E3.15 Councillor for Cricket Green, Merton (via questionnaire)

Q1 It is a very poor solution

The decision to deliver a new model of care has been driven entirely by financial and workforce pressures as opposed to developing a service - within the context of a newly emerging system comprised of a major CCG merger, PCNs and an ICS - that best meets the future clinical needs of patients and local residents. The challenge facing those responding to this consultation is whether or not the preferred Belmont option is based on genuine independent research into the needs of patients (notably deprived and marginalised communities), as the threat to St Helier Hospital's future has been hanging over the heads of local residents for nearly 20 years. Moreover, the financial advantage of placing a major acute site next to the new London Cancer Hub, beside the ICR and The Royal Marsden cannot be overlooked. In terms of whether the new model is a good solution based on workforce challenges, this option is based on the assumption that healthcare professionals will move with the service; recruitment challenges faced by St Helier or Epsom will not be felt in Belmont; and the staff/patient ratio can be addressed via reconfiguration. Indeed, such sites can place staff under more intense pressure through significantly expanded workloads. While I will not dwell on the scale of NHS system changes (or reinventions, rather) over even the past 10 years, it is noteworthy that communication of such changes to patients and the public is not clearly articulated, nor understood. Irrespective of a move towards prevention, the acute care model still exists in England and patients traditionally go to their GP or emergency care when they are sick. It may not be the most appropriate provider - perhaps they could be seen in a more timely fashion at their local pharmacy, for example - but by and large, this message has not reached the public. And it shouldn't be the NHS which enforces a new model which disadvantages a large number of patients (particularly those from the most deprived communities) but rather takes health services to them (as Mike Richards' cancer screening review, for example, clearly indicated). On cost, there is not conclusive evidence that reconfiguration results in savings. I would suggest this is less likely if the preferred proposal is to consolidate acute services on one site and create two new UTCs. A number of reviews (including this of reconfiguration of emergency care in Ireland - https://www.rcpjournals.org/content/futurehosp/7/1/33) has found little to suggest financial savings are a reality, and - importantly - do not suggest reconfiguration improves outcomes. And a final challenge with this proposed model of care is whether there is any guarantee that services would be retained on the non-acute sites when these have not been suggested during prior threats of hospital closure.

Q2a It is a very poor solution

As a councillor for Cricket Green ward - the most deprived ward in Merton, where almost one quarter (23%) of children live in low income families - removing emergency care services from St Helier hospital would be hugely detrimental to those living in Cricket Green, and indeed Merton more broadly. Aligned to my previous response, the suggestion that certain patients should not present at A&E because their condition would not be deemed life-threatening assumes patients should make a decision on the most appropriate treatment based on their symptoms. This is unrealistic and, for the residents I represent, a further blow to access given that the local NHS walk-in centre was closed and is still not operational as a healthcare facility. As you know, people experience poorer outcomes from poorer access to services which in turn has an adverse impact on their life expectancy. Deprived communities are generally more ill, present later and may not have social support at home (Reid FDA, Cook DG, Majeed A. Explaining variation in hospital admission rates between general practices: cross sectional study. BMJ 1999;319:98&#65533;103), meaning accessible emergency services are of huge importance to this population. Moreover there is a strong association between deprivation and multimorbidity (below and Gunther S, Taub N, Rogers S, et al.

What aspects of primary care predict emergency admission rates? A cross sectional study. BMC Health Serv Res 2013;13:11) and therefore, in terms of location / access to reduce health inequalities, St Helier should be considered the preferred option. Evidence shows that people in disadvantaged areas (ie surrounds of St Helier) are at greater risk of having multiple conditions, and are likely to have multiple conditions at younger ages. Around 28% of people in the most deprived fifth of England have 4+ conditions, compared with 16% in the least-deprived fifth. In the least-deprived fifth of areas (ie Belmont), people can expect to have 2+ conditions by the time they are 71 years old, but in the most-deprived fifth, people reach the same level of illness a decade earlier, at 61 years of age. I always query the genuine patient need in Belmont as it is the only option which does not propose a UTC. The fact that Epsom and St Helier will have access to a UTC suggests there is a recognised need for these services. Or else, there is a question about what guarantee these UTCs (and remaining services) are considered for the long-term. Furthermore, the suggestion that patients will not have to travel for more than 30 minutes if they are blue lighted does not factor in ambulance delays, traffic, staff shortages or the challenge of getting speedy A&E care (significant when now defunct waiting time targets are at their worst on record). For people in deprived communities who are more likely to have comorbidities and present later - and therefore at higher risk of complications - this risks the poorest outcomes for the most deprived people. For those who choose to rely on public transport to access A&E (as the majority of people in Mitcham and Morden do not have a car), they will likely travel to St George's rather than Belmont as transport access is better. A patient living in my ward in South Mitcham Community Centre, could get to St Helier or St George's in 25 minutes on public transport whereas it would take them just shy of an hour to reach the Belmont site. This means they are likely to move to St George's rather than Belmont. As such, this will place increased pressure on a Trust that has only just come out of quality special measures and has only just started re-reporting RTT data, this will overwhelm an already fragile provider. Finally, based on the analysis, the Belmont option is the more risky of the two options because the capital requirement is materially higher than St Helier (22% higher on the direct capital investment, or around 19% higher if you include the other providers), yet the returns (in terms of income surplus and Net Present Value) are not much better than St Helier.

Q2b It is a very good solution

One of the core ambitions of the NHS Long Term plan is to reduce health inequalities. The only option that would do so is building the new specialist emergency care hospital on the St Helier Hospital site. I have made the points in previous answers but to summarise, the wards surrounding St Helier (including my own, Cricket Green), are made up of highly deprived communities. Indeed, these communities are far more deprived than those in the surrounding areas of either Epsom or Belmont (which the consultation's own analysis and catchment area admits as only one is nearest to the Belmont site, and 42 of them closest to St Helier). With research clearly showing that more deprived communities tend to present to healthcare services later (often in an emergency) and will also be more likely to have comorbidities (and therefore placed at significant risk during a long ambulance journey), it is these patients who will have a higher reliance on - and need for - acute hospital services. Moreover, the St Helier option would cost the least to build: £430 million. By the consultation document's own admission, it has the most refurbished buildings and keeps the majority of patients in the area.

Q2c It is a very poor solution

Even by the consultation's own admission, this is the least optimal option. Importantly, it - like Belmont - would have a significant impact on the most deprived communities. Compounded to this is that the site would see the greatest increase in average travel times (which, for deprived communities presenting late and with comorbidities will invariably result in poor outcomes). It

would also be more complicated to build and have the most significant impact on neighbouring hospitals.

Q3a People living in the most deprived wards around St Helier Hospital (indeed the vast majority of deprived communities live in and around St Helier) will be significantly disadvantaged by emergency care services being removed from the existing St Helier site. As such communities tend to present later (and therefore sicker), are more likely to be multimorbid and therefore the most reliant on acute services, improved or direct public transport would not address the challenges. However, if patients were to be travelling to any of the sites for emergency treatment, surely this consultation clarifies that they should only be doing so via ambulance and therefore improved public transport should not really factor into the assessment.

Q3b People living in the most deprived wards around St Helier Hospital (indeed the vast majority of deprived communities live in and around St Helier) will be significantly disadvantaged by emergency care services being removed from the existing St Helier site. As such communities tend to present later (and therefore sicker), are more likely to be multimorbid and therefore the most reliant on acute services, improved or direct public transport would not address the challenges. However, if patients were to be travelling to any of the sites for emergency treatment, surely this consultation clarifies that they should only be doing so via ambulance and therefore improved public transport should not really factor into the assessment.

Q3c People living in the most deprived wards around St Helier Hospital (indeed the vast majority of deprived communities live in and around St Helier) will be significantly disadvantaged by emergency care services being removed from the existing St Helier site. As such communities tend to present later (and therefore sicker), are more likely to be multimorbid and therefore the most reliant on acute services, improved or direct public transport would not address the challenges. Moreover, for patients living in Merton, even if transport links were improved between Cricket Green and Belmont (current journey of 50 minutes), existing transport links to St George's mean patients can arrive in 25 minutes. As such, it is unlikely transport links could halve the journey time. This means that increased pressure would be placed on St George's, which has only just been removed from special measures (and still requires improvement). However, if patients were to be travelling to any of the sites for emergency treatment, surely this consultation clarifies that they should only be doing so via ambulance and therefore improved public transport should not really factor into the assessment.

Q4 As noted in previous responses, the preferred option (to consolidate acute services at Belmont) would have a significantly adverse impact on the residents I represent in Cricket Green. As the most deprived ward in the borough of Merton (who have recently had their NHS walk-in service removed also), these residents tend to present to health services later (and more ill), are more likely to have multiple comorbidities and will therefore be more reliant on emergency services. To remove acute services from St Helier and suggest an ambulance would arrive at a a severely ill patient's home to transport them to Belmont within 30 minutes every time - and not face challenges in accessing services on arrival - is not possible. This proposal is a conscious decision to widen health inequalities in South West London.