of major acute services', (Figure 14)*

6.4 Recommendations

- For the IIA:
  - 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.
  - Assess how the initial proposals resulting in possible changes to major acute services could potentially impact on the health usage of people living in the LSOAs in the most deprived quintile, through analysis of patient flows and catchments for hospitals:
- For the IHT Programme:
  - There is no strong evidence on the impact of distance/travel time to maternity services on birth outcomes, implying that major acute obstetric services do not need to be provided particularly close to those accessing it.
- Outside of the IHT Programme, the individual responsible CCGs as part of their wider responsibilities for population health management may wish to consider – for people living in the LSOAs in the most deprived quintile – further research into what works in relation to the needs of these people in relation to managing demand and improving health outcomes

7 Relevant considerations for emerging clinical models

7.1 Summary

The purpose of this report was not to assess potential solutions but to identify the issues and considerations that should be considered as the programme develops.

For this report, and the Programme, which are specifically looking at major acute services:

- Any future model of care **should not materially disadvantage deprived communities in terms of access to major acute services**. This should be for both patients, and their families and friends.

Whilst not specifically part of the scope of this work, if the wider health leadership and wider partners are keen to **reduce health inequalities**, then this cannot be done in major acute services alone, and any future model of care should ensure the elements of the health and care pathway prior to major acute services (including but not limited to: primary care, community care and living environment) are tailored to their local communities, reflecting their characteristics.

7.2 Continuation of access to major acute services

Any future model of care should ensure continuation of access to major acute services. The new model of care **should not materially disadvantage deprived communities in terms of access to major acute services**. This should be for both patients, and their families and friends:

- **Patient access for using major acute services** should be analysed through the travel times modelling through conveyance by ambulance to emergency departments. Expected response and conveyance times should fall within appropriately agreed local thresholds; and
- **Family and friend access to visiting patients using major acute services** should be analysed through travel times modelling through travel times by public transport or walking. Travel times should fall within an appropriately agreed local thresholds. This should include consideration of evening, weekend, and bank holiday services.

The evidence suggests that the combined geographies are relatively well served in terms of access to major acute services. As described in Se**ction 6.3: 49.3% of households within the combined geographies have access to hospitals within 30 minutes by public transport or walking, compared to an England wide average of 38.6%;, and within the most deprived quintile LSOAs within the combined geography, 100% of households within Merton and Sutton are within 45 minutes (the England average is 71.9%), and 100% within 60 minutes (the England average is 87.6%).**

However, if necessary to ensure any future models of care continue to meet standards:

- **Around access to major acute services for patients**, the Improving Healthcare Together: 2020-2030 Programme could consider options around ambulance station locations; and
- **Around access to major acute services for families and friends**, wider community and partner services (such as TfL) could be engaged around local transport improvements

7.3 Reducing health inequalities

The evidence set out in this report has set out some of the specific health needs of the populations of the combined geographies. Any future model of care should ensure deprived communities have access to services which are tailored to their characteristics. In cases where the appropriate service is major acute services, then patient access for using major acute services will be primarily assessed through standards relating to travel times (see Section 7.2).

For services outside of major acute services, then the wider health system and other partners should work together to help reduce health inequalities. This may in turn lead to a **collaborative neighbourhood action plan** which could include:

- **Targeted health services in the community** which may include virtual clinics for diagnostic and assessment tests, proactive community services, social prescribing etc.
- **Targeted community and partner services**, focused on addressing the wider determinants of deprivation, in particular living environment and crime
- **Population health management** which could involve gathering and analysing patient data across multiple health information technology resources, with the aim of improving both clinical and financial outcomes

Much of this work may already be being considered as part of the CCGs' and Local Authorities' local plans to improve the model of care for their populations.

7.4 Recommendations

- For the IIA:
  - 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.

8 Conclusions and areas for further analysis

8.1 Summary

From the evidence reviewed, our conclusions are that:

1) There is a wealth of evidence that health outcomes decline with increasing deprivation;
2) However, there is less evidence linking deprivation with the need/usage of the specific major acute services being considered as part of the IHT Programme;
3) In addition, within the combined geographies, overall deprivation is comparatively limited when compared nationally. There are, however, individual LSOA areas within the most deprived quintile nationally which is a helpful indicator of the areas of greatest need;
4) These pockets of the most deprived LSOAs are dispersed in several locations, in Sutton and Merton;
5) The geographical area of Sutton and Merton containing the pockets of deprivation is fairly concentrated resulting in a relative ease of access to major acute services (see Section 1.5). Initial proposals (see Section 3.5), for any changes to locations of major acute services are likely to have relatively marginal impact on access. However this report understands that the IHT Programme is open to other possible solutions on top of these initial proposals; and
6) Addressing health inequality is an important goal for those accountable for population health, but decisions about the major acute service locations within the combined geographies are likely to only have marginal impacts on this. A greater impact on health outcomes for deprived communities within the combined geographies would be more likely to come from concerted effort earlier in the health and care service pathways prior to need for major acute services. It is also likely to require involvement of wider partners on the wider social determinants of health.

Notwithstanding the points above, additional work could be carried out by the IHT programme to inform decision making about any changes of locations of major acute services.

These could be covered in the IIA which will consider the current (or baseline) situation and then assess positive and negative impacts of a shortlist of options when compared to the baseline. In relation to deprivation, the IIA could:

- 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.

Health outcomes are worse for more deprived communities but mitigating the impact is more likely to come from interventions earlier in the health and care pathways than at the major acute service level. Outside of the IHT Programme, the individual responsible CCGs as part of their wider responsibilities for population health management may wish to consider, for people living in the LSOAs in the most deprived quintile:

- Further research into what works in relation to the needs of these people in relation to managing demand and improving health outcomes;
- Creating an evidence-based plan targeting the specific needs of these people; and
- Formative evaluation to understand and monitor health outcomes.

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Appendix 2: Stakeholder engagement

Table A2-1 below sets out the stakeholders we spoke with as part of our review.

Table A2-1: Stakeholders engaged with

Organisation	Role	Name
Epsom and St Helier University Hospitals NHS Trust	Chief Executive	Daniel Elkeles
Epsom and St Helier University Hospitals NHS Trust	Director of Communications and Patient Experience	Lisa Thomson
Epsom and St Helier University Hospitals NHS Trust	Equality, Diversity and Inclusion Manager	Shabir Abdul
Improving Healthcare Together: 2020-2030 programme	Communications and Engagement Advisor	Rory Hegarty
Merton CCG	Director of Commissioning	Josh Potter
Merton CCG and Wandsworth CCG	Managing Director	James Blythe
Merton Local Authority	Director of Community and Housing	Hannah Doody
Merton Local Authority	Chief Executive	Ged Curran
Merton Local Authority	Director of Public Health	Dagmar Zeuner
South West London Alliance (Kingston, Merton, Richmond, Sutton and Wandsworth CCGs)	Accountable Officer	Sarah Blow
Surrey County Council	Strategic Director of Adult Social Care and Public Health	Helen Atkinson
Surrey County Council	Deputy Director of Public Health	Ruth Hutchinson
Surrey Downs CCG	Managing Director	Colin Thompson
Surrey Downs CCG	GP & Clinical Director of Urgent Care and Integration	Simon Williams
Surrey Heartlands CCGs	Joint Accountable Officer	Matthew Tait
Sutton CCG	Managing Director	Lucie Waters
Sutton Local Authority	Director of Public Health	Imran Choudhury

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Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:**	28 November 2018
Report title:	Improving Healthcare Together 2020-2030 Provider Impact Analysis		
Report from:	Tom Alexander, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author(s)/Contact Number(s):	David Olney, Commissioning & Business Insight Manager 020 8770 5207		
Open/Exempt:	Open		
Signed:		**Date:**	14 November 2018

1. Summary

1.1 A report on the current work to understand the provider impact analysis prepared for the Improving Healthcare Together programme.

2. Recommendations

The Sub Committee is recommended to:

2.1 Consider and comment on the report.

3. Background

3.1 The Improving Healthcare Together 2020-2030 programme has commissioned a range of supporting work for its programme including this provider impact analysis.

3.2 A provider technical group has been established to undertake this work for the IHT programme.

3.3 The Improving Healthcare Together JHSC sub committee will consider and review this as part of their scrutiny oversight of the programme.

4. Appendices and Background Documents

Appendix letter	Title
A	Cover Sheet Provider Impact Analysis
B	Provider Impact Analysis report

Audit Trail		
Version	Final	Date: 14 November 2018

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

JHOSC Sub-Committee Cover Sheet
Attachment: 2
28th November 2018

Title of Document: Provider impact analysis	**Purpose of Report:** For noting
Report Authors: Andrew Demetriades	**Lead Director:** Andrew Demetriades

Executive Summary:

A key part of options analysis is the impact on local providers in South West London and Surrey. To support this, a Technical Group was convened in July, comprising provider Directors of Strategy. This group is considering impacts on estates, finance and workforce. We recognise the importance of partnership working we have sought to engage providers in the programme and understand the impacts on them of different proposed options.

This process has designed to be open and transparent, with emerging work shared with the Technical Group and supported by NHS England and Improvement.

Outputs will support the development of the draft Pre-Consultation Business Case.

As a first step, it is important to understand how many patients may flow to different providers when services change. A range of scenarios and sensitivities have been agreed with providers, based on independent travel time analysis.

Based on this, the programme has developed initial estimates of patient flow in the different options, based on forecast activity. These will be shared at the scoring workshop on 14/11 to support the comparison of options (see Appendix).

To understand the impacts of these flows, providers require more detailed modelling of changes in activity at specialty level. We have an agreed approach with Providers to analyse patient flow using travel time as a core scenario and capturing other impacts via a range of sensitivities, to reflect drivers of patient flow other than travel time.

Providers are developing a detailed impact assessment for each of their Trusts in four areas:

- Capacity
- Estates and capital
- Income and expenditure and,
- Workforce

This detailed modelling, to a specification agreed with providers, will conclude in January so provider Boards can take a fuller view of impacts on them.

The provider impact analysis will be considered by the three CCGs alongside any outputs from the assurance process and phase two IIA before determining whether they wish to proceed to public consultation on any proposals.

No decisions are made until after a consultation has finished and all the evidence and feedback has been assessed.

Key issues to note are:

- Initial estimates of patient flow and impacts on other providers were shared with the scoring workshop 14/11
- Further work in underway to provide detailed specialty modelling to support providers to assess the impact of these flows on: Capacity, Estates and capital, Income and expenditure and, Workforce

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

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Recommendation: Note progress to date
Financial Implications: To be determined
Equality Impact Assessment: An initial equalities scoping has been conducted as part of the IHT programme.
Information Privacy Issues: None
Communication Plan: A communications and engagement plan for the Improving Healthcare Together 2020-2030 has been developed.

Appendix 1: Impact on other providers: Impact on finance and workforce for other health and social care providers (1/2)

Context and background

- Impacts are based on **changes in travel time**
- Beds have been used as a proxy for impact.
- Specific analysis of impacts **requires detailed work,** but initial views have been developed based on programme analysis

Table: Beds required at nearby providers

	No service change	Epsom	St Helier	Sutton
Inflow	-	39	-	84
Outflow	-	252	86	133
TOTAL Net	**-**	**213**	**86**	**49**

Considerations

Each option is expected to lead to some differential impacts on different providers:

- **Epsom:**
  - Significant flow of patients currently using the St Helier site, particularly to St George's and Croydon.
  - Some inflows from emergency surgery patients currently using Surrey Trusts to the Epsom site.
  - Scale of impacts may create delivery challenges at both Trusts.
  - For the London Ambulance Service, this may result in a refurbishment at Sutton Ambulance Station or new premises
- **St Helier:**
  - Flow of patients currently using the Epsom site to multiple providers (Kingston, Croydon, Ashford St Peter's, Surrey and Sussex).
- **Sutton:**
  - Flow of patients currently using the Epsom and St Helier sites to multiple providers (Ashford St Peter's, Kingston, St George's).
  - Some inflows from patients currently using Croydon to the new Sutton site.

Impact on other providers: Impact on finance and workforce for other health and social care providers (2/2)

Net bed change	No service change	Epsom	St Helier	Sutton
Croydon	-	**H** (95)	**L** (19)	**M** (-49)
Kingston[4]	-	**L** (10–17)	**L/M** (23–26)	**L** (23)
St George's	-	**H** (119)	**L** (7)	**M** (36)
Ashford St Peter's	-	**L** (-7)	**L** (20)	**L** (24)
Royal Surrey	-	**L** (-3)	**L** (5)	**L** (9)
Surrey and Sussex	-	**L** (-1)	**L** (12)	**L** (6)
TOTAL	**-**	**213**	**86**	**49**

Key

Impact	Indicative scale	Rationale
L	<25 beds	• <1 ward, likely to require refurbishment
M	25-75 beds	• c. 1-3 wards, likely to need a new block
H	>75 beds	• >3 wards, likely to need significant building work

Notes

(1) Estimates are based on programme analysis and have not been agreed with provider Boards

(2) Estimates are based on a single scenario and do not include sensitivities

(3) More detailed analysis is required before decision-making

(4) Kingston have advised bed impacts may be higher; these estimates are included in the range

Time to build: Length of time taken to build the option

Context and background

- The build of a hospital is complex and takes many years. This often requires patients in wards to be moved temporarily and can cause disruption to services.
- The number and sequencing of moves, and the breadth of refurbishments necessary impacts on the complexity of the build and the time taken to build.

Considerations

Due to their complexity, some options will take more time to build:

- **No service change**: Redevelopment requires multiple phases over 5 years
- **Epsom**: Redevelopment requires multiple phases over 6 years
- **St Helier**: Redevelopment requires multiple phases over 7 years
- **Sutton**: Redevelopment requires multiple phases over 4 years

Time to build (yrs)	No service change	Epsom	St Helier	Sutton
Major acute site	5	5	7	3
Overall time	5	6	7	4

Source: Turner and Townsend

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Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:**	28 November 2018
Report title:	Independent Report on Improving Healthcare Together Engagement Work		
Report from:	Tom Alexander, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author(s)/Contact Number(s):	David Olney, Commissioning & Business Insight Manager - 020 8770 5207		
Open/Exempt:	Open		
Signed:		**Date:**	14 November 2018

1. Summary

1.1 A report prepared by the Campaign Company on the engagement work undertaken to date by the Improving Healthcare Together programme.

2. Recommendations

The Sub Committee is recommended to:

2.1 Consider and comment on the report.

3. Background

3.1 The Improving Healthcare Together 2020-2030 programme has commissioned a range of supporting work for its programme including this independent review of the engagement work undertaked by the IHT programme.

3.2 The independent Campaign Company has undertaken this review of the engagement activity and early views arising from the various engagement activities at this point in the process.

3.3 The Improving Healthcare Together JHSC sub committee will consider and review this as part of their scrutiny oversight of the programme.

Appendices and Background Documents

Appendix letter	Title
A	Cover report - Campaign Company report on Improving Healthcare Together Engagement
B	Campaign Company report on Improving Healthcare Together Engagement

Audit Trail		
Version	Final	Date: 14 November 2018

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

JHOSC Sub-Committee Cover Sheet
Attachment: 3
28th November 2018

Title of Document: Engagement update and feedback from the Campaign Company Report	**Purpose of Report:** For noting
Report Authors: The Campaign Company	**Lead Director:** Andrew Demetriades

Executive Summary:

Our early engagement plan commenced in June 2018. We are committed to a best practice, transparent approach which engages and involves local people and communities at every step of the programme. We have followed NHS England guidance and sought best practice advice from The Consultation Institute.

Between June to November there has been a range of engagement activity by IHT which includes:

- Establishing a Stakeholder Reference Group as a core part of the programme's governance structure
- An initial equalities analysis to understand if the potential clinical vision would impact any specific communities
- Nine workshops led by Healthwatch with groups identified by the equalities analysis who may have a greater use of the services under consideration
- 12 public discussion events led by senior healthcare professionals and independently facilitated
- Six focus groups with users and potential users of maternity, paediatrics and A&E services
- Six high street engagement events to speak with local residents
- Community outreach and engagement with seldom heard and protected characteristics groups
- Communication, engagement and awareness raising through a community newsletter, a programme website, advertising, flyers, posters and social media channels

The programme continues to work with its Stakeholder Reference Group as part of its core governance arrangements. This group is made up of a collection of interested parties, for example local experts, campaign groups, local authorities, resident associations, patients or carers, who will scrutinise our plans and ideas and make recommendations to enhance the proposals.

We have already heard from more than 800 people and organisations. The feedback is helping to shape our proposals providing us with challenge as well as ideas.

Merton, Sutton and Surrey Downs CCGs commissioned The Campaign Company to undertake the analysis of pre-engagement activity conducted between June to October 2018.

The following summary sets out the key findings from the engagement analysis:

- There is a recognition of key elements of the case for change, such as workforce challenges and the problems with current buildings.
- There was support given for the main areas of the clinical vision – such as the focus on integration and prevention. However, there were concerns over deliverability, specifically with regard to financial sustainability.
- There was not a clear consensus of the type of change that should be delivered, with comments made both in favour of consolidation of services and retaining the status quo.
- People tend to advocate for services they are familiar with and solutions that are closer to them with no clear consensus over a single site for acute services.
- There is a particular concern around the transport and accessibility between different sites, such as from St Helier to Epsom and vice versa. This included the need to consider bus routes, the impact of traffic on travel times, and the cost and availability of parking.

Improving Healthcare Together 2020-2030
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JHOSC Sub-Committee Cover Sheet
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28th November 2018

• It was felt that those who are perceived to be most in need - in particular older and less mobile people and those in areas of higher deprivation – would be most impacted by potential changes. Consideration of these factors was felt to be important when developing solutions. • When consulting or engaging in the future, a need was expressed to use approaches and channels that allow all groups in the population to respond in ways that suit their circumstances. It was also felt that the process should be promoted more visibly and for clear, detailed information to be provided to ensure patients and communities can make informed contributions going forward. Healthwatch Surrey, Sutton and Merton have undertaken further engagement activity on protected characteristic groups. The findings from their work will be published on the Healthwatch websites, week commencing the 12th of November. The Improving Healthcare Together website includes a summary of the equalities engagement work. The summary can be found on the IHT website.
Key issues to note are: These findings provide important information which has been used in the evidence packs for the options consideration process. The programme will continue to reflect and listen to local communities' ideas as part of a continued process we are following.
Recommendation: The JHOSC Sub-Committee is asked to note the findings of The Campaign Company
Financial Implications: None
Equality Impact Assessment: An initial equalities scoping has been conducted as part of the IHT programme.
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

Independent analysis of feedback from public engagement

The Campaign Company

October 2018

Contents

1 Executive Summary

1.1 Introduction

This report is an independent analysis of engagement responses from the Improving Healthcare Together engagement from July to October 2018. TCC, a research and engagement consultancy, were commissioned to conduct this analysis by Surrey Downs, Sutton and Merton Clinical Commissioning Groups (CCGs). The report details findings from engagement conducted from July to October 2018 by Improving Healthcare Together to provide evidence and information to help develop options for changes to health services in the area.

1.2 Engagement process

NHS Surrey Downs, Sutton and Merton 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 Improving Healthcare Together 2020-2030 programme which aims to deliver care closer to patients' homes through integration of health and care services, ensure high standards of healthcare and ensure services for patients with serious or life-threatening conditions are kept operating within the local area.

The CCGs are keen to involve the public throughout the process of developing solutions to meet these challenges. As a first step, they published an *Issues Paper* in Summer 2018, as a starting point for engagement and discussion with local people. The *Issues Paper* sets out the key challenges facing the local healthcare system, an emerging clinical model, and provisional short list of potential solutions for consideration.

Engagement took place from July to October to seek staff and public feedback on the *Issues Paper*. This included: public discussion event, mobile pop-up street events, specialist focus groups, and feedback forms. By the end of the engagement, responses from over 800 people have been received.

The issues raised and evidence gathered in this report, alongside other information, will inform the next stage of the CCG's development of options for healthcare in the area.

1.3 Methodology

As with all public engagement, the overall response cannot be seen as representative of the population and is by its nature a partial picture of perceptions and views. The purpose of this analysis is to explain the opinions and arguments of those who have given feedback as part of this engagement process but it is not to recommend any solution. To do this each response, captured through a number of data sources including social media comments, discussion notes, meeting minutes and post-it notes from meetings, has been coded. These have been organised and analysed to cover the following areas based on the issues paper: the case for change, clinical vision for care, developing potential solutions, views on potential solutions, other considerations, views on process, alternative proposals and involving patients and the community.

It is noted that this is the first part of a longer process should formal consultation progress.

1.4 Summary of key findings

The below summary sets out the key findings from the engagement analysis.

- There is dissatisfaction with current health services and a recognition of key elements of the case for change, such as workforce challenges and the problems with current buildings.
- There was support given for the main areas of the clinical vision – such as the focus on integration and prevention. However, there were concerns over deliverability, specifically with regard to financial sustainability.
- There was not a clear consensus of the type of change that should be delivered, with comments made both in favour of consolidation of services and retaining the status quo.
- People tend to advocate for services they are familiar with and solutions that are closer to them with no clear consensus over a single site for acute services.
- There is a particular concern around the transport and accessibility between different sites, such as from St Helier to Epsom and vice versa. This included the need to consider bus routes, the impact of traffic on travel times, and the cost and availability of parking.
- It was felt that those who are perceived to be most in need - in particular older and less mobile people and those in areas of higher deprivation – would be most impacted by potential changes. Consideration of these factors was felt to be important when developing solutions.
- When consulting or engaging in the future, a need was expressed to use approaches and channels that allow all groups in the population to respond in ways that suit their circumstances. It was also felt that the process should be promoted more visibly and for clear, detailed information to be provided to ensure patients and communities can make informed contributions going forward.

1.5 Thematic findings

1.5.1 Views on the Issues

The *Issues Paper* posed key questions for people to consider. The common themes that were raised for each of these across all the engagement activities are summarised below.

The case for change *(pages 4-6 of Issues Paper)*
The key question for consideration was:

In addition to solving the challenges of clinical quality, financial deficit and poor quality buildings in our local NHS, are there any other challenges you think we may need to solve?

Key themes arising in response to this include:

- universal recognition that the buildings needed to be improved not least because of the impact on patient experience
- recognition of the workforce challenges that existed and needed to be overcome to ensure high quality care could continue to be provided

- the need for more transparency and information about the current situation and assumptions underpinning the case for change – especially those relating to finances – in order for patients and public to make informed comments about potential solutions

Our clinical vision for care *(pages 6-10 of Issues Paper)*
The key question for consideration was:

Do you think our vision, based on greater prevention of disease, improved integration of care and the delivery of enhanced standards in major acute services, is the right vision for this area?

Key themes arising in response to this include:

- broad support for the vision and in particular the benefits of integration of care and the need for more focus on prevention
- concerns expressed about how realistic it is to deliver the vision given current structures and ways of working, the financial situation in primary and secondary care and staff shortages across the NHS

Developing potential solutions *(pages 11-15 of Issues Paper)*
The paper describes the process used to come up with a shortlist of 3 potential solutions from a longlist of 78 solutions. This includes testing the longlist against three initial tests:

- does the potential solution **maintain major acute services within the combined geographies**?
- can the agreed **quality standards** for major acute services be met? This considers whether there is likely to be a **workforce solution**.
- from which **sites** is it possible to deliver major acute services? This considers whether different sites are feasible for the delivery of major acute services.

The key question for consideration was:

Do you think we should consider any other initial tests – apart from those described in this document – as we develop the long list of ideas into a final short list?

Key themes arising in response to this include:

- the importance of quality of care received - across the whole patient journey - as a test for consideration
- the need to take into account accessibility and transport infrastructure supporting the sites
- making sure the proposals are sufficiently future-proofed to take into account the needs of growing local populations and not just meet current needs

Views on potential solutions *(pages 11-15 of Issues Paper)*
The paper describes the three potential solutions in the provisional shortlist if the tests above are used:

- locating **major acute services at Epsom Hospital** and continuing to provide all district services at both Epsom and St Helier Hospitals
- locating **major acute services at St Helier Hospital** and continuing to provide all district hospital services at both Epsom and St Helier Hospitals
- locating **major acute services at Sutton Hospital** and continuing to provide all district services at both Epsom and St Helier Hospitals

Key themes arising from comments to these include:

- **Epsom Hospital** – arguments for major acute services to be located here focused on the fact that there is a building and land ready to accommodate this solution and it is accessible for people particularly in the Surrey Downs area. Arguments against included it being viewed as inaccessible and not easy to get to, especially for people in the Merton area.
- **St Helier Hospital** - arguments for major acute services to be located here focused on accessibility and closeness to more deprived areas. Arguments against included the fact that it is not accessible to people from Surrey Downs; is poorly maintained and would need a huge investment to refurbish; and that there are other more local alternatives if people needed to access acute services.
- **Sutton Hospital** - arguments for major acute services to be located here focused on it being accessible and well served by public transport networks, and having strong links to cancer services. Arguments against included that it was not accessible to people from Surrey Downs; that the road networks are often very busy; and that the lack of current provision would mean it would cost more to set-up.

Other considerations *(pages 15-16 of Issues Paper)*
The paper describes a number of other important considerations for patients, their families and carers that the CCGs will consider. These include: travel and access; impact on deprived communities; an equality impact analysis; and impact on other hospitals.

The key question for consideration was:

Do you think there are other important things we should consider as we take this work forward?

Key themes arising in response to this include:

- universal support that transport and accessibility are the most important things to consider particularly for those who are more isolated or less mobile
- making sure that the needs of people in deprived communities were understood and addressed
- making sure the needs of older people and people with disabilities were also met

Views on the process *(pages 16-17 of Issues Paper)*
The key question for consideration was:

Do you have any questions about the process we are proposing to follow or any suggestions for improving it?

Key themes arising in response to this include:

- the need for transparency and inclusivity around the decision-making process
- the need for open and honest communications about the potential solutions and the reasons why certain solutions were being proposed

Alternative proposals to address the challenges *(pages 16-17 of Issues Paper)*
The key question for consideration was:

Can you think of any other ways of tackling the challenges described in this document, within what the document describes as possible?

Alternative proposals identified included:

- keeping the status quo
- investing in transport solutions to make it easier for patients in less accessible areas (eg free shuttle buses between sites)
- looking at other ways to raise money (eg taxes, lobbying Government, etc)

Involving patients and the community *(pages 16-17 of Issues Paper)*
The key question for consideration was:

What are the best ways for involving our patients and community in developing ideas to address the challenges described in this document?

Key themes arising in response to this include:

- using and offering a range of engagement channels to allow different audiences to respond in ways that suited their circumstances
- promoting involvement at hospital sites, GP practices and other public places to reach patients as well as the wider community
- providing more detailed and clear information about the reasons for change to make sure people can make informed contributions.

2 Introduction

2.1 Background

NHS Surrey Downs, Sutton and Merton clinical commissioning groups (CCGs) are the organisations responsible for making decisions about how healthcare services should be provided in their local areas. Their stated aims are to provide the very best quality of care is available to their patients and communities and that these services are sustainable and fit for the future.

In order to achieve this, the three CCGs have come together to develop the **Improving Healthcare Together 2020-2030** programme which aims to:

- deliver care closer to patients' homes by integrating health and care services so they work together in the most effective way
- ensure high standards of healthcare by meeting the clinical standards set for the local area
- ensure services for patients with serious or life-threatening conditions are kept operating within the local area

The Improving Healthcare Together 2020-2030 programme builds on previous work and public engagement carried out by health commissioners and providers. The programme seeks to address three key long-standing challenges:

- improving clinical quality
- providing healthcare from modern buildings
- achieving financial sustainability

The CCGs are keen to involve the public throughout the process of developing solutions to meet these challenges. As a first step, they have published an *Issues Paper*, in Summer 2018, as a starting point for engagement and discussion with local people. The *Issues Paper* sets out:

- the key challenges facing the local health system in the combined areas and describes why change is necessary
- an emerging clinical model for the combined geographies based on clinical standards and evidence based best practice
- a provisional short list of potential solutions for consideration

More information about the Improving Healthcare Together programme including the Issues Paper can be found here: http://www.improvinghealthcaretogether.org.uk.

A number of engagement activities took place from July to September, to seek public feedback on the *Issues* Paper. This report is an independent analysis of the feedback received during this period.

2.2 The engagement process

NHS Surrey Downs, Sutton and Merton CCGs each developed tailored communications and engagement plans for getting feedback on these issues in their local areas.

The main forms of planned engagement throughout the period were:

- Discussion events – members of the public were invited to have their say at 6 discussion events in July and August 2018 (two in each of the CCG areas). These were independently facilitated by Traverse and discussion focussed on key questions raised in the *Issues Paper*. Following these, a further 6 discussion groups were held in September (also two in each of the CCG areas). These were also independently run by Traverse in a market place format with five 'workstations' focussed on: the programme; the clinical model and workforce; deprivation and equalities; travel; and evaluation criteria.
- Mobile pop-up events – 6 events (two in each CCG areas) were organised in public areas of high footfall to encourage local people to engage with the issues. Feedback was captured through a survey.
- Service user conversations on clinical model - 6 focus groups were organised and independently facilitated by Traverse with service users of maternity services; paediatric services and emergency services. These were supplemented by 6 depth interviews with people who had used A&E services.
- Equalities focus groups – Healthwatch Merton, Healthwatch Surrey and Healthwatch Sutton are organising 9 groups with different audiences including older people, carers, young carers, BAME and people with learning difficulties. NB: These will be reported on separately by the local Healthwatch organisations. The IHT programme have also organised targeted focus groups in areas with higher levels of deprivation, with the LGBT+ community and people in poor mental health. These will also be reported on separately.
- NHS employee survey – a bespoke survey was circulated to staff of each of the CCGs, Epsom and St Helier NHS Trust, GP practices and pharmacists. Although not analysed here, there was also clinical engagement with GPs and trust staff through Clinical Reference Groups and other forums.

People were also invited to provide feedback through:

- A feedback form – available online at http://www.improvinghealthcaretogether.org.uk. and in print format.
- Written submissions – in the form of letters and e-mails
- social media – comments were received through the programme's Facebook and Twitter channels

2.3 Feedback received

There is a record of the participation of over 800 people in the engagement process. The number of responses received from different channels is shown in Table 1. It should be noted that this does not account for the possibility of individuals being counted multiple times through involvement in more than one form of engagement, for example, attending more than one event or attending an event and making a social media comment.

Table 1: Responses to the public engagement

Method	*Total number of responses / events*
Public discussion events	12 events (296 attendees)
Mobile pop-up events	6 events (81 forms and over 70 engaged)
Feedback form (online and paper)	14
Service user focus groups (emergency care, maternity services and paediatric services)	6 events (50 attendees)
Service user depth interviews (emergency care)	6
Written submissions from individuals	12
Written submissions from organisations and elected representatives	4
NHS staff survey	205
Stakeholder Reference Group meetings	4 meetings
Social media comments – Facebook and Twitter	169 comments (57 Facebook and 112 Twitter)

NB: This table does not include attendance at the equalities focus groups being organised by local Healthwatch organisations and the IHT programme team.

2.4 Interpreting the response

The Campaign Company was commissioned to provide an independent analysis of the feedback received from the public engagement. This report sets out the findings from this analysis.

The methods used to collect feedback are designed to allow everyone to contribute to the engagement around issues, but the evidence collected is not representative of the population as a whole. For all of the engagement channels (other than focus groups where attendees were recruited), responses are self-selecting: only people who choose to attend give their views. Typically, in public engagement and consultations, responses tend to come from those who feel they are more likely to be impacted by any proposals and more motivated to express

their views. The responses must therefore be seen as representative of those who wanted their views heard.

Open questions and free text responses were analysed using a qualitative data analysis approach. All text comments have been coded thematically to organise the data for systematic analysis. To do this, a code frame was developed to identify common responses; this was then refined throughout the analysis process to ensure that each response could be categorised accurately and could be analysed in context.

It is important to note that where open text comments have been analysed using qualitative methods, these aim to accurately capture and assess the range of points put forward rather than to quantify the number of times specific themes or comments were mentioned. Where appropriate, we have described the strength of feeling expressed for certain points, stating whether a view was expressed by, for example, a large or small number of responses. However, these do not indicate a specific number of responses that could be analysed quantitatively.

The analysis has been presented thematically based on the method through which the responses were received.

The findings from this feedback, as well as other relevant evidence, will be used by the CCGs to inform any future review of potential solutions.

3 Analysis of discussion events responses

3.1 Introduction

Throughout the engagement period, a number of public discussion events, were held at different locations across each of the CCGs. These were held in two waves: 6 were held in July and August and sought feedback on the different subjects raised in the *Issues Paper*; a further 6 were held in September and focussed on detailed discussion around specific topics raised by the public in the previous events.

Each wave of discussion events is reported on separately. The key issues discussed at these events are summarised below.

3.2 Summary of responses from July / August events

Introduction

Six public discussion events took place in July and August across each of the CCG areas. These events were run by *Traverse*, an independent research company. The times and locations of these events were as follows:

- Monday 23rd July, 13:00, Epsom Methodist Church, Surrey Downs
- Tuesday 24th July, 13.30, Trinity Church, Sutton
- Wednesday 25th July, 18:00, Trinity Church, Sutton
- Thursday 26th July, 14:00, Chaucer Centre, Merton
- Thursday 26th July, 18:00, Epsom Methodist Church, Surrey Downs
- Thursday 2nd August, 18.30, Tooting and Mitcham Community Football Club, Merton

Discussion events comprised of table top discussions, captured through notes, with the opportunity for residents to ask questions and receive answers from members representing the IHT programme. The content of these discussions is summarised below.

Summary of responses

The case for change

A number of those attending the events did accept the case for change presented to them. A range of views were expressed in terms of financial sustainability, service demand, staffing, and the quality of buildings.

The financial challenges saw a significant amount of discussion. A number of attendees felt that services were stretched and mentioned hospital closures in the national context.

Current quality of care also received significant discussion. This focused largely around the personal experiences of attendees, such as difficulties in getting tests, poor standards of nursing, inability to access treatment, long waiting times, and low standards of care, although some did say that quality was improving.

In terms of the quality of the local NHS estate, many agreed that the buildings were old and needed refurbishing or replacing. They felt that changes to the population since they were built meant they no longer matched up with local needs. Others felt that the buildings were

in an acceptable condition or that existing sites should not be forgotten about if investment to converge acute services on a different site was made.

The challenge of securing sufficient staff numbers to match the demands of the area was also raised as well as the impact this was having upon care. There was also recognition that every hospital was struggling to recruit and that it might not be possible to improve the situation.

The clinical vision for care

General support was expressed for more prevention and better integration of care. It was viewed as playing an important part in reducing demand for the most overstretched parts of the local health system. However, there were a number of comments highlighting the practical problems in keeping people out of hospitals given GP closures and generally perceived poor signposting of local primary care services.

Questions were raised over how healthcare providers would liaise better, share records quicker, deliver a more personalised service, and how social care providers would be integrated into the system. Comments also included scepticism that there was not sufficient capacity and numbers of staff available to deliver the vision which had been set out.

Others also expressed the view that the vision was wrong if it involved the reconfiguring of acute services.

Some attendees also raised youth mental health services and patient choice as areas which did not appear to have been expressed as part of the vision, and a question around how the whole programme fitted into the bigger picture of the STP.

Some put it into a national context of stretched NHS budgets and consequent hospital closures. Objections to using private money to solve issues was also raised.

Developing potential solutions

Comments relating to what should be taken into account when developing solutions included the importance of considering: the needs of different populations; transport and access; financial sustainability; the impact on other hospitals; and quality of care.

Comments on assessing the needs of populations included reference to future population growth, with some areas experiencing faster population growth than others; and the demographics and level of deprivation affecting health service needs.

Assessing transport times and accessibility was mentioned by a number of attendees with specific reference to reviewing bus times, Tramlink services and road congestion.

The importance of a solution being financially viable was mentioned with concerns over whether the funding has yet been secured for the proposals. Concern around the cost of new buildings compared to renovating or maintaining current buildings was mentioned.

The quality of care was mentioned by some attendees, with reference to care quality standards and the need to balance this need with that of cost. The number of beds was also mentioned as an important criterion.

It was suggested that staffing would be impacted by which area was chosen.

At Merton events, attendees specifically suggested that the desirability of the site and the local area to staff and the cost of building and demolition should not be used as evaluation criteria.

Views on potential solutions

A large number of views were expressed over the three potential solutions in the provisional short list described in the *Issues Paper.* Comments focused on accessibility to the different sites with a preference for more local services expressed by attendees at events held at each location.

Arguments for Epsom Hospital

Epsom was described as being more accessible and better for residents in living in Surrey. Sutton Downs and Sutton attendees mentioned that the presence of an existing hospital was seen a benefit in terms of reducing costs and minimising disruption, with land readily available for expansion.

The proximity to the M25 was highlighted as another potential benefit by Sutton and Surrey Downs Attendees.

Attendees in Sutton mentioned a concern that losing major acute services in Sutton could cause capacity problems for nearby hospitals such as Kingston Hospital.

The geographical area covered by Epsom was described by Surrey Downs attendees as spanning a larger area than other potential solutions. Reference was also made to deprived communities being located close to Epsom Hospital.

Arguments against Epsom Hospital

Accessibility to Epsom Hospital, especially by public transport was described as challenging for those living in areas such as Merton especially by attendees at Sutton and Merton events. There was reference to the hospital being outside the Oyster Card zone, having little public transport access for large parts of the affected population.

Locating a single acute service at this hospital was also felt by some to be a particular disadvantage for those living in more deprived areas.

The condition of buildings was criticised by some and there were questions raised over whether the NHS's land had been sold off and also about the high cost of acquiring new land in the area.

The cost of living in Surrey was also seen as a potential disadvantage in trying to recruit staff.

Arguments for St Helier Hospital

The main comments in favour of a St Helier Hospital site were the proximity to an older, more diverse and more deprived community, who might struggle to access the other sites. Inequality in the north of the catchment area was mentioned at events in all CCG areas. Some respondents described the site as having good public transport links and road infrastructure.

Merton attendees felt that the lower cost of housing in the area might make it easier to attract staff.

The existence of a current hospital on the site was described as providing an opportunity to minimise disruption and be more cost effective.

A view was expressed that the condition of the buildings was not as bad as others had claimed and that it had been deliberately run-down.

The impact on neighbouring hospitals such as St. George's in Tooting, if major acute services were no longer provided there was also mentioned.

There was a view at events in Merton that buildings were in better condition than was generally reported.

Arguments against St Helier Hospital
Transport and accessibility was felt to be poor by attendees, especially those attending Surrey Downs events. Comments included that parking is limited, roads are often congested, and uncertainty over a Tramlink.

The condition of the buildings was a cause for concern for many attendees, with feelings that it would cost more to improve than other hospitals and that there would be limited room for expansion.

Attendees in Surrey Downs mentioned lack of public transport links from Surrey Downs to St Helier.

Some attendees felt that the area was more unattractive and consequently would put staff off joining the hospital.

Arguments for Sutton Hospital
Some attendees felt that the site would be accessible both in terms of road networks and public transport. Some comments also felt that the population in Sutton had high needs in terms of age and socio-economic need.

Connections to the Royal Marsden Hospital were seen as a potential opportunity to strengthen links with cancer services, with the possibility for more efficient referrals between them.

It was mentioned by some attendees that there was empty land available for the hospital, potentially making the process of locating acute services there easier, less disruptive and cheaper than building on an existing site.

Arguments against Sutton Hospital
Transport and accessibility challenges were mentioned by a number of attendees. These comments mentioned the lack of bus routes and traffic and congestion.

The area around the hospital was described as having lower health needs due to being wealthier than areas in more northern parts of the combined geographic areas.

Due to not being a current hospital, the lack of any current community connection to the facility and potentially higher costs to deliver the new facility were mentioned by some attendees. There was also uncertainty expressed as to how provision would be coordinated with the Royal Marsden Hospital.

Other views on possible solutions
Some attendees gave a preference for retaining the status quo or making more minor changes. The main argument made was the importance of retaining services closer to patients.

There was a concern that changes could be part of a wider privatisation agenda. There was also a concern expressed that once a hospital no longer had acute services this could be a stepping stone to being closed, with a reference to Ealing Hospital being made.

Attendees also mentioned the specialities built up in current hospitals that could be lost through changes.

There was also criticism about the geographical catchment area being used.

Other considerations
Attendees gave a number of suggestions of issues that they felt should be also considered. These centred around travel and access and the impact of changes on people with disabilities, less mobile and disadvantaged patients.

Concerns relating to travel and accessibility included: concern about the physical distance of their home to the proposed services, how central each site is to the catchment of the three CCGs; the quality of road infrastructure and public transport to that site; traffic levels; and the impact upon those who lacked access to a car or the ability to afford a taxi. Specific comments on transport links include that there are not good links between Epsom and Sutton; that trams are more reliable than buses so sites served by trams are easier to access quickly; and experience of travelling from alternatives, such as St George's from St Helier, being over an hour.

The importance of considering parking, both in terms of amount of parking available and cost, when reconfiguring services was also mentioned.

A number of comments connected to transport and accessibility, with concerns about the impact on these different groups. The impact of changes on older groups was mentioned. Comments included: that since Epsom is not in the Oyster Zone, older patients would not be eligible to free travel. Also the need to consider how easy it would be for carers was mentioned.

There was a focus on how changes would impact on groups perceived as more deprived and more diverse, for whom St Helier was their local hospital. Comments referenced health inequality concentrated in the St. Helier area. However, some in Sutton were of the view that the Sutton area had a more elderly population across a more dispersed area who would benefit from more centrally provided services.

The potential impact of all the proposed solutions on others hospitals, such as Kingston Hospital and St George's Hospital, was also raised.

Additional considerations include: the impact on younger people; how Brexit could impact on the stockpiling of drugs and availability of capital; the impact for people for whom English is

second language who may have additional challenges negotiating a complex system; and the requirements of ex-military populations.

Views on the process

There were a number of comments on the process conducted so far and proposed next steps. These included: transparency around decision-making; the level of engagement in the current process and in the past; and the importance of clear information.

There was a fair amount of cynicism expressed, based upon the level of engagement which had taken place around potential restructures in the past. It was felt that this had led to a level of engagement apathy, with a feeling that the process was taking too long and that the results of past processes were not being listened to because they had not produced the outcome decision-makers had wanted. A number of comments were made as to the cost involved in the process and a perception that it was wasteful expenditure.

In commenting on the existing engagement process, it was felt that a number of community groups had not been reached out to and that those living in deprived areas had not been adequately engaged. It was felt that there had been insufficient publicity around the events, with other concerns including their timing. location, poor parking arrangements and the semi-structured nature of the discussion. Specifically, it was mentioned that the events being held in the summer holidays meant some people were not able to attend.

At several points the importance of highlighting the distinction between a hospital losing a service and it closing was raised due to concerns it might confuse the public. There was also a view that mixed messages were being given, with refurbishment work taking place at St Helier while the engagement process was ongoing. One attendee objected to the programme's name, feeling that it was too abstract.

With regards to CCGs and Trusts, attendees had concerns over the nature of each set of structures, who was driving the process and whether the visions of each were aligned. The risk of having too many organisations involved was also raised. However, there were positive comments around the leading role of clinicians in the process and that they were more likely to get it right when deciding where to locate service

Attendees also mentioned the need for clear information to be provided. It was mentioned that there was a need to clearly explain what acute services meant and the differences between CCG's and hospital trusts.

There were a number of views expressed about next steps. These included: that those attending the sessions should see feedback on the interim findings; the need for more data evidencing the case for change to be published; for the process to date to be mapped out; for clarity on timelines; for the output from earlier engagement processes to be incorporated into the decision-making process; for the output from earlier engagement processes to not be incorporated into the decision-making process; and for the CCG to take all views into account including non-medical arguments, such as community pride.

Alternative proposals to address the challenges

Alternative proposals to address the challenges from attendees included: building a cottage hospital between Epsom and Ewell to serve the local community; making hospitals more

efficient; using NHS-owned land to deliver keyworker housing to recruit more members of staff; training more doctors and nurses with more affordable fees; building a heliport to help with traffic delays; using polyclinics to take the pressure off hospitals; and providing step-down services to reduce bed blocking.

Involving patients and the community
Attendees made a number of suggestions for involving patients and the community in further engagement activities.

The importance of involving hard-to-reach groups was made by a number of residents, including young people, those suffering from chronic illnesses, individuals living in deprived communities and residents with long working hours. In tackling this it was suggested that a number of groups were approached directly to try to secure their input into the process, such as Black, Asian and Minority Ethnic groups, carers forums, pensioner associations, Patient Participation Group's, Special Educational Needs and disability organisations (including Swail House and Seeability for the blind).

Recommendations for wider public involvement included: approaching organisations with local expertise and a more general reach into the community, residents' associations, religious organisations, housing associations, youth clubs, playgroups, local authorities, voluntary organisations, and schools.

More events like these were felt to be a good idea by some, with a proposal that different times and locations were selected. They also felt the process should be advertised more widely. Suggestions for advertising the process included placing flyers on community noticeboards and advertising or engaging at GP surgeries, outpatient departments, libraries and major shopping locations. It was also felt that local magazines/newspapers, school newsletters, fostering newsletters and newspapers for the blind would help to spread the word.

Other suggested means of reaching out to the community included: talking to patients in each hospital; sending a leaflet to every household in the area; canvassing houses in areas with low response rates; and using new media. The risk of excluding parts of the community through focusing on online advertising or by using excessively complicated language was also raised as considerations.

Attendees also expressed the view that they would like to see more data or more detail of what is being proposed before coming to a firmer position as to whether or not they support them.

3.3 Summary of responses from September events

Introduction

Six discussion events ran in September 2018 These were independently facilitated by Traverse. The times and locations of these events were as follows:

- Wednesday, 12th September, 19:00-21:00, Sutton Masonic Hall, 9 Grove Road, Sutton SM1 1BB
- Tuesday, 18th September, 19:00-21:00, Commonside Community Development Trust New Horizon Centre, Mitcham CR4 1LT

- Wednesday, 19thSeptember, 10:00-12:00, The Thomas Wall Centre, 52 Benhill Avenue, Sutton, SM1 4DP
- Wednesday, 19th September, 19:00-21:00, Bookham Baptist Church, Lower Road, Great Bookham, Leatherhead, KT23 4DH
- Thursday, 20th September, 14:00-16:00, Banstead Methodist Church, The Drive, Banstead, Surrey, SM7 1DA
- Tuesday, 25th September, from 19:00-21:00, The Parish Centre, Mitcham, London, Mitcham CR4 3BN

The objectives of these events were to:

- inform attendees about how the programme has evolved since the Trust engagement last year and how it will proceed, including since July/August events
- explore in more detail the areas of most interest raised in the summer events
- collect feedback on the evaluation criteria that will inform the selection of proposals for the pre-consultation business case

The events used a 'marketplace' format with a number of stations for attendees to discuss different areas in turn. These areas where selected following the July/August engagement. The stations consisted of:

- Introduction - this set out what happened in July/August and was an opportunity for general questions
- Deprivation - with information provided about how the impact on deprived communities is being analysed
- Clinical model and work force - with information provided about how the proposal will change the way services are delivered
- Travel - with information provided about the impact on travel times is being analysed
- Evaluation criteria - with information about the decision making process that will help choose a potential solution

Attendees views and questions were recorded through notes from discussions and post-it notes completed by attendees. The record of these was used to provide the summary of responses below.

Summary of findings

The outputs of each discussion event have been analysed and using the issues framework of the *Issues Paper* to ensure consistency in reporting.

The case for change

Some elements of case for change were accepted by attendees. Key challenges around financial sustainability, staffing, and service demand pressures were mentioned.

Attendees described increased demand and budget cuts as placing pressure on current services. Challenges relating to financial deficit of the hospital trusts was also mentioned.

Comments on specific services included mention of demand pressures with pharmacy services; the need for more carers; the standard and frequency of staff training and quality of patient care; provision of Children and Adolescent Mental Health Services (CAMS); availability

of physiotherapy services; and the closure of Epsom Secure Unit. It was mentioned that service pressures in the health sector were in the context of wider public service cuts in areas such as fire and police and social care.

The condition of the St Helier Hospital building was also mentioned, with attendees referencing its poor condition.

There were a number of comments relating to the need for more staffing. Attendees referred to a need for more doctors and consultants in general as well as a view that the quality of care and training to support this needed to be improved. There was reference to staff conducting training in their own time.

Clinical vision for care

There were a number of comments that related to the clinical vision for care with general support expressed in favour of prevention and integration. A large number of comments provided suggestions for additional elements to consider or areas to prioritise as part of this, rather than either showing support or opposition to key elements of the clinical vision.

Key areas of comments include: further ways to achieve a preventative approach; views around integration and consolidation of services; and factors relating to the quality of care. There were also concerns over the deliverability of the vision in terms of staffing levels and financial sustainability.

Attendees referenced a range of different ways to focus services based on prevention. Models such as social prescribing that utilised the voluntary sector were viewed as important, as well as changing services to have greater involvement of the community. Ensuring better investment and connection with other services such as nursing, alcohol and drug dependency care was also mentioned. Examples cited include the involvement of community and voluntary groups with regard to issues such as loneliness and social isolation to reduce admittances.

Additional comments were made that referenced wider preventative factors such as the importance of healthy eating, the role of education on health, and that community days could foster better health outcomes.

Different views were captured that relate to the integration of care. Attendees supported wider integration with services such as GPs and health and social care, as well as related services such as job centres and social services.

Some comments were sceptical about the model being proposed, commenting that it would be less efficient to have district services in a hospital without acute care services whereas other comments suggested that the acute and district model seemed the correct approach. In one group in Surrey Downs there was a broad consensus around consolidation of services. Another comment suggested that integration should provide a way to assess what people need and provide services responsive to this.

Specific comments were made with regard to maternity care. One comment stated that there is no evidence that concentrating maternity improves outcomes. Another questioned why maternity is included under acute services when a lot of births are straightforward.

The importance of mental health as an area related to the vision was also made.

The way acute services interact with ambulances transfers was also raised as relevant to the clinical model.

A number of factors were mentioned as being important to realising clinical aims for improved acute care standards. These included: the importance of new buildings with facilities required for modern healthcare services; relationships with staff; specialisation of staffing; focus on reducing waiting times; having more beds and places; having all tests available; and following the Kings Model for staff handover.

Developing potential solutions

A significant focus of discussion across the events centred on key factors that should be considered when assessing potential solutions. This was the particular focus on the station on evaluation criteria that considered which tests should be included. The main areas of comment related to: how the different geographic areas could be covered and how plans meet capacity demands; workforce and staffing requirements; the feasibility of different sites; and the standard of care.

A number of comments related to the importance of assessing the population of different areas currently, and anticipated future population growth; as well as factors such as housing allocations and local planning. Specific comments about population growth in different areas included reference to the need to meet maternity service demands due to a higher birth rate in the Mitcham area; the impact of immigration in Surrey; new dwellings that have been built in Hackbridge; and that the Epsom population has grown. There was an additional comment around the combined geographic areas that it felt odd that the catchment area went over regional boundaries.

A key factor relating to which sites could deliver major acute services was transport. Attendees recommended the need to forecast travel traffic in the future once population increases had increased congestion; considering ambulance transport as the most important form of transport for acute services; not analysing travel times based on timings for a young, healthy person; considering frequency and ease of public transport services; considering staff travel; looking at public transport in terms of the number of transfers; modelling based on an ageing population; and considering transport in different weather conditions.

Workforce capacity and staffing was also a frequently mentioned factor. A number of comments stressed the importance of attracting and retaining the best staff and ensuring that staff are not over-worked. The importance of attracting staff with the right attitudes was also mentioned with the need for them to treat patients with respect, treat patient's equality, and also not pursue regulations at the expense of quality of care. It was argued that staffing levels are key to efficiency, with agency staff costing more if adequate staffing levels are not in place.

Whilst quality of care was mentioned as the most important factor for a number of attendees, mixed views were recorded as to different rankings of criteria. Comments included: that attachment to places should come second to the priority of safety and having good care; that having acute services closer to people is most important; that clinical outcomes should come first, then safety, then patient experience; and that having a centre of excellence is most important even if further away. The need to consider meeting targets for

the number of beds as part of quality standards was also mentioned as well as the need to meet the 7 days standard.

Other factors for inclusion as key criteria include: the amount of capacity available; financial sustainability; efficiency; the importance of relationships with doctors; the time that district services will be open; and whether wider services such as social services are in place before changes take place.

Views on potential solutions

Arguments were put forward in favour and against locating major acute services at Epsom Hospital, St Helier Hospital and Sutton Hospital. These often centred on transport and access challenges of reaching particular hospitals. There were also concerns expressed about all proposed changes.

Arguments for Epsom Hospital

The main argument in favour of the Epsom site was made by attendees at Surrey Downs events that felt St Helier and Sutton sites were too far away and would be hard to access. The different barriers to access are noted in the arguments against the other sites.

At the Surrey Downs events, Epsom Hospital was described by some as being the geographic centre of the area and easy to get to for those in the area. Connected to this, it was also argued that for capacity reasons, a case could be made for an additional new hospital in Surrey.

At Surrey Downs events', satisfaction with Epsom Hospital was expressed by some attendees. One attendee mentioning visiting Epsom for two years and being very satisfied and another mentioned that they felt the current system works well and that the community hospital in Epsom works effectively with Epsom Hospital.

An additional comment made at Surrey Downs events was that Epsom might be a more attractive place for clinicians which may help with staff recruitment.

Arguments against Epsom Hospital

Attendees at Merton and Sutton events argued that transport and accessibility to Epsom Hospital would be challenging. Epsom was described as having poor public transport access and congested traffic to get to the hospital. Specifically, transport between St Helier and Epsom was described as being poor by Sutton and Merton event attendees. Car parking was described as expensive.

Other comments made included that Epsom hospital has had 20% of the land sold off and would be expensive. There were mixed views over whether there was enough space for this option to be feasible.

Arguments for St Helier Hospital

Arguments in favour of locating major acute services at St Helier Hospital focused on the accessibility of the hospital for current residents alongside the proximity to areas of higher deprivation and health needs and lower life expectancy such as Mitcham. Specifically, attendees mentioned that the population in the area has lower levels of car use and those in areas such as the St Helier estate would be impacted most if acute services were moved to another hospital.

Pride and connection to St Helier Hospital alongside public support for acute services to remain at the hospital was mentioned. Accessibility of the Hospital was remarked on positively.

Attendees mentioned that St Helier has cheaper accommodation options that may assist with staff recruitment which might not be feasible in other locations.

Arguments against St Helier Hospital
The main arguments made against St Helier regarded transport and accessibility. Surrey Downs attendees described St Helier as too far away and difficult to access. Examples include, that it would take attendees 1.45 hours to get to St Helier and that public transport from Cobham would require three buses. Parking including disabled parking and bus services were described as poor at St Helier.

The sale of land for a school and the cancer hub was felt to mean there would be large amounts of traffic and congestion.

Arguments for a new Sutton Hospital
Arguments in favour of a new hospital being built in Sutton included the comment at events in Sutton that there would be a benefit of building alongside other services.

Against a new Sutton Hospital
The site was described as being difficult to access by attendees at all events. Access and traffic was mentioned, with an attendee in Merton estimating that it would take an hour to get to Sutton. The nature of the area and congestion at times such as the school run was mentioned.

Sutton was described as an affluent area at the Merton event with comparisons given to areas such as Mitcham. There was also concern that there would be private funding as part of a new Sutton Hospital.

Other views on possible options
There were a number of broader concerns that refer to all options as well as support for maintaining the status quo. These focused around the number of beds, the structure and financing of healthcare as well as how a single hospital would cope with the pressure. Concern about increased waiting times was mentioned in this context.

A concern expressed at a number of events centred around whether changes would mean privatisation, with private hospitals taking up places in buildings or payment being required for services. Connected to this, there was a view that the changes would be part of a reduction in NHS services in general which would impact negatively on patient safety and health outcomes. There was specific mention of concern that Marsden would go private and there would be private funding for a Sutton Hospital.

There was also a view that all the services across the three hospital sites should meet 21st standards not just acute care services.

There was a view that focus on primary rather than acute care would have a greater impact on health outcomes.

There was also concern over the finances of different hospital trusts. Sutton deficits were mentioned in Surrey Downs.

Other considerations

Attendees suggested a number of additional considerations. These focused on: travel and access to the different sites; the impact on deprived communities; impact on other hospitals and services; mental health services; and the importance of age as a factor.

A number of comments mentioned the transport needs of different groups of service users. There was a concern that older, less mobile and less affluent people would find it harder to travel further distances to reach hospitals. Specific comments included: that older people are more reliant on buses, that small changes such as how far away bus steps are from hospital can make a big difference, and that station steps can cause barriers.

Attendees mentioned the need to consider accessibility for family members - with receiving visitors described as aiding recovery for patients. Attendees also mentioned the need to consider how factors such as potholes and weather could impact on timings, and the need for public transport services to cover different times and be fully functioning on Sundays. The need to analyse the impact of change on community transport was also mentioned.

Attendees in Surrey Downs commented on the lack of public transport options in more rural areas and that the routes to alternative sites should be considered.

Parking was felt to be an important consideration by a number of attendees. The need to have adequate spaces, especially for blue badge holders, and that costs for parking for less affluent patients was viewed as an important consideration.

The importance of considering how changes would impact on deprived communities was discussed at a dedicated workstation at each event. Attendees suggested further consideration on a number of aspects of this, including: how deprivation correlates with density; how deprivation is defined; how the work should link to the research of Richard Wilkinson in the book The Spirit Level; how there were pockets of deprivation even in the most affluent areas; that carers as well as older people should be included in analysis of deprivation; that a definition of deprivation should include more than just income; and that inequality and housing were key factors linked to deprivation. However, there was scepticism from one attendee that deprivation is used as a front for other motivations.

Other issues were raised that relate to deprivation, including: homelessness (specifically in relation to Merton); education; employment; and the impact of universal credit issues on people with learning difficulties. Social isolation was also mentioned as an important issue to consider.

There were different views about which areas were most deprived and how this relates to the location of services. At events in all areas, Sutton and the more northernly areas were described as having more deprivation. At the Merton event, it was commented that areas such as Pollard Hill and Mitcham have higher deprivation. At the Surrey Downs event comments included: that although the area is prosperous, there are food banks and areas such as Preston and Court Lodge are more deprived parts of the area. At a Merton event, Pollard Hill and Mitcham were described as having lower life expectancy than Sutton and Epsom, with foodbank use in Pollard Hill mentioned.

The importance of mental health services was mentioned at a number of events. Comments included: the need to factor in the demand for mental health services; that there is currently insufficient provision of mental health services; that mental health services are linked closely to A&E and ambulance services; the need for 24/7 or longer hours services relating to mental health; and that there is a need for more training for staff around mental health. At the Surrey Downs there was mention of crime in the area and a view that this was linked to the increase in mental health illness in the area.

Age and disability
The impact on older people and patients with disabilities was specifically mentioned by number of attendees. Comments mentioned the different service and access needs of different ages, the impact of a high percentage of older people living alone, and the need for care pathways for effective discharge from hospital.

Impact on other hospitals
There was a concern about how changes would affect other hospitals. Attendees suggested there is a need to consider the impact on St George's Hospital, Croydon University Hospital, other service services, and the Royal Surrey Hospital. Attendees in Merton in particular mentioned using St George's Hospital.

Process
Attendees made a number of comments about the process conducted so far and the proposed next steps. These focused on how information is presented, particularly around funding, and how the decision making should be conducted.

A comment made by a number of attendees was that it felt that a course of action was already being prescribed since at least one acute hospital would no longer be providing those services and beds would be lost as a consequence.

More clarity and information was requested around a number of areas, such as around the evidence that informed the *Issues Paper*; where funding was coming from and how this would be secured; and the timeline for the process. Comments were made that the issues paper was not clear enough and that it should refer to a viability case rather than pre-consultation business case.

There was a view expressed by attendees that the decision has already been made. The sale of land in Epsom and St Helier was cited as evidence of this. Another comment made was that it felt that the decision is being rushed. There was also interest in who would be making the final decisions.

The need for a process for independent scrutiny of the proposals that included patients was also suggested.

Alternative proposals to address the challenges
A range of alternative suggestions to address the challenges were made. These included: increasing taxes to pay for the NHS and social care; reducing outsourcing of services to save money; putting pressure on the government or lobbying to improve services; saving money through less outsourcing; and in Sutton it was suggested that St Helier should be rebuilt instead. Specific suggestions in terms of travel and access included investing in hospital

shuttle buses as part of any proposed changes and free car parking for patients, staff and patients with disabilities through a ticketing system.

Involving patients and the community

There were a number of issues raised relating to the engagement and involvement methods used so far as well as ways of involving patients and the community in the future.

Attendees comments around engagement so far focused on groups that have not been engaged so far, that the reach of engagement has not been wide enough, or comments on specific engagement activities and materials. The timing of consultation events in August was criticised due to people potentially being away and unable to attend at this time of year.

The programme document was described as being not easy to read and dishonest and the language used in reports and video as misleading. Attendees described hearing about the events through email and Twitter.

There were mixed views about the format of this set of discussion events. While some enjoyed the opportunity to visit different stations, others stated they would have preferred to stay in the same place or attend a larger public meeting with a Q&A rather than discussions. The venue for the event on the 12th September 2018 in Sutton was criticised with the civic centre proposed as a preferable alternative.

A range of different channels and mentioned as ways to engage patients and the community in the future. These include: promoting engagement on the back of hospital parking tickets; an SMS mailshot; leaflets at hospitals, GP practices and mail outs; daytime events; a hospital feedback box; direct engagement with deprived people; door knocking to reach those most at risk; direct engagement on the St Helier estate; and an email via schools.

Suggestions for future materials included providing colour-blind maps, clearer materials, and greater explanation of funding.

4 Analysis of service user conversations on clinical model

4.1 Introduction

During the engagement period, Traverse were commissioned to independently facilitate focus groups with services users from three acute services: accident and emergency (A&E); maternity services and paediatric services. In addition, 6 depth telephone interviews were conducted with residents who had used St Helier or Epsom Hospital A&E services in the past 6 months.

The groups were designed to get feedback on how the proposed solutions might impact on them as service users. Attendees were also asked how they would like to be involved in future discussions. (Note: there is currently no acute service provision at Sutton).

The key issues discussed for each of these service areas are summarised below.

4.2 A&E focus group and interview responses

One focus group was held with 8 users of the A&E unit at St Helier and one group was held with 8 users of the A&E unit at Epsom Hospital. 6 people were interviewed by phone. Attendees were asked to comment on how the potential solutions would affect them personally and how they would affect other users.

Overall comments on potential solutions

There was concern that locating acute services to one of the three hospitals only would place more pressure on the 'chosen' hospital for example, increases in waiting times at A&E (especially based on current experience). Some also thought that there would be pressure on the ambulance service with people potentially misusing ambulances because they would not be able to get to the hospital using normal transport.

There was also a view that if these solutions were being proposed to alleviate pressure on A&E services then there should be more education to stop people using A&E as a 'walk-in' centre. This included improving booking systems for GP appointments instead to encourage people to go there in the first instance.

There was a feeling that the status quo should remain – the services were well established and money should be spent on improving them instead.

Some also felt that the needs of older people should be taken into account when considering the solutions. It was recognised by people in both groups that there was probably an older, less mobile population near St Helier.

Views on Epsom Hospital

People who were familiar with the hospital had a preference for keeping all acute services there. They felt it would be a cheaper option of the three since it was cleaner / needed less refurbishment than St Helier

It was mentioned that retention of A&E here was important since it was the only trauma centre near the M25.

Users of St Helier were concerned about going to Epsom Hospital as an alternative – especially if they have to rely on public transport. Parking was also cited as being expensive.

Views on St Helier Hospital
While some recognised that St Helier had a poor reputation and felt run-down, it would still be a loss to the community not to have easy access to A&E services. Of those who has used it, they praised the quality of staff and care that they had received. Their preference was to invest in the infrastructure to improve the buildings.

Population growth in the area was expected so many felt that acute services should stay there.

People familiar with Epsom Hospital were not pleased at the prospect of going to St Helier – they cited the distance, its reputation and its state of disrepair as key factors. Some felt that even if it became "a shiny new place" that people would not go there.

People also felt that parking was not good at St Helier.

Views on Sutton Hospital
Some people in both groups felt that Sutton Hospital could also be a suitable alternative for them. They saw the benefits of building a new hospital there and felt it was fairly central. However, there were concerns raised about the levels of traffic.

There was concern that if there was a new hospital in Sutton that there would no longer be investment in St Helier or Epsom Hospitals.

Involving patients and public in the future
People welcomed the opportunity to take part in discussions like this – they had learnt more about the process and it was interesting for them to look at issues from other people's perspectives. They felt there should be more opportunities like this.

Other ways of giving feedback were raised including surveys, forums with elected representatives, etc.

The need to give feedback to attendees was also mentioned.

There was a comment raising scepticism about public involvement because they felt the weight of financial decisions was much stronger than that of 'public voice'. Only one attendee would not take part in future events.

4.3 Maternity focus group responses

Drop-in sessions were held at Newminster Children's Centre (close to St Helier's) and the Epsom Sure Start Centre. 19 people were interviewed. Some of the attendees at the Newminster Children's Centre had language or other communications issues but trusted third parties brokered the conversations.

Overall comments on potential solutions
People in Newminster had slightly more pragmatic views on the solutions – some used neighbouring hospitals such as Kingston Hospital, Queen Mary's Hospital and St George's Hospital so did not feel they would be impacted by this. Some others felt that as long as they could get somewhere then it would not be an issue.

Travel and childcare were seen as important considerations when making a final decision about potential solutions. It was recognised that many of the people near both the St Helier and Epsom areas did not drive so a more local solution was preferred. Making sure the place was accessibility to family visitors was also cited as being important.

There was also recognition that if there was going to be change then this should be communicated widely to avoid confusion among people at critical times.

Views on Epsom Hospital
People who were familiar with the hospital had a preference for keeping all acute services there because it was more local. Positive experiences of the maternity services were also mentioned including the fact that it was compact and family orientated.

However, even though it was cited as a preference there was still a concern that if all the maternity services were located there, then it would become even busier and more chaotic than usual.

Potential service users near St Helier were concerned about going to Epsom Hospital as an alternative because of the time and the cost to get there. They felt this would not be suitable for vulnerable and deprived families. There was also a recognition that people who were more likely to use that hospital needed access to translation services which they may not be able to get at Epsom. Merton residents said they would probably use St George's Hospital as an alternative but this would increase pressure on that hospital.

Views on St Helier Hospital
People who had used the services there praised the high quality care and service and good waiting times at St Helier's (comparing it with bad experiences at Croydon and elsewhere). They had been concerned about the potential changes planned at the hospital which they had previously heard about through the *Keep Our St Helier's Hospital* campaign.

People familiar with Epsom Hospital were not pleased at the prospect of going to St Helier – they felt that travelling further away would cause more distress / stress for the mother and her birth. They also felt it would be more expensive to get too. Parking was also seen as problematic. Some people mentioned its' reputation and 'state of disrepair'.

Views on Sutton Hospital
Some people in the St Helier group felt that Sutton Hospital could also be a suitable alternative for them.

People in the Epsom group were not too keen and one had a friend who had contracted an illness during childbirth at Sutton Hospital in the past so they were cautious.

Involving patients and public in the future
People felt that face-to-face discussions at places where 'mums to be' would be at such as children's centres should be used in the future.

Communicating with people on apps or social media groups such as WhatsApp groups or Facebook groups was also suggested.

Leaflets were not felt to be a good form of communication with this busy audience.

4.4 Paediatric focus group responses

One focus group was held with 7 parents of users of paediatrics services at St Helier and one group was held with 8 parents of users of paediatric services Epsom Hospital. Some of the conditions that their children needed specialist support for included autism, Down's Syndrome, diabetes, cancer, ADHD and anxiety. Attendees were asked to comment on how the potential solutions would affect their families personally and how they would affect other users.

Overall comments on potential solutions
There was concern across both groups about the impact of all the solutions on travel times and potentially increased waiting times (both to get an appointment and to be seen on the day). This could also impact on their children's education since they would have to be taken out of school for longer periods of time to accommodate hospital visits.

It was also felt that any change would be particularly difficult for their children to understand or adjust to.

Some questioned why acute services were being 'merged' rather than district services – they felt that any changes to the latter would be easier to accommodate.

While the benefits of having specialist services in one place (a "super" hospital) was recognised, there was also a feeling that the scope of paediatric services was so vast that patients might lose out from centralisation and that there would be a benefit in retaining both sites. Some also felt that "super hospitals" would work if they were centrally located but none of the proposed solutions were.

Members from both sets of service users stated that they had been concerned about proposed changes before attending the discussion groups: some members of the St Helier group had signed up to the *Keep Our St Helier Hospital* campaign and members of the Epsom group had heard murmurings that the land at Epsom Hospital was being sold. They felt that it was important to have clear communication and information about changes from trusted sources.

Views on Epsom Hospital
People who were familiar with the hospital were keen to continue to use services there. They did recognise that people from St Helier might struggle though, and that it was outside the 'Oyster Card' zone so could be more expensive for them.

Users of St Helier were concerned about going to Epsom Hospital as an alternative because they felt it was too far. The cost of parking, as well as the limited parking (only 6 disabled parking bays was mentioned) was also a cause for concern.

Views on St Helier Hospital
Accessibility by transport and free road parking were mentioned as positive features of St Helier Hospital.

There was concern by some who used services there regularly that there would have to be a huge investment to cope with the additional demands on the system if they were to take on additional acute services.

People familiar with Epsom Hospital were not pleased at the prospect of travelling further to go to St Helier. They thought the unfamiliar surroundings would also destabilise their children.

People also felt that parking was not good at St Helier.

Views on Sutton Hospital
There was question about whether Sutton Hospital was a viable option given the fact that there was not an existing infrastructure to support paediatric services in place. The construction of a new school at the Sutton Hospital site (mentioned by both groups) also made some people feel that the Sutton Hospital site was not an 'honest' option.

Involving patients and public in the future
Channels such as Facebook and What'sApp were mentioned as ways of promoting involvement opportunities in the future. Promoting engagement at GP practices and other health-settings was also mentioned.

5 Analysis of pop-up events responses

5.1 Introduction

Over the course of the consultation period 6 mobile pop-up engagement events were held in public locations across the footprint of the three Clinical Commissioning Groups to secure greater involvement in the process from the wider community. These events took place on:

- Saturday 8th September at Mitcham Market
- Monday 10th September at St Helier Hospital
- Tuesday 11th September at the Nelson Health Centre
- Thursday 13th September at Epsom Hospital
- Friday 14th September at Asda Superstore, Sutton
- Saturday 15 September at the Ashley Shopping Centre, Epsom

The aim of these mobile pop-up engagement events was to:

- Engage local residents in areas of high footfall to hear a wider variety of voices
- Seek public feedback on the challenges we face and potential solutions
- Raise awareness of the September discussion events and other ways of giving us feedback

As part of the engagement process, members of the public were asked to complete a short survey. The programme staff who were present at the events also captured qualitative feedback from respondents.

In total there were 81 responses for this survey. The breakdown of these respondents is detailed below. Only headline findings are shown due to the small sample size. The number of respondents for each question are shown below each graph. Percentages may not add up to 100% due to rounding and questions that allowed multiple responses.

5.2 Summary of qualitative findings

Most of the qualitative data captured at these events focused on the competing issues of needing ease of access to healthcare versus the potential benefits of accessing higher quality care and more modern equipment in a centralised location.

Arguments in relation to travel included the importance treatment times can play in health outcomes; the difficulties for those without a car in accessing hospital sites via public transport - particularly for older people; the cost of parking at hospitals; the availability of parking in Sutton and a willingness to travel whatever distance in order to access the best quality of treatment.

Those discussing more centralised provision raised the potential for better quality facilities, access to everything on a single site, greater efficiency of money and staffing, the ability of paramedics and logistics to overcome issues with transport. However, others commented that smaller facilities could offer more relevant care, that services should be spread around, that

there could be difficulties accessing post-surgical care; potential problems with the ability to access tests at night and close to home; and past successes with stroke services.

Several respondents registered concern that reductions in hospitals providing acute services would mean insufficient beds for treatment; while others raised the importance of patient choice and case studies of other trusts maintaining A&E provision despite tough financial circumstances. One respondent felt that St Helier's needed additional clinics in the vicinity in order to alleviate current pressures.

Current waiting times were also raised as a concern, both in terms of accessing immediate treatment in the event of an emergency and for surgical procedures.

Large numbers of respondents provided anecdotal evidence, either of themselves or a relative, involving local healthcare facilities, both expressing positive and negative views.

More negative accounts in relation to treatment or the physical condition of the infrastructure appeared to relate to St Helier's than to other hospitals. However, various other respondents also indicated that they supported campaign efforts to keep the hospital open, with a public view that St Helier and Epsom Hospitals were at risk of closure.

Various respondents raised the age and condition of the building at St Helier, highlighting a need for investment in the estate.

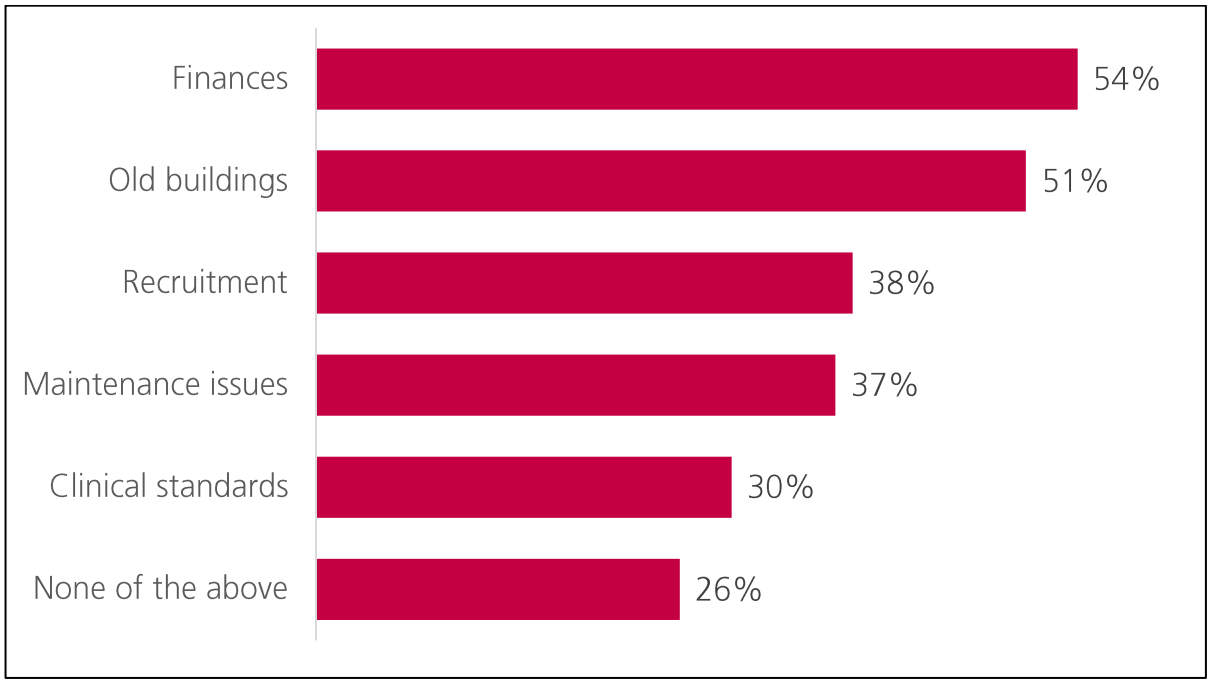
There was also a view from several respondents that Sutton was in need of its own facility.

5.3 Summary of quantitative findings

A bespoke survey for the mobile engagement events had been developed. The findings are described below

i) There are a lot of longstanding challenges at Epsom and St Helier hospitals. Which ones are you aware of?

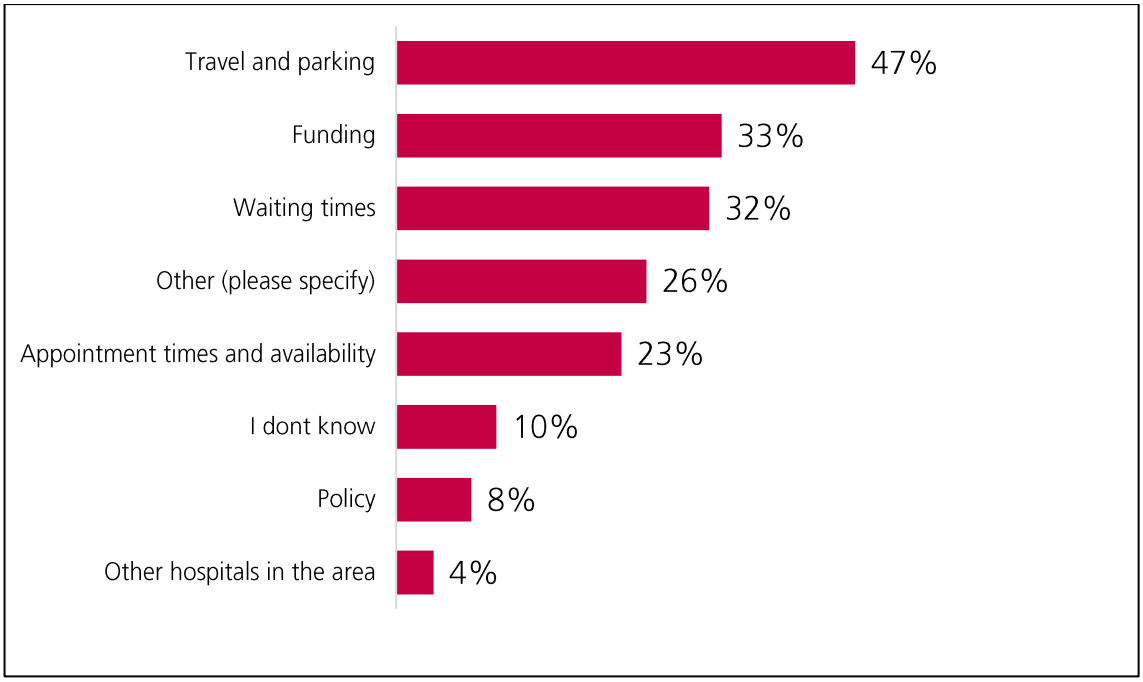
More than half of respondents were aware of financial and building challenges. Just over a quarter (26 per cent) were not aware of any of the challenges.



Total responses: 81; skipped 0

ii) What other issues do you think there are?

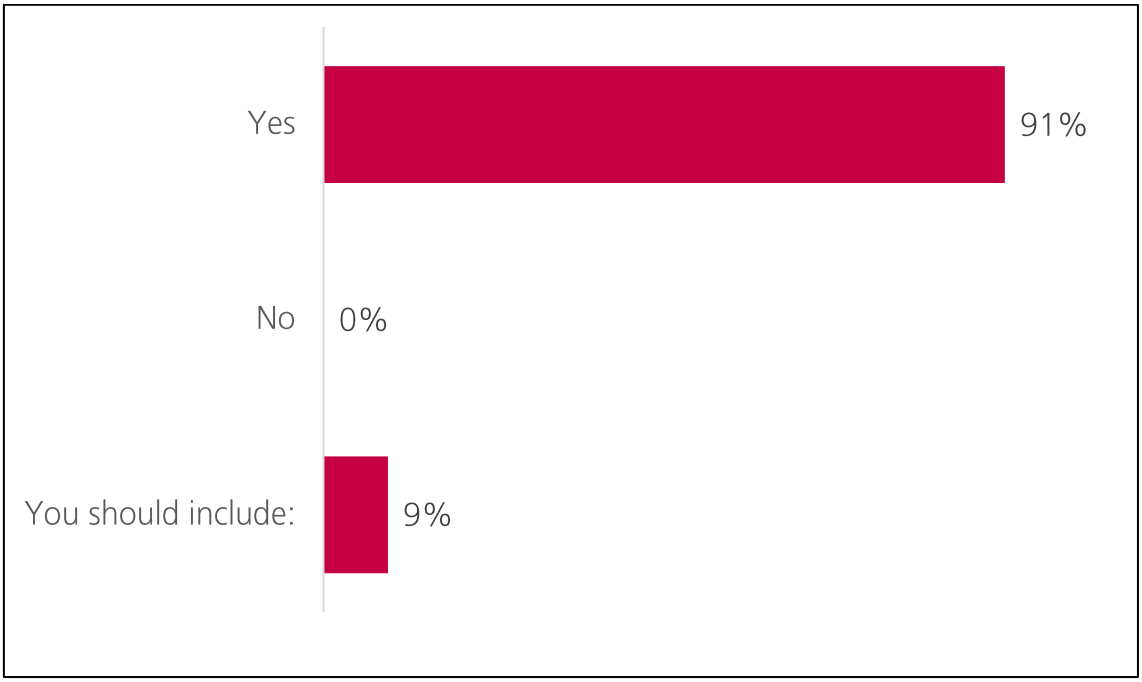
The main additional issue selected was travel and parking, followed by funding and waiting times. Comments that referred to 'Other' included a range of issues included specific service challenges such as crowding in physio, A&E waiting times, and lack of information about the future



Total responses: 78; skipped 3

iii) Do you think our vision is the right one?

More than nine in ten respondents feel that the vision is the right one. Nine per cent (7 respondents) suggested elements that should be included for the vision to work, these included: suggesting that there should be engagement and participation of patients, that it will cost a lot of money to deliver, a need for shorter waiting times, better liaison between GP surgeries and hospitals and retention of hospitals in the local area.

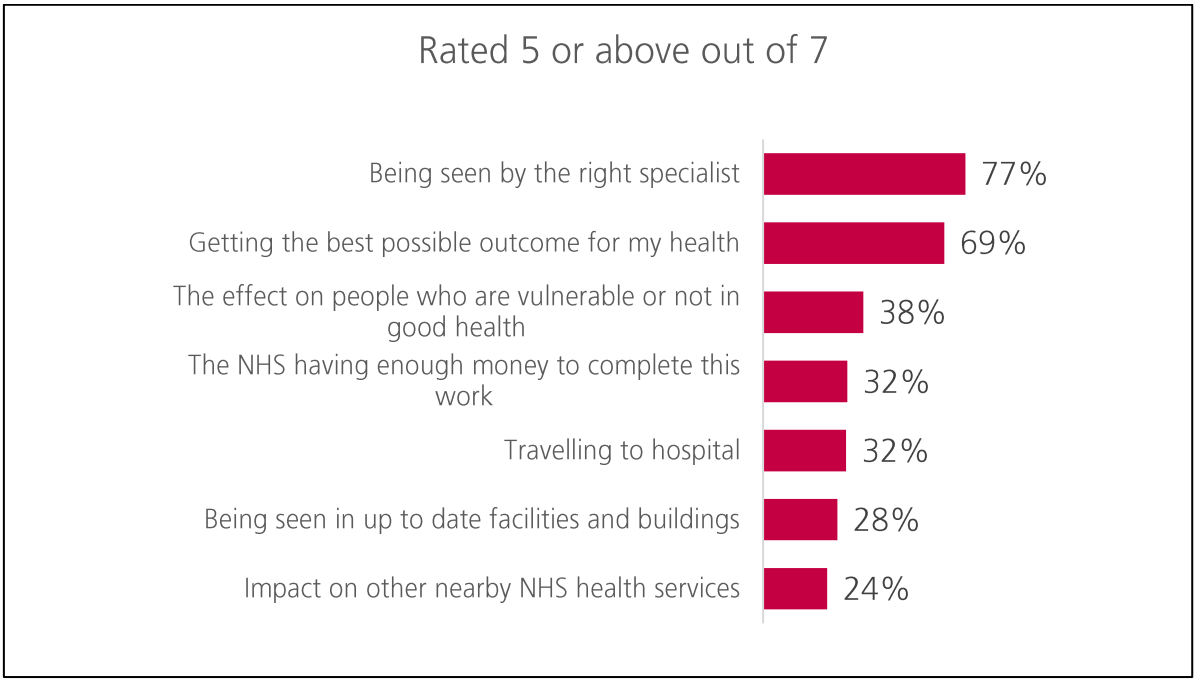


Total responses: 81; skipped 3

iv) In terms of our proposed solutions, please rank what are the most important considerations for you (Please score as 1 being the lowest and 7 being the highest priority)

Being seen by the right specialist was the top priority for respondents (42 per cent scored it 7 out of 7, and 77 per cent rated it 5 or more). This was followed by getting the best outcome for my health (scored more than 5 by 69 per cent of respondents).

	1	2	3	4	5	6	7
Being seen by the right specialist	10%	6%	4%	3%	10%	24%	42%
Getting the best possible outcome for my health	3%	13%	4%	12%	23%	25%	21%
The effect on people who are vulnerable or not in good health	3%	14%	18%	26%	17%	12%	9%
The NHS having enough money to complete this work	21%	12%	24%	12%	17%	6%	9%
Travelling to hospital	30%	13%	12%	13%	7%	18%	7%
Being seen in up to date facilities and buildings	23%	8%	18%	23%	14%	8%	6%
Impact on other nearby NHS health services	9%	32%	20%	14%	14%	7%	4%



Total responses: 79; skipped 2

Sample Profile

16 respondents were from Epsom, 14 from Sutton, 13 from Mitcham and 10 from Carshalton. A further 29 were from other areas.

Responses were overwhelmingly from female respondents (82 per cent). More than three quarters were over 45 and 39 per cent over 65. Over three quarters were White, 10 per cent Asian and 9 per cent Black.

Which area are you from?

Answer Choices	Responses	
Epsom	20%	16
Sutton	17%	14
Other (please specify)	16%	13
Mitcham	15%	12
Carshalton	12%	10
Wimbledon	6%	5
Wallington	5%	4
Morden	5%	4
Other	3%	3
Total		81
Skipped		0

Gender

Answer Choices	Responses	
Female	82%	65
Male	18%	14
Other (please specify)	0%	0
Total		79
Skipped		2

Age

Answer Choices	Responses	
18 and under	1%	1
18 to 24	3%	2
25 to 34	13%	10
35 to 44	8%	6
45 to 54	15%	12
55 to 64	22%	17
65 to 74	15%	12
75 or older	24%	19
	Total	79
	Skipped	2

Sexuality

Answer Choices	Responses	
Heterosexual	95%	74
None of the above, please specify	4%	3
Pansexual	1%	1
Total		78
Skipped		3

What is your ethnic group

Answer Choices	Responses	
White	77%	60
Mixed or multiple ethnic groups	0%	0
Asian or Asian British	10%	8
Black/ African/ Caribbean/ Black British	9%	7
Other ethnic group	4%	3
Total		78
Skipped		3

Do you have a long term health condition or illness?

Answer Choices	Responses	
Yes	47%	35
No	48%	36
Prefer not to say	5%	4
Total		75
Skipped		6

6 Analysis of feedback forms

6.1 Introduction

During the engagement period, stakeholders have had the ability to make submissions via the 'Feedback' facility on the Improving Healthcare Together website, with 14 responses received in this way. The online feedback system required respondents to provide answers to eight set questions, in addition to their name and optional contact details. These questions were also included in a freepost paper survey which was circulated at some discussion events, containing the same questions. These responses to these questions, received electronically or on paper, are summarised together below.

6.2 Summary of findings

Do you have any general comments about Improving Healthcare Together 2020-2030?

A range of comments were included in response to this question covering a number of healthcare issues and perspectives.

A concern was raised about liaison between health and social care providers leading to situations where people are discharged without a proper care package, leading to future hospitalisation and the need to properly connect with social care.

Views were put forward including: that both hospitals should be kept; that staff and patients do not want to close hospitals; that it is sensible to concentrate expertise for acute care; that St Helier too far north and difficult to access from Surrey Hills and St George's is relatively close by in areas closer to centre of London; that the growing population in Epsom is creating a need for more medical facilities; that there are challenges with the cost of agency staff and bed blockers; that there should be modern estates built and a combined workforce for the next 10-50 years; that waiting times should be improved; that there is a need for more fluid services, with each department speaking to each; and that the Red Bag scheme should be used for care at home as well as improving experience in care homes.

Individual experiences included: capacity problems at St Helier and clinicians being unwilling to visit non-surgical day wards to see 'overflow' patients; challenges arranging appointments with consultants; experience as a carer being frustrated by having to repeat information again and again that can be frustrating and upsetting, and that plans are reliant on communication and information and it is important to hold records electronically to avoid this.

In addition to solving the challenges of clinical quality, financial deficit and poor quality buildings in our local NHS, are there any other challenges you think we may need to solve?

Challenges raised include: more available and convenient appointments for various services; improvements in car parking; an ageing population; increased population levels with older people living longer; the increased use of expensive technology due to improved clinical techniques; the need for more GP facilities; low morale and vacancies in the workforce, especially at trainee doctor level; inefficiency with the booking system; a need for later and early GP appointments to not be given to non-working patients; and the need for better provision for those with mental health issues. A view was also expressed that senior management were out of touch and too close to property developers.

Do you think our vision, based on greater prevention of disease, improved integration of care and the delivery of enhanced standards in major acute services, is the right vision for this area?

Some respondents felt that the vision which had been outlined was the right one for the area, but that it would require a larger, better resourced and more motivated workforce to deliver. Others expressed general opposition.

Specific comments include: that there is a need to see the best specialist possible, that you should be able to have tests and results at all times of the day; that for residents in the Bookham area, they feel left out and on the edge of the area and Sutton is far away – over an hour by car; that a more logical area for a plan would be for the northern areas to be included as part of London and the southern ones as part of Surrey; that the old Sutton Hospital site should be sold off to fund new buildings; and that there should be plans for staff accommodation and convalescent facilities.

Do you think we should consider any other initial tests – apart from those described in this document – as we develop the long list of ideas into a short list?

Submissions raised a number of areas where service improvements were felt to be desirable, including: ease of access to specialists, round the clock tests and results, and better protection for whistle-blowers. Others felt that the knock-on impact upon ambulance services needed to be considered and the risks involved if longer travel times reduced their availability. The importance of consulting with NHS workers in taking ideas forward was also highlighted.

Other comments include: do not penalise whistleblowers, finding out what is going wrong is vital to changing procedures to improve safety and reduce waste; need to consider the impact of house building in Mole Valley on the population; the need to consider what medical facilities are needed in the short and long time; how to resolve the shortage of qualified staff; how to remove bed blocking; and how a solution would respond to a major incident without Epsom Hospital A&E's proximity to M25 and Gatwick.

Do you think there are other important things we should consider as we take this work forward?

In answer to this question, respondents highlighted the need to consult with the public, patients and staff members as far as possible. They also raised the importance of considering those with protected characteristics such as people with disabilities or older people who needed support, with particular concerns that the reduction in workers from the EU would have a serious impact upon social care. In addition, the potential impact of deprivation upon people's health was raised as something which should be factored in. Other responses included: that NHS property should be retained for a healthcare use rather than being sold off; the need to consider patient access on public transport; the importance of access for carers who may need to travel back and forth each day; that St Helier has had substantial improvements; and criticism over the selection of venues for resident engagement in the process and a question over whether a change of Government would have any impact.

Do you have any questions about the process we are proposing to follow or any suggestions for improving it?

It was felt to be important that those working in the local NHS were able to participate fully in the process in order to ensure frontline experience helped to ensure the best possible outcome. The importance of reaching carers in their home environment was mentioned. Some scepticism over the engagement process was also raised in response to this question with a request for reassurance that the process is not just a paper exercise.

Can you think of any other ways of tackling the challenges described in this document, within what the document describes as possible?

Amongst the submissions was the idea that the Government should change its policy on public spending and that a new A&E was built upon a local car park with the existing site being turned into a car park.

What are the best ways for involving our patients and community in developing ideas to address the challenges described in the document?

Responses to this question suggested involving a range of different community, NHS staff and care worker groups, ambulance drivers, and using methods such as door to door leaflets and social media to reach out to people. There was also some criticism of the cost involved in the engagement process.

7 Analysis of written submissions

7.1 Introduction

Throughout the engagement programme Improving Healthcare Together and its consultation partners have publicised an email account 'hello@improvinghealthcaretogether.org.uk', a telephone number and a freepost address as a means for individuals and organisations to feed thoughts, questions and comments into the process. 12 submissions were received from individuals in total and four were received from organisations and elected representatives. A summary of these is shown below.

7.2 Summary of findings from individual submissions

Individual submissions were received in two formats: 9 written submissions have been received by post the form of a model survey (created by a member of the public) which has been circulated for people to respond to and a further 3 individual submissions sent to hello@improvinghealthcaretogether.org.uk email address which contained responses with content referring the issues paper.

7.1.1 Unstructured responses

Comments received included: that geography, time, distance and difficulty of travel are the most important factors to be considered and that it is not solely how easy or difficult it is for ambulances to travel quickly to hospital in an emergency but also how those visiting loved ones access the hospital by car or public transport; that it is challenging for those in the south of the combined geographies to access St Helier; that the vision is right for the area but needs to be qualified by financial constraints and transport issues; that there is a need to consider how compatible the process is with separate work going on for developing and updating Epsom Hospital, Sutton Hospital and St. Helier Hospital; that involvement of patients and community in progressing the challenges is vital; that there should be more publicity for the engagement; that closing hospitals will make it more difficult for people in the area, particularly older people; and that Epsom Hospital would be a good site due to its location to Epsom Rail Station and the M25.

One submission was from a clinician commenting on their experience attending an engagement event at the Sutton Masonic Hall where they felt that the event was hijacked by "Save St Helier" campaigners. They suggested that more information be provided that explain the clinical reasons behind locating acute services in a single location, including reference to survival rates and outcomes.

7.1.2 Model survey responses

Q1a) How do you improve hospitals?

Respondents felt that hospitals should be regularly maintained so that are problems are fixed before they escalate. Some also felt that they should be refurbished to being them up to good standards. A number felt that a new hospital should be built on the St Helier site.

Q1b) How do you reduce costs?

There were a number of common responses including:

- providing care for older people in their homes to reduce the cost of hospital care
- reopening the Wilson Health Centre
- Put healthcare in areas of most need
- Holding contractors to account and reducing layers of management
- Stop wasting money on consultations

Q1c) How do you get enough trained staff?

Most responses advocated the abolishing of university/ training fees for student nurses. Some also felt that providing certainty about the future of St Helier would reassure staff.

There was a suggestion to ensure the Living Wage was being paid as a minimum and another suggestion to charge health visitors for services to pay for staff training.

Q1d) Are there any other challenges you think we may need to solve?

Most responses reflected the concern to patients and the community there would be if acute services at St Helier's were to be relocated.

Others also felt that the anxiety and stress of to the community caused by constant consultations on what appeared to be the same issue was a concern.

Ensuring the needs of a growing older population were met was also raised as a challenge.

Q2) Is our vision for healthcare services the right one for the area?

There was consensus that this was not the right vision unless a new fit for purpose hospital was built on St Helier site.

Q3) What tests should we consider in deciding to locate a hospital?

Recommended tests included:

- Close to those in most need
- Close to those with lowest income
- Somewhere with close transport links and accessible by car
- Impact on other local hospitals
- Ease of access – including level access
- population density against key demographics

Q4) How can we improve the consultation?

- Leaflet every home and advertise more widely
- Hold public meetings at convenient times
- Work with local MPs and councillors
- Listen to what people say and being willing to change your minds – this is the 5th /6th consultation on the same issue
- Give and publish feedback and make sure process is transparent

Q5) Are there other ways to tackle this problem?

The two main ways cited to tackle this problem were to build a new hospital on the current St Helier site and to focus on patient preferences (not management preferences).

Q6) How do we involve our community and patients?

Suggestions included:

- CCG board members live in and are representative of the communities they serve
- Listen to what patients and the community are saying
- Assess impact on neighbouring hospitals including St George's, Kingston, Croydon.
- Leaflets in public spaces.
- Clear information

7.3 Summary of findings from organisations and elected representatives

Four submissions were received from an organisation and elected representatives. Key themes and issues arising from these are summarised below.

Submission from Leatherhead Community Association and Leatherhead Residents Association

There was agreement with the case for change outlined in the *Issues Paper* and concern that there were currently acute services being provided in hospitals that were not fit for purpose. There was recognition that each potential solution would cause travel concerns for patients in different parts of the geographic areas. There was also recognition that none of these solutions would work if there were not enough staff so this was an important factor to address – particularly to ensure continuity in level of services provided going forward.

The submission expressed support for acute services to be provided at a new "independent" hospital at the Sutton Hospital site (even though Epsom Hospital was more convenient for them).

Whichever option was chosen to provide acute services, it was hoped that Leatherhead Hospital could be considered as a site for follow-up services for people who lived locally. It was also hoped that decisions would be made quickly and that regular progress updates would be given to patients and public.

Submission from Crispin Blunt MP

A letter from a constituent was forwarded on by Crispin Blunt MP (Member of Parliament for Reigate). This was making the case for retaining acute services at both St Helier and Epsom Hospitals to meet the current and future needs of communities they serve.

Submission from Siobhain McDonagh MP

Siobhain McDonagh MP (Member of Parliament for Mitcham and Morden) wrote a number of letters over the engagement period that sought clarification about:

- how the engagement was being communicated to the public and how 'seldom heard' groups would be engaged in this process
- the decision-making process and what weight this engagement process would have alongside the other evidence that would be considered as part of the decision-making process.

These clarifications were being raised to ensure that residents of Mitcham and Morden would be taking part in a fair and unbiased process.

Submission from the London Borough of Sutton

A number of additional challenges were referenced that relate to how the solutions can be sustained. These included mention of issues around workforce recruitment and retention; how local arrangements fit with and work well with broader London and national changes; and hand how other partners and the wider public are convinced to work with the solutions. Specific questions were raised with regard to how the proposals will affect waiting times, whether there is a compromise on patient care and service, how short-falls of consultants will be met, how additional finances will be secured, and how transport and parking issues will be addressed.

In response to the healthcare vision, questions were asked concerning how prevention will be achieved at the same time as continuing financial pressures and what progress has been achieved so far in terms of integration with examples cited being quite new. Comment on acute services included that this required issues of access and transport for patients, carers and visitors to get to a single acute quite quickly and at a reasonable cost to be met. And for the issues of sufficiency of workforce to be dealt with now and in the future.

Additional tests mentioned in the response include: factoring accessibility needs into Test or adding a new test relating to access/transport/parking.

Comments relating to involving patients and the community in the future include: that the document provides a good starting point but there is a need to indicate that this is a limited discussion with decisions effective being made already; and that both informal 'engagement' and consultation needs to be thorough, clear and very accessible and both phases need to be able to show that comments have been listened to and not just treated as steps on an already predetermined path.

8 Analysis of social media responses

8.1 Introduction

As part of their public engagement process *Improving Healthcare Together 2020-2030* appointed *Freshwater*, an independent communications consultancy, to capture public discussion of the programme online via two social media channels: Twitter and Facebook. This section of the report analyses the content of those online discussions.

In all, 112 Twitter posts discussed the programme in some way and 57 Facebook posts raised the programme, with a 169 posts in total.

8.2 Summary of findings

Much of the interaction on Twitter occurred between handles connected to either the media, politics, the NHS or local campaign organisations, whereas the messages on Facebook appear to have originated form personal accounts.

A large number of the comments related to poor experiences of care with current services. These included: experience waiting 4 hours in A&E; experience of relatives experiencing poor surgical care and having operations rescheduled a number of times; waiting times for a serious neurological appointment; need for better mental health services; long waiting times for Autism Spectrum Disorder diagnosis assessments; problems getting appointments for facet joint injections. There were a small number of comments that were positive about the care they received at St Helier.

Clinical trials taking place at the Royal Marsden were mentioned as a particular risk if patients were forced to move on to free up beds, as clinicians at other facilities would not have a complete understanding of their condition mid-trial. Several comments also commented on a need to see fewer operations cancelled and a view that reductions in services seem to be focused on more deprived communities.

Large numbers expressed cynicism or raised complaints over the engagement process, a number suggested that the outcome of the process had already been pre-determined, with others saying that they felt the events had been insufficiently well advertised, that there were accessibility issues and that groups had been denied the opportunity to speak.

Concerns were expressed with plans that would mean closing the St Helier site. Challenges were raised relating to this such as potential issues disposing land due to planning and lease condition constraints and that selling land would break local and London plan and be a break on 1938 lease conditions. Other comments stated preferences for more funding of NHS services; that given money has been invested in St Helier it should be managed better rather than a new hospital being built; and that both hospitals' services should be retained.

There were a number of comments relating to previous engagement events, such as that at the event in Pollards Hill many were vocal that St Helier should remain a critical care hospital with an A&E rebuilt on the current site in an area of greatest health need; that a church is not an equal setting for an event; problems with events where an interpreter was promised but not provided; that at an event in Mitcham most of the audience were very angry about the

perceived flawed nature of the process; and that a comment from a St Helier event on 25th June that someone from @Save_ST_Helier was denied a question by the chair.

Other social media comments include: concern that changes are part of privatisation; the there should be free defibrillator training for all with easy access to equipment; criticism of Surrey Downs being defined as a geographical area; and concern about the impact of potential changes on St George's Trust in Tooting.

9 Analysis of Stakeholder Reference Group Feedback

9.1 Introduction

The Stakeholder Reference Group (SRG) was set up to ensure appropriate stakeholder involvement in the development of local health services. The SRG is comprised of representatives from different communities of interest in the local area including patient groups, community groups, and voluntary groups that wish to be involved in the programme. The SRG's terms of reference written on the 13th June 2018 states the aims of the group as: to offer advice, views, suggestions or options on: plans for public engagement; the language, style and tone of public consultation materials; and which seldom-heard groups should be consulted and how.

The SRG was independently chaired with meetings of varying size of membership. The following meetings were held:

- 15th May, Epsom Hospital
- 13th June, Raynes Park Library
- 18th July, Sutton Life Centre
- 15th August, St Mary's Church, Surrey
- 19th September, Sutton Life Centre

9.2 Summary of findings

15th May

13 attendees and four programme representatives attended. Questions were raised over whether smaller changes could be made to continue delivery as it currently is rather than consolidating on one site. A concern was raised regarding transport and access for older people and people with disabilities. Some of the group felt that transport between Epsom Hospital and St Helier Hospital is not good and would need to be looked at closely.

13th June

13 attendees and five programme representatives attended. Comments included the suggestion that the programme have a more jargon-free name "Improving Healthcare together 2020-2030".

Comments were made around changes such as: how Alzheimer's was the cause of a high number of deaths and that care for older people should be a focus; concern about where palliative care would be delivered; the importance of transport and the need for reliable public transport to meet any significant changes; the need for information about how improvements are being funded and the importance of remaining within financial

parameters; and that staff are key and the programme must consider the uncertainty they face.

18th July

16 stakeholders and two programme representatives attended. The meeting included a presentation from Keep Our St Helier Hospital and an overview of a potential engagement and work plan.

Stakeholders raised questions a number of questions covering a range of areas. These included whether:

- a methodology was being used relating to winter times and winter weather
- both existing hospitals would continue until a new hospital is built if major acute services were located at Sutton Hospital
- services can be guaranteed beyond 2020
- there is a commitment to retaining the same number of beds
- there is clinical evidence that collocating acute services in one location brings any benefit
- there is a commitment to retain the same number of beds
- there is clinical evidence that collocating acute services in one location brings any benefit
- five acute hospitals will reduce to four or three
- the Best Service Value approach has fallen by the wayside or the current approach is similar
- Healthwatch groups talk together
- the board are aware of an American company trying to infiltrate UK boards with a view to taking them over.

There was also a comment that Epsom and St Helier University Hospitals Trust is not mandated to make a surplus and has a major deficit and that the NHS accepts this, and that this need to be reflected when modelling is carried out.

15th August, St Mary's Church, Surrey

14 stakeholders, three programme representatives and two participants from Mott McDonald attended the meeting. The main included an update on the programme; a presentation by Mott McDonald on the methodology and approach of travel analysis work; and a presentation on the objectives and next stages for the Integrated Impact Assessment.

Stakeholders raised questions a number of questions covering a range of areas. Questions included:

- Whether publicity material will be available in text and Braille for the visually impaired.
- What engagement with the voluntary sector will be conducted.
- How engagement events will be fed back

Comments made throughout the meeting included:

- That the discussion events appear to be London centric, especially those led by the Trust and that Epsom is in Surrey not London.
- The cost of car parking being one of the 3 key issues from a carers' perspective with St Helier costs £3.00/hour with a further £2.00 charge for being a minute over.
- That 14% of Ewell Borough in Surrey is from BAME communities and the programme is responsible for including those people.

19th September

Five stakeholders, three programme representatives and a participant from Mott McDonald attended the meeting. The agenda included and update on the programme and a presentation on the Integrated Impact Assessment.

Questions were asked around whether homeless people were included in assessments, the dates for the public consultation, how carers will be incorporated, what definition of carers will be used, whether life expectancy differences are being considered, and the need to consider the future demand of workforce and demographic change.

10 Staff survey

10.1 Introduction

A survey was emailed to staff members at Epsom and St Helier NHS Trust, NHS Merton CCG, NHS Sutton CCG, NHS Surrey Downs CCG, GP practice, community service and pharmacist. The questions were developed by Improving Healthcare Together with a mixture of open and closed questions. In total 205 responses were received.

10.2 Summary of Findings

There are challenges at Epsom and St Helier Hospitals around clinical standards, finances and buildings. Are there any other issues you are aware of?

106 respondents raised additional challenges at St Helier Hospitals. The main challenges mentioned concerned: workforce recruitment and retention; working conditions; quality of specific services; communication between departments; and lack of resources.

Recruitment and retention of staff was mentioned by a number of responses. Specific points referenced shortages of trained nursing staff and challenges in retaining BME staff at Band 6 and above.

A range of service pressures were mentioned including: lack of acute beds to cope with winter pressures; poor provision of Community Paediatrics at St Helier/QMHC; lack of acute adult beds to cope with winter pressures with paediatric beds used for adults; less efficient pharmacy services provided at ward level; lack of capacity in operating theatres and surgical bed space; IT underfunding with legacy systems that pose a cyber security risk; and outpatient waiting times in neurology requiring patients being referred out of areas.

Respondents raised challenges around working conditions. These included: staff not feeling valued or being satisfied; challenges of multi-site working; relationships between professionals and departments; work load for junior staff; poor working hours for staff maintaining services with impact on work life balance and health and wellbeing; culture of low trust; and appropriate staff grading especially at levels 2-4, lack of recognition for working unpaid hours. Staff also mentioned anxiety caused by uncertainty over the future of services.

Negative views of leadership and priorities were also mentioned, such as a perceived lack of transparency and strategic direction; clinical staff not being listened to; and a focus on A&E targets and costs rather than the quality of care or patient safety.

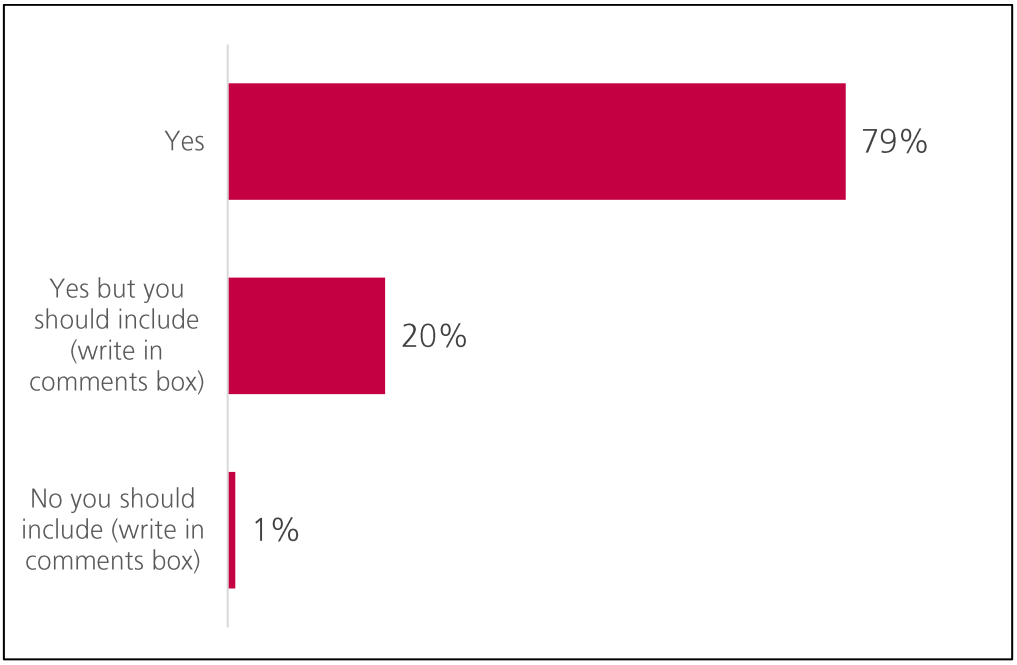
A lack of funding and resources for services was mentioned by a number of respondents.

Other challenges raised include: problems with heating at St Helier – with the temperature being either too hot or too cold; the IT system is not efficient; discharge issues with summaries not being provided; the inefficiency of a two site model; and parking.

i) Our vision is to make sure local people have the very best quality of care, in buildings that are suitable and safe, and available for the years ahead. At the heart of our vision we want to:· Keep people well· Deliver as much care as close to people's homes as possible· Make sure GPs and clinicians from hospitals, community and mental health organisations, are all working together alongside social care and the voluntary sector· And when people are seriously unwell or at risk of becoming seriously unwell, they have access locally to the highest quality care, available at any time of day or night and on any day of the week.

Do you think our vision is the right one?

Four out of five respondents described responded that the vision outlined is the right one.



Total responses: 204; skipped 1

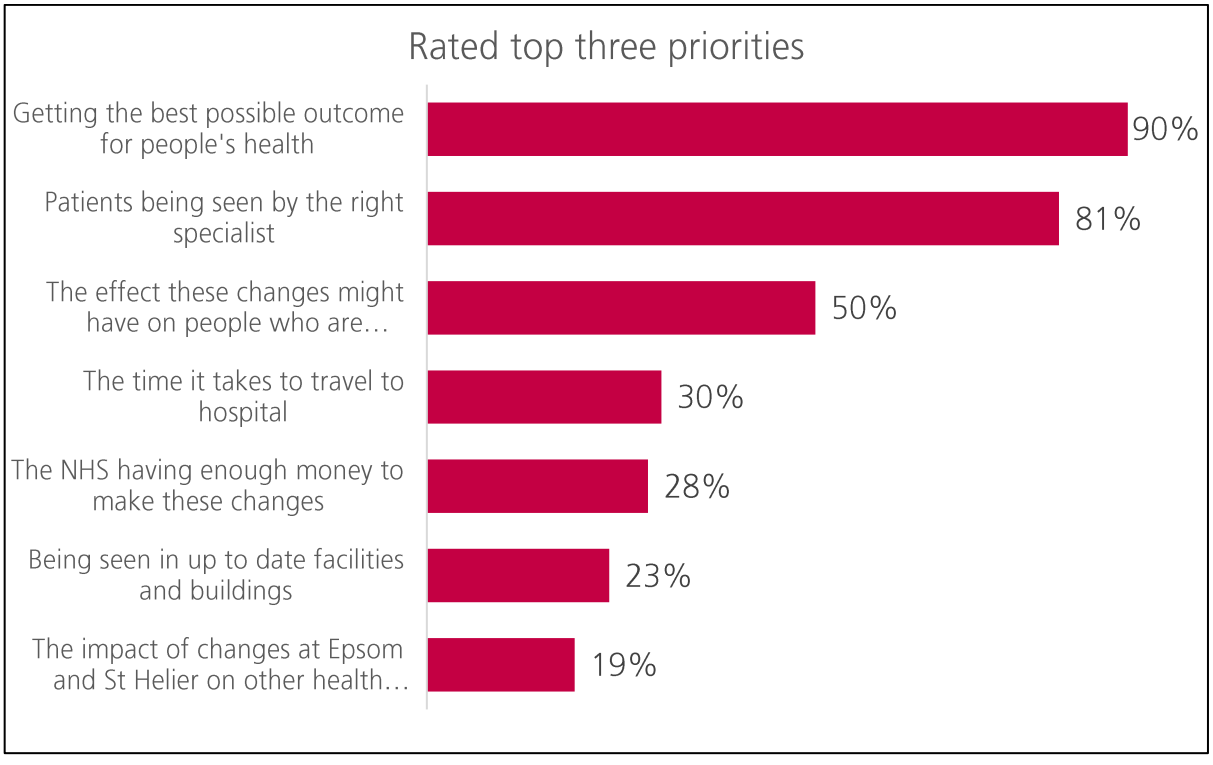
44 respondents made additional comments with suggestions of what should be included in the vision. These include suggestions that reference should be made to: good workplace and professional development; health inequalities; awareness of services and access to public transport; the geography of the areas – for example that Surrey residents are not residents of South West London; staffing; non-acute services such as Community Paediatrics as well as admin support; that this should tie into Community and Primary Care Level; effective referral pathways to state-of-the-art facilities and tertiary hospital s=sustainability; waste reduction;

Other responses commented on the vision. These included: that there should be a strategic alliance with the Royal Marsden Hospital; that the statement is too long; that the statement refers to services the public currently expect thus implying they are not currently being provided; more involvement of mental health services in the process; and that there is a hidden agenda to reduce secondary care services in the area.

ii) Our proposed solutions are: locating major acute services at Epsom Hospital, and continuing to provide all district services at both Epsom and St Helier Hospitals. Locating major acute services at St Helier Hospital, and continuing to provide all district hospital services at both Epsom and St Helier Hospitals. Locating major acute services at Sutton Hospital, and continuing to provide all district services at both Epsom and St Helier Hospitals. What are the priorities we should be taking into account when judging these solutions? (1 is the highest priority and 7 the lowest)

Nine in ten respondents selected getting the best possible outcome for people's health as a top three priority, followed by being seen by the right specialist (81%), then the effect these changes might have on people who are vulnerable (50%).

	1	2	3	4	5	6	7
Patients being seen by the right specialist	19%	45%	17%	10%	5%	5%	2%
The time it takes to travel to hospital	5%	10%	14%	15%	15%	15%	19%
Getting the best possible outcome for people's health	61%	20%	9%	4%	1%	1%	4%
Being seen in up to date facilities and buildings	2%	6%	16%	21%	16%	16%	21%
The impact of changes at Epsom and St Helier on other health services	1%	3%	15%	16%	23%	23%	16%
The NHS having enough money to make these changes	8%	9%	11%	15%	16%	16%	26%
The effect these changes might have on people who are vulnerable, e.g. on a low income, or not in good health, e.g. have a long term condition	15%	13%	21%	19%	18%	18%	7%



Total responses: 204; skipped 1

iii) Can you think of any other potential solutions to tackle the challenges at Epsom and St Helier? Are there any other priorities we should focus on when judging the potential solutions?

155 respondents suggested other solutions to tackle the challenges of Epsom and St Helier. These included comments around assessing the impact; accessibility; service quality; and site alternatives.

Responses mentioned the importance of assessing the impact on communities, vulnerable residents and in developing services that respond to the population needs of different areas. There was specific reference of the need to consider travel and public transport.

A number of responses referenced a need to consider issues relating to staffing, conditions and pay. There was mention of challenges to be overcome in terms of morale, the working environment and culture and the need to treat all demographic groups equally.

Comments around ways to improve quality of services included: 7 day working and extended GP working hours; more walk-in centres; cheaper and healthier canteen food; focus on social determinants to prevent disease; building more community hospitals; and approaches that have more integrated care.

A number of responses were given in support of a single site. One comment mentioned a potential benefit to patient care of having trauma networks under one roof. Another mentioned that a single site for Paediatrics and Queen Mary's Hospital would be preferred solution. Other's suggested a single site in Sutton would be better for the quality of care.

Alternative suggestions given included: demolishing and rebuilding both sites; splitting connection between both sites; and aligning with the Royal Marsden.

Additional comments include: having a local public vote; eliminating parking charges; giving everyone the freedom to share their views; considering the environmental impact; and reviewing the geographical and commissioning boundaries.

iv) Sample Profile

The overwhelming number of responses were from staff working for Epsom and St Helier NHS Trust. The sample is three-quarters Female, 65% over 45 in age; and 87% White.

Where do you work?

Answer Choices	Responses	
Epsom and St Helier NHS Trust	83%	171
NHS Merton CCG	7%	14
NHS Sutton CCG	2%	5
NHS Surrey Downs CCG	2%	5
GP practice	2%	4
Community service	0%	0
Pharmacist	0%	0
Other (please specify)	4%	8
Total		205
Skipped		0

Where do you live?

Answer Choices	Responses	
Carshalton	10%	21
Wallington	4%	9
Cheam	6%	13
Mitcham	0%	0
Wimbledon	4%	8
Morden	4%	9
Epsom	15%	30
Dorking	1%	2
Elmbridge	1%	2
Mole Valley	1%	3
Sutton	14%	28
Reigate	2%	4
Surrey Heath	1%	1
Ewell	1%	2
East Surrey	2%	4
Runnymead	0%	0
Weybridge	1%	2
Spelthorne	1%	1
Woking	1%	2
Guilford	0%	0
Esher	1%	2
Walton	0%	0
Other (please specify)	29%	59

Total	202
Skipped	3

Gender

Answer Choices	Responses	
Female	75%	154
Male	23%	47
Other (please specify)	2%	4
Total		205
Skipped		0

Age

Answer Choices	Responses	
18 and under	0%	0
18 to 24	1%	3
25 to 34	14%	29
35 to 44	18%	37
45 to 54	40%	83
55 to 64	22%	46
65 to 74	3%	7
75 or older	0%	0
Total		205
Skipped		0

Sexuality

Answer Choices	Responses	
Heterosexual	83%	168
None of the above, please specify	1%	2
Pansexual	2%	5
Queer	1%	2
Gay	12%	24
Bisexual	0%	0
Asexual	0%	0
Total		203
Skipped		2

What is your ethnic group

Answer Choices	Responses	
White	87%	174
Mixed or multiple ethnic groups	1%	2
Asian or Asian British	6%	13
Black/ African/ Caribbean/ Black British	2%	5
Other ethnic group	3%	7
Total		201
Skipped		4