Surrey Downs, Sutton and Merton Clinical Commissioning Groups (CCGs)
Improving Healthcare Together 2020 to 2030 (IHT)
Committees in Common
Minutes

6th January 2020, from 11:00 – 13:00
Venue: Main Hall, Bourne Hall, Spring Street, Ewell, Surrey, KT17 1UF

Convenor: Jonathan Perkins

Name	Initials	Role
Jonathan Perkins	JP	Convenor
Gavin Grey	GG	Independent facilitator
Dr Russell Hills	RH	Clinical Chair, Surrey Downs CCG
Colin Thompson	CT	Managing Director, Surrey Downs CCG
Julia Dutchman-Bailey	JD	Independent Nurse Governing Body member, Surrey Downs CCG
Jacky Oliver	JO	Lay Governing Body member, Patient and Public Involvement, Surrey Downs CCG
Kate Scribbins	SK	Chief Executive Officer, Healthwatch Surrey
Matthew Tait	MT	Joint Accountable Officer, Surrey Heartlands Health and Care Partnership
Jacqui Burke	JB	Lay Governing Body member, Surrey Downs CCG
Andrew Demetriades	AD	Programme Director, Improving Healthcare Together 2020 to 2030
Sarah Blow	SB	Accountable Officer, NHS South West London Alliance (Merton Managerial representative at this meeting)
Dr Tim Hodgson	TH	GP Governing Body member, Merton CCG
Dr Andrew Murray	AM	Clinical Chairs, Merton CCG
David Smith	DS	Lay Governing Body member, Merton CCG
Brian Dillion	BD	Chair, Healthwatch Merton
Dr Jeffrey Croucher	JC	Clinical Chair, Sutton CCG
Lucie Waters	LW	Managing Director, Sutton CCG
Pippa Barber	PB	Independent Nurse Governing Body member, Sutton CCG
Susan Gibbins	SG	Lay Governing Body Member, Performance, Sutton CCG
Michelle Ramen	MR	Deputy Managing Director, Sutton CCG
Stephanie Philips	SP	Lay Governing Member, Patient and Public Involvement, Sutton CCG
Pete Flavell	PF	Chief Executive Officer, Healthwatch Sutton

Please note that these minutes are not verbatim but a summary of the statements and conversations that occurred during the meeting. Potentially derogatory comments about individuals in attendance at the meeting have not been recorded in the minutes.

No.	Agenda Item	Who
1.	**Welcome and introductions**	
	The independent host noted that: • This meeting is a formal meeting in public. • The meeting will be filmed and the video will be published on the IHT website. • Questions from the public will be taken at the end of the meeting when the formal agenda items have been completed. The convenor welcomed all members and confirmed that no apologies were noted.	
2.	**Declarations of interests**	
	The Convenor advised that all panel members' declarations of interests are publically available on the Surrey Downs, Sutton and Merton CCGs' websites as these were declared for the three CCGs' Governing Bodies. No new changes were noted to the register of declared interests.	
3.	**Minutes of the previous Committees in Common on 21st June 2018**	
	The draft notes of the previous Commitees in Common meeting held on the 21st of June 2018 were approved as accurate.	
4.	**Pre Consultation Business Case (PCBC)**	
	AD advised: • The draft PCBC is a key document which details the journey of the programme to date and outlines the unified position of Surrey Downs, Sutton and Merton CCGs' Governing Bodies in setting out the proposals for change. • This document outlines key areas including the: o Case for change which identifies the local challenges facing Epsom and St Helier Hospitals; o Development of the clinical model; o Programme of early engagement with the public and stakeholders o Options development and consideration process; and o Any subsequent work undertaken to date which includes the process for identifying a preferred option to consider in a public consultation. **a) The case for change** RH outlined the local challenges facing Epsom and St Helier Hospitals which include: 1. Clinical quality standards: with a focus on the difficulty of running two A&E departments across two hospitals and the current shortage of consultants in A&E and acute medicine 2. Old buildings: structure and condition of buildings are inadequate for modern day healthcare with the third highest backlog maintenance in England; and 3. The increasing financial pressures due to issues 1 and 2: the growing financial deficit that the Trust faces will continue to worsen if we do not solve these challenges as set out in the case for change RH highlighted that these challenges need to be solved to improve local services for local people, NHS staff and healthcare long term sustainability in the Surrey Downs, Sutton and Merton areas.	

RH explained that the CCGs have proposed a new way of organising services which will bring several important benefits including:

- Consultant-led 7 day services – multi-disciplinary consultant presence and seven day services will improve care, quality and outcomes
- Workforce, technology and estates – focused on ensuring a sustainable workforce, fit for purpose facilities and integrated digital care records
- Admission avoidance and early discharge - delivering patient benefits by providing care in the most appropriate setting
- Bringing services together – the proposed clinical model allows for a high volume of cases to be undertaken by specialists
- Improved access to services; and
- Integrated care – focused on prevention, improved pathways and a better experience for patients working closely with local communities

RH highlighted the extensive work undertaken in the development of a robust clinical model through engagement with local clinical leads, healthcare professionals, the public, carers, deprived communities and protected characteristics groups.

The development of the clinical model was overseen by the IHT Clinical Advisory Group. This group was established to provide clinical leadership to the programme and includes in its membership GP, Midwife, Nurse and other clinical representation.

RH emphasized that co-locating services in a new Specialist Emergency Care Hospital (SECH) and integrated district services will deliver improved clinical standards and the quality of care.

b) Clinical model

AM outlined the two critical elements of the clinical model:

1. **Building on the locally delivered district hospital services at Epsom and St Helier Hospitals**
    - District hospital services include the majority of hospital services, which do not rely on critical care such as: day case surgery, outpatients, ante/post-natal clinics, chemotherapy, dialysis, endoscopy and imaging and diagnostics.
    - The CCGs are committed to keeping district services local - under the three options 85% of services will stay at Epsom and St Helier Hospitals while being further integrated with other services people use.
    - Additionally the clinical model further builds opon these services through the provision of:
        - Urgent Treatment Centres (UTCs) - which would be open 24 hours/ 7 days a week
        - District beds for medically stable patients - for those ‘stepping down’ from high acuity services, and those ‘stepping up’ from the community and directly admitted via a UTC
        - Rehabilitation services - with input from social care, to scrutinise patient needs and to effectively discharge them quicker (AM provided as an example the ‘At Home’ model piloted at Epsom Hospital which reduced by one day the length of stay for patient over 65 years old)

2. **Investing in a new Specialist Emergency Care Hospital for the local population which brings together the six major acute services at the two current hospital sites**
    - The six core services for the most unwell patients include: major emergency department, acute medicine, critical care, emergency surgery, births and inpatient paediatrics (children's beds).
    - Bringing together these six services will deliver the clinical standards and improve the care for patients as they would be assessed by senior clinicians earlier in their care and as specialist teams will be available at the site throughout the week.
    - One example of other services being brought together which improved quality of care and outcomes is the co-location of hip fractures services at St Helier Hospital with positive outcomes for patients.

c) Programme of early engagement with the public and stakeholders on the case for change and the options appraisal proces

JC explained that:

- A comprehensive programme of engagement was undertaken from June 2018 with patients, carers, local residents and partners to understand the views of the local population on the preliminary proposals.
- The extensive engagement activities have been co-designed with various groups within the programme which include, for example, the Stakeholder Reference Group, Consultation Oversight Group, Travel and Acccess Working Group and the Integrated Impact Assessment Steering Group.
- Some of the engagement channels included pre-consultation listening and pop-up events, an NHS staff survey, online feedback form, focus groups/interviews with protected characteristic, deprived communities and other vulnerable groups.
- The CCGs have also commissioned other work including a Deprivation Impact Assessment and an Integrated Impact Assessment.
- The feedback received during the early engagement exercise and second phase of the Integrated Impact Assessment has been published.
- The feedback showed:
    - Clear consensus that things must change although there is not yet agreement about the type of change needed.
    - That people value their local services while many responses highlighted that people are willing to go further for better care.
    - People raised concerns about travel and access to hospitals.

d) Options development and considerations process

SB outlined the steps involved in the options development and appraisal process which include:

- **The development of an initial long list of 73 potential options** to address the case for change and deliver the clinical model

- **The development and application of three initial tests to reach a provisional short list of potentially feasible solutions**. The tests included:
    1. Does the solution maintain services within the combined geographies?
    2. Is there likely to be a workforce solution to deliver the potential solution?
    3. Which sites are viable to deliver major acute services?
    - The application of the three tests reduced the options list to three potential solutions:

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

- **An initial options appraisal process** – This process included an evaluation of each of the options using a range of non-financial criteria which were co-developed with and jointly applied by the public and professionals. This process was independently facilitated and a report produced by Traverse (the organisation who led the facilitation of the options appraisal process).
- **Further work undertaken to understand the impacts of the proposed changes** included:
  - *An impact assessment of each one of the options on six other local hospitals*
    - With the right support, all provider organisations have confirmed that the options are deliverable. Overall, impacts are mixed depending on the location of the provider and the option under consideration.
  - *A deprivation impact analysis*, undertaken by the Nuffield Trust, Cobic and PPL.
  - *An Integrated Impact Assessment*, undertaken by Mott MacDonald, which included assessments on equality, health, travel and wider sustainability .
    - The interim report highlights both positive and potentially adverse impacts on the local populations as well as mitigations actions for reducing the adverse impacts on the model. This work will be refreshed in light of the findings from consultation to ensure the full range of impacts and mitigations have been considered.
    - MT advised that as all options for change involve moving acute services from two sites to one, all are likely to result in longer journey times for at least some patients. 99.7% of patients within the Surrey Downs, Sutton and Merton area will be able to access major acute services within 30 minutes by either car or blue light ambulance (based on morning weekday rush hour).

- **An analysis of the change in the number of beds**
  MT advised:
  - The assessment of the changes in the population needs and the changes in technologies, treatments and the way services are delivered has shown that a small increase in the number of beds will be needed in the future as those existent.
  - 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.

- **A financial assessment of the options** against a number of key financial measures including: the activity and beds, size of the hospital needed, capital investment, cost of the new model and the estimated of the impact on neighbouring providers.

e) External assurance of proposals

MT explained:

- The London and South East Clinical Senates have reviewed the proposed clinical model and have provided a detailed report with recommendations. This is available on the IHT website.
- The proposals have been reviewed by NHS regulators - the PCBC has been assured and approved both regionally and nationally.
- The Consultation Institute has provided independent assurance of the process undertaken to date based on best practice.

MT highlighted that the programme has compared the three options for locating a new specialist emergency care hospital against the developed criteria and has highlighted the reasons why Sutton has been identified as the preferred option based on the evidence available to date.

The Convenor thanked the presenters and opened the floor for a panel discussion.

The following questions were raised by Committee members:

- **How would the proposed clinical model impact on the out-of-hospital initiatives in particular in relation to the impact on the elderly populations in Surrey Downs?**

LW explained that the local CCGs have been working on the integration of primary, community, social, mental and acute hospital care over the past few years to develop models of care not only for the elderly population but also people with complex needs. Out of hospital services are essential to the delivery of care local to people's homes. The proposed clinical model builds on and will be integrated with existing out of hospital services across the geography. The CCGs are confident that integrated care will enable better patient care in their homes or local to their homes via the district services and better outcomes.

- **JB asked how we can be sure of the financial modelling undertaken and that the preferred option deliver best value for the tax payer and how has the model been stress tested against sensitivities?**

MT advised that the financial model had been extensively reviewed by NHS England and NHS Improvement. The team has stress tested the model against a range of sensitivities to test the impact of flexing key assumptions on the options. This process has been outlined in the PCBC. Following these tests the ordering of the options has not changed. MT confirmed that the CCGs are confident that conlusions reached at this stage are based on robust evidence.

- **PB asked for further reassurance with regard to whether the district and acute hospitals models will enable the Trust to secure the right workforce to solve the workforce challenges it is currently facing with.**

JC highlighted the importance of having a sustainable workforce solution within the clinical model. The programme has undertaken extensive work around both the district and acute hospitals models and has worked in partnership with external bodies such as Health Education England to develop and test the proposed workforce model. JC advised that the workforce solutions is a vital piece of work underpinning the PCBC.

- **SG asked for clarification on the factors to determine a sustainable bed number and for further clarification around transfer from one site to another, including the case of other local providers.**

	MT explained that detailed work on bed modelling was undertaken. He acknowledged that in some areas of disease prevalence and estimated population growth there may be a greater demand for beds and that this will be approapriately reflected in the model. MT also highlighted that technological advances in healthcare, changes in treatment and the way services wil be delivered such as out-of-hospital models would have a positive impact on beds numbers going forward. SB clarified that other local providers have been involved in the development of the PCBC who had confirmed through their Boards that all three options are deliverable. Providers indicated the impacts on other local hospitals would be dependent on the location of the specialist emergency hospital and recognised the level of impact of some of the options would be greater than others. This work has looked in detail at beds, workforce and finance considerations. • **Further clarication was requested on what travel analysis was carried out and its findings particularly as some local residents may experience longer travel times to the new specialist emergency care hospital.** MT advised that the travel time analysis was carried out as part of the Integrated Impact Assessment work. This analysis was was run at different time periods, on different days of the week and using various modes of transport which include blue light ambulance, car and public transport. The travel times across the area are relatively low, and there are only small differences between the options which were captured in the PCBC. As all options for change involve moving acute services from two sites to one, all are likely to result in longer journey times for at least some patients. • **Further clarification was asked on the impact of the clinical model on patients safety by bringing together major acute services on to one site, longer journey times and other considerations.** AM advised that bringing the six core acute service on to one site will ensure the right number of consultations will be available through the week to deliver the clinical standards and better outcomes for patients. For example bringing stroke services together into specialist centres in London such as St George's Hospital has shown improvements in patients' outcomes and that more lives were saved. This is due to the quality of care which the proposed clinical model aims to deliver locally. The Convenor asked Committees in Common members to: • Approve the PCBC; and • Agree to proceed to a period of consultation on the proposals and all options for change as set out in the PCBC. Each of the Merton, Sutton and Surrey Downs Committees in Common: • Approved the PCBC; and • Agreed to proceed to consultation on the proposals and all options for change as set out in the PCBC.	
5.	**Consultation plan and associated draft documentation**	
	AD explained: • Through the formal public consultation, the CCGs will test and gather views as far and wide as possible of the local populations and partners in Merton, Sutton and	

Surrey Downs and neighbouring impacted areas on the proposals to build a new specialist emergency care hospital.

- In order to deliver a best practice consultation the programme has developed a consultation plan working with various stakeholder groups, as well as a consultation mandate and other consultation documentation including: a summary consultation document, full consultation document and consultation questionnaire.
- The programme has worked closely with the Consultation Institute (tCI) to ensure that it adopts best practice standards. tCI have reviewed all consultation documentsto ensure they are accessible and meet best practice standards.
- All documents will be subject to a Plain English review which will be completed by the Plain English Campaign Company prior to consultation launch.
- The Consultation Plan sets out an approach on how the CCGs are looking to reach out, listen to and gather the views from local people using a range of over 15 methods.
- The CCGs will continue throughout the consultation to adapt and seek different ways to engage with the local populations.

AD further advised that at the end of the consultation period there will be a number of important steps to take before any decision is made. These include:

- An independent anlayis of all consultation information
- This report will be published on the IHT website and shared as widely a possible with communities, patients and stakeholders which includes the South West London and Surrey Joint Health and Overview Scrutiny sub-committee The CCGs will consider their comments, the consultation report and any further available evidence, including for example the final Integrated Impact Assessment, before making any decisions.

The Covenor asked for clarification with regards to the date for consultation launch.

AD confirmed the consultation will begin on the 8th of January.

KS asked for clarification around:

- How the potential changes and their implications are described in the preamble of the questionnaire to ensure respondents have the necessary information before completing the consultation questionnaire;
- Whether the questionnaire has been tested in any way; and
- If any community groups and organisations have been involved in the development of the questionnaire.

AD explained:

- Both the consultation questionnaire and summary documents have been tested with the Plain English Campaign and both documents have achieved the Plain English kitemark. The other consultation documents are also subject to a Plain English review.
- To ensure materials are accessible, the questionnaire and consultation summary document have been converted into Easy Read formats by Easy Read UK. Both easy read documents were reviewed by an independent advocacy panel composed of people with a learning disability. The consultation materials in Easy Read will be published on the IHT website at consultation launch.
- The Consultation Oversight Group has provided input in the development of the consultation questionnaire.
- The questionnaire aims to capture a summary of the proposal and a set of questions as simply as possible to obtain the richest information through the consultation process.

	SB asked for reassurance that as part of the door drop the leaflet will be distributed as widely as possible, including a number of areas highlighted by the Merton Council. AD advised that the door drop will aim to distribute the leaflet as widely as possible in the combined geographies of the three CCGs and a number of impacted neighbouring areas. The Convenor asked Committees in Common members to approve the: • Consultation plan and mandate • Summary consultation document • Full consultation document; and the • Consultation questionnaire. Each of the Merton, Sutton and Surrey Downs Committees in Common approved the: • Consultation plan and mandate • Summary consultation document • Full consultation document; and the • Consultation questionnaire.	
	AOB	
	No AOB was raised at the meeting.	
6.	**Questions from the public**	
	During this part of the meeting the Committees in Common members responded to pre-submitted questions from the public and questions from the floor (as per agenda timings permitted). <u>Question from Hilary Porter,:</u> • What will happen between now and the building of this unit? The rebuilding of the Chairing Cross Hospital did not take 5 years as planned. It took 10 years • I am concerned about the bed occupancy. If this unit will not be built for the next 10 years, the bed occupancy is not adequate. <u>Question from Keith Francis:</u> • Will we be provided with a budget for the works and order of execution and the possible time scale? SB advised that 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. SB explained the building of new site will differ in terms of time and complexity by option and is, therefore, dependent on the chosen location of the specialist emergency care hospital. No decisions will be made on the proposals until after the public consultation has taken place and the CCGs have considered all feedback from consultation and other new evidence. The new site could be built at the earliest by 2025 and this is in the case of the preffered option as it is easiest to build. <u>Question from Marylise Orderly:</u> • The joint Clinic Senates report specifically asks the Board to both extend the demographic modelling through to 2030 which does not appear to have been done in the pre-consultation business case. The Senate's report said the activity projections are only taken up to 2025-2026 not 2030 in spite of the title of this programme especially since the implementation of the figure would not likely to become	

operational before 2021-22 at the earliest and presumably you need at least 10 years capacity planning required.

AD explained that the bed modelling undertaken was based on recongnised best practice and that further modelling will be undertaken post-consultation as part of the decision-making business case process.

Question from Cllr Oonagh Moulton, Merton Council:

a. A local pharmacy leader said he was not invited to this meeting and that he would like to be included in this work. Can you clarify if pharmacies have been involved in this work?
b. Need to ensure we have an increase in better care for Merton residents. A lot of that work around how primary care and district service are coming together should be done anyway. A number of people have concerns about how people will be getting around. Can you provide clarification on why this will be better for Merton residents in particular.

AM advised that Merton CCG is working with pharmacies in Merton independently of the IHT programme to deliver better joined-up care.

AM highlighted that 85% of the services that people already access at St Helier hospital will stay put. For those conditions that will need to be treated at the specialist emergency care hospital, a small number of people may indeed need to travel further. As all options for change involve moving acute services from two sites to one, all are likely to result in longer journey times for some patients. In all the examples where specialist services have been brought together on one site, the outcomes for patients improve. Merton CCG fully supports the clinical model and its priorities to get the best care, the best outcomes for people in Merton and that's why we are fully behind those proposals because we think it will deliver just that.

Statement from Dr Bob Gill, General Practitioner:

- This is a system that will drive this through irrespective of the impact on care. Evidence shows that the changes that people are signed up to across the country have costed 120,000 deaths and the life expectancy of people over 60 has declined by 6 months (study published by the Oxford and the London School of Hygiene and Tropical Studies). The cuts and closures to local services have resulted to 120 patients lying in corridors waiting for beds in Queen Elisabeth Hospital, Woolwich. A study found that 5500 have died waiting for a bed in hospital in the last 3 years.

AM explained that the purpose of this meeting is to discuss proposals to invest £500 million to improve the quality of care for people in Surrey Downs, Sutton and Merton. Local GPs and a wide range of clinicians have worked closely to develp a clinical model for the challenges faced by the Epsom and St Helier hospitals. The staff at Epsom and St Helier work hard to continue to maintain safe and effective services but they are operating from old buildings where for example patients need to be transported outside from one one part of the hospital to another when the lifts break down. The CCGs are fully committed to get the best outcomes for local patients and that proposals translate into that.

Comments from Siobhain McDonagh, MP for Mitcham and Morden:

- I represent the constituency with the shortest life expectancy, greatest deprivation, the most ill health and people, least access to care and who will have to travel further with the closure of the A&E and the maternity unit at St Helier Hospital.

- £2.2 million were spent with 837 responses received to your consultation.
- 6000 Merton constituents' responses were not considered because they were not on the right form.
- No constituent has received the leaflet.
- With regards to the deprivation analysis, you suggest that Pollards Hill is outside your catchment area when 34% of GPs in the local area at Wide Way send patients to the St Helier hospital. Lavender is not mentioned in the health inequalities and 20% of GP surgeries send their patients to St Helier hospital.
- What confidence can we have that you take notice of what people say and that you will even endeavour to listen to what they have to say to you?

<u>Question from Bess Harding:</u>

- Why is the meeting on a Monday at lunch time. How many people have been able to attend?

<u>Question from Clive Morris:</u>

- Are any subsequent meetings at Epsom and St Helier hospital to be held on a Saturday or are all going to be held on a weekday to make it more difficult for the public to get to them and raise objections?

SB explained that the Commitees in Common meeting is not part of the consultation as this is yet to be launched. This meeting has been held during the CCGs' business hours and has been attended by many members of the public. The programme will use different consultation methods and channels to listen to people's views including for example face-to-face meetings and events, and social media.

AM advised that consultation events will be held at different times of the day in the afternoon and in the evening, and on different days including at weekends as needed. In line with the consultation plan, a 12 week programme of engagement using different methods will be undertaken. This will include targeted engagement with various local communities, protected characteristics and seldom-heard groups as identified in the impact assessments. The programme will continue to adapt its engagement approach based on the feedback from consultation.

<u>Comments from Sandra Ash:</u>

- I attended the engagement meetings held and the feedback was that people do not want to lose their local acute hospital.
- I was part of the Stakeholder Reference Group and attended most of the meetings except the options evaluation workshops where decisions were made as to which should be the chosen hospital site for the new hospital.
- The closure process is part of the of the Sustainability and Transformation plan which includes £22 billion cuts to NHS spending nationally. The plans intend to close one or two of the local major acute hospitals.
- The Competitions and Mergers Authority have said that merging hospitals increases deaths by 550%. More beds are needed than fewer. There are too many people in too many beds which leads to cross-infections in hospitals.
- You should be building on the existing facilities.
- There will be a 25% population growth in this area in the next 20 years. This area has fewer beds per thousands of people than in the rest of England.
- You've had time to train consultants.

Committee members explained that:

- No hospitals will close – under the proposals, 85% of the services will remain at both Epsom and St Helier hospital regardless of the options proposed for the the new specialist emergency care hospital.
- There needs to be change by bringing together the six core services for the most unwell patients. The Clinician's' view that these services need to be delivered together to provide the quality of care local people deserve.

With regards to the questions raised about the number of beds; Committee members confirmed that there would be a small increase in the number of beds included in the proposals.

Question from Bernie Muir, County Cllr for Epsom West and Borough Cllr for Stamford ward:

- The figures of the travel analysis and the likely population increase in Epsom and sorrounding areas are wrong. The roads are going to be significantly more congested. Some paramedics are not able to achieve the travel times with the the blue light put on. Transport is an important issue in terms of patient outcomes looking at how patients and the elderly can get to hospitals. I am on the Planning and Regulatory Committee and there are no plans for additional roads and no mitigation. Can you shows us the proper figures for population increase and likely transport?

Committee members advised that the travel times analysis was undertaken independently by Mott MacDonald as part of the interim Integrated Impact Assessment. The impact assessments were tested and agreed by the Integrated Impact Assessment Steering Group which included representation from Local Authorities. The interim Integrated Impact Assessment will be refreshed in light of any new feedback from consultation.

Question from Josephine Alipour:

- How are you going to ensure that new buildings and the design, meet the needs of disabled people trying to access those services?

SB explained that under the proposals the new specialist emergency care hospital and refurbished buildings at the Epsom and St Helier hospitals will be accessible to people with a disability.

Statement from Bob Mackison:

- The consultation documentation needs to be avaible for the public to access before the consultation is launched. Running a consultation now is a waste of time and doesn't suit the purpose of the public.

Question from Simon McGrath, Cllr for the Dundonald ward, Merton:

- Could you clarify the phasing of any changes? If there is a new build, will the services at the other hospitals close before the new build is open?

SB explained that in line with the proposals the new site will be built first before refurbishments of the district services start.

Questions from Chris Long:

- I am a diabetic and one night I went hypo and although the crash team was called, this did not arrive. Why wasn't there a crash team available that night when I nearly died? H1 is under review. This bus would be better utilised by/for patients going to the two hospitals. The Sutton site is derelict and the roads are crowded. What is the transportation cost and impact?

Panel members thanked Chris for sharing her feedback and highlighted the importance of the proposed clinical model to improve the quality of care and avoid any situations like this in the future.

Question from David Ash, Keep our St Helier Hospital campaign group:

- The Clinical Senate's report highlighted that there were 4 options included in the PCBC. The 4th option missing from this PCBC is the option of 'no change'. Why was this removed? You are proposing to provide acute care on fewer sites with fewer acute beds and with fewer consultants. These will be located further away for most people and would be accessible via an ambulance or referral from your GP. What is the evidence that this will improve anything? Responses to this question at CCGs and Trust meetings include stroke and fractured femur examples but not the services you intend to remove from the local hospitals. Have you carried out a vote of a survey of your board members before the decision taken today? Most GPs do not know about the programme and wouldn't endorse this decision.

Questions from Prof James Woodhouse, Forecaster:

- How do you measure the 85% of services that will be retained at Epsom and St Helier hospitals? Why are your forecasts vague about 2025 and 2030 and complacent about transport congestion and the state of this country's infrastructure and population growth? Why are you so tolerant about people needing to spend an extra 5 minutes travelling and assume they won't mind in exchange for a better service? Will you include the 4th option?

AD advised that the 'no service change/do minimum' has been included in the PCBC as a comparator as the status quo; it did not pass the initial three tests at the options appraisal process.

AM confirmed that the CCGs have been engaging with their local GP memberships throughout the process to ensure their input in the developemnt of the proposals. As GPs, they cannot recommended keeping the status quo as it doesn't improve the quality of care nor meet clinical standards.

AD explained that the 85% calculation was based on the number of contacts measured across the hospitals – this is explained in the consultation documentation and in the related evidence. With regards to the question on travel related impacts of the proposals, he advised that the CCGs have and will continue to consider and develop a range of travel and access mitigation and enhancement actions using the feedback from consultation and Integrated Impact Assessment recommendations.

Question from Dan Ashcroft:

- This seems to be another bogus consultation. Having read the documents published last year, the gaps in Merton have been staggering after being pointed out and not replaced. How will responses from local communities be measured? How will any changes or recommendations be made?

Pre-submitted question by John Evers:

- Considering that many elderly people are not IT iliterate, why isn't there the option to submit questions by post?

SB advised that the different methods through which people can respond to the consultation will also include a freepost address. Through this consultation the CCGs aim to present their

	current thinking, based on the evidence available to date, and listen to local populations' views on the proposals, any concerns in relation to their potential impacts and any other new information the CCGs haven't yet considered. All feedback from consultation will be analysed in an independent report which will be considered by the three CCGs. The feedback from consultation and any other new evidence will inform and shape the decision-making process and any further recommendations.	
7.	**The Convenor closed the meeting.**	