Improving Healthcare Together **2020 to 2030**

We are consulting on our proposal to invest in both Epsom and St Helier hospitals and build a new specialist emergency care hospital which could be located at Epsom, St Helier or Sutton hospital.

Full public consultation document

The consultation is being led by NHS Surrey Downs Clinical Commissioning Group, NHS Sutton Clinical Commissioning Group and NHS Merton Clinical Commissioning Group. They are responsible for planning local healthcare services. The consultation is taking place over 12 weeks starting on the 8 January 2020. It will finish on 1 April 2020.

Get in touch. We are listening.

This document is available on our website in an easy-read format, as a Word document for screen readers, and in large print. Visit **www.improvinghealthcaretogether.org.uk.**

If you would like this document in a different format or another language, call **(02038 800 271)** (24-hour answer machine) or email us at **hello@improvinghealthcaretogether.org.uk.**

You can also ask us for a copy of our summary consultation document, which gives you the main information provided in this document. You can contact us in the following ways.

Phone: 02038 800 271

Email: hello@improvinghealthcaretogether.org.uk

Send a text message on: 07500 063191

Write to: Opinion Research Services, FREEPOST SS1018, PO Box 530, Swansea, SA1 1ZL

Twitter: @IHTogether

Facebook: @ImprovingHealthcareTogether

Website: www.improvinghealthcaretogether.org.uk

Your feedback on this consultation will help us provide safe, high-quality hospital services for our communities and for future generations across Surrey Downs, Sutton and Merton.

Please take the time to read this document and fill in the questionnaire at the end. Send your filled-in questionnaire to **Opinion Research Services, FREEPOST SS1018, PO Box 530, Swansea, SA1 1ZL.** You will not need a stamp. If you prefer, you can fill in the questionnaire on our website at www.improvinghealthcaretogether.org.uk.

We must receive your questionnaire by 12am (midnight) on 1 April 2020 for your opinions to be included in the consultation.

Data protection
We will protect the information we receive and store it securely in line with data-protection rules. We will keep your information confidential, and will not share any of your personal information when reporting statistics.

This document includes some medical and technical words. We define these words in the glossary at the end of this document (page 55).

Please contact us if you would like us to explain any part of this document.

DRAFT FOR DISCUSSION – SUBJECT TO IHT COMMITTEES IN COMMON REVIEW AND APPROVAL

Foreword

We are GPs and leaders of the local NHS in Surrey Downs, Sutton and Merton. Our NHS organisations, called clinical commissioning groups (CCGs), plan NHS services for local people.

As local GPs we want the best for our patients. We know that our local hospitals, Epsom and St Helier, are facing problems with quality of services, buildings and finance. Despite the hard work and commitment of staff, the hospitals are not able to meet all the necessary quality standards we would expect to see. We want to solve these problems and we believe that to do this we need to create a new 'clinical model of care' to change how hospital care is provided in the future.

Over the last two years we have worked with doctors, nurses, clinical staff and local people to develop a new way of working. We will base our proposals for change on this. We want our local hospitals to continue to be safe for local people, attract expert staff, and care for our patients in modern, state-of-the art buildings.

The Government has allocated £500 million to invest in improving the current buildings at Epsom and St Helier hospitals, and to build a new specialist emergency care hospital. This new hospital would be built at Epsom, St Helier or Sutton hospital.

We believe that we can make hospital services better for local people, better for NHS staff and better for the long-term future of the NHS in our area. As the organisations responsible for arranging healthcare across our combined areas, that is why we (the three CCGs) are leading this consultation process. Following the consultation, we will be making the joint decision about what happens in the future.

We will only make the final decision once we have considered all the feedback we have received from this public consultation, and other evidence we have gathered as part of this work.

Your views are really important to us.

Dr Russell Hills
Clinical Chair of NHS Surrey Downs Clinical Commissioning Group

Dr Jeffrey Croucher
Clinical Chair of NHS Sutton Clinical Commissioning Group

Dr Andrew Murray
Clinical Chair of NHS Merton Clinical Commissioning Group

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What is this consultation about?

We (NHS Surrey Downs CCG, NHS Sutton CCG and NHS Merton CCG) are leading this public consultation to ask for your views on proposals to change hospital services. We want to hear from patients, carers, representatives from community and voluntary-sector organisations, parents and guardians, children and young people, elderly people, health and social-care professionals, regulators and the public in Sutton, Merton and Surrey Downs areas and the neighbouring CCG areas.

We are consulting on the options for local hospital services in the area, and will focus on the problems Epsom and St Helier hospitals are facing. This includes consulting on our proposals for how services may change, investing in our current buildings at Epsom Hospital and St Helier Hospital, and building a new specialist emergency care hospital. This consultation document sets out the changes we are proposing and explains the reasons for our proposals.

Under our proposals:

- the **majority of services would stay** at both Epsom and St Helier hospitals, in refurbished buildings, with both hospitals running 24 hours a day, 365 days a year, and an urgent treatment centre at each hospital, and
- we would bring together **six core (major) services**, which are the majors part of the emergency department, acute medicine, emergency surgery, critical care and children's beds for the most unwell patients, those who need more specialist care, and women giving birth in hospital. These core services would be provided on one site, in a new specialist emergency care hospital which could be built at Epsom Hospital, St Helier Hospital or Sutton Hospital.

We have developed the proposals over the last two years, and have involved patients and stakeholders (those with an interest in our services). We will continue to respond to issues raised by the public through ongoing conversations around the future of local hospital services.

This document explains:

- why we need to make changes to the services provided at Epsom and St Helier hospitals
- our proposal for changing our hospital services and the three options we want your views on
- our preferred option
- what these changes would mean to you and your family, and
- how people and organisations across Surrey Downs, Sutton and Merton can get involved and what happens next.

We have also included a questionnaire in the middle of this document. **(Or you can fill in the questionnaire on our website at www.improvinghealthcaretogether.org.uk if you prefer.)**

It is important to emphasise that we will continue to need both Epsom and St Helier hospitals. We are not proposing to close either hospital. All options would see significant investment in both Epsom and St Helier hospitals.

Who we are

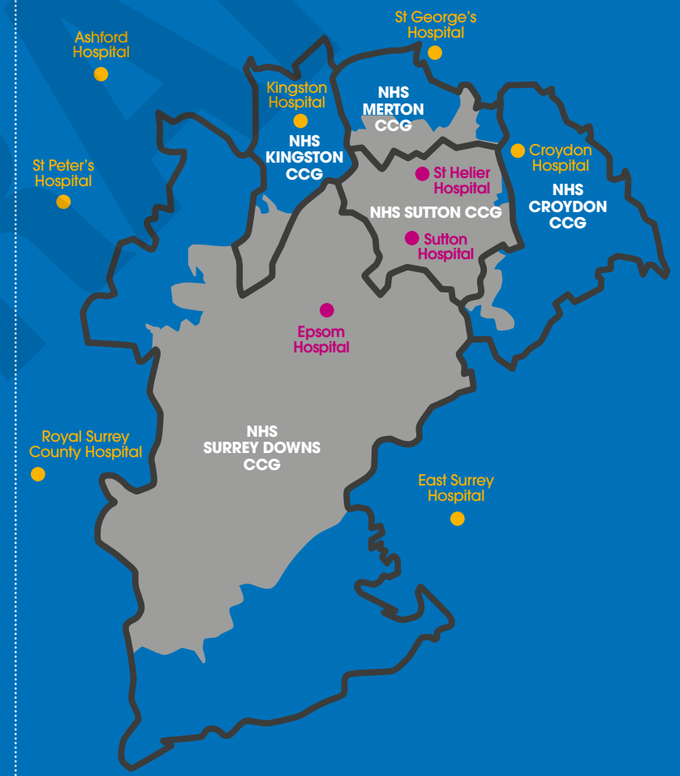
We are NHS Surrey Downs, NHS Sutton and NHS Merton CCGs. We are responsible for making sure that the services commissioned in our combined geographic area are high quality, safe and sustainable, and that budgets are managed efficiently and effectively. Our organisations are located across Surrey and South West London. Together, we plan services for a combined population of 720,000.

Epsom and St Helier University Hospitals NHS Trust is the main hospital provider within our combined geographical area. It provides hospital services to around 500,000 people from Epsom Hospital, St Helier Hospital and Sutton Hospital.

Today, the hospitals provide a wide range of hospital services for people who mostly live in the London Borough of Sutton, the south of the London Borough of Merton and, in Surrey, for the people of Epsom and Ewell, and parts of Mole Valley, Elmbridge, Reigate and Banstead.

Combined geography of the three CCGs

Catchment area for Epsom and St Helier University Hospitals NHS Trust



Key ● Trust catchment

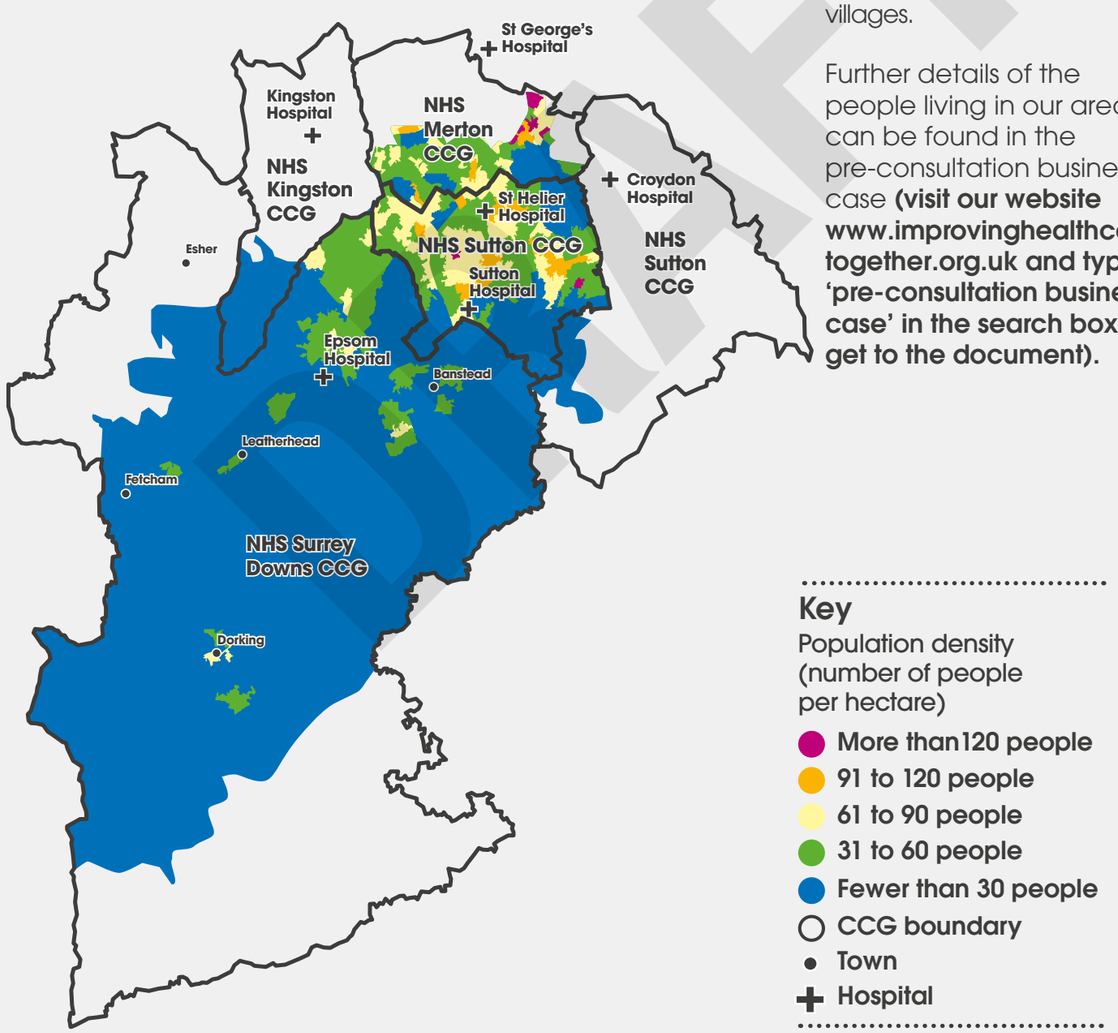
Most people living in Surrey Downs, Sutton and Merton are generally in good health and use hospital services less regularly than in other areas of England. (For example, if they have a common illness, or need a minor operation, they will visit their GP.)

Surrey Downs has an older and less ethnically diverse population, living in more rural areas, and is wealthier than the average for England as a whole. Outcomes for people living in this area who need to visit hospital are better than the England average.

- In Sutton, health outcomes are also better than the average for England, and the borough is wealthier than the England average. However, there are health inequalities and pockets of deprivation which result in differences in life expectancy for people living in this area.
- In Merton, the population is older and health outcomes are also better than the averages for London and England. However, there are social inequalities which mean that the life expectancy gap between people living in the most and least deprived areas is six years for men and four years for women.

There are also huge differences in where the people in our communities live, ranging from areas of densely populated housing to sparsely populated rural villages.

Further details of the people living in our area can be found in the pre-consultation business case **(visit our website www.improvinghealthcaretogether.org.uk and type 'pre-consultation business case' in the search box to get to the document).**



Why change is needed

There are three main reasons why we have to change the way we deliver local NHS services.

1. Quality

There are not enough specialist doctors, nurses and clinical staff for some of the most important emergency services. This is an issue facing many hospitals and especially those providing the same services on more than one site where they are located close together.

2. Buildings

Many of the hospital buildings are older than the NHS, and over half of the hospital space has been assessed as not suitable for treating patients to modern healthcare standards.

3. Finances

Not having enough staff and having to maintain old buildings contribute to a worsening financial position for the local NHS.

We want to deal with these challenges and we believe that the best way to do this is by looking at how best to provide care in the future. We are doing this with our partners from all health and social care providers in the area.

We are clear we want to do three things to improve healthcare locally:

- Ensure we can deliver high quality hospital services by bringing together six core (major) services onto a new single site, at either Epsom Hospital, St Helier Hospital or Sutton Hospital
- Deliver better joined up services, improve continuity of care, patient experience and patient outcomes, and
- Deliver district services locally and ensure patients have access to local urgent treatment 24 hours a day, 365 days of the year.

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Meeting the quality challenges

Our role as commissioners is to set clinical standards for care, assess how these standards can best be met and then hold hospitals to account to provide services that meet the standards. In line with national best practice, in 2017 we defined clear clinical standards for six acute services.

These standards set out expected senior staffing levels. We asked local hospitals whether they believe they can meet these quality standards, and all except Epsom and St Helier hospitals said they could. This is why Epsom and St Helier hospitals are the focus of this public consultation.

Based on the agreed standards, there is a shortage of consultants (the most senior doctors) in emergency departments, acute medicine and intensive care. Epsom and St Helier hospitals are not meeting the Royal College of Emergency Medicine's guidance for consultant cover. This is something the Care Quality Commission (CQC), the independent regulator of services, identified recently when it inspected the hospitals. There is also a shortage of middle-grade doctors and nursing staff.

Nationally, there is a known shortage of clinical staff in many areas.

In November 2018, The Health Foundation, The King's Fund and the Nuffield Trust published a joint briefing, highlighting the scale of workforce challenges facing the health service and how these challenges threaten the delivery and quality of care over the next 10 years. The briefing showed that NHS hospitals and providers of mental-health and community services are currently reporting a shortage of more than 100,000 full-time equivalent staff (representing one in 11 posts), severely affecting some key staff groups. One of the greatest challenges lies in nursing, with 41,000 vacant nursing posts (one in eight posts), but there are also problems in medicine, particularly in some specialties. (Visit www.nuffieldtrust.org.uk and type 'The health care workforce in England: make or break?' into the the search box to get to the document).

Epsom and St Helier hospitals:

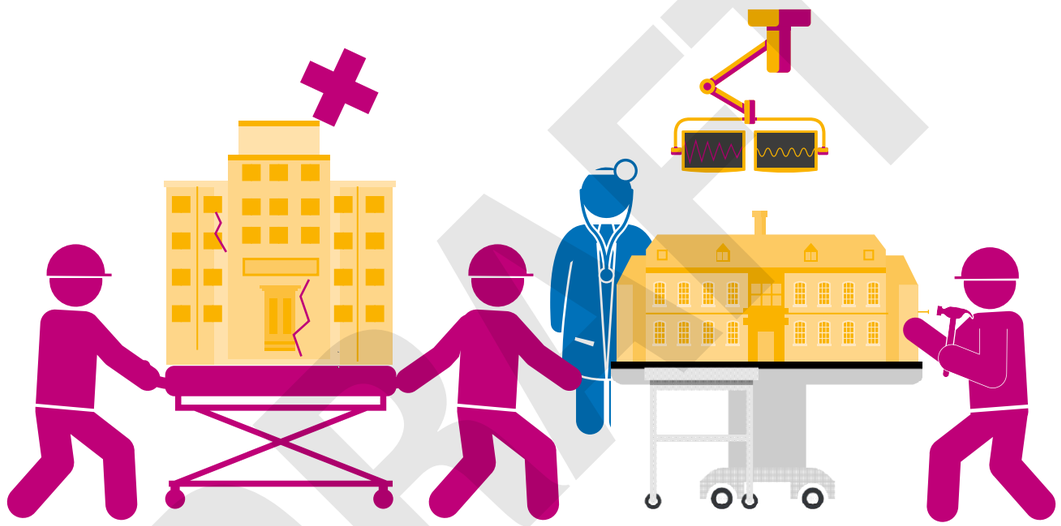
- cannot meet the consultant workforce standards set for major acute services across two sites
- have vacant consultant posts and gaps in the staff rota (reducing the quality of care and creating financial pressure)
- have shortages of junior doctors and middle-grade doctors (so the hospitals have to employ temporary staff to fill the gaps in the rotas), and
- have high vacancy rates for nursing and midwifery staff.

Details of the staffing problems facing Epsom and St Helier hospitals can be found on our website **(visit www.improvinghealthcare together.org.uk and type 'pre-consultation business case' in the search box to get to the document).**

The hospital buildings are not fit to deliver 21st century healthcare

Our local hospital buildings are old – 57% of the hospital buildings (91% of the St Helier Hospital buildings and 14% of the Epsom Hospital buildings) were built before 1948. This means that most of the buildings are older than the NHS itself. The buildings need significant and ongoing maintenance, and are not designed in a way that supports modern healthcare.

Significant investment is needed to make sure hospital buildings are safe.



"… in many areas the environment was not always appropriate for the services being delivered, due to the age and structure of the estate."

CQC report, September 2019.

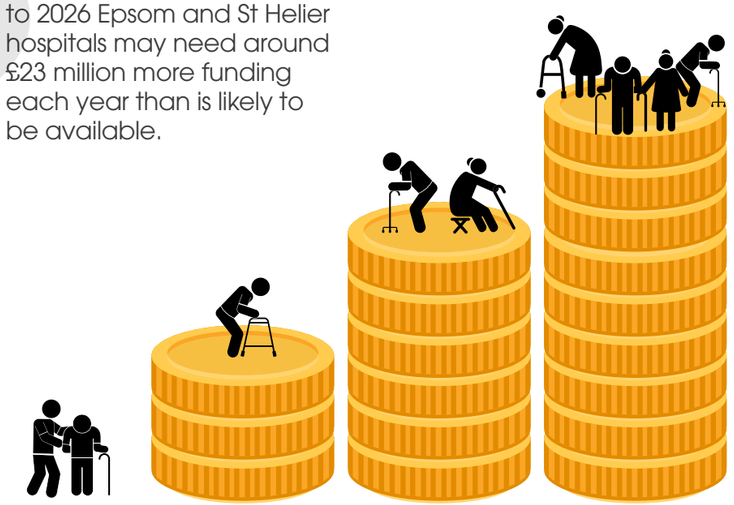
The Care Quality Commission (CQC), the independent regulator of health and social care, has continued to rate both Epsom and St Helier hospitals as 'requires improvement' for emergency services, despite giving the Trust an overall rating of 'good'.

Achieving financial sustainability

Currently, Epsom and St Helier hospitals spend more than they receive in funding, and this is expected to continue unless we change the way care is provided. This is due to the increase in costs for temporary clinical staff to cover vacancies and gaps in staff rotas, the increasing costs of maintaining hospital buildings, and the reduction in opportunities to make savings.

We want our local NHS to be able to run our hospitals with the money they have available.

To meet expected increases in demand for hospital services from an ageing population, and other increases in costs, by 2025 to 2026 Epsom and St Helier hospitals may need around £23 million more funding each year than is likely to be available.



What we are proposing?

We have a clear clinical vision – to make sure the very best quality of care is available to people living in Surrey Downs, Sutton and Merton. At the heart of our vision is keeping local people well, and providing as much care as possible close to people's homes.

We want to make sure the very best care is available to our patients and communities, and that this care can continue to be provided in buildings which are fit for purpose. We need to make sure that when you are seriously ill or at risk of becoming seriously ill, you have access to the highest-quality care locally, at any time of day, 365 days a year.

We are clear we want to do three things to improve healthcare locally:

- deliver better integrated services,
- deliver district services locally in fit for purpose buildings and ensure that patients have access to local urgent treatment 24 hours a day, 365 days of the year, and
- ensure we can deliver high quality key (major) acute services by bringing six services together on a single site in a new purpose-built specialist emergency care hospital which could be located at Epsom, St Helier or Sutton hospital.

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District hospital services

District hospital services include urgent treatment centres, outpatients, day case surgery, low-risk antenatal and postnatal care, imaging and diagnostics, and district beds (for patients who are no-longer acutely ill). District hospital services are also supported by services in the community, such as GP appointments, social prescribing (where health professionals refer patients to support in the community, in order to improve their health and wellbeing) and mental health services.

District hospital services should be closer to patients' homes, as these are the services that people may need more often.

Under our proposals, both Epsom and St Helier hospitals would continue to provide district hospital services, with GPs, community health, public health, social care and mental health services coming together with hospital clinicians to support people in their communities. Both hospitals would have urgent treatment centres (UTCs) which would be open 24 hours a day, 365 days a year. The UTCs would be staffed by doctors and specialist nurses.

Joining up services

We have been working to join up primary, community, social, mental-health and hospital care.

Epsom and St Helier hospitals are already working in partnership with other health and social-care services to provide care. This has resulted in fewer people needing to be admitted to hospital and a shorter stay for people who do need hospital care. The hospitals have received feedback from patients using these services (and their carers) which shows they feel more supported and able to manage their ongoing health issues.

Urgent treatment centres

In our proposals, the UTCs would be open 24 hours a day, 365 days a year, and would be staffed by doctors and emergency care nurses. This would mean that if you had an injury or health condition that was not life-threatening, you would continue to go to your own local hospital, just like you do now.

We are proposing that both Epsom and St Helier hospitals would have a UTC. If the new specialist emergency care hospital was built at Sutton, there would be an extra UTC based at Sutton Hospital.

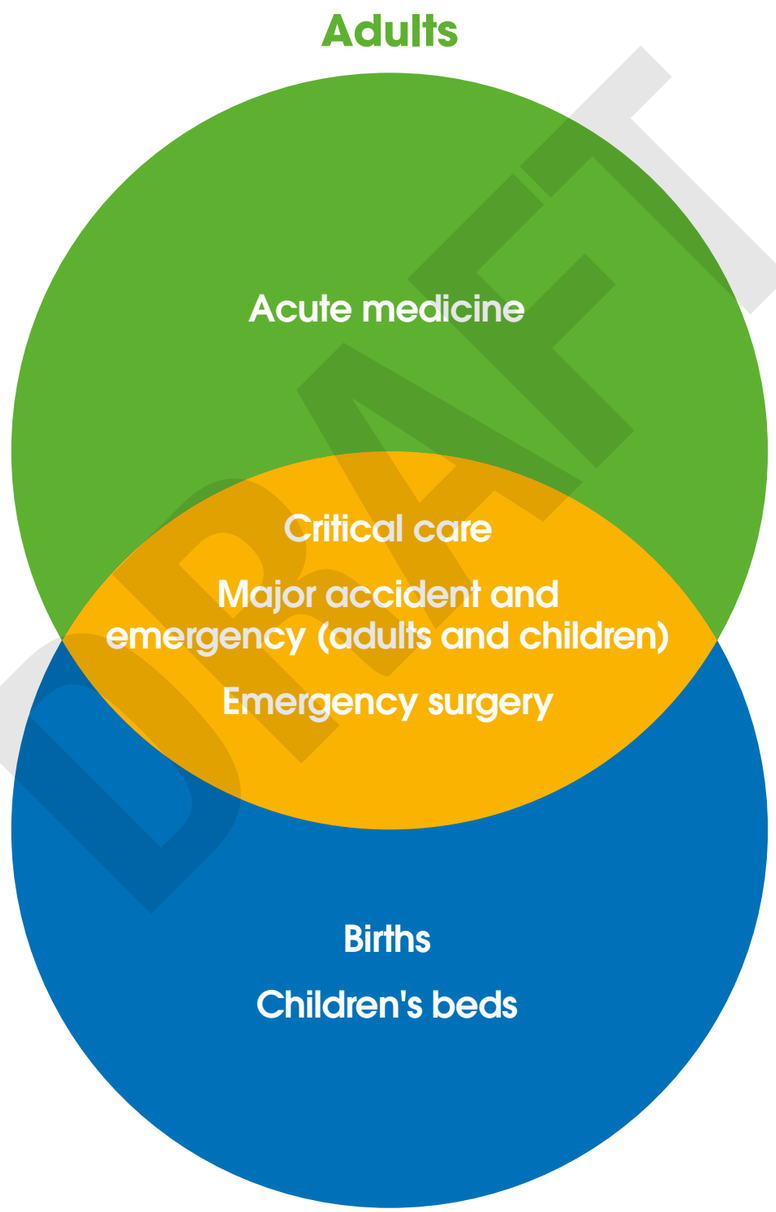
Merton GP and Clinical Chair of NHS Merton Dr Andrew Murray said:
"If we don't change how we provide our hospital services, the quality and safety of care for people is going to get worse – we already face a shortage of doctors, and never-ending repair costs for very old buildings."

Surrey GP and Clinical Chair of NHS Surrey Downs Dr Russell Hills said:
"It's important to stress that under all the proposals and options, the vast majority of the current services would continue at refurbished Epsom and St Helier Hospitals. Both hospitals would continue to provide care for people with injuries like broken bones, for day surgery, beds for older people recovering from illness and outpatient services – with urgent treatment available for local people day and night."

Sutton GP, and Clinical Chair of NHS Sutton, Dr Jeff Croucher said:
"It's not acceptable that we don't have enough single rooms at our hospitals for patients who are at the end of their lives or for patients who need better privacy and dignity. We must make sure this investment comes into the Epsom and St Helier Trust, for the sake of all our local patients, their children and grandchildren."

Major acute hospital services

Major acute hospital services are the services you may need if you are very unwell. They include emergency departments, acute medicine, critical care, emergency surgery, obstetrician-led births, and paediatrics. Major acute hospital services all use intensive care services, and specialists need to be involved in caring for high-risk patients who need hospital care. These services are 'co-dependent' which means that need to be close together.



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We believe that six core services should be brought together in a new specialist emergency care hospital so that the most unwell patients, those who need more specialist care, and women giving birth in hospital get the right support straight away from senior specialist staff.

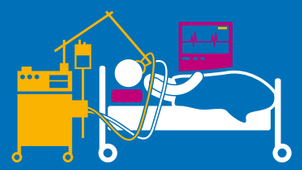
We want to bring together at one site (Epsom, St Helier or Sutton) six core (major) services for the most unwell patients and those who need more specialist care

Specialist emergency care hospital

A major emergency department
for the sickest patients with life-threatening conditions, including a specialist children's A&E

Acute medicine
for patients with the most urgent medical needs, for example, severe pneumonia

Emergency surgery
for patients who need emergency surgical assessment, treatment and operations for conditions such as appendicitis



Critical care
for the specialist care of patients whose conditions are life-threatening and need constant monitoring, usually in an intensive care unit

Births
bringing together current birth services in one place, creating a midwife-led unit and a consultant delivered unit for more complicated births, and also supporting women giving birth at home if they choose to do so

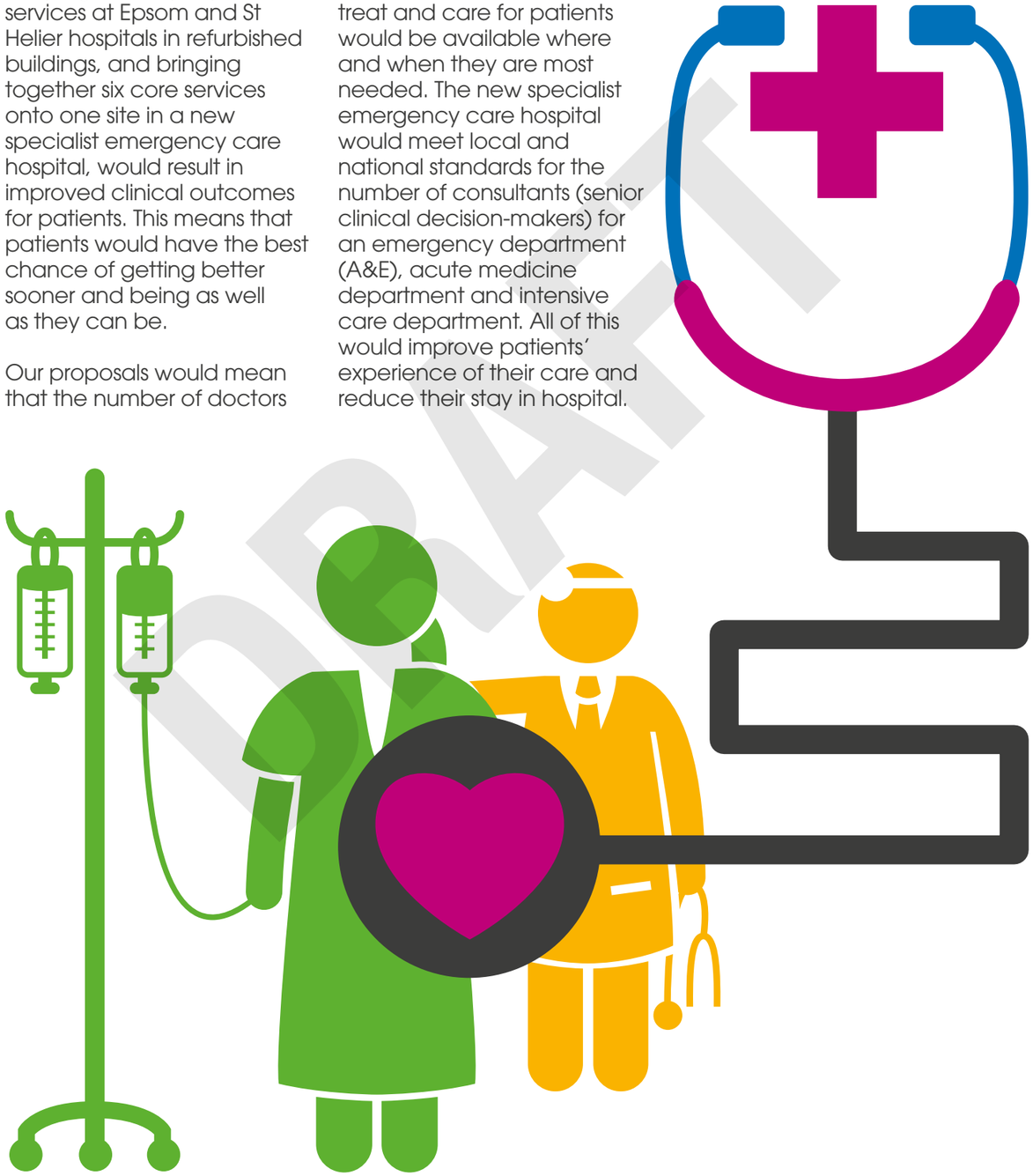
Inpatient paediatrics or children's beds
for children who need to stay overnight in hospital for treatment or observation

Of these six services, emergency surgery and intensive care are currently only provided at St Helier Hospital.

What these changes would mean

Keeping the majority of services at Epsom and St Helier hospitals in refurbished buildings, and bringing together six core services onto one site in a new specialist emergency care hospital, would result in improved clinical outcomes for patients. This means that patients would have the best chance of getting better sooner and being as well as they can be.

Our proposals would mean that the number of doctors and nurses needed to treat and care for patients would be available where and when they are most needed. The new specialist emergency care hospital would meet local and national standards for the number of consultants (senior clinical decision-makers) for an emergency department (A&E), acute medicine department and intensive care department. All of this would improve patients' experience of their care and reduce their stay in hospital.



What the proposed changes mean.

Our proposed changes would have potential benefits.

- More consultants would be on duty in hospital to care for patients who are very sick or who are at risk of becoming seriously ill. This means we would be meeting the standards for the number of consultants on-site, which we know improves care, quality and outcomes and helps make sure patients receive specialist care and assessments without delay.
- The quality and outcome of care would improve. Reducing differences in care by providing services seven days a week has been shown to improve clinical outcomes and patient experience, reducing the risk of further illness and death which could be avoided.
- Patients would have access to more specialist doctors and nurses. Bringing six services together onto one site means that more patients would be seen by the clinical team. This would help staff maintain and improve their skills and expertise
- Patients would have access to 'co-dependent services' when needed as the core services would be provided on one site. This would improve outcomes for patients.
- Patients' experience of hospital would improve as a result of being treated in modern buildings that are fit for purpose, and in the most appropriate care settings, closer to home where possible.
- Mental-health services would improve, as psychiatry services would be introduced.
- Workforce challenges would improve as staff would be working in better buildings and meeting minimum standards, and would have more time to provide care direct to patients, and junior staff would receive better training and supervision with an improved approach to multi-disciplinary care (care involving several different departments and specialists).

Our proposed changes would have potential negative impacts.

- The proposed changes would mean that hospital births would no longer be available at both Epsom and St Helier hospitals. Also five other services would only be available on one site (the specialist emergency care hospital). This would mean that patients needing a major accident and emergency department, critical care, emergency s surgery, acute medicine and children's hospital beds would have these provided on one site, instead of two.
- Under the proposed changes the movement of the six services onto a new single site would result in some patients having to travel further to the new specialist emergency hospital.
- Moving the six services from two sites onto a new single site could be seen as limiting choice and making services less accessible.
- Some visitors may have to travel further and experience longer journey times when visiting someone in the specialist emergency care hospital.
- For some people, journeys to the specialist emergency care hospital could become costlier and more complex. This could require multiple modes of transport. Where this becomes the case, it is likely to have an effect on older people, disabled people, people from minority ethnic groups, pregnant women and people living in deprived areas.

Dr Amir Hassan, Clinical Director Emergency Medicine at Epsom and St Helier hospitals said:

"By focussing the more unwell patients on a single site, we will be able to consolidate our junior and senior workforce, providing better quality care, more consistent consultant presence in the emergency department later into the evening and greater depth of staffing to provide more timely care to our patients."

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Marion Louki, Director of Midwifery and Gynaecology Nursing at Epsom and St Helier hospitals said:

"Bringing the two maternity units together onto one site, would mean we can ensure a greater number of hours of consultant presence in the hospital. It would mean we would have the specialist medical and midwifery to support women, families and staff when it is needed, providing the very best care to women and babies."

The following case studies describe our vision for local healthcare under these proposals.

Kushi's story - having a baby

Kushi is very excited as she has found out she is pregnant. After telling her partner and her mum, she makes an appointment to see her GP. Her GP talks to her about the choices for having her baby. She lives near to one of the district hospitals and chooses to have her appointments here instead of with the midwife in a community clinic. She also sees her GP regularly.

After discussing it with her partner and her Mum, Kushi decides she wants to have her baby in hospital. This means she would be having her baby in the specialist emergency care hospital rather than at home. Her sister had a difficult birth with her first child, so Kushi wants to make sure there is an expert doctor available at any time of the day or night to help if needed.

When the time comes for Kushi to have her baby, her partner drives her to the specialist emergency care hospital. Everything goes well and the midwife delivers the baby. Kushi is relaxed as she knows that a consultant is on the labour ward 24 hours a day, seven days a week, so help will be available if she or the baby needs it.

Kushi goes home the next day and her midwife visits her to make sure she is settled and has everything she needs, including a number to call if she or her baby needs help. Kushi and her baby have routine baby checks at the local community clinic and GP practice.

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Mary's story – being unwell and recovering

Mary is 85 and has lived alone since her husband died a year ago. She is well-supported by her daughter, who lives locally, but is still getting used to life alone. Mary is proud of her independence and until recently has managed her type 2 diabetes well. Mary's health needs are complicated because she also has lung problems which cause breathing difficulties.

When Mary's husband died her GP arranged for her to be looked after by a team of health and care professionals with different skills. This included a doctor, physiotherapist, social worker and pharmacist. They assessed Mary's physical needs, as well as her mental wellbeing, and agreed a plan for how the best way to care for her and help her to live independently.

With Mary's agreement, this care plan can be seen by all the health and care professionals involved in her care. Her daughter can also read it on an app on her mobile phone. The actions on the care plan include checking Mary's blood to monitor her diabetes, regular medication reviews, an invitation to a wellbeing class and an introduction to a local book club, as she is a keen reader. All the professionals in Mary's health and care team work together and are closely linked to the district hospital. One member of the team is her key contact, and they keep in touch regularly.

Unexpectedly, at 8pm on a Friday night, Mary develops bad tummy pains. She calls her daughter, who immediately calls 999. The ambulance crew can see Mary's care plan, including what tablets she takes and what her health issues are. The ambulance takes her straight to the specialist emergency care hospital.

Mary needs emergency surgery and she is looked after in the intensive care unit before and after her operation.

Mary's operation goes well and she feels much better and is out of intensive care in a couple of days. However, the treatment has left her feeling weak and has made her diabetes a bit harder to manage. Her daughter is worried about her going home.

Mary is transferred to her local district hospital, where a team focuses on getting her fit, strong and ready to go home. Mary's care is led by a new type of health professional, who is a specialist in looking after people who are getting ready to go home and who has expert knowledge of both community and hospital services.

Mary's care plan is strengthened with more care and support. This includes a mental wellbeing assessment and a visit by her key contact from the team who support her at home. The hospital team agree she can go home, but will receive extra support and care until she regains her confidence. Over the next few weeks Mary gets back into her usual routine, including catching up on her reading for her book club.

Thomas's story – a severe accident

Thomas buys his first car at the weekend. On Saturday evening he loses control on a wet road near the specialist emergency care hospital and suffers severe brain injuries.

Even though the specialist emergency care hospital is very close, the ambulance crew drive him with blue lights straight to St George's Hospital, which is the nearest 'major trauma' (severe accident response) centre.

It is very important that Thomas receives specialist and expert care from the experienced doctors, nurses and other specialists in the trauma team. There are four of these teams at four NHS trusts in London, including St George's Hospital in South West London. Because the ambulance bypasses his local A&E and takes Thomas straight to the nearest trauma centre, he has the best chance of survival and the smallest risk of permanent disability.

Thanks to the specialist trauma team at St George's Hospital, Thomas is able to walk, talk and play football again only 10 months after the accident. This system of bypassing local A&Es and taking patients to specialist trauma centres (if this means they will receive the most appropriate care) has been in place in London since 2009 and has saved many lives. The same system is used for patients who have had a heart attack or stroke. This system would continue under these new proposals.

Farrah's story – a young person with diabetes

Farrah is 15 years old and lives with her family near a district hospital. Farrah has type 1 diabetes, which develops early in life, and she needs daily insulin injections. Farrah's parents help her control her diabetes (manage her blood-sugar levels), making sure she takes the right amount of insulin at the right times, that her school has up-to-date knowledge of her care, and that she has regular follow-up appointments with the paediatric diabetic specialist team (a diabetes team that deals with children and young people).

The team runs regular outpatient clinics at both district hospital sites. Farrah or her parents can also contact the diabetes specialist nurse, 24 hours a day, every day of the week, if they have any concerns.

If Farrah has any kind of diabetes-related emergency, an ambulance will take her to the paediatric emergency centre at the specialist emergency care hospital.

There is little change to the day-to-day clinical care of Farrah's diabetes. Almost all children's diabetes care can be managed in outpatient departments, with very few children ever needing to be admitted to hospital. However, if Farrah did require specialist inpatient care, under the proposals a team of specialist clinical staff could give her round-the-clock specialist care at the specialist emergency care hospital.

There would also be dedicated children's high-dependency beds at the specialist emergency care hospital (currently not available at Epsom and St Helier hospitals) so that children could receive the very highest level of care if they ever needed it.

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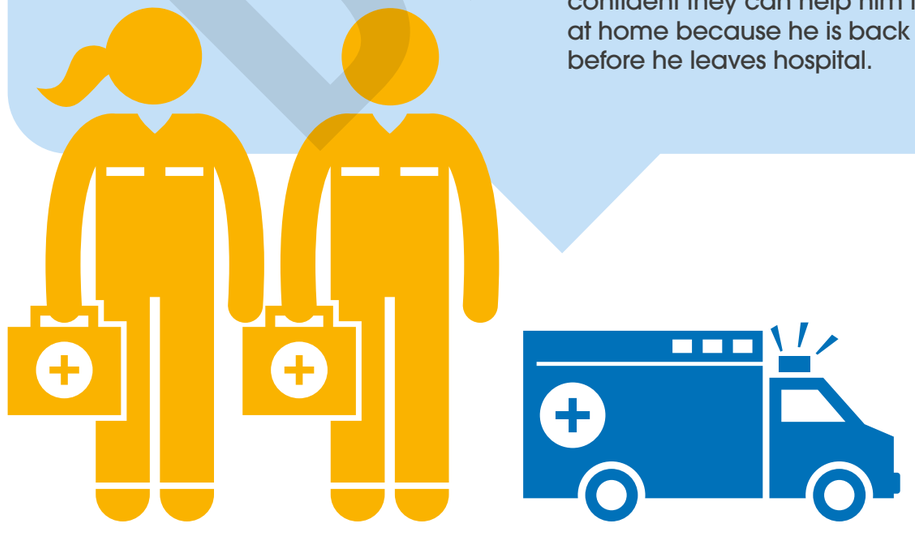
Frank's story – severe chest infection and recovering

Frank is 72 years old. He lives alone at home and has family and friends close by. Frank has been unwell with a cough and a temperature for a week or so. He becomes severely short of breath and unable to talk easily. On Friday evening his friend calls the ambulance and tells the paramedics that Frank is struggling to breathe and talk. When the paramedics arrive, they carry out continuous observations on Frank, closely monitoring him and giving him oxygen treatment in the ambulance on the way to the specialist emergency care hospital. The consultant in the emergency department assesses Frank's condition and diagnoses him with pneumonia (a severe chest infection). She immediately refers him to the intensive care unit (ICU). Frank is reviewed by the ICU consultant and team, who very quickly put a clear treatment plan in place.

By Sunday evening, Frank is well enough to be moved out of ICU to a medical ward at the specialist emergency care hospital. He still needs antibiotic injections and a daily medical review, as well as treatment from the chest physiotherapist on the ward. He is gradually getting better but is not yet well enough to go home. After five days in hospital, Frank can breathe more easily and is taking antibiotics tablets rather than having antibiotic injections. He is keen to go home, but his time in hospital has left him feeling weak and unable to walk very far.

The team at the specialist emergency care hospital recommend that Frank has some focused rehabilitation in a district hospital to help speed up his recovery. He can continue the treatment for his pneumonia and focus more on getting his strength and his confidence back. Frank is reassured to see the district hospital team are involved in seeing him each day on the ward even before he leaves the specialist emergency care hospital.

Frank is transferred to the district hospital for another five days, before going home feeling stronger and more confident. His family and friends are confident they can help him to manage at home because he is back on his feet before he leaves hospital.



What people have told us

Over the past two years we have been gathering local people's views on hospital services. This has included involving groups who are most likely to be affected by our proposal to bring the six hospital services onto one new site, including people who use children's, maternity and emergency services. We used different methods to involve as many residents as possible across the Surrey Downs, Sutton and Merton area.

From the responses we received, we learnt that:

- people agree that things must change to make sure there is high-quality hospital care for future generations
- people recognise that workforce challenges and problems with current buildings need creative solutions, but there was no clear agreement about the type of change needed
- people value their local health services and, on the whole, are in favour of keeping services closer to home
- some people are willing to travel further and some would prefer to be cared for at home or closer to home, and
- people are concerned about how long it takes to travel to hospital, the cost of transport, parking and other access issues, especially for older people, people living with long term illnesses and those who live on a low income or have trouble getting out and about.

We have published this feedback on our website **(visit www.improving healthcaretogether.org.uk and type 'independent analysis on feedback' in the search box to get to the document).**

How local people have influenced our proposals

We have used the feedback we have received from residents, patients and carers at each stage of developing our proposals to:

- help shape a new clinical model, including extending the opening hours of the proposed UTCs from 8am to 8pm, to 24 hours a day, 365 days of the year
- design the criteria we used to assess the options and discuss what is important to local people by looking at the advantages and disadvantages of each option, and
- highlight the effects the proposals could have on different communities (for example, residents on a low income and those living with long term illnesses) so we can strengthen the proposals.

We have also used feedback from patients and the public to assess how the proposals might affect different groups, including older people and people from an ethnic minority. We are continuing to do this through our integrated impact assessment, which is described on page 36.

What do doctors, nurses and other NHS staff say?

There have been many discussions involving GPs, hospital doctors, nurses and healthcare professionals about the need for change and what that means for local hospital services. These local discussions have shown there is a lot of support for bringing six hospital services together onto one new hospital site.

The Clinical Senates of London and the South East have also provided independent advice. The senates are made up of highly experienced senior doctors, nurses and other clinicians who are experts in their own fields. They have studied the proposed changes and have stated that there are significant benefits to bringing together the six core services at a new purpose-built specialist emergency care hospital. The senates' report is available on our website **(visit www.improving healthcaretogether.org.uk and type 'clinical senates report' in the search box to get to the document).**

We also have a Clinical Advisory Group, made up of local clinicians from across primary and hospital care, including hospital doctors and GPs, nurses and other clinical leaders from across Surrey Downs, Sutton and Merton. This group has led the development of the proposed changes.

We have also included other local hospitals and ambulance services in the proposals, to look in detail at how possible changes might affect the services they provide (see page 41).

How we developed our options

To identify the different potential solutions that could address our case for change and deliver our clinical model, we have considered four ways that services can be organised. This is intended to capture as many potential solutions as possible to create a long list. We have considered:

- The number of major acute hospitals in our combined geographies.
- The services offered by these major acute hospitals.
- Ways that additional workforce from outside the area can support services.
- The sites that can be used to deliver major acute services.

At this stage, we are focused on the widest range of potential solutions and this is described in our pre-consultation business case **(visit www.improvinghealth caretogether.org.uk and type 'pre-consultation business case' in the search box to get to the document).**

We want to maintain both Epsom and St Helier hospitals as thriving district hospitals and ensure hospital services remain within the Surrey Downs, Sutton and Merton area.

Understanding all the possible solutions

We followed a best-practice approach to understand all the possible solutions to the challenges facing Epsom and St Helier hospitals. We narrowed these down to a shortlist which would provide the best care and outcomes to the people of Surrey Downs, Sutton and Merton.

This involved six main steps.

1 Developing all the potential solutions to the challenges facing Epsom and St Helier hospitals and applying initial tests to reach a shortlist of options that would deliver the best outcomes and benefits to patients.

2 Developing and evaluating the shortlist of options using specific criteria which were important to patients and the public.

3 Developing further evidence to understand the benefits of each of the options.

4 Carrying out a financial analysis for each option.

5 Having the evaluation of the options considered by NHS England and NHS Improvement the Clinical Senates and the Improving Healthcare Together Programme Board.

6 Setting up a Committee of the three Clinical Commissioning Groups to consider all the evidence for the shortlist.

The process to get to the shortlist was tested with the public before a final short list was agreed.

Developing all the possible solutions to our challenges

We began our work by setting out the clinical standards we need to achieve, based on regional, national and Royal College guidance, to provide the best outcomes and benefits to patients. We worked with clinicians from the hospitals and local GPs to consider this when developing the new clinical model. To make sure that the possible solutions would work, we looked at three main tests.

1 Would the potential solution keep major services within Surrey Downs, Sutton and Merton? All the solutions need to keep all major acute services within the Surrey Downs, Sutton and Merton area. We ruled out all options that would mean moving any services out of this area.

2 Would the potential solution reduce staff shortages and challenges the hospitals are facing? The only options which would solve staff shortages were those that would bring the six services together onto one of the three hospital sites – Epsom, St Helier or Sutton.

3 Where would it be possible to build a new specialist emergency care hospital? We considered if it would be possible to build a new specialist emergency care hospital on each of the current Epsom, St Helier and Sutton hospital sites, and any other sites that are not already part of the NHS. We found there is no affordable, appropriate land available in the Surrey Downs, Sutton or Merton areas, other than on Epsom, St Helier and Sutton hospital sites.

Details of the workforce solutions can be found on our website **(visit www.improvinghealthcaretogether.org.uk and type 'pre-consultation business case' in the search box to get to the document).**

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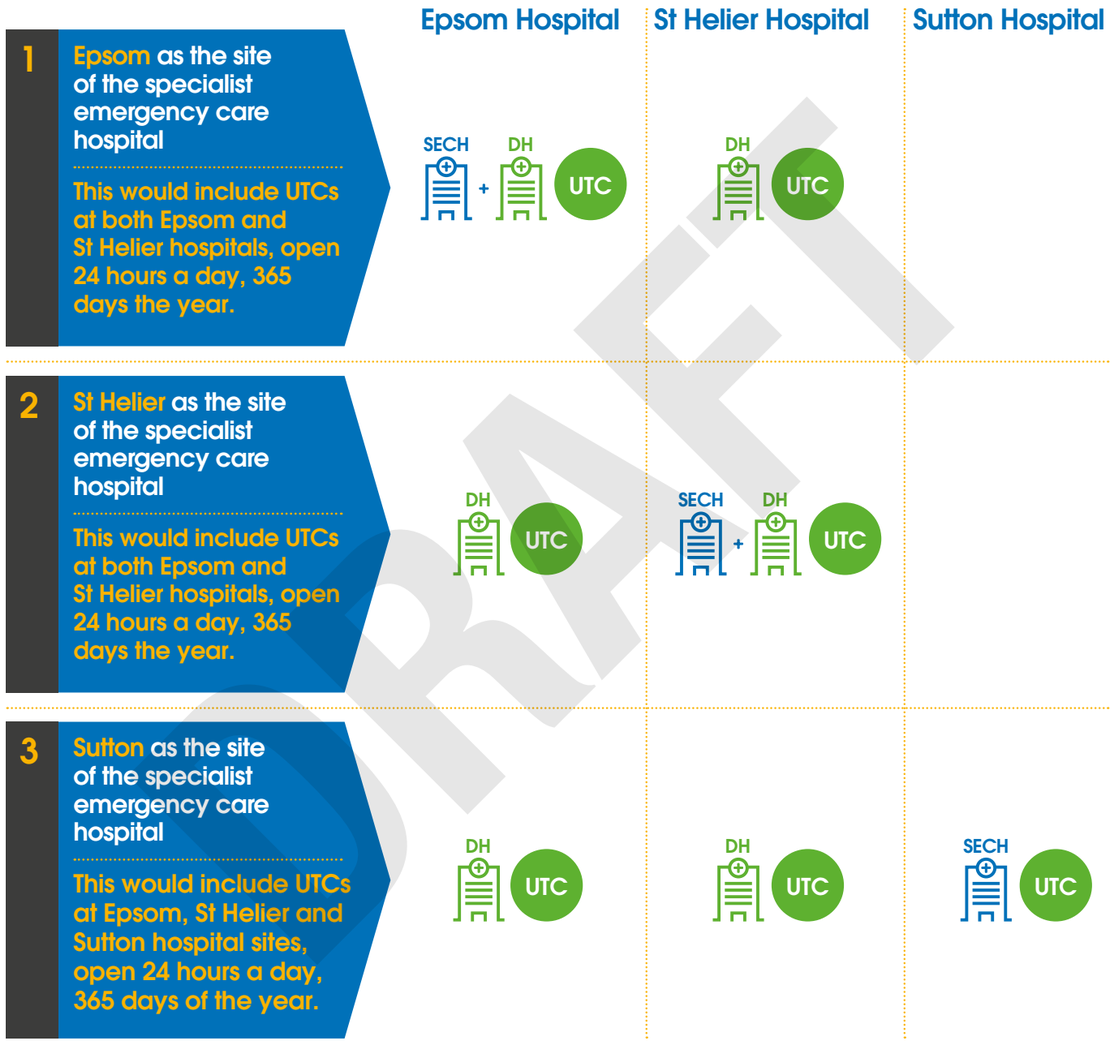
Applying these three tests resulted in a shortlist of three options.

We concluded that there are three possible options.



SECH **Specialist emergency care hospital (SECH) services,** including major emergencies, acute medicine, inpatient surgery, paediatrics, births and critical care

DH **District hospital (DH) services,** including inpatient beds, urgent treatment centre (UTC), outpatients, day case surgery, dialysis and chemotherapy

UTC **Urgent treatment centre**

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Assessing the shortlist of options

We used specific criteria to develop and assess the shortlist of options. These criteria were developed by members of the public, clinicians and healthcare professionals from across the local area.

There is an independent report of this process on our website **(visit www.improvinghealthcare together.org.uk and type 'options report' in the search box to get to the document).**

The public identified 16 non-financial criteria, reflecting what was important to patients and the public. These non-financial criteria were grouped into six categories.

Assessing the shortlist of options

(https://improvinghealthcare together.org.uk/wp-content/ uploads/2019/05/Options-consideration-report-December-2018.pdf).

Non-financial criteria and domains

Quality of care

- a Clinical quality
- b Patient experience
- c Safety

Long-term clinical sustainability

- a Availability of beds
- b Delivering urgent and emergency care
- c Staff availability
- d Workforce safety, recruitment and retention

Meeting the health needs of local people

- a Deprivation
- b Health inequalities
- c Older people

Fit with the NHS Long Term Plan

- a Alignment with wider health plans
- b Integration of care

Access, including travel

- a Accessibility

How easy it is to deliver?

- a Complexity of build
- b Effect on other providers
- c Time to build

Sutton Hospital received the highest score by the public and clinicians as the proposed site for the new specialist emergency care hospital. This was followed by St Helier and then Epsom.

The non-financial evaluation criteria that were developed by the public reflect local priorities and were used to score each of the options within the shortlist.

Further evidence

Following the development of the criteria and the scoring of options, we looked at further evidence to understand the advantages of each of the shortlist of options. This included understanding the benefits of the clinical model, the effect on other local hospitals, and understanding the effects on deprived populations, older people and health inequalities for each of the options.

This further evidence was assessed by the CCGs to understand any effects on the shortlist of options and the advantages of each of them. This was then further built upon by a financial analysis of the options.

Deprivation impact analysis

We have commissioned an independent report into how the proposed changes might affect deprived communities. The full report is on our website **(visit www.improvinghealthcare together.org.uk and type 'deprivation impact assessment' in the search box to get to the document).**

Deprivation is a key factor linked to health inequalities and any changes to the health outcomes for those from deprived areas could be affected by our proposals.

Health inequalities may be made worse by longer journey times particularly where these journey times affect deprived communities. However, the planned changes to district services may act to reduce health inequalities. District hospital services could reduce health inequalities for deprived communities by, for example, creating a proactive focus on wellbeing and an increased focus on prevention.

This study found that:

- there is evidence that health outcomes are worse in deprived communities
- there is less evidence linking deprivation with the need to use major acute services
- people living in our areas currently have relatively easy access to major acute services
- proposals for changing the location of major acute services are likely to have little effect on access to these services, and
- improving the health and care services that people may use before they need major acute services is likely to have a bigger effect on improving health outcomes for deprived communities within our combined area

Integrated impact assessment

It is best practice for decision-makers to carry out an integrated impact assessment to assess the likely effects of any proposed changes to services for local communities.

We have carried out an integrated impact assessment which provides evidence and recommendations for each of our proposed options across four different assessment areas – equality, health, travel and access, and sustainability.

The integrated impact assessment looks at the possible effects of our proposals on the whole population, as well as highlighting certain groups of people (sometimes referred to as equalities groups or protected characteristic groups) who may be affected differently by our proposals.

The integrated impact assessment is available on our website **(visit www.improvinghealthcare together.org.uk and type 'integrated impact assessment' in the search box to get to the document).**

Following our public consultation, we will review the integrated impact assessment against the findings of the consultation, and update the assessment to include any further effects and recommendations.

Patient outcomes

Across all three options, patients are likely to experience improved outcomes as a result of:

- hospitals achieving workforce standards which promote care being provided by consultants
- differences in the quality of services being reduced as services are provided seven days a week
- by bringing the services together it would allow for a critical mass of cases to be undertaken and provides opportunities for sub-specialisation, and
- having access to co-dependent services because they would be provided on one site in buildings that are fit for purpose.

This is likely to have a particularly positive effect on people in the protected characteristics groups which have been identified as having a greater need for acute services than most people.

Health equalities

Health outcomes across the Merton, Sutton and Surrey Downs areas are generally in line with or better than those in London or the rest of England. However, there are health inequalities in certain areas. Deprivation is a key factor that is linked to health inequalities. Any changes to the health outcomes for people from deprived areas, as a result of the proposed options, are likely to affect health inequalities.

Deprived communities in our combined area are likely to be only slightly affected by longer journey times under the St Helier and Sutton hospital options. The option for building the new specialist emergency care hospital at Epsom Hospital would have a bigger effect on deprived communities when looking at how people would need to travel to hospital (by car, blue light ambulance or public transport). For example, for people travelling to hospital by blue light ambulance, some people from deprived communities may experience increases in journey times of between 15 and 30 minutes under the Epsom option. However, for ambulance journey times, older people are expected to be disproportionately affected if the new specialist emergency care hospital is built at St Helier Hospital when compared to the other options. This is because many of the older people in our area live in the more rural south of Surrey Downs.

The planned changes to district services may lead to improved health outcomes for people from deprived areas and bring about changes which would help to reduce health inequalities. The district services would play an important role in creating a focus on wellbeing and preventing people from becoming very ill, and would help us target our efforts on helping patients make changes to their behaviour that is linked to poor health outcomes.

Accessibility of district hospital services

The proposed options for change may improve patient access for some services as there would be different defined points where people could access urgent care services.

All communities are likely to use and need district hospital services more frequently than acute emergency services. Keeping district hospital services as local as possible and transforming the way they work may go some way in reducing any potential negative effect from deprived communities having to travel further to access acute services.

There is an impact on patient choice for 24 hour urgent care as two major accident and emergency departments come together on one site. However, there will be either two or three urgent treatment centres located at the district hospitals (three for the Sutton option) which would be open 24 hours a day, 365 days of the year.

Patient experience

It is likely that patients' experience of hospital services will improve as a result of the care they receive being more consistent and joined up, improved care being provided by consultants (which will reduce differences in the quality of care), and services being provided in buildings that are fit for purpose.

Workforce

Hospital staff are likely to see longer-term positive effects as a result of rotas which are filled with the right number of experienced staff, new job roles, training opportunities, and through working as part of larger clinical teams. This may help the hospitals to keep the staff they have and recruit new staff.

The proposed changes may personally affect some staff as they become used to a change in their workplace and possible changes to the work patterns, their position and the teams they work in.

Accessibility of hospital services

Across the options for change, fit for purpose hospital buildings would benefit those protected characteristic groups who face challenges with the accessibility of the current hospital buildings, such as older people and those with a disability or mobility issues. The full report provides details of the effect on each protected characteristic group.

(Visit www.improvinghealthcaretogether.org.uk and type 'first draft interim IIA report' in the search box to get to the document).

Patient choice

The proposed changes would mean that five services would no longer be available at both Epsom and St Helier hospitals. This means that patients needing majors accident and emergency, critical care, emergency surgery, acute medicine, births and children's hospital beds would have these provided on one site, instead of two.

Travel times for patients

As all three options involve moving acute services from two sites to one, they are all likely to result in longer journey times for some patients.

The majority of patients (99.7%) within the Surrey Downs, Sutton and Merton area will be able to travel to an acute service within 30 minutes by either car or blue light ambulance. (The acute service they travel to may not be at Epsom, St Helier or Sutton hospitals, but at another hospital.)

Further detail on travel times can be found on our website **(visit www.imporvinghealthcaretogether.orguk and type 'baseline travel analysis' in the search box to get to the information).**

As an example, the proportion of people in the Surrey Downs, Sutton and Merton area who can access the new specialist emergency care hospital within 30 minutes on a Tuesday morning (peak time 7am to 9am).

Method of transport	Before any change	If the specialist emergency care hospital is located at Epsom	If the specialist emergency care hospital is located at St Helier	If the specialist emergency care hospital is located at Sutton
Car	99.7%	99.7%	99.2%	99.7%
Ambulance	99.7%	99.7%	99.7%	99.7%
Public transport	68.9%	49.1%	53.0%	58.7%

Summary of travel times for each option

Epsom as the site of the specialist emergency care hospital: People would need to travel to the specialist emergency care hospital at Epsom Hospital or a hospital out of our area

We predict that this option would have the biggest effect on accessibility for all residents in our combined area, with the journey to hospital taking less than 30 minutes for people travelling by car or ambulance.

- People living in the Merton or Sutton areas would be particularly affected, with people in Sutton likely to experience the biggest increase in travel times. For these residents, St Helier Hospital is currently the closest hospital, so they would have a longer journey to hospital if the core services moved to Epsom Hospital. However, even for these people, we do not expect that anyone would have to travel for longer than 30 minutes to hospital for specialist emergency care.
- People living in deprived areas are expected to be affected more than others in this option by increased journey times as more people from deprived areas live in Sutton or Merton.

St Helier as the site of the specialist emergency care hospital: People would need to travel to the specialist emergency care hospital at St Helier Hospital or a hospital out of our area

We believe this is the second best option in terms of people having to travel less than 30 minutes to access services at the specialist emergency care hospital.

- People living in Surrey Downs would experience the most significant changes to journey times, as they would have to travel either to St Helier Hospital or to a hospital outside our combined area, such as East Surrey or Royal Surrey hospital.
- For ambulance journey times, older people are expected to be disproportionately affected. This is because many of the older people in our area live in the more rural south of Surrey Downs.

Sutton as the site of the specialist emergency care hospital: People would need to travel to the specialist emergency care hospital at Sutton Hospital or a hospital out of our area

- If the specialist emergency care hospital is built at Sutton Hospital, this is likely to be the best option in terms of accessibility for the local community.
- In the more densely populated areas of Merton and Sutton, many people would be likely to be able to travel to Sutton Hospital or a hospital outside our combined area within 15 minutes.

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Transport costs and accessibility

The majority of patients would continue to use the district services available at both Epsom and St Helier hospitals. In most cases, travel times for patients and visitors would not change. For some people who need to use the services provided at the specialist emergency care hospital, journey times by public transport may increase. This could result in their journey becoming more complicated and more expensive, and may mean using several methods of transport (for example, bus and train). If this becomes the case, it is likely to affect older people, disabled people, people from ethnic-minority groups, pregnant women and people living in deprived areas.

Effect on other local hospitals

We have looked at the possible effect of the proposals on other local hospitals. This has included working with the following organisations.

- Ashford and St Peter's Hospitals NHS Foundation Trust (St Peter's Hospital, Chertsey),
- Croydon Health Services NHS Trust (Croydon Hospital, Croydon),
- Kingston Hospital NHS Foundation Trust (Kingston Hospital, Kingston),
- Royal Surrey NHS Foundation Trust (Royal Surrey County Hospital, Guildford),
- St George's University Hospitals NHS Foundation Trust (St George's Hospital, Tooting)
- Surrey and Sussex Healthcare NHS Trust (East Surrey Hospital, Redhill), and
- London Ambulance Service and South East Coast Ambulance Service.

For each option, we have worked with providers to estimate the possible effect on neighbouring hospitals. For example, changing where services are provided at Epsom and St Helier hospitals may mean that more beds and capital investment would be needed in other hospitals. We included the possible extra costs to other hospitals when considering the financial cost of each of the options.

With the right support, all the organisations listed have indicated that the options would be possible sites for building the new specialist emergency care hospital.

The Epsom option would have the biggest effect on other local hospitals. Building the specialist emergency care hospital at Epsom would mean that some patients who live in the north of Sutton and Merton and currently use St Helier Hospital would need to go to other hospitals, outside our area, for these services.

Financial analysis for each shortlisted option

As well as providing better care outcomes for patients, bringing together the six core services onto one site in one new building is expected to reduce the financial challenges the hospitals are facing. The financial analysis looked at the following five areas.

1 Activity and beds
Understand how many hospital beds will be needed in the future, according to our local population and how this is expected to change in the next 10 years.

2 Size of hospital needed
For each option, estimate how big each hospital site needs to be, based on the services provided, and how patients are expected to access services.

3 Capital investment
For each option, estimate the upfront investment that would be needed to carry out the work on the sites – for example, refurbishing existing buildings or developing new sites.

4 Costs
For each option, estimate the costs of running services. (The new model is expected to use doctors' and nurses' time more effectively).

5 Effect on other hospitals
For each option, estimate the effect on neighbouring healthcare providers. For example, changes to Epsom and St Helier hospitals may mean that more beds are needed in other hospitals.

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We used the above measures to assess the financial effect of the shortlisted options, then considered the overall financial value of each one.

Our analysis suggests that all the options are affordable and would considerably reduce the financial difficulties the hospitals are facing. Overall, Sutton offers the greatest financial value. (This is based on the net present value, which combines all costs and benefits over time to measure overall value for money – a high net present value means better value for money.)

Summary of key financial metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Epsom and St Helier hospitals key financial metrics	Total capital investment (£ million)	(225)	(466)	(430)	(511)
	Epsom and St Helier hospitals 2025 to 2026 in year income and expenditure (£ million) This includes paying more interest and depreciation on the refurbished and new hospital buildings		6.5	5.2	12.7
System key financial metrics	System return on investment 2025 to 2026 (£ million)		5.3%	7.4%	7.3%
	System net present value (50 years, £ million) (ranking)	50	354 (3)	487 (2)	584 (1)

Details on the financial metrics are available on our website in the pre-consultation business case **(visit www.improvinghealthcaretogether.org.uk and type 'pre consultation business case' in the search box to get to the document)**.

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Confirming our assessment of the options

To make sure we had considered all of the options on the shortlist thoroughly, we brought together all the evidence and asked the clinical Senates of London and the South, and NHS England and Improvement to test our clinical model and the options.

These organisations carried out their own assessment of all the evidence. In particular, for each option they looked at the number of beds that would be provided, whether people would still have a choice of services in the local area, and the evidence we based our assessment on. They also checked that we had considered all the feedback we received from the public.

Numbers of beds

We have looked at how many beds we need in the future. This has been based on people in our area getting older and our population getting bigger and means we need more beds.

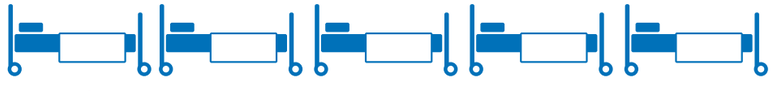
We then looked at how medicine is changing and how technology is being used to shorten the length of time people need to spend in hospital and also the move to treat people in their own homes. This means that less beds are needed. A few years ago people undergoing a knee replacement would stay in hospital after their operation for between three and five days but now increasing numbers of patients go home on the same day as their operation.

When we put together the changes in the population needs and the changes in technologies, treatments and the way services are delivered we have calculated that we will need a similar number of beds in the future as we do now. While the total number of beds are expected to be the same across all options (a slight increase on what is available now), the hospitals where these beds are needed is different by option. This makes the capital investment needed between options different.

Further information can be found on our website **(visit www.improvinghealthcaretogether.org.uk and type 'pre consultation business case' in the search box to get to the document).**

Epsom and St Helier hospitals have

1,048 beds



In the future we have worked out that we will need

1,052 beds

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Summary of options

For all three options, we have looked at both the financial and non-financial measures, as well as the possible effects on people who currently use hospital services.

The Epsom option

	Epsom
Quality of care: Would it improve safety and quality of clinical care?	The proposed changes would deliver improved quality of care in all options. In all options how care is delivered would be the same. There would be the same number of beds and the workforce issues would be resolved.
Long-term clinical sustainability: Does it improve access to urgent and emergency care and are there other clinical benefits for patients?	Two urgent treatment centres (one at Epsom Hospital and one at St Helier Hospital) that would be open 24 hours a day, 365 days of the year.
Meeting the health needs of local people: What would the effect be on older people and people from deprived communities?	Least effect on travel for older people and greatest effect on travel for people from deprived communities.
Fit with the NHS Long Term Plan: Would this fit with the Long Term Plan and support bringing services together?	All options would deliver a similar fit with how the NHS Long Term Plan sees healthcare delivered in the future.
Access including travel: What would the effect be on travel and accessibility?	Greatest increase in average travel time. A large number of local people would have to travel further with more complicated journeys.
How easy is it to deliver? Complexity and length of time to build and effect on neighbouring hospitals	More complicated to build – would take six years. Greatest effect on neighbouring hospitals – 205 beds would move to other hospitals.
Finance: What is the capital cost to build and long-term financial benefit to the NHS over 50 years, which is the planned lifetime of hospital buildings?	The capital requirement for the build at Epsom is lower than Sutton, however it also has the largest investment required for neighbouring hospitals due to the movement of patients to their hospitals. Over time, there are fewer financial benefits than St Helier and Sutton, and it is therefore of the least value for the taxpayer.

The proportion of people in the Surrey Downs, Sutton and Merton area who can access the new specialist emergency care hospital within 30 minutes on a Tuesday morning (peak time 7am to 9am).

Method	Current average	Epsom
Car	99.7%	99.7%
Ambulance	99.7%	99.7%
Public transport	68.9%	49.1%

Metric	Epsom
Total capital investment (£ million)	(466)
Epsom and St Helier hospitals 2025 to 2026 in year income and expenditure (£ million)	6.5
System return on investment 2025 to 2026 (£ million)	5.3%
System net present value (50 years, £ million) (ranking)	354

Category	Epsom
Advantages	• Delivers the clinical model and associated benefits • Lower effect on older people (when compared to St Helier as the site for the specialist emergency care hospital)
Disadvantages	• Greatest increase in median travel time • Greatest effect on other hospitals • High effect on deprived communities • Greatest effect on deprived communities • Medium complex build – extensive refurbishment • Second shortest time to build • Lowest net present value of the options • Second highest total capital requirement
Risks	• Staffing and maintaining a Level 2 neonatal unit • Significant capacity needed from other hospitals • Intersite transfers required

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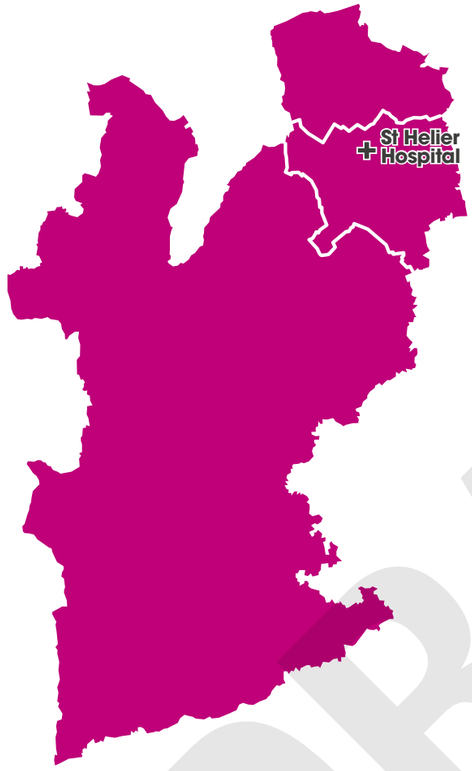
The St Helier option

	St Helier
Quality of care: Would it improve safety and quality of clinical care?	The proposed changes would deliver improved quality of care in all options. In all options how care is delivered would be the same. There would be the same number of beds and the workforce issues would be resolved.
Long-term clinical sustainability: Does it improve access to urgent and emergency care and are there other clinical benefits for patients?	Two urgent treatment centres (one at Epsom Hospital and one at St Helier Hospital) that would be open 24 hours a day, 365 days of the year.
Meeting the health needs of local people: What would the effect be on older people and people from deprived communities?	Greatest effect on travel for older people and least effect on travel for people from deprived communities.
Fit with the NHS Long Term Plan: Would this fit with the Long Term Plan and support bringing services together?	All options would deliver a similar fit with how the NHS Long Term Plan sees healthcare delivered in the future.
Access including travel: What would the effect be on travel and accessibility?	Second greatest increase in average travel time. More local people would have to travel further with more complicated journeys.
How easy is it to deliver? Complexity and length of time to build and effect on neighbouring hospitals	More complicated to build at seven years. Bigger effect on neighbouring hospitals – 81 beds move to other hospitals.
Finance: What is the capital cost to build and long-term financial benefit to the NHS over 50 years, which is the planned lifetime of hospital buildings?	The capital requirement for the build at St Helier is the lowest of the options, however, over time, there are fewer financial benefits for this option than Sutton, and it is therefore of lower value for the taxpayer.



The proportion of people in the Surrey Downs, Sutton and Merton area who can access the new specialist emergency care hospital within 30 minutes on a Tuesday morning (peak time 7am to 9am).

Method	Current average	St Helier
Car	99.7%	99.2%
Ambulance	99.7%	99.7%
Public transport	68.9%	53.0%

Metric	St Helier
Total capital investment (£ million)	(430)
Epsom and St Helier hospitals 2025 to 2026 in year income and expenditure (£ million)	5.2
System return on investment 2025 to 2026 (£ million)	7.4%
System net present value (50 years, £ million) (ranking)	487

Category	St Helier
Advantages	• Delivers the clinical model and associated benefits • Lower effect on deprived communities (when compared to Epsom as the site for the specialist emergency care hospital) • Lowest total capital requirement for the options
Disadvantages	• Some effect on other hospitals • Second greatest increase in median travel time • Greatest effect on older people • Most complex build – extensive refurbishment with multiple decants and phases • Longest time to build • Second highest net present value
Risks	• Intersite transfers required

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The Sutton option

	Sutton
Quality of care: Would it improve safety and quality of clinical care?	The proposed changes would deliver improved quality of care in all options. In all options how care is delivered would be the same. There would be the same number of beds and the workforce issues would be resolved.
Long-term clinical sustainability: Does it improve access to urgent and emergency care and are there other clinical benefits for patients?	Three urgent treatment centres (one at Epsom Hospital, one at St Helier Hospital and one at Sutton Hospital) that would be open 24 hours a day, 365 days of the year. located with the Royal Marsden it would also improve care for Epsom and St Helier hospitals cancer patients.
Meeting the health needs of local people: What would the effect be on older people and people from deprived communities?	Least overall impact on travel for older people and people from deprived communities.
Fit with the NHS Long Term Plan: Would this fit with the Long Term Plan and support bringing services together?	All options would deliver a similar fit with how the NHS Long Term Plan sees healthcare delivered in the future.
Access including travel: What would the impact be on travel and accessibility?	Smallest increase in average travel time. Fewer local people would have to travel further as Sutton is the most central to where people live in the area of Surrey Downs, Sutton and Merton.
How easy is it to deliver? Complexity and length of time to build and effect on neighbouring hospitals	Easiest to build at four years. Least effect on neighbouring hospitals – 50 beds move to other hospitals.
Finance: What is the capital cost to build and long-term financial benefit to the NHS over 50 years, which is the planned lifetime of hospital buildings?	The capital requirement for the build at Sutton is the highest of the options, however, over time, it has the most financial benefits, and has therefore the highest value for the taxpayer.

The proportion of people in the Surrey Downs, Sutton and Merton area who can access the new specialist emergency care hospital within 30 minutes on a Tuesday morning (peak time 7am to 9am).

Method average	Current	Sutton
Car	99.7%	99.7%
Ambulance	99.7%	99.7%
Public transport	68.9%	58.7%

Metric	Sutton
Total capital investment (£ million)	(511)
Epsom and St Helier hospitals 2025 to 2026 in year income and expenditure (£ million)	12.7
System return on investment 2025 to 2026 (£ million)	7.3%
System net present value (50 years, £ million) (ranking)	584

Category	Sutton
Advantages	• Delivers the clinical model and associated benefits • Joint working with the Royal Marsden Hospital • Delivers an additional urgent treatment centre • Lowest increase in median travel time • Lower effect on older people (when compared to St Helier as the site for the specialist emergency care hospital) and deprived communities (when compared to Epsom as the site for the specialist emergency care hospital) • Least complex build – new build • Shortest build time • Highest net present value of the options
Disadvantages	• Highest total capital requirement of the options • Some effect on neighbouring hospitals
Risks	• Potential additional effects on other hospitals from any further changes • Greater number of intersite transfers required

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Our preferred option

After gathering all the evidence and assessing our options, we came together as CCGs to consider all the evidence that related to the three options on the shortlist.

Having considered all the evidence, we have identified Sutton as the site we prefer for the specialist emergency care hospital to be built. We believe this option would provide the most benefits for people living in our combined area, patients and staff. This option would:

- allow us to provide high-quality services for everyone living in our area
- make sure most people can use core services, as the new specialist emergency care hospital would be built at a central location
- allow us to offer a third urgent treatment centre alongside the emergency department, and
- have less of an effect on older people and deprived communities than the other options.

Whilst Sutton is currently our preferred option for the location of the specialist emergency care hospital, we remain open-minded about all three options and any other solutions that the public might suggest.

Preferred option

Criteria	Sutton	St Helier	Epsom
Quality of care Would it improve safety and quality of clinical care, improve patient experience, provide the number of beds needed and solve the issues surrounding workforce, recruitment and keeping staff?	The proposed changes would deliver improved quality of care in all options. In all options, how we deliver care would be the same. There would be the same number of beds (a slight increase on what is available now) and the workforce issues would be solved.		
Long-term clinical sustainability Does it improve access to urgent and emergency care and are there other clinical benefits for patients?	Three urgent treatment centres that would be open 24 hours a day, 365 days of the year. Located with Royal Marsden, it would improve care for Epsom and St Helier cancer patients.	Two urgent treatment centres that would be open 24 hours a day, 365 days of the year.	Two urgent treatment centres that would be open 24 hours a day, 365 days of the year.
Meeting the health needs of local people What would the effect be on older people and people from deprived communities?	Least overall effect on travel for older people and people from deprived communities.	Greatest effect on travel for older people and least effect on travel for people from deprived communities.	Least effect on travel for older people and greatest effect on travel for people from deprived communities.
Fit with the NHS Long Term Plan Would it fit with the NHS Long Term Plan and support bringing health and care services together?	All options would be similar to how the NHS Long Term Plan sees healthcare delivered in the future.		
Access, including travel What would the effect be on travel and accessibility?	Smallest increase in average travel times. Fewer local people would have to travel further, as Sutton is the most central to where people live in the areas of Surrey Downs, Sutton and Merton.	Second greatest increase in average travel times. More local people would have to travel further, with more complicated journeys.	Greatest increase in average travel times. A larger number of local people would have to travel further, with more complicated journeys.
How easy it is to deliver? How complex would it be to build and how long would it take? What would be the effect on neighbouring hospitals?	**Easiest to build.** Would take four years to build. Least effect on neighbouring hospitals – 50 beds move to other local hospitals.	**More complicated to build.** Would take seven years to build. Bigger effect on neighbouring hospitals – 81 beds move to other local hospitals.	**More complicated to build.** Would take six years to build. Greatest effect on neighbouring hospitals – 205 beds move to other local hospitals.
Finance What is the cost to build and the long-term financial benefit to the NHS over 50 years, which is the planned lifetime of hospital buildings?	Most cost to build: £511 million. It has the most new buildings but because it keeps the most patients in the area it is the best value for the taxpayer. There are extra benefits of being located with the Royal Marsden.	Least cost to build: £430 million. It has the most refurbished buildings and keeps the majority of patients in the area, making it medium value for the taxpayer.	Medium cost to build: £466 million. The build size is smaller as it keeps the least number of patients in the area. It also has the largest investment needed at other hospitals and so is the least value for the taxpayer.

Timetable

We know it is important to keep you updated on our proposals, especially when you have taken the time to share your thoughts and views with us. When the consultation closes on 1 April 2020, an independent research organisation (Opinion Research Services Limited) will analyse all the feedback we received. ORS will manage the feedback from the consultation and will provide an independent consultation report which will make sure that the feedback we receive from individuals is anonymous. Views provided by organisations or people acting in an official capacity may be published in full. ORS will process any information you provide in response to this consultation in line with the latest data protection regulations. ORS will only use your information for this consultation. They will not keep any personal information that could identify you for more than one year after any decisions have been finalised. For more information, **visit www. improvinghealthcare together.org.uk and type 'consultation privacy notice' in the search box or www.ors.org.uk/privacy.**

ORS will produce a consultation report, which we will consider fully. We will publish the report on our website, and we will let you know when it is available. We will share the report as widely as possible with people living in our areas, patients and stakeholders.

The report will cover the major themes from consultation, a summary of the responses received about the proposals and a summary of the consolation process. We will share the report with stakeholders, including with the Joint Health Overview and Scrutiny Committee, so they can give their comments. This information, alongside all the other available evidence including the final integrated impact assessment, will be considered before any final decisions are taken.

A decision-making business case will be produced which brings together all the information required by the CCGs' Governing bodies to make their decision on how services may be improved moving forward to any implementation phase.

None of the six services would be brought together until the new specialist emergency care hospital is built which, under the preferred option, would be 2025 at the earliest.

The three CCGs' joint committee, known as the 'Improving Healthcare Together Committees in Common' is where the CCGs' leaders come together to agree proposals and make decisions about how Epsom and St Helier hospital services might change in the future. The meeting to make any decisions will be held in public and will consider all of the evidence and the consultation report.

Our proposed decision-making timetable

- **1 April 2020** – Consultation ends
- **Spring 2020** – CCGs publish independent consultation report
- **Summer 2020** – Consideration of feedback and evidence from consultation
- **Summer 2020** – CCG Committees in Common meet to make a final decision
- **2023** – Subject to approval building work starts
- **2025** – Specialist emergency care hospital opens (earliest)

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GLOSSARY

Acute care – care people need when they are very unwell and are admitted to hospital for tests and treatment.

CCGs – refers to NHS Surrey Downs Clinical Commissioning Group, NHS Sutton Clinical Commissioning Group and NHS Merton Clinical Commissioning Group. These organisations are led by GPs, supported by other healthcare professionals and lay people. Their role is to plan and commission (buy) the majority of hospital and community health services for their populations.

Care Closer to Home – programmes that are running in Surrey Downs, Sutton and Merton to provide more care closer to where people live, to support them to stay well and independent and reduce avoidable hospital admissions.

Centralised – this means bringing together services on one site (ie rather than them being provided on the two hospital sites).

Consultant-led maternity unit – this is where there are consultants (the most senior doctors) available should problems occur during labour and delivery.

Elective care – care that is planned and includes those routine procedures and operations that don't need to be done as emergencies but from the patient's point of view need to done as quickly as possible.

Emergency care – specialised care people need when they are very ill or have a serious injury which can be life-threatening.

Integrated care – integrated care happens when NHS organisations work together to meet the needs of local people.

Long term conditions – conditions that cannot be cured but are managed through medication, therapy and supported self-management (this includes diabetes, heart disease, chronic chest disease).

NHS 111 – telephone service available around the clock to provide advice to people when they have an urgent health need and signpost them to where they can get the right care as soon as possible.

Neonatal – care relating to new born babies.

NHS England – is the national body that leads the NHS in England. It sets priorities and direction for the NHS. Paediatric care – healthcare services for babies, children and young people.

Sustainability and transformation partnerships (STPs) - are partnerships covering all of England, where local NHS organisations and councils drew up shared proposals to improve health and care in the areas they serve.

Urgent care – care people need when they have a condition or injury that needs to be attended to urgently but is not life-threatening.

Trust – refers to Epsom and St Helier University Hospitals NHS Trust, the organisation that manages Epsom Hospital, St Helier Hospital and Sutton Hospital.

If you need help or more information to help you to respond to this consultation, or have further questions, email us at **hello@improvinghealthcaretogether.org.uk** or call us on 02038 800 271 or send us a text message to 07500 063191.

Please be aware that if you do require assistance, calls will be strictly confidential, and you should be assured that you can be frank and feel free to make any comments you wish.

Data Protection

No personal information will be released when reporting statistical data and data will be protected and stored securely in line with data protection rules. This information will be kept confidential. **(Further information is available on our website, visit www.improvinghealthcaretogether.org.uk and type 'consultation privacy notice' in the search box).**

If you or someone you know cannot read this document, please contact us by email at hello@improvinghealthcaretogether.org.uk or phone 02038 800 271 and we will do our best to provide the information in a suitable format or language.

Jeśli Ty lub Twój znajomy nie jest w stanie przeczytać tego dokumentu, prosimy o kontakt z nami pod adresem e-mail: hello@improvinghealthcaretogether.org.uk lub telefonicznie pod numerem 02038 800 271. Dołożymy wszelkich starań, by przekazać informacje w odpowiednim formacie lub języku.

நீங்களோ அல்லது உங்களுக்கு தெரிந்த மற்றொருவரோ இந்த ஆவணத்தைப் படித்தறிய இயவில்லை எனில், தயவுசெய்து hello@improvinghealthcaretogether.org.uk என்ற மின்னஞ்சல் அல்லது தொலைபேசி எண் 02038 800 271 மூலமாக தொடர்புகொண்டு எமக்கு தெரிவித்தால், தகுந்த மொழியிலோ அல்லது வடிவத்திலோ தகவலை உங்களுக்கு அறிவிக்க எம்மால் இயன்றவரையிலும் முயற்சி எடுப்போம்.

اگر آپ یا آپ کے کوئی جاننے والے اس دستاویز کو پڑھ نہیں سکتے ہیں تو برائے مہربانی اس ای میل پتہ کے ذریعہ ہم سے رابطہ کریں hello@improvinghealthcaretogether.org.uk یا اس نمبر پر فون کریں: 02038 800 271 اور ہم ان معلومات کو مناسب صورت یا زبان میں فراہم کرنے کی پوری کوشش کریں گے۔