SUBJECT TO CIC DECISION-MAKING

IMPROVING HEALTHCARE TOGETHER 2020-2030 DECISION-MAKING BUSINESS CASE

SUBJECT TO COMMITTEES IN COMMON (CIC) DECISION-MAKING

Surrey Heartlands and South West London Clinical Commissioning Groups

June 2020

EXECUTIVE SUMMARY

As commissioners of healthcare in the local area, we (NHS Surrey Heartlands CCG and NHS South West London CCG) have been exploring the best way to meet the healthcare needs of our populations in a sustainable way. This included working to identify priorities for the delivery of high quality, affordable and sustainable care.

From the 1st April 2020, Surrey Heartlands CCG was formed as a new organisation, comprising of Surrey Downs CCG and three other CCGs in Surrey. In addition South West London CCG was formed, comprising of Sutton and Merton CCGs, having merged with four other CCGs.

The Government has recently allocated £500 million to invest in Epsom and St Helier University Hospitals Trust (ESTH). In January 2020, we launched a 12 week consultation period following the publication of our pre-consultation business case (PCBC).

This DMBC is based on the evidence compiled in the pre-consultation business case, feedback from consultation and further evidence compiled post-consultation. **The purpose of this decision-making business case (DMBC) is to make a decision on the future site of the specialist emergency care hospital.**

This DMBC reviews the outcomes from the consultation report and seeks to ensure that progress to decision-making and implementation is fully informed by detailed analysis of consultation outcomes. It also ensures that the final proposal is sustainable in service, economic and financial terms.

This DMBC is not a final implementation plan for the proposal, nor a replacement for the further detailed work required for any potential outline business case (OBC) or full business case (FBC) that required at a later stage in the process. To ensure appropriate implementation it does, however, create clear requirements of any subsequent business cases. This will need to be met as a condition of commissioner support for further business cases.

This document has been written at a point in time, reflecting information (including sources and references accessed) as of the date of publication. The document, including its related analysis and conclusions, may change based on new or additional information which is made available to the programme.

Chapter 1: Introduction

As commissioners of healthcare across Surrey Downs, Sutton and Merton areas, we are clear that we must ensure that the needs of our populations are met and support improved health of our populations, both currently and in the future. This includes rapid access for urgent care needs, consistency in care for long-term conditions and access to specialists for the sickest patients or those most at risk.

To meet these needs, we have a vision for future healthcare:

- **Preventing illness**, including both preventing people becoming sick and preventing illness getting worse.
- **Integrating care** for those patients who need care frequently and delivering this integrated care as close to patients' homes as possible.
- **Ensuring high quality major acute services** by setting clear standards for the delivery of major acute emergency, paediatric and maternity services.

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 to change how hospital care is provided in the future.

Chapter 2: Case for change

We have identified a number of barriers to delivering our vision. In particular, we have three core challenges with our main acute provider, Epsom and St Helier University Hospitals NHS Trust (ESTH):

- **Delivering clinical quality**: ESTH is the only acute trust in South West London that is not clinically sustainable in the emergency department and acute medicine due to a 25 consultant shortage against our standards. Additionally there are shortages in middle grade doctors, junior doctors and nursing staff. The Care Quality Commission has highlighted workforce shortages across its two sites as a critical issue.
- **Providing healthcare from modern buildings**: Our acute hospital buildings are ageing and are not designed for modern healthcare delivery. Over 90% of St Helier Hospital is older than the NHS; its condition has been highlighted by the Care Quality Commission as requiring improvement.
- **Achieving financial sustainability**: The cost of maintaining acute services across two hospital sites is a major driver of the system's deficit. In particular, by 2025/26, ESTH may need c. £23m of additional annual funding above that which is likely to be available, based on current services. This is a major challenge to the sustainability of the local health economy.

Chapter 3: Clinical model

Our clinical model aims to ensure the very best quality of care is available to our populations and sets the direction for care in our combined geographies.

It describes how we will deliver **district hospital services** and **major acute services** to provide excellent care in the future, integrated with and supported by **out of hospital services**.

- The aim of our community-facing, proactive health, wellness and rehabilitation district hospital model is to support people who do not require high acuity services but who still need some medical input. This includes district beds for patients 'stepping down' from a major acute facility, 'stepping up' from the community and directly admitted via an urgent treatment centre(s). For the district hospital model, access is therefore important due to the frequency of contact. Our clinical model keeps district services as local as possible and these services will continue to be delivered from both Epsom and St Helier Hospitals, whilst being further integrated with other services people use.
- Major acute services are for the treatment of patients who are acutely unwell or are at risk of becoming unwell, such as those treated within the emergency department. These are services that require 24/7 delivery and include the highest acuity services which are less frequently contacted that district hospital services. We have considered the co-dependencies between these services, to define the minimum set of services that need to be co-located. For major acute services clinical standards of care and co-location are central to clinical outcomes due to the importance of consultant input and critical nature of the care – and the aim is to ensure these services are co-located appropriately.

We believe that this clinical model – where local access to district services is maintained and major acute services are co-located – will benefit the quality of our services and the experience offered to patients.

Chapter 4: Options to deliver the clinical model

In order to determine the potential solutions to address our case for change and deliver the clinical model, we have followed a standard approach for options consideration. This involved:

1. Developing an initial long list of options to address our case for change and deliver the clinical model.
2. Developing and applying initial tests to reduce the long list to reach a manageable short list. This allowed us to focus on evaluating the short list to ensure they are feasible.

3. Developing and evaluating the short list of options through non-financial evaluation criteria in line with guidance from The Consultation Institute.
4. Carrying out a financial analysis and reporting a series of financial metrics for each short listed option.

This process resulted in four potential solutions in the short list, which includes:

- The 'no service change': Continuing current services at Epsom Hospital and St Helier Hospital.
- A single major acute site, the location of a new Specialist Emergency Care Hospital (SECH), at Epsom Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
- A single major acute site at St Helier Hospital, the location of a new Specialist Emergency Care Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
- A single major acute site at Sutton Hospital, the location of a new Specialist Emergency Care Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.

The following stage of options appraisal involved a non-financial and financial options consideration. This non-financial and financial assessment was part of the evidence considered by the CCGs' Committees in Common prior to their decision to go to consultation.

Chapter 5: Previous assurance undertaken

At the pre-consultation stage, our proposals were assured by a range of organisations. This included:

- **NHS England and Improvement**: Any proposal for service change must satisfy the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks and be affordable in capital and revenue terms.
- **The Joint Clinical Senate for London and the South East**: This organisation scrutinised the clinical model and provided recommendations to address, which have been incorporated within the PCBC.
- **The joint health authority oversight and scrutiny committee** reviews the PCBC as it relates to the planning, provision and operation of health services in their local area.

An interim (phase 2) Integrated Impact Assessment (IIA) was also undertaken. The IIA is a continuous process that explores local issues and evidence in relation to any potential positive and negative impacts to changes in local services. The IIA is completed by independent experts and overseen by an independently chaired steering group that includes experts from the NHS, local councils, voluntary organisations and public health departments.

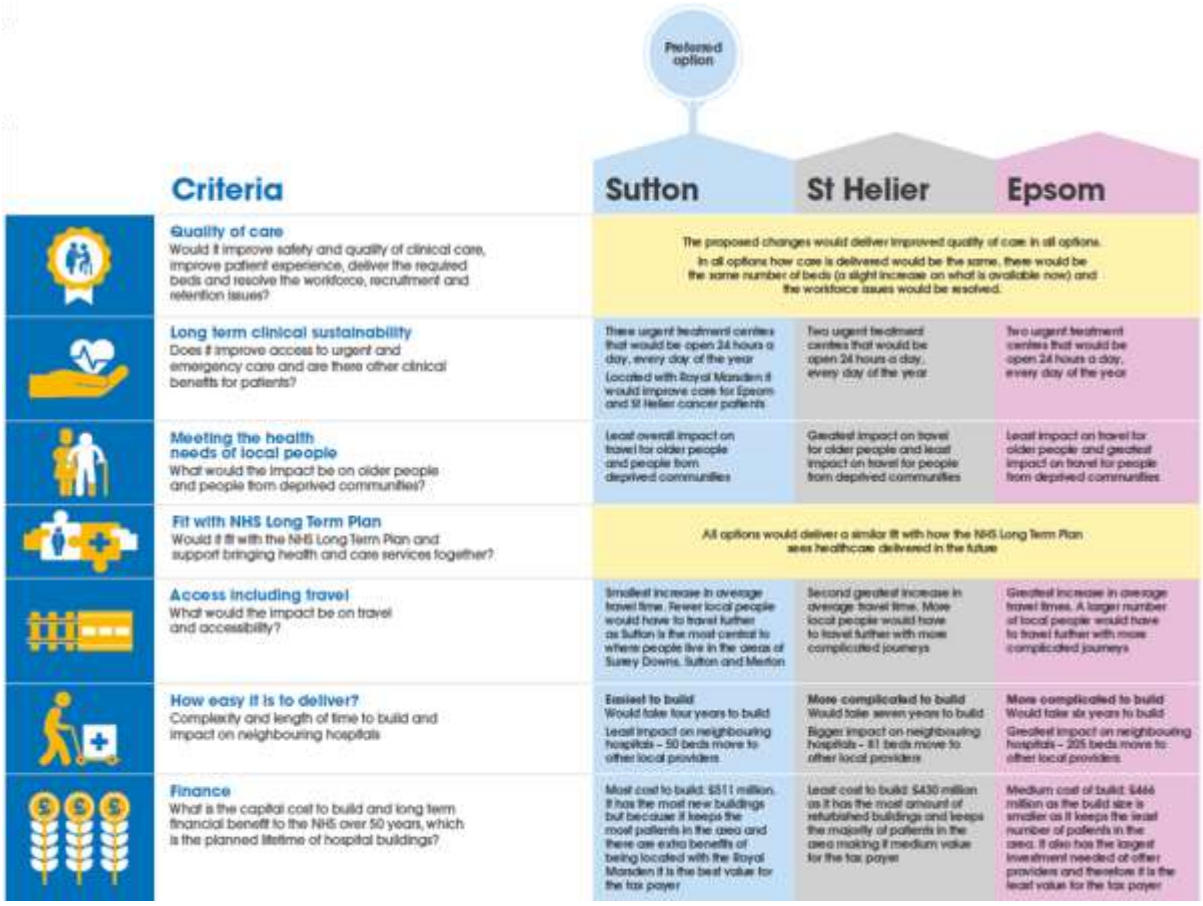
Chapter 6: Decision-making for consultation

The Committees in Common considered all the evidence and established a preferred option.

The Committees in Common considered all the evidence set out within the PCBC and concluded that:

- The three options are viable and should be included in any public consultation.
- The options continue to be ranked as:
    - Sutton as the top ranked and, on this basis, the preferred option;
    - St Helier as the second ranked option; and
    - Epsom as the lowest ranked option.

Figure 1: Summary of non-financial evidence, financial evidence and overall preferred option



Chapter 7: Consultation and engagement process

The Improving Healthcare Together consultation on the options for delivering the clinical model and addressing the case for change was launched on 8 January 2020, for 12 weeks, and closed on 1 April 2020. This involved working with a wide range of partners to carry out the consultation activities and analyse the responses. The Improving Healthcare Together Programme led on these activities, supported by:

- **Opinion Research Services (ORS)**: Reviewing and analysing emails, petitions and online and paper questionnaires, as well as pulling together all of the reports by other partners into the overall consultation report.
- **Community and Voluntary Sector (CVS)**: Commissioned by the programme to hold meetings with protected characteristics and seldom heard groups.
- **YouGov**: Carried out focus groups, interviews and events.
- **Ipsos Mori**: Conducted telephone interviews.

The consultation consisted of a detailed programme to listen to the views of the local population. This included:

- A series of 9 public listening events (3 in each area)
- Community outreach work undertaken by CCG teams
- Funding voluntary groups (via the Community Voluntary Sector Incentive Scheme
- Eleven focus groups
- Six 1:1 interviews with harder to reach populations.
- Telephone surveys
- 16 Mobile roadshows in busy places
- 16 Clinical pop-ups
- Royal Mail door to door leaflet drop
- Distribution of consultation materials
- The consultation questionnaire and consultation summary

- Social media
- Radio advertising
- Print advertising

The activities, feedback and analysis formed the basis for the CCGs to understand the views of their population.

Chapter 8: Feedback from consultation

Feedback from the consultation across all strands was analysed and collated by ORS. They produced a full report[1] which can be referred to for more detailed insights and understanding of the views and opinions about the possible changes to how health and care services are organised across the combined geography.

A number of consistent themes were identified. These included travel and access, workforce, clinical model, population and bed modelling, deprivation, out of hospital and site-specific themes (such as multi-site working). Many of these themes are consistent to areas identified in pre-consultation early public engagement and the Interim Integrated Impact Assessment.

Overall, views on the options varied according to where the respondent lives, where those who live close to the proposed hospital site favoured this as the site for the new SECH. In the consultation questionnaire, this was true of both individual respondents and NHS employees, although more pronounced for the former. NHS employees tended to favour the new SECH on the Sutton site, with more than three quarters (77%) stating that would be a good or very good solution. Whereas only 24% and 15% and said that using St Helier or Epsom would be a good and very good solution, respectively.

Overall, non-NHS-staff individual respondents were also most positive about locating the new hospital at Sutton; however, views were less clear cut and varied considerably by geography. Almost half (48%) felt that building on the Sutton site would be a good or very good solution (52% of those living within the ESTH catchment), compared with just over a third for St Helier (37%) and just over a quarter for Epsom (27%).

Chapter 9: Addressing themes from consultation

The section sets out:

- How for each theme how we have listened to the consultation feedback as set out in Chapter 8;
- How we have developed and assessed any new evidence or alternative options and its materiality as a result of this feedback; and
- How we have listened to this feedback and incorporated this into our decision-making.

The consultation feedback and our actions as a result of this have been summarised in the table below.

Table 1: Consultation themes

Theme	You said	We did
Travel and access	There needs to be good access to services, including the SECH	A refresh of the travel analysis with the latest data, and committed to extend the H1 bus route into Merton and South of Epsom Hospital.
	There needs to be sufficient parking at the hospitals for patients, visitors and staff	• A review of the parking capacity for each of the options and confirmed sufficient space is available to accommodate predicted numbers of staff, patients and the public

[1] https://improvinghealthcaretogether.org.uk/document/independent-analysis-of-feedback-from-consultation-report/

Theme	You said	We did
	There needs to be good access for protected characteristics, deprived communities and vulnerable groups to services	• Refreshed travel analysis and reviewed impacts on the options • Carried out an additional deprivation study • Updated information within the phase 3 IIA • Defined that as part of implementation plans requirements and enhancements for protected characteristics, vulnerable groups and deprived communities are specifically addressed • Responded positively to the suggestions from Sutton and Merton councils on increasing range of services that could be available as part of the District Hospital services at St Helier
	There needs to be good local access to district services	The CAG carried out a further review of district services and their link with out of hospital services. Additional work was carried out to establish how they are already integrated locally.
Clinical model	There needs to be a robust evidence base for the clinical model and the benefits need to be continually reviewed so they are fully implemented.	Further reviewed the evidence through CAG and confirmed the benefits within an updated paper, considering the balance of evidence.
	There needs to be clarity on access for the SECH and district sites	Reviewed the current level of understanding with CAG, building on the likely cohorts of patients as described at each of the sites within the PCBC.
	Other local providers need to be supported if there are any impacts on the running of their service	Reviewed the provider responses during consultation which confirmed previous analysis that all options are deliverable. Confirmed that as part of implementation we will look to work with providers to ensure assumptions are reviewed and tested, and support all providers in ensuring they receive the appropriate investment to ensure delivery of the options
	Continuity of carer model is key to the maternity and paediatrics model	Reviewed the continuity of carer model through the CAG
	Implementing the district hospital model	Reviewed the district hospital model as an essential enabler to the clinical model
Workforce	There is public support for the case for change, however some stakeholders felt that workforce challenges should not be a driver of change.	Reviewed our workforce challenge with CAG and the Trust and confirmed this is still a key part of our case for change, with no other solutions available to address this challenge.
	The workforce model needs to be sustainable and deliver sufficient training	Reviewed the workforce and training requirements at CAG and confirmed that these are deliverable

Theme	You said	We did
Population and bed modelling	Bed modelling should forecast to 2029/30 and account for housing growth	• We extended the bed modelling to 2029/30 and considered the impact of housing developments on population and activity growth. • This increased the number of beds needed by 14 which we have factored into the model. • Reviewed how the out of hospital initiatives are currently being implemented and how they support the current assumptions within the bed base
Deprivation and health inequalities	There needs to be sufficient account taken on the impact of the option on deprivation and health inequalities	• Carried out additional deprivation analysis as part of the IIA and assessed the impact on health inequalities. Reviewed the district and out of hospital initiatives to understand how they are impacting earlier in the pathway on care provision
Multi-site working	The types of care delivered across different sites needs to meet patient needs, with a consideration of transfers	Reviewed the clinical model and the needs of the different patient cohorts for district services and SECH services.
Digital	Ensure state of the art facilities and technology throughout all three hospitals	Ensured Electronic Patient Record (EPR) is incorporated as part of implementation with the necessary investment and that it will be delivered in advance of the SECH opening
Environmental considerations	Hospital design needs to take into account environmental considerations	Ensured that environmental considerations are incorporated as part of implementation
Funding	We are concerned funding may not be available for the delivery of the IHT proposals	Confirmed that ESTH remains one of the HIP1 schemes with an allocation of £500m
Covid-19	There needs to be a consideration of how changes related to Covid-19 may impact the clinical model and option	An interim review of the impacts and concluded that: • The need to consolidate acute services in a modern fit for purpose SECH is even more important to do now. • We may need to alter the design of both the SECH and the district hospitals to reflect the learning from Covid-19. • Further analysis will need be undertaken as more information about impact and learning from COVID becomes available. • We are requiring the Trust to demonstrate how the design of the hospital meets the learning from Covid as part of its Outline Business Case.
Renal services	Consolidation of renal services currently delivered by St George's and ESTH could result in improved outcomes for patients.	Considered the feedback with the Clinical Advisory Group which recognised the potential merit in the proposals and agreed that this should be considered separately from the IHT process following decision making.

Theme	You said	We did
Feedback from Sutton and Merton Councils	Specific services should be considered for St Helier Hospital if it is not the SECH to ensure it remains at the heart of the community.	Considered their proposals and confirmed that space would be available on the St Helier site to deliver them. Commissioned additional work to be undertaken in partnership with the local authorities, the community, other relevant providers and the Trust on whether these services should be included in implementation planning.

Chapter 10: Further assurance of proposals

Three key areas of further assurance have taken place following consultation. This includes the phase 3 IIA which identified further enhancements to the proposals that could be made, the Mayor's assurances and the JHOSC.

The final IIA report builds on the interim report and incorporates evidence gathered through:

- Refreshed analysis with new data sources
- **Additional analysis on deprivation**: this considers the impact of proposed changes on those living in deprived areas compared with other areas of the impacted study area for each area and the extent to which their use and experience of hospital services is different.
- **Review of the consultation responses**: This enabled the final IIA to incorporate any additional impacts or mitigating actions which had not been identified as part of the interim report.
- **Covid-19:** it is acknowledged that the Covid-19 pandemic may have implications for the way in which health services are planned and delivered in the future; although the learning associated with this may take some time to emerge.

The Mayor has set out six key assurances needed from Government to ensure Londoners get the best healthcare possible. Prior to the DMBC, following on from the publishing of the PCBC, the Mayor has assessed the work the IHT programme has undertaken against the first four of the six tests. The letter[2] from the Mayor stated his support for the investment, subject to some specific considerations:

"The Government's capital allocation will allow significant facilities to be provided at all three hospital sites: St Helier Hospital, Epsom Hospital and Sutton Hospital. Continuing to provide district hospital services as well as providing a new acute hospital is critical to maintaining access for the diverse populations served across the combined geographies."

The Mayor made specific comments regarding his findings as a result of the tests. This included providing further detail on bed modelling, health inequalities, social and community care and financial investment in the light of Covid-19.

The CCGs confirm that if further information or recommendations are received from the Mayor's Office after the Improving Healthcare Together Committees in Common meeting on 3rd July 2020 these will be reviewed as part of any further implementation planning.

The South West London and Surrey Joint Health and Overview Scrutiny Sub-committee for Improving Healthcare Together 2020-2030 (JHOSC) reviewed our work as it relates to the planning, provision and operation of health services in their local area. The JHOSC has responded to the proposals and supports the case for change but seeks clarification or has a number of concerns across a number of areas, including the clinical model, the site of the SECH, transport and travel and procedure. These have all been responded to within this chapter.

[2] Mayor's Office initial response to the Improving Healthcare Together 2020-2030; Accessible at:https://www.london.gov.uk/what-we-do/health/champion-and-challenge/mayors-six-tests#acc-i-61199

Chapter 11: Decision-making

Within Section 9, each theme is considered as to its impacts on the option ranking and the impact on decision making.

Impacts on the option ranking are material for this DMBC, which will determine the preferred site option to be implemented.

Impacts and considerations for implementation are material to further business cases (see Section 12), which will determine how this site option is designed and implemented. However, this DMBC will ensure these are implemented through the ongoing IHT governance.

Section 9 describes for each theme how and why the additional evidence and consultation feedback considered impacts on the option ranking. The PCBC options appraisal considered the vast majority of the themes raised, with any updated evidence or analysis (e.g. travel times), having only a marginal change, with no impacts on the option rankings.

Table 2: Impact of the consultation themes on option ranking and implementation planning

Area	Impacts on the option ranking?	Should be considered as part of implementation?
Accessibility to services	×	✓
Parking	×	✓
Travel impacts on people with protected characteristics, deprived communities and vulnerable groups	×	✓
Keeping services local	×	✓
Clinical evidence base	×	✓
Clarity on site access according to needs	×	✓
Local providers	×	✓
Pregnancy and maternity	×	✓
District services	×	✓
Workforce as a driver for change	×	✓
Workforce sustainability and training	×	✓
Population and bed modelling	×	✓
Deprivation and health inequalities	×	✓
Multi-site working	×	✓
Digital	×	✓
Environmental considerations	×	✓
Funding	×	✓
Covid-19	×	✓
Renal services	×	✓

Area	Impacts on the option ranking?	Should be considered as part of implementation?
Feedback from Sutton and Merton Councils	×	✓

The Programme Board has reviewed the feedback from consultation and the additional evidence developed as part of this DMBC.

The Programme Board has considered the impact of the feedback from consultation and additional evidence on the proposed clinical model, the ranking of the options, and the recommendations for implementation. The feedback from consultation and additional evidence has not materially impacted on the relative ranking of the options.

Therefore it is the Programme Board's recommendation to the Committees in Common that the following resolutions should be considered for agreement and approval, taking into account all the evidence that has been made available, on the basis that they represent the best solution to address the case for change:

- To agree and adopt the clinical model for the delivery of district hospital services and the SECH;
- To agree that the preferred option for the location of the SECH is Sutton, with continued provision of district hospital services at Epsom Hospital and St Helier Hospital.
- To agree and adopt the recommendations for implementation; and
- To establish a Strategic Executive Group and Strategic Oversight Group to monitor the delivery of the recommendations throughout implementation.

In their decision-making, the Committees in Common will consider:

- All available evidence previously considered prior to consultation, which lead to the ranking of the options for consultation, with the Sutton option ranked highest;
- The consultation responses; and
- Subsequent to consultation, the evidence within this DMBC and its supporting appendices, including:
    - The consultation analysis report;
    - Supporting analytical reports of the consultation, such as the IPSOS Mori and YouGov reports; and
    - The phase 3 IIA.

The evidence set out within this DMBC is one of the factors the Committees in Common will consider as part of their decision-making process.

No decision has been made.

As part of implementation of the preferred option, considering all the feedback received from consultation and the evidence developed, commissioners have developed the following recommendations for the Trust to deliver as part of its implementation planning. This includes the actions arising from the IIA.

These recommendations will need to be met for commissioners to provide formal support to any future business cases related to IHT.

Table 3: Recommendations

#	Area	Recommendation	Relevant IIA enhancement

1	Preferred option	The Trust should implement the preferred option as decided by commissioners.	
2	Assurance and implement ation	The Trust will report on the delivery of the recommendations and implementation of the OBC and FBC to commissioners. This includes reporting through the establishment of a Strategic Executive Group and Strategic Oversight Group.	
3	Travel and access	A full travel and access strategy should be carried out, including additional access roads and public transport routes, and review of any subsidised travel and parking The Trust should establish a Travel and Transport Working Group and Travel and Transport Reference Group to ensure local communities inform these plans The Trust and the CCGs will publish the travel action plan.	Effective communication of transport options and travel plan to staff, patients and visitors (IIA Action 5) Build site specific transport offerings (IIA Action 8) Explore the possibility of ensuring more personalised support to patients in promoting clarity around transport options (IIA Action 9)
4	Travel and access	The Trust will develop plans/proposals for car parking at the SECH and district sites, and ensure appropriate parking capacity and site accessibility is available for our local population, including staff, patients and visitors.	Ensure appropriate parking capacity on the site chosen to host acute services (IIA Action 6)
5	Travel and access	Access to services for protected characteristics and vulnerable groups should be specifically addressed within the travel and access strategy to meet the needs of these groups including older people. The Travel and Transport Working Group should: Explore and make recommendations to improve existing transport opportunities to/from the hospital sites. Explore new transport links in particular new bus routes connecting Surrey (i.e. Leatherhead, Banstead, Epsom) to the SECH. The Travel and Transport Reference Group should review and recommend potential alternative travel solutions for vulnerable groups for example (and not limited to): the good neighbour car scheme (operating in Surrey), Dial-a-ride, and services provided by the Merton and Sutton Community Transport.	Support development and capacity building of community transport options and make the community aware of the options available to them (IIA Action 7) Work with local councils and transport providers (IIA Action 10) Ensuring accessibility to hospital site (IIA Action 22)
6	Travel and access	The design work within the OBC and the implementation of the clinical model should ensure appropriate access to district services	Continuous review of service model (IIA Action 11)

		and out of hospital services in conjunction with CCG and other stakeholder plans There should be representation from system partners in the further design of pathways, including primary care, community care and patients.	Ensure district services are joined up with local strategies (IIA Action 21)
7	Workforce	In addition to the work already undertaken, the Trust will develop a detailed workforce implementation plan, including recruitment and retention plans, continuing to work in partnership with HEE, Royal Colleges, local clinicians and stakeholders.	Ensure workforce requirements are met (IIA Action 1) Develop a clear workforce plan (IIA Action 15) Understand clinical training and supervision needs at district sites (IIA Action 17) Detailed workforce analysis on staff groups affected by change, understanding their demographics and the impact on travel (IIA Action 18)
8	Workforce	The Trust carries out further staff (including clinical) engagement to develop the design and implementation of the SECH and district hospital clinical models.	Ensure staff are involved in the design of consolidated services (IIA Action 19)
9	Multi-site working	Transfer protocols are developed for implementation, working with ambulance providers and the voluntary sector.	Introduce appropriate transfer protocols and action to reduce transfers (IIA Action 3)
10	Clinical model	The clinical model should continue to be developed based on the latest evidence. The Trust should report regularly on implementation of the benefits realisation and evaluation plan.	Continuous review of service model (IIA Action 11) Develop an evaluation plan (IIA Action 4)
11	Clinical model	A communications and engagement plan will be developed to ensure clarity for the public on when to attend a SECH or District Hospital.	Provide clear communication about patient pathways and undertake an awareness raising campaign (IIA Action 2) Support patient clarity on accessing district services (IIA Action 16)
12	Clinical model	The Trust should implement the continuity of care model for maternity through a team approach, to ensure each woman has a named midwife and continuity of carer from the first prenatal appointment to the last antenatal appointment.	
13	Clinical model	The Trust should establish joint arrangements with local providers as part of the OBC to ensure patient flow assumptions are tested and reviewed as implementation plans are	Continued work with neighbouring providers (IIA Action 24)

		developed, including supporting them in their capital requirements.	
14	Clinical model	The Trust should ensure district services are fully implemented and in place to support patient flow and the operation of the SECH.	Ensure district service enhancements and sufficient lead in time (IIA Action 14) Ensure district services are joined up with local strategies (IIA Action 21)
15	Population and future bed requirements	The Trust should provide the 1,066 beds to reflect the bed requirements to 29/30. This should continue to be reviewed and refined as further population growth forecasts, housing growth forecasts, and demand management initiatives are developed and delivered.	
16	Deprivation and health inequalities	It is a key requirement that the Trust, working with other partners ensures the implementation of district services, enhanced local services and the targeted local strategies developed by CCGs to reduce health inequalities through increased access to local primary or community care are realised, with a focus on prevention, as well as targeted initiatives to manage patients with risk factors around diabetes or high blood pressure and supporting behaviour change. See also recommendation 23.	Review district service provision against local health inequalities (IIA Action 12) Re-assess accessibility issues for deprivation groups for preferred option (IIA Action 13) Continuously review needs of equality groups (IIA Action 23)
17	Deprivation and health inequalities	NHS South West London CCG will work with local partners to undertake a further focused deprivation review specific to East Merton and North Sutton residents to determine whether any additional services should be made available locally.	
18	Digital	The Trust should continue to develop plans to implement EPR in advance of SECH implementation. Digital technology should be fully incorporated into the design of the hospitals and enable connectivity with wider healthcare providers.	
19	Environmental	The Trust should work towards implementation of a carbon net zero building. The Trust should address sustainable green travel alternatives as part of the travel and access plan.	Introduce and encourage more sustainable/green travel (IIA Action 25 Seek to implement carbon offsetting strategies across the Trust (IIA Action 26) Further air quality and carbon assessment following selection of preferred option (IIA Action 27)

20	Funding	The Trust should develop an Outline Business Case keeping within the funding envelope as confirmed by Department of Health / NHSE/I	
21	Covid-19	The Trust should ensure there is future capacity within the hospital design to incorporate flexibility to respond to future surges in demand across inpatient beds and ITU. The local health and care partners should monitor the latest guidance on implementing the response to COVID-19, including any further requirements for protected characteristics (e.g. BAME), deprived communities and vulnerable groups.	Ensure flexibility and adaptability in the design for the new major acute hospital (IIA Action 20)
22	Renal	The Trust should undertake a further appraisal of the options for renal services. Should significant service change be proposed, this will require further consideration by commissioners.	
23	Primary and community services	Commissioners should undertake further work in partnership with local authorities and the Trust to appraise the additional services (including community beds, primary care, CAMHS, mental health, and a children's hub) that could be located on district site(s) or other local settings to best serve local community health needs.	
24	Social care	Working in partnership with local authorities, any potential financial or non-financial impact on social care and community services should be taken into account in implementation planning, both system wide and for the district hospital site(s).	

Chapter 12: Implementation

The IHT Programme Board, which has representation from CCGs, regulators and ESTH, has provided strategic oversight to the Programme to date. During implementation, the Programme Board will become the Trust IHT Implementation Board with responsibility for overseeing the development and implementation of the programme.

Commissioners would have oversight of the implementation of the recommendations set out within this DMBC and the implementation of the OBC. This would be in the form of a Strategic Oversight Group, consisting of the two CCGs and regulators. This group would meet on a bi-monthly basis as a forum to report progress. On the intervening months, the Strategic Executive Group would meet, consisting of the two CCG accountable officers and the Trust Chief Executive.

Clear, consistent and effective governance arrangements at all levels across the system wide implementation will be key to manage risks and dependencies across the system. The governance arrangements will build on the governance structures and processes that have been in place for the development of the PCBC and DMBC, but will pass over to the Trust rather than continuing to be the responsibility of commissioners.

Given the scale of capital requirements, securing capital investment will require trust-led business case processes dependent on the outcomes of decision making.

To secure funding for the preferred option, ESTH will need to:

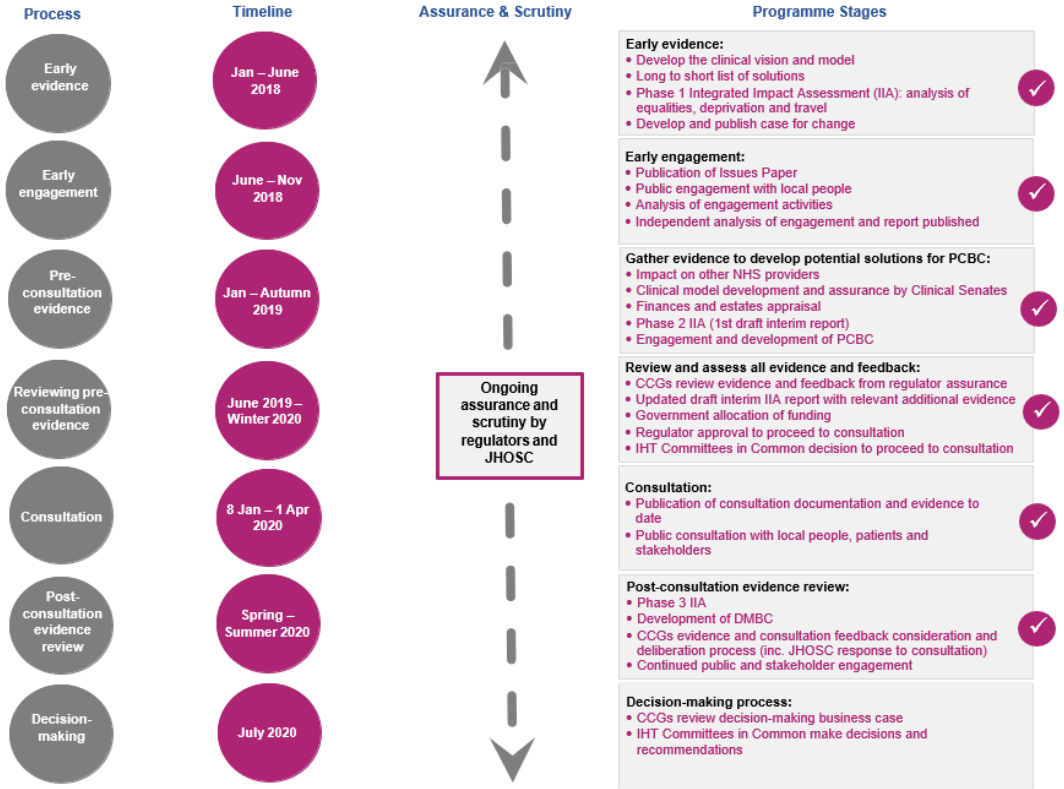
- Develop an outline business case; and
- Develop a full business case.

As part of this process, ESTH will need to secure commissioner support for its outline business case and full business case. This support will be contingent upon meeting the recommendations in this DMBC.

Chapter 13: Conclusion and next steps

This DMBC is the result of 2.5 years of evidence development, assurance and review of proposals to deliver a solution that addresses our case for change and delivers our clinical model.

Figure 2: Process of the IHT programme



The feedback from consultation has shown that there is clear public support for our case for change. As commissioners, we believe we have identified the best solution to deliver healthcare for our local population, and have tested this with the public through consultation. Further work has been undertaken to ensure that we have understood the themes from public consultation, and how this affected the ranking of the options and how the preferred option should be implemented.

The Trust will now be asked to implement the preferred option. We will continue to have a role in ensuring that the Trust implements all the recommendations as developed through our review of the consultation feedback, as well as the IIA enhancements, through the Strategic Oversight Group and Strategic Executive Group.

PURPOSE OF THIS DOCUMENT

The purpose of this decision-making business case (DMBC) is to make a decision on the future site of the specialist emergency care hospital.

This decision-making business case (DMBC) is based on the evidence compiled in the pre-consultation business case, feedback from consultation and further evidence compiled post-consultation.

This DMBC reviews the outcomes from the consultation report and seeks to ensure that progress to decision-making and implementation is fully informed by detailed analysis of consultation outcomes. It also ensures that the final proposal is sustainable in service, economic and financial terms.

This DMBC is not a final implementation plan for the proposal, nor a replacement for the further detailed work required for any potential outline business case (OBC) or full business case (FBC) that may be required at a later stage in the process.

To ensure appropriate implementation it does, however, create clear requirements of any subsequent business cases. This will need to be met as a condition of commissioner support for further business cases.

This document has been written at a point in time, reflecting information (including sources and references accessed) as of the date of publication. The document, including its related analysis and conclusions, may change based on new or additional information which is made available to the programme.

CONTENTS

1 INTRODUCTION

The Improving Healthcare Together 2020-2030 programme was established by Surrey Downs CCG, Sutton CCG and Merton CCG to address long-standing issues within our combined geographies.

From the 1st April 2020, Surrey Heartlands CCG was formed as a new organisation, comprising of Surrey Downs CCG and three other CCGs in Surrey. South West London CCG was also formed, comprising of Sutton and Merton CCGs, having merged with four other CCGs.

Surrey Heartlands CCG and South West London CCG therefore include the Surrey Downs, Sutton and Merton areas, referred to in this document as the combined geographies, which commission services for a combined population of 720,000.

In January 2020, we published a PCBC setting out our options for delivering this solution and launched a 12 week consultation to gather the views of our local population.

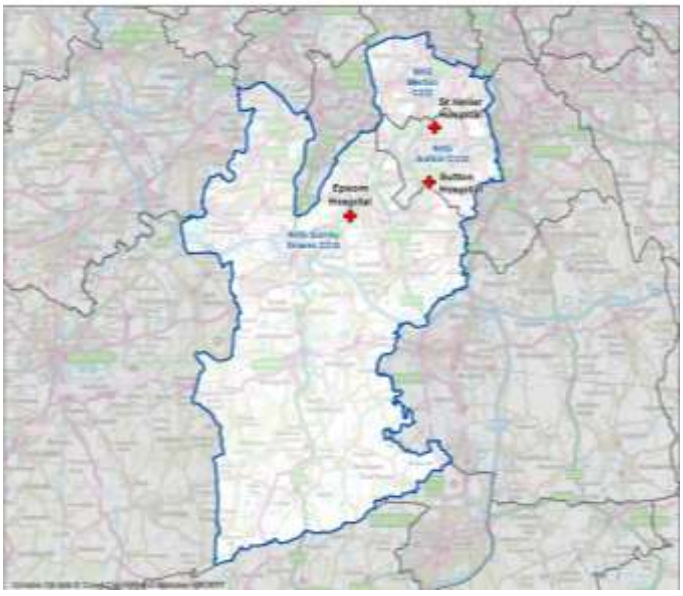
1.1 Who we are

As commissioners of healthcare in the local area, we (NHS Surrey Heartlands CCG and NHS South West London CCG) have been exploring the best way to meet the healthcare needs of our populations in a sustainable way. This included working to identify priorities for the delivery of high quality, affordable and sustainable care.

From the 1st April 2020, Surrey Heartlands CCG was formed as a new organisation, comprising of Surrey Downs CCG and three other CCGs in Surrey. In addition South West London CCG was formed, comprising of Sutton and Merton CCGs, having merged with four other CCGs in South West London.

Within Surrey Heartlands CCG and South West London CCG, the Surrey Downs, Sutton and Merton areas commission healthcare services for a combined population of 720,000 people. The geographic areas covered by these three areas are referred to as our ‘combined geographies’ (see Figure 3).

Figure 3: Combined geographies of Surrey Downs, Sutton and Merton[3]



[3] Improving Healthcare Together 2020-2030 analysis

We sit within two Integrated Care Systems (ICS), Surrey Heartlands and South West London (SWL), and have clear plans to improve healthcare in these regions.[4]

Our populations are served and represented by different local authorities:

- Surrey Heartlands CCG covers the areas within Surrey County Council, including the whole of Epsom & Ewell Borough Council and Mole Valley District Council and Elmbridge Borough Council and Reigate & Banstead Borough Council.
- South West London CCG, for the Sutton and Merton areas, include the London Borough of Sutton (Sutton Council) and the London Borough of Merton (Merton Council).

The populations across Surrey Downs, Sutton and Merton have a range of different needs for health and social care services, which are considered when developing future plans. It is also important to understand how the needs of local people are likely to change, to ensure the future care system can be designed in the right way.

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.

1.2 Our vision and commitment

As commissioners of healthcare across Surrey Downs, Sutton and Merton, we are clear that we must ensure that the needs of our populations are met and support improved health of our populations, both currently and in the future. This includes rapid access for urgent care needs, consistency in care for long-term conditions and access to specialists for the sickest patients or those most at risk.

To meet these needs, we have a vision for future healthcare:

- **Preventing illness**, including both preventing people becoming sick and preventing illness getting worse.
- **Integrating care** for those patients who need care frequently and delivering this integrated care as close to patients' homes as possible.
- **Ensuring high quality major acute services** by setting clear standards for the delivery of major acute emergency, paediatric and maternity services.

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 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, which formed the basis of the development of our proposals set out in this document. 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 recently allocated £511 million to invest in ESTH. This document and the previously published pre-consultation business case (PCBC) considers the evidence and feedback we have received to date on our proposals on how this money should be invested.

[4] This includes: *South West London Five Year Forward Plan* (October 2016) https://www.swlondon.nhs.uk/wp-content/uploads/2016/11/SWL-Five-Year-Forward-Plan-21-October-2016.pdf; *South West London Health and Care Partnership: One Year On* (November 2017) https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf; *Surrey Heartlands Sustainability and Transformation Plan* (June 2016); *Surrey Heartlands Sustainability and Transformation Plan* (October 2016) http://www.surreyheartlands.uk/wp-content/uploads/2017/04/surrey-heartlands-stp-october-2016.pdf

1.3 Aims of the decision-making business case

This programme seeks to address long-standing issues in our combined geographies.

We have identified specific issues with the long-term sustainability of healthcare in our combined geographies (i.e., the geographic areas covered by Surrey Downs, Sutton and Merton). Specifically, there are issues with clinical quality, estates and finance that create a need for us to consider how healthcare should change. These issues specifically affect the major acute trust in our combined geographies, Epsom & St Helier University Hospitals NHS Trust (ESTH).

We have previously published:

- the *Issues Paper*, published in June 2018, which described the challenges at ESTH and launched a programme of public engagement on the case for change, clinical model and development of potential solutions.
- the *pre-consultation business case*, published in January 2020, which further built upon the Issues Paper and carried out a non-financial and financial appraisal of the shortlist of options to determine a preferred option, and launched the consultation on our proposals.

Following consultation, we have now developed this DMBC. The DMBC collates and considers the range of evidence and feedback, and concludes upon the best way forward.

1.4 The process we are undertaking

We developed the Improving Healthcare Together programme to identify potential solutions to our challenges, ensure consensus is maintained across the system and enable a decision to be made on the best solution.

The issues at ESTH are longstanding and there have been numerous attempts to resolve them. These did not address a number of critical challenges and did not have full commissioner support, and therefore were not successful. However, these issues have remained and worsened, creating a need for change at ESTH.

In recent years ESTH, and we as commissioners, have revisited these issues to determine the potential solutions through a number of business cases.

1.4.1 Strategic outline case

In 2017 ESTH published a strategic outline case (SOC) for investment in its hospitals.[5] This document described ESTH's view of its challenges. As commissioners, we accepted that there were issues to address and agreed to commence further work to explore the future for healthcare locally. This led to the development of the pre-consultation business case (PCBC), which reconsidered the challenges within our combined geographies, and assessed potential solutions to address this.

1.4.2 Pre-consultation business case

To develop the pre-consultation business case, Improving Healthcare Together developed principles, processes and governance that supported decision-making. The development of the PCBC was clinically led, informed by engagement with key stakeholders and the public and worked with partners across our combined geographies.

Governance groups were established to make recommendations that would be considered by the Committees in Common (CiC) as part of the decision-making process. These groups were supported by workstreams to carry out key elements of work.

Four key processes supported the development of the pre-consultation business case:

[5] *Strategic outline case for investment in our hospitals 2020-2030* (2017) https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93jijm4n8158.pdf

- **The development of the clinical model**, overseen by the Clinical Advisory Group, which included initially defining an emerging clinical model for public engagement, and a further phase where areas of work were identified following a review by the Joint Clinical Senate for London and the South East.
- **The development of the finance and activity model**, overseen by the Finance, Activity and Estates Group, which modelled the short list of options to determine their impacts.
- **The options consideration process**, which established the approach to developing a long list, short list and evaluation thereof and involved the public in the consideration of a short list of options.
- **Public and stakeholder engagement**, which tested proposals and the options consideration process with the public through extensive engagement, including on the Issues Paper in summer 2018, involvement in the options appraisal, and through our Stakeholder Reference Group (SRG) and Consultation Oversight Group (COG).

This work culminated in the production of the PCBC, which launched a public consultation in January 2020.

1.4.3 Consultation

1.4.3.1 Aims of the consultation

The consultation was carried out over a 12 week period and involved a sequence of online and face-to-face events. The aim of the consultation was to seek the public's views on the proposals in order to assist the programme with its decision-making. The consultation activities therefore aimed to ensure people in the affected CCG areas were aware of and understood the proposed options for change, by providing information in clear and simple language in a variety of formats.

In this way we heard people's views on the proposed changes to major acute services at Epsom and St Helier hospitals. This ensured the CCGs had the evidence from the consultation feedback to contribute to decision-making. The aim was also to further hear ideas for alternative solutions to solve the challenges identified in the case for change.

1.4.3.2 Key areas of work and outputs

The consultation was extensive and used a wide range of methods and materials to reach people and collect their views and feedback, described further in Section 7. This included 11 focus groups, 3 deliberative events and 9 listening events, 750 telephone surveys and Community and Voluntary Sector (CVS) surveys.

This informed the development of the consultation analysis report (outputs described in Section 8), which itself collated further data from social media and events. This feedback also informed the development of the phase 3 integrated impact assessment (outputs described in Section 10.1). This informed the development of the DMBC and further decision-making.

1.4.3.3 Impact of COVID-19 on the consultation

In the context of COVID-19, face-to-face meetings were halted in late March, leading to the cancellation of three public and focus group events, which continued virtually. By this time the vast majority of face to face activities had been concluded. All further meetings continued virtually as planned. More details are provided in Section 7.

1.4.4 Decision-making business case

Following the closure of consultation, the programme has carried out extensive work to understand the evidence and feedback that has been developed through consultation. The feedback and responses from the public and stakeholders have been used within this DMBC to determine what the right solution is for our local population.

The process to bring together this evidence and feedback involved several stages:

1. Collate the feedback and evidence from consultation into a consultation analysis report;
2. Development of the phase 3 integrated impact assessment;
3. Review and deliberation of consultation findings;
4. Development of further analysis and evidence to understand the views and impacts emerging from consultation; and
5. The decision-making process.

This is further described below.

1.4.4.1 Development of the consultation analysis report

The consultation analysis report brings together all the outputs associated with the activities carried out as part of the consultation and all of the feedback. This includes an overview of the consultation, the consultation process, and key findings across a number of themes including:

- Questionnaire findings
- Residents' survey findings
- Focus groups
- Deliberative events
- Listening events
- Written submissions
- Petitions
- Social and other media

The consultation analysis considered feedback on the case for change, clinical model, the proposed options and the possible impacts of the options. A full description of the outputs of this analysis can be found in Section 8.

1.4.4.2 Development of the phase 3 IIA

To understand the impacts of the proposals and inform decision-making an Integrated Impact Assessment (IIA) was commissioned, which involves three phases. Phase 1 and 2 were completed pre-consultation. The phase 2 interim Integrated Impact Assessment report forms the basis for the phase 3 report which is produced after consultation. Updates within the phase 3 report include:

- Findings from the public consultation process;
- Additional analysis undertaken; and
- New data sources that have been made available since the publication of the interim report.

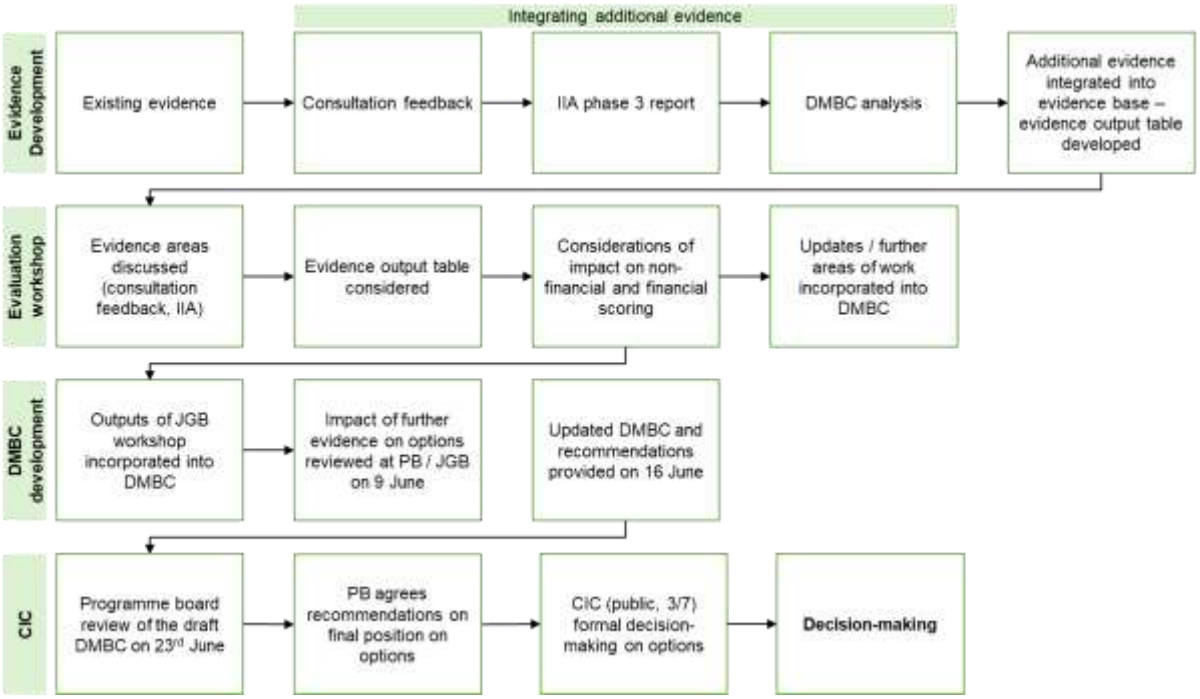
This includes the outputs and outcomes from additional deprivation analysis and travel and access workshops, as well as additional analysis of the impact of proposed changes on those living in deprived areas compared with other areas of the impacted study area, and the extent to which their use and experience of hospital services is different. This is further described in Section 10.1. The IIA was further refreshed with the updated Index of Multiple Deprivation analysis, released by the Government in late 2019.

1.4.4.3 Review and deliberation of consultation findings

The programme and its governance have been through an extensive process of understanding the consultation findings to help to arrive at the right solution.

This process is outlined in the figure below, and the main themes considered are set out in Section 9.

Figure 4: Process of deliberating the consultation findings



1.4.4.4 Development of further evidence

Within this DMBC, we have used the feedback from consultation to help us find the right solution for our population. Given this feedback, we have spent particular time reviewing and developing further evidence across a number of areas. This evidence is summarised in Section 9.

1.4.4.5 Decision-making process

Within this DMBC, we have used the feedback from consultation to help us find the right solution for our population. This DMBC includes a detailed description of how we have considered the evidence to determine the right solution for our combined geographies in Sections 8, 9 and 11.

2 CASE FOR CHANGE

We have identified a number of barriers to delivering our vision. In particular, we have three core challenges with our main acute provider, Epsom and St Helier University Hospitals NHS Trust (ESTH):

- **Delivering clinical quality:** ESTH is the only acute trust in South West London that is not clinically sustainable in the emergency department and acute medicine due to a 25 consultant shortage against our standards. Additionally, there are shortages in middle grade doctors, junior doctors and nursing staff. The Care Quality Commission has highlighted workforce shortages across its two sites as a critical issue.
- **Providing healthcare from modern buildings:** Our acute hospital buildings are ageing and are not designed for modern healthcare delivery. Over 90% of St Helier Hospital is older than the NHS; its condition has been highlighted by the Care Quality Commission as requiring improvement.
- **Achieving financial sustainability:** The cost of maintaining acute services across two hospital sites is a major driver of the system's deficit. In particular, by 2025/26, ESTH may need c. £23m of additional annual funding above that which is likely to be available, based on current services. This is a major challenge to the sustainability of the local health economy.

We have significant variation in health outcomes and access across our geography, which needs to be addressed.

In particular, we have challenges within our hospital services, with three core challenges with our main acute provider Epsom and St Helier University Hospitals NHS Trust (ESTH).

2.1 Addressing health economy challenges

As commissioners, we face challenges in achieving our aims; in particular, we face clinical quality, estates and financial sustainability challenges.

In seeking to achieve our aims, we have identified five issues which are aligned to our priorities for healthcare, principally:

- Preventing ill health.
- Growing demand for healthcare as the population ages and healthcare becomes more complex.
- Delivering clinical quality, including challenges with recruiting and retaining sufficient staff.
- Delivering care in fit-for-purpose buildings.
- Growing financial pressures as the costs of healthcare increase.

The populations across Surrey Downs, Sutton and Merton vary significantly, although outcomes across all three areas are generally better than the average for England.[6]

[6] For example: assessments of the healthcare needs of local populations, including joint strategic needs assessments (JSNAs) maintained by local authorities. *The Merton Story – Key Issues in Merton* https://www2.merton.gov.uk/Merton-story-final.pdf; *Sutton Population Fact Sheet* (2017) https://data.sutton.gov.uk/sutton_jsna/; *Surrey Downs: Surrey Downs CCG Health Profile* (2015) http://www.surreydownsccg.nhs.uk/media/144405/sdccg_health_profile_2015.pdf

- Surrey Downs has a comparatively older and less ethnically diverse population, living in more rural areas, and is more affluent than the England average. [7] While outcomes are better than the England average, there is some variation, including cancer survival rates.
- In Sutton, health outcomes are better than the average in England, and the borough is affluent on average, however there are health inequalities and significant pockets of deprivation within the borough, which drive differences in life expectancy.
- In Merton, the population is older and health outcomes are similarly better than the London and England average, however there are significant social inequalities and areas of deprivation which mean that the life expectancy gap between the most and least deprived areas is six years for men and four years for women.[8]

In addition, mental ill health is becoming increasingly common, particularly in parts of Sutton and Merton, and we need to do more to achieve parity between physical and mental health.

Prevention and growing demand will be addressed through our existing and future plans as described within the PCBC. However, addressing the issues of clinical quality, estates and finance will be more significant – in these areas, there is a clear case for major service change.

2.2 The clinical challenge

2.2.1 Our acute workforce challenges

We have significant acute workforce challenges in our geography, and in particular at ESTH.

In September 2017, the SWL ICS – working with Surrey Downs – defined clinical standards for six acute services provided in South West London or operated by a South West London trust.[9] The services in scope were the ED, acute medicine, paediatrics, emergency general surgery, obstetrics and intensive care.

The standards were based on national standards and developed by the medical directors of the four acute trusts in SWL. They were approved by the SWL Clinical Senate on 28th September 2017. When assessed against our standards, there are significant gaps in consultant workforce. In particular, ESTH has major gaps in emergency department and acute medicine that mean it is not clinically sustainable. In particular, at ESTH issues include:

- **Meeting standards for acute care**: Our major acute trust, ESTH, cannot meet the consultant workforce standards we have set for major acute services across two sites and has a shortage of 25 consultants in emergency department, acute medicine and intensive care.
- **Recruitment and retention**: ESTH has made significant efforts to enhance recruitment and retention of consultant workforce but despite this, there are still vacancies and rota gaps.
- **Junior doctors and middle grades**: Junior doctors training posts are allocated by Health Education England (HEE) on a trust basis, whereas ESTH must staff its rotas across two sites, leading to a structural shortage of trainees.
- **Nursing and midwifery posts**: ESTH currently has a vacancy rate of 29% for nursing, midwifery and health visiting staff[10]. There is currently a 12% vacancy rate in midwifery posts specifically[11].
- **Specialties**: The increasing specialisation of medicine creates additional staffing pressures across two sites. Due to a lack of consultants, ESTH cannot operate seven-day consultant-led

[7] For example: 56% of the population is of persons aged between 20–64 years and 20% are aged 65 years and over.

[8] *South West London Health and Care Partnership: One Year On* (2017) https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf

[9] *Clinical quality standards for acute services provided in South West London or operated by a South West London Trust* (2017) https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf. These standards were agreed with the SWL Clinical Senate but have not been clinically signed off in Surrey Heartlands.

[10] ESTH workforce data

[11] ESTH workforce data

rotas in GI bleed (ESTH relies on a networked solution), cardiology (ESTH relies on general physicians), and respiratory (including ventilation).

These challenges are mirrored nationally: regulators and workforce planning bodies have identified significant workforce gaps in emergency department consultant staffing. In 2017, HEE, NHS England and NHS Improvement (NHSE/I) and Royal College of Emergency Medicine (RCEM) collectively identified that a combination of demand pressures and increasing standards have created significant pressures on emergency department staffing. This leads to high locum spend, attrition rates and early retirement. The four bodies therefore identified that "we need more clinical staff" across all grades and have established a priority plan to help close this gap, primarily through new roles and multidisciplinary teams, reduced attrition and improved retention.[12]

We do not expect workforce growth to enable us to close the critical gaps we have in the consultant workforce. Since 2012, consultant numbers have increased by c. 3.4% p.a. nationally across key specialties. By 2025/26, looking at the local, regional and national growth rates in consultants, the gap in intensive care consultants may be closed at ESTH. However, the gap in ED and acute medicine consultants may not be closed when applying any of the growth rates (ESTH: 5.0%, South London and Kent, Surrey and Sussex 4.4%, national: 3.4%). This means that availability of new consultants of itself may not close key gaps.

2.3 Providing healthcare from modern buildings

We need to ensure our buildings are safe, fit for purpose and can support the delivery of 21st century care.

The ICSs set out an ambition to deliver a future model of care from facilities that are accessible, safe, fit for purpose and cost effective. Well-designed physical settings of hospital care play an important role in patient health outcomes, experience of care, as well as making it a better place for staff to work. The design of estates also has implications in terms of the effectiveness of the models of care they enable, as well as the ongoing running costs of maintenance. Poor quality estates can increase the cost of care delivery and disrupt services while being more expensive to maintain.

There are particular challenges with ESTH and especially at the St Helier Hospital site, where over 90% of the buildings are older than the NHS. This contributes to ESTH having the third largest maintenance backlog in the country.

Table 4: Trusts with highest estates maintenance backlog[13]

Organisation	Backlog £ million	Backlog per m^2
Imperial College Healthcare NHST	669.6	£2,360
The Hillingdon Hospitals NHSFT	98.9	£1,172
Epsom And St Helier University Hospitals NHST	93.1	£817

Significant investment is required to meet safety standards, including new boilers, a plant for the heating and hot water systems and investment to ensure compliance with asbestos, fire and water regulations.

[12] *Securing the future workforce for emergency departments in England* (2017) https://improvement.nhs.uk/documents/1826/Emergency_department_workforce_plan_-_111017_Final.3.pdf

[13] ERIC return

2.4 Achieving financial sustainability

We currently spend more than we receive in funding across Surrey Heartlands and South West London, and expect this to continue unless we change the way we deliver care. At ESTH, average increases in funding are outstripped by demand growth, cost inflation, the cost of meeting clinical standards, and the high cost of maintaining the existing estate.

The increasing demand on the system cannot always be met by appropriately moving care out of the hospital and into the community. Therefore, it is essential that a solution is found that addresses the financial deficit at ESTH, while working with the wider system to further support the strain on resources[14].

Despite all efforts to reach financial balance, without change ESTH will still face a deficit, largely driven by providing major acute services across two sites and therefore duplicating rotas and support services. The scale of this deficit means our local healthcare system will not achieve financial sustainability unless we can address the challenges at ESTH.

2.5 The growing need for change

To address these challenges, significant changes are needed that solve the clinical, estates and financial challenges.

These challenges – in particular the challenge of staffing major acute services sufficiently – are so significant that large changes are needed in how healthcare is organised and delivered in our combined geographies.

This case for change does not – and is not intended to – provide a solution for all providers within the ICS boundaries. Surrey Heartland and SWL are continuing work to develop plans to deliver sustainability, however changes at ESTH are needed to support retention of services in the combined geographies. And we believe this change is only needed to those major acute services where there is a clear case for change – all other services should continue to develop in line with existing plans.

This is the focus of our work. As commissioners, we are committed to maintaining services within our combined geographies and this has been a priority as part of this process.

[14] Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017*), Shifting the balance of care: great expectations*. Research report. Nuffield Trust.

3 CLINICAL MODEL

Our clinical model aims to ensure the very best quality of care is available to our populations and sets the direction for care in our combined geographies.

It describes how we will deliver **district hospital services** and **major acute services** to provide excellent care in the future, integrated with and supported by **out of hospital services**.

- The aim of our community-facing, proactive health, wellness and rehabilitation district hospital model is to support people who do not require high acuity services but who still need some medical input.
- Major acute services are for the treatment of patients who are acutely unwell or are at risk of becoming unwell, such as those treated within the emergency department.

We believe that this clinical model – where local access to district services is maintained and major acute services are co-located – will benefit the quality of our services and the experience offered to patients.

We have set out a clinical model to meet the needs of our populations and deliver our vision. This improved clinical model is based on clinical standards and evidence based best practice. This model was developed by our Clinical Advisory Group, which has a membership drawn from acute and non-acute clinical leaders from across the Surrey Downs, Sutton and Merton area. A review by the Joint Clinical Senate for London and the South East as part of the assurance process supported the aims and direction of our clinical model.

3.1 Overall model

Our clinical model aims to ensure the very best quality of care is available to our populations and sets the direction for care in our combined geographies.

It describes how we will deliver **district hospital services** and **major acute services** to provide excellent care in the future, integrated with and supported by **out of hospital services**.

- The aim of our **community-facing, proactive health, wellness and rehabilitation district hospital model** is to support people who do not require high acuity services but who still need some medical input. This includes district beds for patients ‘stepping down’ from a major acute facility, ‘stepping up’ from the community and directly admitted via an urgent treatment centre(s). For the district hospital model, access is therefore important due to the frequency of contact. Our clinical model keeps district services as local as possible and these services will continue to be delivered from both Epsom and St Helier Hospitals, whilst being further integrated with other services people use.
- **Major acute services are for the treatment of patients who are acutely unwell or are at risk of becoming unwell**, such as those treated within the emergency department. These are services that require 24/7 delivery and include the highest acuity services. We have considered the co-dependencies between these services, to define the minimum set of services that need to be co-located. For major acute services clinical standards of care and co-location are central to clinical outcomes due to the importance of consultant input and the critical nature of the care – and the aim is to ensure these services are co-located appropriately.

We believe that this clinical model – where local access to district services is maintained and major acute services are co-located – will benefit the quality of our services and the experience offered to patients.

3.2 Out of hospital services

Out of hospital services are essential to the delivery of care local to people's homes. Our out of hospital services across the geography will be integrated with the clinical model.

Within current models, often patients are admitted to hospitals when they may be better benefitted by services that can be provided outside of the hospital. Surrey Downs, Sutton and Merton areas have developed local health and care plans that describe initiatives across the geography, predominantly focusing on:

- Person-centred integrated care;
- Primary care networks; and
- Bed-based care.

These are described in more detail in the PCBC.

3.3 The district hospital model

District hospital services are those that patients are likely to require more frequently, and often benefit from being strongly integrated with community health and care settings. This integration can provide benefits such as improved continuity of care and patient experience.

District hospital services include:

- Urgent treatment centres (appropriate for c. 99,000 patients p.a.);
- Endoscopy (used by c. 12,000 patients p.a.);
- Outpatients (used by c. 610,000 patients p.a.);
- Daycase surgery (used by c. 14,000 patients p.a.);
- Rehabilitation;
- Low risk antenatal and postnatal care (used by c. 3000 patients p.a.);
- Imaging and diagnostics;
- Dialysis (used by c. 2,400 patients p.a.);
- Chemotherapy (used by c. 1,500 patients p.a.); and
- District hospital beds (appropriate for c. 10,000 patients p.a.)[15].

District hospital services do not require critical care or services on which critical care depends. These services are defined and described further in the PCBC.

While major acute hospital beds will be used for our sickest and highest risk patients, multiple bed audits have identified a cohort of c. 47–60% of existing inpatients who require a hospital bed but do not require any of the major acute services[16].

These audits suggest there is a patient cohort that needs inpatient care but within a lower acuity setting. Our clinical model proposes that this is a cohort of patients whose care requirements could be met via a district hospital bed, supported by a new model of care.

At both Epsom and St Helier hospitals, these patients are already being treated in a different manner as inpatients. In the clinical model these beds would remain at each site with a new model of care. The table below shows district hospital services delivered in the community, and in the hospital.

[15] ESTH data 18/19

[16] ESTH audits, 2019

Figure 5: District services in the hospital and the community

District services in the community	District services in the hospital
• 111 • Proactive community services • Reactive community services • Home births • Admission avoidance • Self-management • Social prescribing • Therapy services (speech and language, physiotherapy, OT) • Urgent home visiting services • Health visiting • School nursing • Child and adolescent mental health teams • Learning disability community services • Community mental health teams • End of life care • Rehabilitation • Community beds • Pharmacies • GP appointments	• Urgent treatment centre • Endoscopy • Outpatients • Daycase surgery • Rehabilitation • Low risk antenatal and postnatal care • Imaging and diagnostics • Dialysis • Chemotherapy • District hospital beds

The district hospital services are among the most frequently accessed by patients at ESTH, and we are committed to continuing to provide these services from both Epsom and St Helier Hospitals.

3.4 Major acute services

Major acute services are required for the highest risk and sickest patients.

Major acute services include:

- Major emergency department – the areas of A&E for the sickest patients, including major emergencies, resuscitation and dedicated children's A&E (used by c. 53,000 patients p.a.);
- Acute medicine (used by c. 30,000 patients p.a.);
- Critical care (used by c. 300 patients p.a.);
- Emergency surgery (used by c. 2,800 patients p.a.);
- Births (excluding home births) (used by c. 4,800 patients p.a.); and
- Inpatient paediatrics (used by c. 2,100 patients p.a.).

These services are defined and described further in the PCBC.

Our clinical model will allow us to deliver major acute standards and evidence based best practice through co-location of major acute services.

Figure 6: Major acute services

We believe that this clinical model – where local access to district services is maintained and major acute services are co-located – will deliver our vision for patients and increase the quality of delivery of care across our combined geographies.

3.5 Benefits

The clinical model is expected to bring a wide range of positive impacts, including clinical benefits, workforce benefits, technology benefits and estates benefits.

Overall the clinical model is expected to translate into improved clinical outcomes for patients, an improved way of working for staff, opportunities for the implementation of new technology, fewer patient falls and transfers, fewer adverse drug events and infections, an improved patient experience and shorter stays in hospital.

The clinical model formed the basis of our planning for potential solutions for our combined geographies. It was tested with the public and clinical senates and through the consultation process.

4 OPTIONS TO DELIVER THE CLINICAL MODEL

In order to determine the potential solutions to address our case for change and deliver the clinical model, we have followed a standard approach for options consideration. This process resulted in four potential solutions in the short list, which includes:

- 'No service change': Continuing current services at Epsom Hospital and St Helier Hospital. This was included for comparator purposes.
- A single major acute site at Epsom Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
- A single major acute site at St Helier Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
- A single major acute site at Sutton Hospital, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.

The following stage of options appraisal involved a non-financial and financial options consideration. This non-financial and financial assessment was part of the evidence considered by the Committees in Common prior to their decision to proceed to consultation.

4.1 Options long list and short listing

This process was informed by previous engagement with the public on the potential solutions to the issues we face and extensive discussion within the local area, including amongst clinicians, commissioners, providers and regulators.

In order to determine the potential solutions to address our case for change and deliver the clinical model, we followed a standard approach for options consideration. This involved:

1. Developing an **initial long list of options** to address our case for change and deliver the clinical model.
2. Developing and applying **initial tests to reduce the long list** to reach a manageable short list. This allowed us to focus on evaluating the short list to ensure they are feasible.
3. Developing and **evaluating the short list of options** through non-financial evaluation criteria in line with guidance from The Consultation Institute.
4. Carrying out a **financial analysis** and reporting a series of financial metrics for each short listed option.

We developed an initial long list of options to address our case for change and deliver the clinical model.

Our development of potential solutions explored ways our case for change can be addressed, our clinical model can be delivered and our hospitals maintained into the future. We focused this in two ways.

- **First, we focused on major acute services only**, as there is a need for significant changes in these services. In all options, district hospitals remain on the existing sites (Epsom and St Helier Hospitals).
- Second, we focused only on changes within our combined geographies.

Based on this, we then considered how potential solutions might vary to develop a **long list of potential solutions**. This intended to capture a wide range of potential solutions – consideration of their viability was a subsequent step.

We considered:

- **How many major acute hospitals can be provided in the combined geographies?** This included considering providing zero, one or two major acute sites in the combined geographies. Although not providing a major acute hospital site(s) did not align with our commitment to maintaining major acute services within our combined geographies, it was included for completeness.
- **Which major acute services do these hospitals provide?** There are two potential configurations of major acute services: (i) major acute hospital(s) could provide adult major emergency department(s) with supporting major acute services only or (ii) provide major adult emergency department(s) with supporting major acute services alongside women's and children's services.
- **Is workforce from outside the area used to supplement rotas?** Possible solutions included relying only on workforce within our local area and using workforce from nearby providers to supplement rotas.
- **Which sites could be used to deliver major acute services?** Possible solutions included using existing acute hospital site(s) (i.e., Epsom, St Helier and/or Sutton Hospital site) and/or using a new site within our combined geographies.

All the combinations of these factors led to 73 potential solutions. This formed our long list.

Our long list was refined by testing the viability of potential solutions against three initial tests

The initial tests we applied were:

1. Did the potential solution **maintain major acute services within the combined geographies**? This was a key commitment for us – any potential solution must maintain all major acute services within our combined geographies.
2. Was there likely to be a **workforce solution** to deliver the potential solution? This included ensuring any potential solution met our standards for the quality of major acute services with the available workforce.
3. From which **sites** was it possible to deliver major acute services? This considered whether different sites are feasible for the delivery of a major acute hospital.

Applying these tests sequentially reduced the long list:

- After the first test, **any potential solution that did not offer all major acute services within the combined geographies was eliminated** (e.g. no major acute hospitals or only providing major adult emergency department services within the combined geographies). *This resulted in 50 potential solutions.*
- After the second test, workforce limitations and co-dependencies meant that any potential solution with more than one major acute site and any potential solution relying on external workforce were eliminated. *This resulted in 4 potential solutions – a single major acute site from one of four sites (Epsom Hospital, St Helier Hospital, Sutton Hospital, or a new site within our combined geographies).*
- After the third test, **only existing sites appear feasible**. *This resulted in 3 potential solutions.*

In addition, our short list included a 'no service change' counterfactual – continuing with existing service provision at both Epsom Hospital and St Helier Hospital.

There were therefore four options on our short list:

- **The 'no service change'**: Continuing current services at Epsom Hospital and St Helier Hospital. This was included for comparator purposes.
- A **single specialist emergency care hospital at Epsom Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.

- A **single specialist emergency care hospital at St Helier Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
- A **single specialist emergency care hospital at Sutton Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.

This short-listing process and supporting evidence was tested with the public before further analysis was completed.

The following stage of options appraisal involved a non-financial and financial options consideration, and all evidence inputting into the appraisal was reviewed before and after the appraisal by CAG, Finance, Activity and Estates(FAE) and Programme Board, as described in the following sections.

4.2 Non-financial assessment

We developed and evaluated the short list of options through non-financial evaluation criteria in line with guidance from The Consultation Institute

We undertook a standard process for the development of the non-financial criteria and scoring of options against these criteria. This was based on the recommendation of The Consultation Institute, which offered expert advice and guidance of public consultation and engagement, based on relevant legislation and case law, and informed by previous experience of this process from across the UK.

There were three steps to this process:

1. **Pre-consultation engagement** captured public priorities and feedback.
2. Three different **groups of balanced representative people** were identified, drawn from across Surrey Downs, Sutton and Merton areas (including the public, clinicians and professionals), where:
    - the first facilitated group agreed **non-financial criteria**;
    - the second facilitated group agreed what **weighting** each non-financial criterion should carry; and
    - the third facilitated group **scored the shortlisted options** against the non-financial criteria, without sight of the weightings.
3. Application of the weightings to the scores to **report to Programme Board and the Joint Governing Body** of the outcome of the non-financial scoring process.

The evidence for the workshops was developed and signed off through the programme governance groups, including CAG, FAE and Programme Board.

Based on the assessment of the workshop participants:

- **Sutton** scored most highly for **11 criteria**: availability of beds, delivering urgent and emergency care, workforce safety, recruitment and retention, alignment with wider health plans, integration of care, complexity of build, impact on other providers, time to build, deprivation, health inequalities and safety.
- **St Helier** scored most highly for **3 criteria**: staff availability, clinical quality and patient experience.
- **Epsom** scored most highly for **1 criterion**: older people.
- **No service change** scored most highly for **1 criterion**: access.

The table below shows the average scores once weightings were applied and the total scores for each of the options.

Table 5: Average scores of scoring workshop with weightings applied to show total average score

Domain	Criteria	Weighting	No service change	Epsom	St Helier	Sutton
Access	Accessibility	*8.4%*	**0.56**	0.45	0.44	0.52
Clinical sustainability	Availability of beds	*5.0%*	0.28	0.33	0.37	**0.37**
	Delivering urgent and emergency care	*8.6%*	0.55	0.50	0.54	**0.60**
	Staff availability	*7.1%*	0.23	0.53	**0.56**	0.55
	Workforce safety, recruitment and retention	*6.9%*	0.28	0.45	0.47	**0.48**
Contribution to wider healthcare aims	Alignment with wider health plans	*3.9%*	0.11	0.27	0.26	**0.28**
	Integration of care	*6.8%*	0.36	0.42	0.42	**0.46**
Deliverability	Complexity of build	*5.0%*	0.23	0.30	0.25	**0.40**
	Impact on other providers	*5.3%*	0.29	0.19	0.34	**0.35**
	Time to build	*3.0%*	0.15	0.17	0.14	**0.23**
Meeting population health needs	Deprivation	*6.3%*	0.31	0.26	0.33	**0.35**
	Health inequalities	*6.0%*	0.21	0.22	0.23	**0.25**
	Older people	*6.0%*	0.33	**0.38**	0.33	0.36
Quality of care	Clinical quality	*7.8%*	0.29	0.50	**0.54**	0.49
	Patient experience	*6.6%*	0.29	0.40	**0.44**	0.42
	Safety	*7.3%*	0.34	0.51	0.54	**0.54**
	Total	***100%***	**4.79**	**5.89**	**6.21**	**6.65**

Overall, all the options scored more highly than no service change (4.8). The Sutton option (6.7) scores more highly than Epsom (5.9) or St Helier (6.2) options.

This overall ranking was endorsed by the Programme Board as reflecting the overall non-financial evidence and merits of the options.

4.3 Financial assessment

To determine the financial impact of the shortlisted options, a range of financial metrics were developed by the Finance, Activity and Estates workstream. These metrics were produced to determine the affordability and feasibility of delivering the options.

The clinical model and consolidation of key services is expected to result in a range of financial benefits by 2025/26. This includes cost reductions and a number of income improvements. Through delivering the benefits of the clinical model, the options are expected to deliver financial benefits of c. £33–49m per annum by 25/26.

In order to deliver the significant benefits expected, a large capital investment in the hospital sites is required across all options. In particular, capital investment of between £292m and £472m is required (including at other hospitals) after accounting for financing already secured.

Initial analysis suggests that all financing scenarios can help to drive a positive income and expenditure for the options.

The system net present value (NPV) of the options considered the total benefits for each option. NPV is used as best practice within The Green Book[17] as an objective measure for comparing total benefits for different options over an extended period of time.

We used NPV to provide a financial ranking of the options.

Table 6: System NPV

Category	No service change	Epsom	St Helier	Sutton
System NPV (50 years) (£m)	50	354	487	584
Option financial ranking	-	3	2	1

Table 7 below shows a summary of the key financial metrics for each of the options.

Table 7: Summary of key financial metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
ESTH key financial metrics	ESTH net capital investment (£m)	(225)	(292)	(386)	(472)
	Capital investment other providers (£m)		(174)	(44)	(39)
	ESTH return on investment 25/26 (%)		11.5%	8.8%	8.4%
	ESTH 25/26 in year I&E, with PDC financing (preferred route) (£m)		11.1	12.2	16.3
System key financial metrics	System return on investment 25/26 (£m)		5.3%	7.4%	7.3%
	System net present value (50 years) (£m)	50	354	487	584

4.4 Conclusion of the assessment

This non-financial and financial assessment was part of the evidence considered by the Committees in Common during their pre-consultation decision making (see Section 6).

[17] The Green Book, Central government guidance on appraisal and evaluation, HM Treasury, 2018

5 PREVIOUS ASSURANCE

At the pre-consultation stage, our proposals were assured by a range of organisations. This included:

- **NHS England and Improvement:** Any proposal for service change must satisfy the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks and be affordable in capital and revenue terms.
- **The Joint Clinical Senate for London and the South East:** This organisation scrutinised the clinical model and provided recommendations to address.
- **The joint health authority oversight and scrutiny committee** reviews the PCBC as it relates to the planning, provision and operation of health services in their local area.
- **An interim Integrated Impact Assessment** was also undertaken. The IIA is a continuous process that explores local issues and evidence in relation to any potential positive and negative impacts to changes in local services.

5.1 Assurance undertaken by national bodies

NHS England assures CCGs against their statutory duties and other responsibilities under the CCG Assurance Framework. Prior to public consultation, both NHS England and Improvement considered the financial proposal in terms of both capital and revenue and its sustainability. This ensured each option submitted for public consultation is:

- Sustainable in service and revenue and capital affordability terms;
- Proportionate in terms of scheme size; and
- Capable of meeting applicable value for money and return on investment criteria.[18]

Service change proposals are typically assured at a regional level. However, due to the size of this proposal assurance and decision making was undertaken by the Delivery, Quality and Performance Committee in Common (DQPCiC) which is a national body. The oversight of the national work programme for service change takes place through the Oversight Group for Service Change and Reconfiguration (OGSCR) as a sub-committee of the DQPCiC.

As part of the Health Infrastructure Plan published on 30th September 2019, the Government announced funding for six new large hospital builds, which included allocated investment in Epsom and St Helier University Hospitals.

5.1.1 Regulatory tests

Any proposal for service change must satisfy the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks and be affordable in capital and revenue terms.

We met all these tests:

1. **Strong public and patient engagement**: We undertook significant patient and public engagement during our programme of early engagement. The programme adopted The Consultation Institute best practice processes to work collaboratively with local people to evaluate the proposed options.
2. **Consistency with current and prospective need for patient choice:** All major acute and district services would continue to be offered by Epsom and St Helier NHS Trust, within the combined geographies regardless of the shortlisted option. The choice of any service at Epsom

[18] NHS England, *Planning, assuring and delivering service change for patients*, 2018

and St Helier Trust remains open regardless of the location of the major acute site, including the range of maternity services.

3. **A clear, clinical evidence base**: The PCBC was produced on the basis of clear, clinical evidence, including our case for change, clinical model and process for developing and appraising options.
4. **Support for proposals from clinical commissioners:** Clinical commissioners led the IHT programme from its outset. This included the Clinical Advisory Group, which included as members the CCG chairs and local GPs from across the area. All decision-making takes place through a committees in common (CiC) of CCGs, formed by Surrey Heartlands CCG and South West London CCG.
5. **Bed capacity**[19]: Within the PCBC we expected to need 1,052–1,082 beds for the population in 25/26. Currently there are 1,048 at ESTH. There is therefore an increase in the number of beds across the system. This coupled with the out of hospital initiatives means there is a strong foundation across the system to ensure there is sufficient bed capacity. This has been updated with further detail in included in Section 9.4.

5.1.2 Financial metrics

A range of financial metrics have been used to determine the feasibility of delivering the options and their overall affordability. The options have an improved I&E position relative to the no service change counterfactual. While there are additional financing costs compared to the no service change comparator due to the capital investment required, this improvement is driven by the benefits from consolidating major acute services.

Table 8: Outputs for finance metrics

Category	Metric	No service change	Epsom	St Helier	Sutton
Finance	ESTH 25/26 in year I&E (£m)	(22.6)	10.9	11.3	17.0

5.2 Clinical Senate

We followed best practice for substantial service change, seeking advice from the clinical senate on proposals. The Joint Clinical Senate for London and the South East provided review of the clinical model and draft PCBC in two stages:

- Initial review of our case for change, clinical model and long list of options (December 2018)
- Full review of our draft PCBC (March 2019)

Following their full review, the Clinical Senate provided 94 recommendations to the programme. The Senate stated clearly that there are significant benefits to bringing together the six major acute hospital services into a new purpose built facility located on one of the three hospital sites.

All 94 recommendations were responded to within the final PCBC – either to address them or describe further work planned for subsequent stages. The Senate confirmed they did not need to review the revised PCBC, published in January 2020.

The models of care have been and continue to be developed by clinicians from across Surrey Downs, Sutton and Merton including physicians, surgeons, GPs, nurses and therapists. The reconfiguration plans are designed to provide safe and sustainable services for the whole of our population in coming years.

[19] NHS England, *Planning, assuring and delivering service change for patients*, 2018

5.2.1 Outputs and actions from the review

A detailed action plan was developed by CAG to address the recommendations of the Clinical Senate. This allowed key action points to be developed, provided a structure for internal review and identified whether specific working groups needed to be set up.

The recommendations from the Clinical Senate fell into a number of categories. These recommendations were reviewed and responded to by specific working groups to develop further detail within the PCBC and set out any further actions.

- **Finance, activity and estates modelling**: Addressed through the programme's dedicated finance, activity and estates group (FAE).
- **Risk and benefit analysis**: A specific risk and benefits group was set up, including clinicians from across the area as well as externally for additional check and challenge.
- **Transfers and ambulance impacts**: Considered through a specific intra- and intersite group, with further impacts on ambulances considered through FAE.
- **Workforce**: Examined through Clinical Advisory Group and the risk and benefits group.
- **District hospital and urgent treatment centres (UTCs)**: Considered through various working groups, including CAG, the intra- and intersite group and the risk and benefits group.
- **Patient pathways**: Examined through Clinical Advisory Group and the risk and benefits group.
- **General clarifications**: A number of strategic recommendations were made by the Senate, which were examined through Clinical Advisory Group and the risk and benefits group.

The CAG, FAE, intra- and intersite group, risks and benefits group, as well as a maternity and paediatrics group, considered the recommendations allocated to them and developed further work as required. Specific further work that was carried out included:

- Further analysis of risks and benefits of the clinical model, including transition risks
- Specific work with other providers developing the patient transfer model, including eligibility criteria
- Further patient audits to understand the district hospital cohort
- Further detail of workforce models
- Revisions to finance and activity models
- Development of detailed patient pathways
- A range of general clarifications and matters of accuracy

The PCBC was refined to reflect these comments and additional work, and was then further assured regionally and nationally described below.

5.2.2 Further assurance of the model

The clinical model and draft PCBC were further reviewed regionally and nationally by NHS England and NHS Improvement following implementation of responses to the clinical recommendations.

This included:

- The London Regional Executive Team (LRET)
- The Oversight Group for Service Change and Reconfiguration (OGSCR)
- Delivery, Quality and Performance Committees in Common (DQPCIC)

The London Medical Director led two assurance panels which considered key aspects of the proposals including:

- How the clinical model and proposed staffing met the case for change
- The practical implementation of the clinical staffing proposals and new clinical roles
- Potential clinical synergies
- Digital strategy and its alignment to clinical objectives.

These areas were reviewed by the programme and the Clinical Advisory Group, and further work carried out to ensure the clinical model met these recommendations.

5.3 Interim integrated impact assessment (phase 2)

The IIA is a continuous process that explores local issues and evidence in relation to any potential positive and negative impacts to changes in local services. The IIA is completed by independent experts and overseen by an independently chaired steering group that includes experts from the NHS, local councils, voluntary organisations and public health departments. This assessment takes place in three phases.

Phase one consisted of an early assessment of equalities, travel and deprivation impacts. The second phase of the IIA builds on information collected in the first phase with further research, data collection, engagement and analysis. This included in-depth engagement with a range of local people from different backgrounds and protected characteristic and seldom heard groups (this includes deprived communities and carers). The interim IIA explored equalities, health, travel and environmental impacts, and is summarised below.

The third and final phase was completed after public consultation, and is described in summary in Section 10.1.

5.3.1 Summary of potential impact

The interim IIA indicated there is no one option which has a significantly greater impact than others, but there are small differentiating factors. These are outlined in the table below.

Table 9: IIA option consideration

Area	Detail
Health inequalities	• The district hospital model will potentially positively impact on health inequalities. • Option 1: Epsom likely to result in the greatest proportion of people from deprived communities experiencing longer journey times.
Longer journey times for patients and visitors	• Option 1: Epsom Hospital - Merton and Sutton particularly likely to experience longer journey times by car and blue light ambulance, and public transport • Option 2: St Helier Hospital - Surrey Downs particularly likely to experience longer journey times by car and blue light ambulance, and public transport • Option 3: Sutton Hospital - All areas expected to see increases in journey times by car, blue light ambulance and public transport but small proportion in Sutton who may see journey time decreases.
Patient provision	• The movement of the ED onto a single site will result in some services no longer being locally available to some patients. This will likely be perceived as limiting their choice.
Other providers	• Option 1: Epsom predicted to result in the greatest increases in patient flows to other sites and will therefore have the most significant impact on providers. • Option 3: Sutton modelled to have the least impact with smaller proportions of patients predicted to flow to other providers
Wider sustainability	• Option 1: Epsom Hospital - Air quality impact likely to have a greater impact than other options due to patients' flow being increased to area of existing poor air quality. • Option 2: St Helier Hospital – Green House Gases expected to be the worst under this option due to a higher proportion of local residents having to travel further to access acute services. • Option 3: Sutton Hospital - Slight improvements in air quality expected due to the movement of patients away from areas of poor air quality.

Area	Detail
Transportation cost and accessibility of acute services	• Option 1: Epsom - Merton and Sutton particularly likely to experience increased costs and complex journeys • Option 2: St Helier - Surrey Downs particularly likely to experience increased costs and complex journeys • Option 3: Sutton - Merton and Surrey Downs particularly likely to experience increased costs and complex journeys

5.3.1.1 Benefits of the new clinical model

Overall benefits of the clinical model found within the phase two IIA include:

- **Patient experience** – Patient experience will be enhanced in the long term. Consistent access to the right specialist and services in an emergency, seven days a week, every day of the year will mean patients are diagnosed quicker, spend less time in hospital and are less likely to be readmitted.
- **Clinical quality** – Better clinical quality and standards for our sickest patients and those most at risk of becoming seriously ill, with consultant cover that meets regional and national safety standards. The district hospital model will provide clinically appropriate care delivered as close to people's homes as possible.
- **Estates** – With redesigned facilities brought together onto a single site the Trust has the opportunity to invest in the latest technology to support treatment and care. Modern buildings are better for patient care, because they are more efficient and easier to maintain and clean.

5.3.1.2 Health inequalities

District services can play an important role in reducing health inequalities. District services delivered across both existing hospitals and the community are centred on providing a proactive focus on health and wellbeing, empowering people to take greater responsibility for managing their own health.

The developments to district services proposed as part of the service redesign will accelerate growth and improvement of these services and are expected to result in improved health outcomes for those from areas of high deprivation, helping to tackle health inequalities.

The highest densities of deprived communities exist within Merton and Sutton. Given longer journey times for those in Merton and Sutton to Epsom Hospital, the Epsom Hospital option may impact on a slightly greater proportion of deprived communities compared with the other options. However, this potential impact is in part mitigated by the improvements to district hospital services which communities are likely to engage with more frequently than acute services.

5.3.1.3 Journey times

The majority of patients would be treated in district hospital services which will continue to be provided at both Epsom and St Helier hospitals. This means in most cases travel requirements for patients and visitors will not change. However, as all options involve moving acute services from two sites to one, some patients and their visitors will experience longer journey times.

5.3.2 Summary of solutions to potential impacts

The IIA identified 25 potential solutions, each one linked to the impact areas identified. These can be summarised as:

- Clear communication with the local population about the changes to services and new patient pathways.
- Raise awareness of new and existing transport options to and from hospitals, as well as site specific transport offerings.
- Work with local councils and transport providers to support the development of community transport options and make the community aware of what is available.

- Explore the possibility of more personalised transport support to assist visitors with more complex journeys.
- Make sure there is sufficient parking capacity on the hospitals' sites.
- Continue to undertake detailed work with neighbouring NHS providers to understand their ability to accommodate any changes in activity and the impacts for them.
- Continuously review the service model to make sure it meets the health needs of the protected characteristic groups and seldom heard groups.
- Make sure there is the appropriate workforce in place to deliver the new clinical model.
- Introduce appropriate emergency transfer and handover protocols between sites and reduce the need for transfers between sites.
- Make sure the district services hospitals are joined up with local strategies by working closely with CCGs, providers, local councils, other services and hospitals.
- Introduce and encourage more sustainable and green travel for visitors and staff.

These have been further updated in Section 10.1.

6 DECISION-MAKING FOR CONSULTATION

The Committees in Common considered all the evidence and established a preferred option.

The Committees in Common considered all the evidence set out within the PCBC and concluded that:

- The three options are viable and should be included in any public consultation, with the no service change comparator not included in consultation as it is not a proposal for change.
- The options continue to be ranked as:
  - Sutton as the top ranked and, on this basis, the preferred option;
  - St Helier as the second ranked option; and
  - Epsom as the lowest ranked option.

Programme Board and the Committees in Common considered the evidence to determine whether the options were viable, and whether there was a preferred option.

This evidence is summarised below for each of the options.

Major acute services at Epsom Hospital

- **Non-financial**: All the options deliver the clinical model and associated benefits. The non-financial analysis suggests Epsom is the least favourable of the short list of options (excluding the no service comparator). In addition, there is a risk that the level of births expected for the Epsom option may impact on the viability of a level 2 neonatal unit.
- **Financial**: The Epsom option has the lowest system NPV and the second highest capital requirement.
- **Local provider impact**: The Epsom option has the highest impact on local providers outside of the combined geographies, with the highest outflow of beds and highest capital requirement.
- **Interim integrated impact assessment**: The change in median travel time is highest for the Epsom option. While the Epsom option has a lower impact than other options on older people, it has the greatest impact on deprived communities.

Major acute services at St Helier Hospital

- **Non-financial**: All the options deliver the clinical model and associated benefits. The non-financial analysis suggests St Helier is mid-ranked of the short list of options (excluding the no service change comparator). Building this option is the most complex of the three options, due to the difficulties redeveloping the St Helier site.
- **Financial**: The St Helier option has the lowest capital requirement of the options, but does not deliver the highest NPV of the options, with the Sutton option having a higher NPV.
- **Local provider impact**: There is a lower impact on other providers for the St Helier option than the Epsom option, although there is a higher capital requirement for other providers than the Sutton option.
- **Interim integrated impact assessment**: St Helier has the lowest impact on deprived communities, however it also has the highest impact on older people of the options.

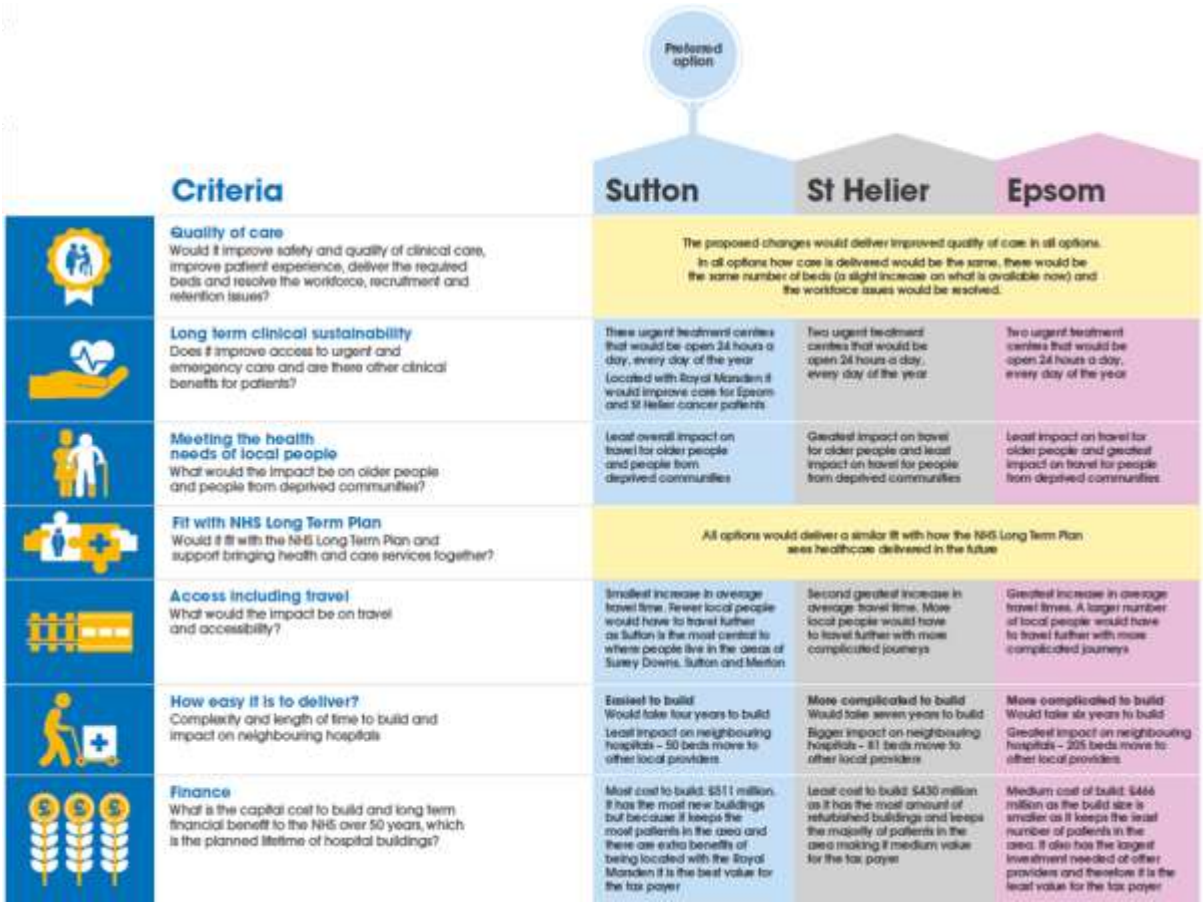
Major acute services at Sutton

- **Non-financial**: All the options deliver the clinical model and associated benefits, with the addition of a third UTC on the Sutton site. The Sutton option ranks most highly against non-financial criteria. As a new build on an unused site, it is the simplest option to build. In

addition, co-locating with the Royal Marsden Hospital offers further opportunities for joint working.

- **Financial**: The Sutton option has the highest capital requirement of the short list of options, however it also delivers the highest NPV of the options.
- **Local provider impact**: The Sutton option, located between Epsom and St Helier, has the lowest impact on other providers. It requires the least incremental capital for other providers and has the lowest net impact on numbers of beds.
- **Interim integrated impact assessment**: The median increase in travel time is lowest for the Sutton option. It has a lower impact on deprived communities compared to the Epsom option, and a lower impact on older people compared to the St Helier option.

Figure 7: Summary of non-financial evidence, financial evidence and overall preferred option



The Committees in Common considered all the evidence and established a preferred option for consultation.

The Committees in Common considered all the evidence set out within the pre-consultation business case and concluded that:

- The three options are viable and should be included in any public consultation.
- The options continue to be ranked as:
    - Sutton as the top ranked and, on this basis, the preferred option;
    - St Helier as the second ranked option; and
    - Epsom as the lowest ranked option.

An overall summary of the options is shown below.

Table 10: Overall summary of options

Category	*No service change*	Sutton *(preferred)*	St Helier	Epsom
Non-financial rank	*NA*	**1**	2	3
Financial rank	*NA*	**1**	2	3
Advantages		• Delivers the clinical model and associated benefits • Joint working with RMH • Delivers an additional UTC • Lowest increase in median travel time • Lower impact on older people (vs. St Helier) and deprived communities (vs. Epsom) • Some impact on providers • Least complex build – new build • Shortest build time • Highest NPV of the options	• Delivers the clinical model and associated benefits • Some impact on other providers • Lower impact on deprived communities (vs. Epsom) • Lowest total capital requirement for the options	• Delivers the clinical model and associated benefits • Lower impact on older people (vs. St Helier)
Disadvantages	*Undeliverable – for comparative purposes only*	• Highest total capital requirement of the options	• Second greatest increase in median travel time • Greatest impact on older people • Most complex build – extensive refurbishment with multiple decants/phases • Longest time to build • Second highest NPV	• Greatest increase in median travel time • High impact on providers • Greatest impact on deprived communities • Medium complex build – extensive refurbishment • Second shortest time to build • Lowest NPV of the options • Second highest total capital requirement
Risks		• Potential further benefits from London Cancer Hub – including potential shared surgical centre • Risk of additional provider impacts from further development • Greater number of intersite transfers required	• Intersite transfers required	• Staffing and maintaining a L2 neonatal unit • Significant capacity required from other providers • Intersite transfers required

7 CONSULTATION AND ENGAGEMENT PROCESS

The Improving Healthcare Together consultation on the options for delivering the clinical model and addressing the case for change was launched on 8 January 2020, for 12 weeks, and closed on 1 April 2020. This involved working with a wide range of partners to carry out the consultation activities and analyse the responses.

The Improving Healthcare Together consultation on the options for delivering the clinical model and addressing the case for change was launched on 8 January 2020, for 12 weeks, and closed on 1 April 2020.

In the development of its consultation plan and process the programme has considered the feedback from its early and pre-consultation engagement on the case for change and options appraisal and has worked closely with a range of stakeholder groups including for example the Consultation Oversight Group and the Stakeholder Reference Group.

The approach to the public consultation was to use a range of methods and channels to ensure local residents, patients, their families and carers, as well as healthcare partners and key stakeholders were aware of, and able to engage and respond to the consultation. The programme sought to reach a broad range of people, beyond those in statutory organisations, partner organisations and those with a vested interest, or those already highly engaged who usually respond to consultations. This included extensive targeted engagement across various consultation strands with protected characteristics, deprived communities and other seldom-heard groups to capture and understand a broader range of views as possible on the proposals.

All methods for consultation were developed in line with best practice and co-designed with local stakeholders as well as input and oversight from the Consultation Institute.

In line with the consultation plan[20], the Improving Healthcare Together Programme worked closely with a wide range of partners to carry out the consultation activities and analyse the responses. The Programme Team led on these activities, supported by:

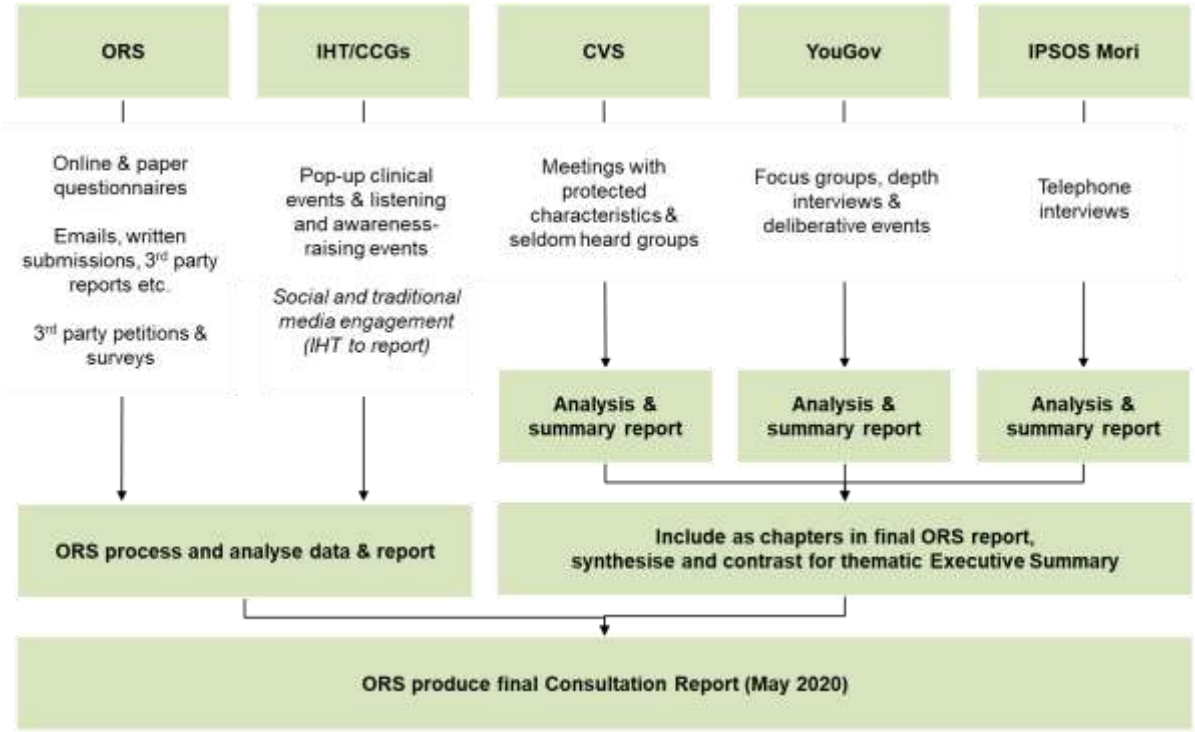
- **Opinion Research Services (ORS)**: Hosted the consultation questionnaire, reviewed and analysed emails, petitions and online and paper questionnaires, and pulled together all the reports by other partners into the overall consultation report.
- **The three lead Councils for Voluntary Services (CVS)**: Commissioned by the programme to manage a Community and Voluntary Sector (CVS) Scheme, organise or support other voluntary or community groups to organise, meetings and events to provide people with information about the consultation and the opportunity to take part.
- **YouGov**: Carried out focus groups, interviews and deliberative events.
- **Ipsos Mori**: Conducted telephone interviews.
- **Colleagues at Surrey Downs, Sutton and Merton CCGs**: Either hosted or attended many outreach meetings and events to promote the consultation, offer information and encourage people to complete the questionnaire.
- **Colleagues at the Epsom and St Helier University NHS Trust (ESTH)**: Organised extensive communications and promotional activity of the consultation questionnaire to all staff working at the Epsom and St Helier hospitals.

This work has been summarised within this DMBC. The full consultation report can be found here[21].

[20] Consultation plan; Accessible at: https://improvinghealthcaretogether.org.uk/document/consultation-plan/

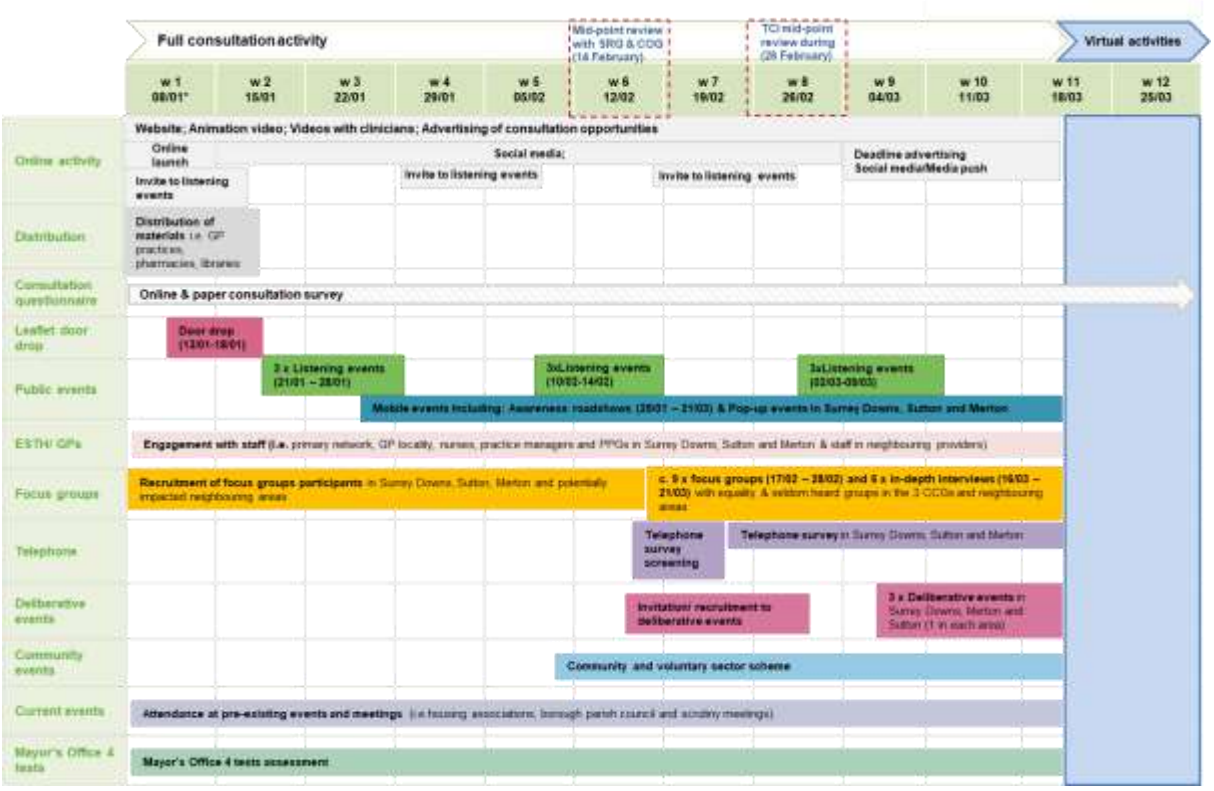
[21] https://improvinghealthcaretogether.org.uk/document/independent-analysis-of-feedback-from-consultation-report/

Figure 8: Consultation partners and main activities



7.1 Summary of consultation activities

The Improving Healthcare Together consultation involved an extensive programme to gather people's views for 12 weeks finishing on 1 April 2020.



The consultation consisted of a detailed programme to provide information, reach out and listen to the views of the local population. This included:

- **A series of 8 public listening events (across the 3 CCG areas)**: open invite events to share information on proposed options for change, answer specific questions from the public to increase understanding of the consultation and proposals, as well as invite and listen to feedback and encourage people to respond to the consultation questionnaire.
- **Community outreach work undertaken by CCG teams**: targeted engagement activities with groups such as older people and deprived communities as well as seldom heard groups like people with learning disabilities; also responding to invites to local groups and attending local events and venues to promote the consultation.
- **Funding voluntary groups via the Community Voluntary Sector Incentive Scheme:** to help communities with various protected characteristics and seldom heard groups engage with the consultation; working with lead voluntary and community organisation in each CCG.
- **Three deliberative events (1 in each CCG area)**: informed two-way discussions over a full day with participants recruited to ensure representative sample from Trust catchment (age, gender, ethnicity and socio-economic status).
- **Eleven focus groups**: Small group discussions with participants recruited from key populations identified in impact assessments (older people, pregnant women/women who have recently given birth, parents of under 16s and 16-24-year-olds).
- **Six 1:1 interviews** with harder to reach populations.
- **Telephone surveys**: based on the questions within the consultation questionnaire and which targeted a representative range of views from the combined geographies and neighbouring areas.
- **17 Mobile roadshows in busy places**: to raise awareness of the consultation targeting specific groups, share information and encourage people to ask questions and complete the consultation questionnaire.
- **13 Clinical pop-ups:** raising awareness with patients and staff in GP surgeries, and St Helier and Epsom Hospitals to encourage people to ask questions and complete the consultation questionnaire.
- **Royal Mail door to door leaflet drop:** a leaflet which summarised the proposals and gave details on planned engagement activities was posted to residents across Merton, Sutton and Surrey Downs and a number of impacted neighbouring areas between 13th January – 18th January.
- **Distribution of consultation materials:** paper copies of the summary consultation document, questionnaire and leaflets were also made available from a variety of locations including 98 GP practices, 135 pharmacies, 107 dentists' surgeries, 72 opticians, and 26 libraries across the three CCGs. They were also provided to all local authorities, the CCGs and hospitals in the area, community and voluntary groups, Citizens' Advice and job centres, 73 primary schools, 7 gyms, and via email to various residents' associations and parish councils. All consultation materials were also available for distribution upon request.
- **Improving Healthcare Together Website**: All consultation documentation, information on how people can request consultation materials in other formats and give their views as well as the engagement and evidence gathered to date were available on the website from the launch of the consultation. The website address was promoted in all the main consultation materials and in all publicity across all formats and channels.
- **Social media**: using social media channels including Facebook and Twitter across South West London and Surrey Downs and targeted advertising to share information, raise awareness of how people can access information, have their say and complete the consultation questionnaire.
- **Media:** issued various press releases to raise awareness of engagement opportunities during the public consultation, disseminate information and signpost local people to different ways in which they can find out more about and respond to the consultation.
- **IHT telephone, texting and emailing facilities:** The IHT programme team managed and responded to email, telephone and text queries. Where people have clearly expressed an

opinion on the proposals these were logged. This feedback was reported to and analysed by Opinions Research Services.

These activities were led by the IHT programme and by other partners. The process around this and their contribution to the consultation report is described further below.

7.1.1 Improving Healthcare Together Programme

The IHT programme had oversight of the consultation activities and led on listening events and media engagement. It launched the consultation on 8 January following the decision of the Improving Healthcare Together Committees in Common to proceed to consultation.

7.1.1.1 Consultation materials

The programme developed a wide range of materials for the consultation, including:

- A consultation summary document
- A full consultation document
- A consultation questionnaire (online and hard copy)
- Clinical model fact sheets
- Range of videos (an animation film, videos with local clinicians, video explaining what services will stay at Epsom Hospital and St Helier Hospitals)
- Leaflet
- Case studies
- A consultation plan
- Poster
- Banner
- Postcards
- Display materials at public events
- Drawings of the three proposed options sites
- Frequently asked questions

Further materials were produced to meet the needs of people with additional requirements, including:

- Documents in plain English – various consultation materials including the consultation questionnaire, summary and full consultation documents have achieved the Plain Crystal Mark
- An ‘Easy Read’ summary consultation document and consultation questionnaire which were tested with an independent advocacy panel composed of people with a learning disability. Converted Easy Read materials will adhere to Mencap Easy Read Guidance, Department of Health guidance and the European Easy-to-Read Guidance.
- A translated summary consultation document and questionnaire into the three most common other languages within the combined population: Urdu, Tamil and Polish

The consultation documentation was also available in a range of formats on the Improving Healthcare Together website. The consultation website featured software designed to support anyone with a visual impairment, learning disability or where English is a secondary language. Browsealoud is a support tool which reads aloud, magnifies and translates all the content (including pdfs) on the IHT website.

7.1.1.2 Distribution of consultation materials

Printed copies of the leaflet and summary consultation document were distributed to key stakeholder organisations at the start of the consultation and made available at all public listening and mobile pop-up events. Paper copies of the consultation documentation were available and promoted at all engagement events.

During the consultation, online and hard copies of consultation materials were distributed to key stakeholders as appropriate. These included:

- All Local Authorities in Surrey Downs, Sutton and Merton
- 14 Parish Councils in Surrey Downs
- Surrey Downs, Sutton and Merton CCGs
- Epsom and St Helier hospitals
- 91 GP practices
- 136 Pharmacies
- 26 Libraries
- 3 Lead Councils for Voluntary Services organisations
- 72 opticians
- 107 dentists
- Leisure Centres
- 3 Job Centres
- 9 Citizens Advice Bureau
- 37 Sure Start Centres
- 35 Resident Associations
- Local residents (upon request)
- 7 GP practices in impacted neighbouring areas.

In addition, a Royal Mail door to door leaflet drop over the first two weeks of the consultation provided a summary of proposals and details of planned engagement activities to residents across Merton, Sutton and Surrey Downs and a number of impacted neighbouring areas. The leaflet was also distributed across GP Practices, pharmacies, St Helier and Epsom Hospitals, Councils and Libraries.

7.1.1.3 IHT website

The consultation website was developed to provide easy access to key consultation documents, the schedule of events and additional information. The website included:

- Key consultation materials and technical documents – all core documentation (including easy read any translated documents in other languages) was available on the website from the launch of the consultation
- The online questionnaire
- A videos section
- Explainers on various topics to answer questions that have been most commonly raised by members of the public online and at public events.
- A public events section
- Consultation news
- Feedback form
- Frequently asked questions
- Information on how people can share their views on the proposals and/or request information in different formats

The website address was promoted in all the main consultation materials and in all publicity across all formats and channels, including social media activity. Links on Merton, Sutton and Surrey Downs CCGs websites ensured residents from across our consultation geography were signposted to the consultation section of the website, enabling them to access information and give their feedback.

The website had over 85,000 page views by over 71,000 visitors during the consultation period. The most popular page was the ‘Talk to us’ page with 25,738 page views, followed by the consultation questionnaire with 6,744 views.

7.1.1.4 Social media

The IHT social media activity delivered significant levels of engagement with the website throughout the consultation period. This included direct engagement with social media posts to answer specific questions and paid for social media on Facebook to raise awareness among a wider range of

audiences and demographics, encouraging residents to visit the IHT website and complete the consultation questionnaire.

The messaging and assets were flexed during the consultation to reflect feedback from the public during the consultation. This included:

- Strengthening the messaging around the case for change from week three to engage audiences less familiar with the NHS;
- Introducing animated explainers to answer frequently asked question from weeks five and six (see examples below);
- Introducing data visualisations to refresh the assets in the final two weeks; and
- Increasing the emphasis on 'have your say' and completing the questionnaire in the final two weeks.

Figure 9: Example of Explainers introduced in weeks 5 and 6 to answer frequently asked questions

Overall figures for free, organic social media show:

- Over 1,160 social posts across all social media channels;
- 843,000 impressions;
- Over 1,730 engagements; and
- Almost 15 percent growth in social media followers for IHT.

Overall figures for paid social media advertising on Facebook show:

- 15,079 link clicks to the IHT website;
- 1,475,107 impressions;
- 214,276 reach; and
- Good reach across all age demographics, but weaker when targeting health professionals.

7.1.1.5 General media

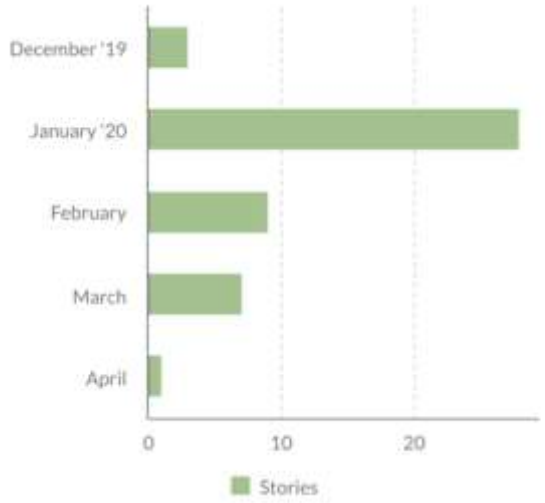
The programme proactively engaged the media to raise awareness of the proposals and the consultation and encourage residents (including staff, stakeholders and representative groups) to complete the consultation questionnaire. This included issuing eleven press releases some of which are captured in the headlines below.

Figure 10: Snapshot of media headlines on the IHT programme and consultation

The IHT consultation was featured as the lead item on BBC London News and was also covered in-depth in the London segment of the BBC Politics Show. Over the course of the consultation IHT stories were covered 25 times in local and pan-London newspapers, eight times on radio, nine times on online-only news websites and four times in trade media. The most popular stories were the launch of the consultation and release of 'artist impressions' of the new hospital(s).

The graph below shows the number of stories covered by month during the consultation period.

Figure 11: Media coverage of the proposals and consultation by month



7.1.1.6 Mobile roadshows and clinical pop-ups

17 mobile roadshows were held in areas of high footfall including in deprived wards to raise awareness of the consultation, share information, answer questions and encourage people to complete the questionnaire. The delivery of these events was supported by CCGs representatives.

7.1.1.7 Listening events

The programme planned to host nine public listening events (three in each CCG area) across the consultation period. Eight of these were held as planned, however the final event in Surrey Downs was cancelled following public health guidance and social distancing measures for Coronavirus. Local residents and stakeholders in Surrey Downs were invited to respond through other means (see section 7.1.7 on the impact of COVID-19 and the IHT mitigation actions).

Listening events were widely publicised with an open invite to provide an opportunity to share information on the proposals for service change, answer specific questions from the public to increase understanding of the consultation and proposals, as well as invite and listen to feedback and encourage people to respond to the consultation questionnaire.

The listening events were well-attended with over 1,000 attendees which included a significant presence from political stakeholders, particularly in Merton.

Listening Event	Location	Date	Time of day	Approximate No. of attendees
Sutton 1	Sutton	21 January 2020	EVE	150
Merton 1	Morden	24 January 2020	PM	94
Epsom 1	Epsom	28 January 2020	PM	125
Epsom 2	Spalding	11 February 2020	EVE	270
Merton 2	Mitcham	12 February 2020	EVE	160
Sutton 3	Wallington	12 February 2020	PM	120
Sutton 3	Carshalton	2 March 2020	EVE	47+
Merton 3	Mitcham	5 March 2020	PM	85
Epsom 3	Leatherhead	17 March 2020	CANCELLED DUE TO COVID-19	

The cancelled Leatherhead event was replaced with an online event.

7.1.2 CCG community outreach

This engagement programme used a targeted approach based on the findings from the independent Deprivation Impact Assessment and draft interim Integrated Impact Assessment which identified protected characteristic groups and hard to reach communities that may be potentially impacted by the proposals.

The CCGs hosted a series of meetings and pop-up events with a range of stakeholders and interest groups as well as responded to invitations to speak at various existing local meetings.

Stakeholders engaged included residents associations, groups involving people with various disabilities, long term conditions or learning difficulties; women who were pregnant or had recently given birth; young people under 25; parents of children under 16; older people; BAME communities; deprived and; deprived communities; homeless people; housebound people; migrants, refugees, asylum seekers; and Gypsy, Roma and Travellers. 13 clinical popups were run in GP practices and health clinics in Merton, Sutton and Surrey Downs including sessions held in surgeries located in deprived wards and where baby clinics were held to raise awareness among patients and staff.

Over 5,000 individuals were engaged through these activities including NHS staff, protected characteristic groups and those living in deprived areas.

7.1.3 YouGov

7.1.3.1 Overview

YouGov were commissioned to conduct targeted engagement with key populations identified as potentially impacted groups as identified in the integrated impact assessment from across the CCGs and neighbouring areas. This included eleven focus group discussions with participants including older people, pregnant women or women who have recently given birth, parents of under 16s and 16-24-year-olds and six in-depth interviews with harder to reach populations.

Three deliberative events (one in each of the CCG areas) were also run to allow more in-depth and informed discussions over a full day with participants recruited to ensure representative sample from Trust catchment (age, gender, ethnicity and socio-economic status).

7.1.3.2 Methodology

The eleven 90 minute focus groups aimed at reaching those who may face a greater impact from the proposed changes to services – recent users of maternity services, people aged 65+ (and people aged 55+ with long-term health conditions), parents of children aged 16 and under, and young people up to age 24.

Six individual depth interviews were used to speak with people who identify as transgender and those in the Gypsy Roma Traveller (GRT) community, as these individuals are known to be harder to reach.

Three day-long workshops with a sample reflective of the general population sought deliberative feedback based on a full day of consideration and discussion of the proposals.

At the project outset, all research activities carried out by YouGov were scheduled to be held face to face at accessible venues in Merton, Sutton and Surrey Downs. However, due to the timing of COVID-19 and the associated restrictions around face to face gatherings, the final focus group (Young People) was carried out online. The final deliberative event (Merton) was also adapted, resulting in four 90 minute online focus groups carried out with participants who had initially opted in to the face to face event. Three individual depth interviews were carried out by telephone.

During face to face discussions, participants were shown consultation information about the proposed changes to local hospital services using a projector and / or a printed information pack. Online focus groups were held as text-based chats using a secure online platform, and participants were shown consultation information on a series of whiteboards before discussing the information with the moderator. For telephone depth interviews, consultation information was sent to participants via email and read out over the telephone. Participants were also shown a short video outlining the proposed changes.

In all discussions, consultation information was covered one stage at a time – looking first at the case for change, followed by the proposed model of care, and finally the three site options. This was to ensure that participants had the opportunity to ask questions and clarify information, before discussing their immediate and more considered reactions.

7.1.3.3 Sample

Focus groups were recruited to reflect specific groups (as summarised below).

Table 11: Focus group composition and attendance by CCG

Area	Group No.	Date	Composition	Recruitment approach	Attendees
Merton	2	19th February	All aged 65+ or 55+ with limiting long-term condition	Living in Merton	9
Merton	5	25th February	All women aged 18-44 Using / have used obstetric services in past 18 months (50% to have used maternity Epsom & St Helier)	Living in Merton	8
Merton	6	25th February	All parents of children U16 (60% under 8)	Living in Merton	7
Sutton	3	20th February	All aged 65+ or 55+ with limiting long-term condition	Living in Sutton	10
Sutton	9	27th February	All women aged 18-44	Living in Sutton	7

Area	Group No.	Date	Composition	Recruitment approach	Attendees
			Using / have used obstetric services in past 18 months (50% to have used maternity at Epsom & St Helier)		
Sutton	10	27th February	All parents of children U16 (60% under 8)	Living in Sutton	6
Surrey Downs	1	18th February	All aged 65+ or 55+ with limiting long-term condition	Living in Surrey Downs	9
Surrey Downs	7	26th February	All women aged 18-44 Using / have used obstetric services in past 18 months (50% to have used maternity at Epsom & St Helier)	Living in Surrey Downs	8
Surrey Downs	8	26th February	All parents of children U16 (60% under 8)	Living in Surrey Downs	10
Mixed	4	20th February	All aged 16-24	Living in Surrey Downs, Sutton and Merton	8
Mixed	11	31st March	Younger people aged 16 – 24 years old	Living in Surrey Downs, Sutton and Merton (now online)	6

In addition, the focus groups were recruited to include a mix of wards within the relevant CCG catchment (including deprived wards), mix of social grade, mix of household income, mix of gender (except obstetrics) and a mix of ethnicity. A number of additional criteria were recorded including: benefits received, carer status, health status / disability, religious affiliation, sexuality, whether they would use Epsom / St Helier hospital services, and whether they had used hospital services at any of the sites in past 12 months.

Workshops were recruited to be more reflective of the general population, and as such included some people who fall into the wider Trust catchment, going beyond the core CCG catchment areas.

Table 12: Deliberative workshop composition and attendance by CCG

Area	Group No.	Date	Composition	Recruitment approach	Attendees
Surrey Downs	1	7th March	Mix of social grade, gender, age 18+, ethnicity, health status, urban / rural	Living in Surrey Downs	38
Sutton	2	14th March	Mix of social grade, gender, age 18+, ethnicity, health status, urban / rural	Living in Sutton	37
Merton	3	w/c 23th March (online)	Mix of social grade, gender, age 18+, ethnicity, health status, urban / rural	Living in Merton	33

Additional demographic information was recorded for those attending the workshops: Employment status (including some students), benefits claimed, household composition, use of local hospitals in past 18 months, sexuality and religion. Participants were recruited from a mix of wards within each catchment area, including some from deprived wards.

In addition to focus groups and workshops, six individual depth interviews were conducted with those who identify as transgender or those identifying as Gypsy Roma Traveller. Interviewees were recruited from the three core CCG catchments plus the wider Trust catchment.

7.1.3.4 Recruitment

A majority of participants were recruited using the YouGov online panel – participants were targeted using a screening questionnaire, which initially screened participants in or out depending on their postcode. Additional information was then collected, and participants were selected to include a mix of demographics, as outlined in the sample frame for each method.

Where necessary, trusted recruitment partners were used to free-find participants, using the same screening questions. Community groups were also contacted in order to schedule interviews with those identifying as Gypsy Roma Traveller.

In line with guidelines, all participants were incentivised for their time with either cash or retail vouchers (dependent on the method used).

7.1.4 Ipsos Mori

7.1.4.1 Overview

Ipsos Mori were commissioned to conduct telephone surveys based on the consultation questionnaire. The principle aim of the research was to engage with members of the general public who use health services across Surrey Downs, Sutton and Merton CCGs to gather their views on how they feel about the proposals for change.

More specifically, the research sought to achieve the following objectives:

- Engage with a representative sample of the general population to explore attitudes towards the proposals.
- Reach beyond those most engaged and informed, to people whose views may not otherwise have been heard.
- Provide insight into if and how attitudes vary in different regional contexts and across different sub-groups of participants.

This approach was designed to capture an overall view from the general public towards the proposals, as put forward under the Improving Healthcare Together programme.

7.1.4.2 Methodology

In total, 751 members of the general public aged 16 and over were interviewed via telephone between 20th February and 18th March 2020.

The sample was designed to be representative, to include participants across Surrey Downs, Merton and Sutton CCGs, as well as a smaller proportion of interviews with those who fell outside of the IHT CCGs but may well still use the services within the Epsom and St Helier University Hospitals NHS Trust. As a result, based on population size from census data, the following number of interviews were achieved in each area:

- Surrey Downs (274);
- Merton (195);
- Sutton (186);
- Non-IHT CCGs (96).

Quotas were also set within each of these areas based on age, gender, ethnicity and working status, adjusted to reflect the demographic profile of each area outlined above. This means targets were set

for the number of interviews achieved within each group, to reflect the demographic profile of each area as closely as possible – the results are representative within each area, as well as overall.

7.1.4.3 Questionnaire

The finalised questionnaire included the following:

- **Screener demographics** – this verified that the participant was eligible to take part due to postcode and age, plus gathered more detail based on gender, ethnicity and working status.
- **Local NHS** – this section aimed to understand participants' usage of hospitals in the local area.
- **IHT overall proposals** – designed to explore awareness of the IHT programme, and briefly outline proposals before asking for their overall view and their reasoning for this.
- **Views of sites** – participants were asked to consider the factors they deemed most important when considering the site for locating the new hospital, plus their thoughts on each individual site as a solution.
- **Impact of sites** – explored the impact each proposed site could have on participants and their family, the reasons for this, and how easy or difficult it would be to travel to the new hospital (based on each site scenario).
- **Key demographics** – additional sub-group data was gathered based on pregnancy, whether the participant was a parent to a child under the age of 16 and whether they had a disability.

7.1.5 Community and Voluntary Sector engagement

The programme worked with the three lead local Councils for Voluntary Services (including Central Surrey Voluntary Action, Community Action Sutton and Merton Voluntary Service) to complement the CCGs' outreach programme in reaching groups identified by the Integrated Impact Assessment as likely to experience a disproportionate impact. These organisations were commissioned to oversee and co-ordinate the Community and Voluntary Sector Incentive scheme. This involved both organising and supporting other local voluntary and community groups to organise, facilitate and capture feedback on the IHT proposals at their meetings, events and sessions with their organisations' service users.

Around 225 individuals were engaged through a variety of activities. This included for example older residents, young people, people with disabilities and mental health conditions (and their carers), BAME communities, parents and refugees.

7.1.6 Staff engagement

ESTH has organised extensive communications and promotional activity of the consultation and consultation questionnaire to all staff working at the Epsom and St Helier hospitals.

Engagement activities included: weekly messaging from the CEO, website and social media promotion of the consultation, as well as presentations at various divisional and public board meetings. ESTH has also supported the cascade of the consultation questionnaire via HR down the management structure.

Additionally, the Trust has distributed leaflets, summary documents and questionnaires to various patient areas within the hospitals.

7.1.7 Adapting to COVID-19

Following public health regulations that people should avoid all unnecessary social contact with others and all unnecessary travel[22], the remaining face-to-face engagement activity, planned as part of the consultation, was cancelled from 17 March 2020.

The impact experienced as a result of social distancing measures for COVID-19 was minimal as the vast majority of face-to-face engagement activities had been planned to take place over the first 10

[22] https://www.gov.uk/coronavirus

weeks of the consultation due to the planned London Mayor elections and associated purdah period originally scheduled to commence on 23rd March.

In accordance with the consultation plan the majority of planned activity over the remaining two weeks focussed on social media and online activity. Mitigation plans were also put in place for the remaining face-to-face events which were cancelled as summarised below.

Table 13: Face-to-face events cancelled due to COVID-19 and mitigations

Type of event	Mitigations
Final listening event in Surrey Downs	Notified stakeholders of cancellation of this event via social media. Uploaded the IHT listening event presentation onto the IHT website. Emailed stakeholders including, for example, the Stakeholder Reference Group and the Consultation Oversight Group. Encouraged local people via social media to raise questions via the IHT email inbox.
Final deliberative event in Merton	This deliberative event took place online and was attended by the same previously recruited 40 participants for this event. YouGov undertook this research via 4 'chat-based' separate focus groups (of 10 representatives each) during week commencing 23rd March.
Final YouGov focus group with young people	This remaining focus group was delivered by YouGov online.

7.2 Analysis of consultation responses

YouGov and Ipsos Mori produced independent reports which summarised their findings. This was combined by ORS with the IHT activities and findings, and the ORS analysis of the consultation questionnaire (online and paper).

This additional ORS analysis covered:

- Consultation questionnaire feedback (4,173 responses)
- 434 written and email submissions from organisations, key stakeholders, campaign groups and unions, and individuals respondents, including several detailed reports;
- 8 IHT listening events;
- Activities run by the three CCGs involving 5,000+ members of the public;
- 2 Petitions;
- 3 Independently organised surveys;
- Demographic / equalities profiling forms;
- A summary chapter covering events run by community voluntary organisations in the three CCG areas; and
- A summary chapter or section related to equalities impacts drawn from all consultation strands.

ORS produced an executive summary and methodology/consultation overview chapter which draws together all of the above as well as the YouGov and Ipsos MORI reports and a section on social and other media.

The activities, feedback and analysis described in this Section formed the basis for the CCGs to understand the views of their population. Section 8 describes the main areas of feedback, followed by Section 9 on how this feedback was addressed.

7.3 The Consultation Institute's assurance process

The Consultation Institute (tCI) has assured the consultation. The tCI assurance process includes 6 checkpoints at different stages of a consultation:

1. **Pre-consultation planning:**
    - Scoping and Governance (the basics of the consultation are agreed)
    - Project plan (consultation activities are set out and organised)
    - Documentation (all hard copy and electronic versions are fit for purpose and that questionnaires conform to best practice)
2. **During consultation:**
    - Mid-point review (assess whether all relevant views are being considered)
    - Closing date review (to finalise plans for analysis, feedback and influencing processes)
3. **Post-consultation**
    - Final report

The programme has completed the tCI assurance process of this consultation. tCI has confirmed that the programme has fully met the requirements of a 'best practice' consultation.

8 FEEDBACK FROM CONSULTATION

Feedback from the consultation across all strands was analysed and collated by ORS. A number of consistent themes were identified. These included travel and access, workforce, clinical model, population and bed modelling, deprivation, out of hospital and site-specific themes (such as multi-site working). Many of these themes are consistent to areas identified in pre-consultation early public engagement and the Interim Integrated Impact Assessment.

8.1 Summary of consultation feedback

Feedback from the consultation across all strands was analysed and collated by ORS. They produced a full report[23] which can be referred to for more detailed insights and understanding of the views and opinions about the possible changes to how health and care services are organised across the combined geography.

This section provides a summary of the main finding of the report. A number of consistent themes were identified. These included travel and access, workforce, clinical model, population and bed modelling, deprivation, out of hospital and site-specific themes (such as multi-site working).

8.1.1 Key Findings

The key findings from the consultation report are:

- Many consultees recognised the challenges facing the NHS nationally, and ESTH hospitals in particular, and welcomed the proposed investment into local hospitals;
- There is widespread support for the clinical model from respondents, and particularly from clinical stakeholders and NHS staff, on the basis that it addresses the case for change. However, levels of support varied across geography with more individuals living in the Merton area stating that the model of care is a poor or very poor solution;
- Looking across all consultation strands, on balance Sutton received more support as a potential site for a new SECH, although views varied by where respondents lived. Support for Sutton as a site was greater among those who also supported the proposed model of care;
- Support for Epsom or St Helier as the site of the SECH tended to be focussed mainly by respondents in the immediate vicinity of those hospitals, preferring to retain all acute services at their local hospital;
- The most common concerns shared by respondents related to access to services, the impacts of the proposed changes on local communities and travel and transport to the SECH;
- There was concern that the proposed changes might lead to poorer health outcomes and unnecessary risk to life, primarily as a result of longer journey times. The feedback received stated that travel and access to a new SECH, wherever it might be built, would be difficult, time-consuming and expensive, with concerns about private and public transport, and parking provision at hospital sites;
- A common concern was that separation of pre-natal, ante-natal and maternity care staff to different hospitals reduces consistency of care and support, and could potentially alter decisions on where to give birth;
- Concern was expressed around health inequality and the potential for adverse impacts arising from the proposed changes on people living in socio-economically deprived areas, compared to those living in more affluent areas, largely due to the greater challenges around travel and access;

[23] https://improvinghealthcaretogether.org.uk/document/independent-analysis-of-feedback-from-consultation-report/

- Some respondents and participants proposed alternatives or contrary evidence during the consultation, summarised and presented throughout the report; and
- Other themes included the impact on other providers/hospitals, three-site working including staffing and hospital transfers, insufficient bed numbers for a growing older population, and concerns around possible future privatisation.

8.2 Feedback by consultation strand

The responses were broadly consistent across consultation strands, though there was more support for the clinical model in deliberative sessions. In general, these sessions provided more time to discuss the proposals and the rationale behind developing the proposed clinical model.

The key findings by strand are:

- **CCG community outreach.** At events involving a broad range of attendees across the combined geographies, there was support for the clinical model. Having a new specialist hospital in the area with new equipment was considered by many to be positive. There was also support for the refurbishment of St Helier and Epsom hospitals. There was some confusion around the difference between the provision of services at UTCs and A&Es.
- **CVS.** There was some support for the clinical model, with people acknowledging that Epsom and St Helier hospitals need upgrading. The idea of a new hospital with all specialisms under one roof was welcomed, with an acknowledgment of the benefits this would bring to the community. There was some concern over the possible closure of St Helier and Epsom hospitals, whether the proposals are the best use of funding and overall the need for hospitals to remain within their communities.
- **YouGov targeted engagement.** Research participants agreed, based on their experiences of local healthcare provision, that change was needed. They generally agreed with the idea of centralising emergency care. With the right reassurances given to them on providing a joined up multi-agency approach on transport infrastructure, they were more accepting of the idea of a new SECH that was further away from their current A&E department. The overwhelming consensus across the groups was that Sutton was the best option for the building of the new SECH.
- **Ipsos Mori telephone surveys.** Overall, most people three-fifths (60%) of research participants agreed, based on their experiences of local healthcare provision, that change was needed with people from BAME backgrounds, younger people and those living in more deprived areas as particularly positive. Those with a positive response to the proposal tend to agree with the case for change and the principle of centralising services. In contrast, 14% of research participants think it is neither a good nor poor solution, and around one in ten (9%) don't know or are unsure of the merits of the proposal. Those living in Merton CCG are more likely to rate the proposal as very good or good compared with people in Surrey Downs CCG (66% versus 55%). This may be linked to the higher proportions of people in Merton CCG from black and minority ethnic backgrounds and living in more deprived areas than in Surrey Downs CCG. One fifth (17%) of people think it is a poor or very poor solution.
- **Consultation questionnaire.** Those responding as NHS employees were positive about the proposed model of care: around four in five (81%) felt it is a good or very good solution. More than half of the other respondents shared this view (56%), although a third of them felt the proposed model is a poor or very poor solution (33%) and views varied considerably by where respondents lived.
- **Public listening events.** Overall the balance of opinion at the events was in favour of refurbishment of St Helier and Epsom hospitals but against a new specialist and emergency hospital at Sutton. Some found the shortage of medical staff of all kinds concerning and questioned how the proposed model would overcome this issue.
- **Petitions and third party surveys.** Two petitions and four questionnaires were locally organised. The petitions opposed closures of hospitals or cuts to services and the many of

the respondents to the questionnaire expressed a need to retain services at hospitals to serve the needs of local people.

- **Social media.** Comments on social media reflected the range of views expressed through other strands of the consultation. For example, there was some support for the centralisation of services and acknowledgement that a new modern hospital is needed. However, some opposed the centralisation of services.
- **Written submissions.** There were 434 written submissions received as part of the formal consultation process, 359 from individual residents, 32 from counsellors and political groups, 15 from members of parliament, 9 from charities and special interest /community groups, 8 from NHS trusts and professional groups, 7 form local authorities and 4 from trade unions/councils. There was widespread support for the case for change and the proposed model of care, particularly among NHS Trusts and professional/clinical groups. However, there was also significant opposition to the model of care – especially among some of the MPs, councillors, trade unions, campaign groups and local residents (of the St Helier area in particular).

8.3 Overall views on the options

Following a comprehensive evaluation and options appraisal process, three options were shortlisted to take forward to wider formal consultation:

1. A **single major acute site at Epsom Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
2. A **single major acute site at St Helier Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.
3. A **single major acute site at Sutton Hospital**, providing all major acute services with continued provision of district hospital services at Epsom and St Helier Hospitals.

The 'no service change' option was not consulted on as it is not a proposal for change. The preferred option going into consultation for a new specialist emergency care hospital was the Sutton Hospital site. The consultation document[24] demonstrated how each option compared against the others based on a number of key criteria, namely: Quality of Care, Sustainability and Fit with Long Term Plan, Travel and Access, Deliverability, and Finances. There was some feedback received that there should not have been a preferred option without properly discussing the potential benefits of other options (such as 'business as usual' and 'do minimum').

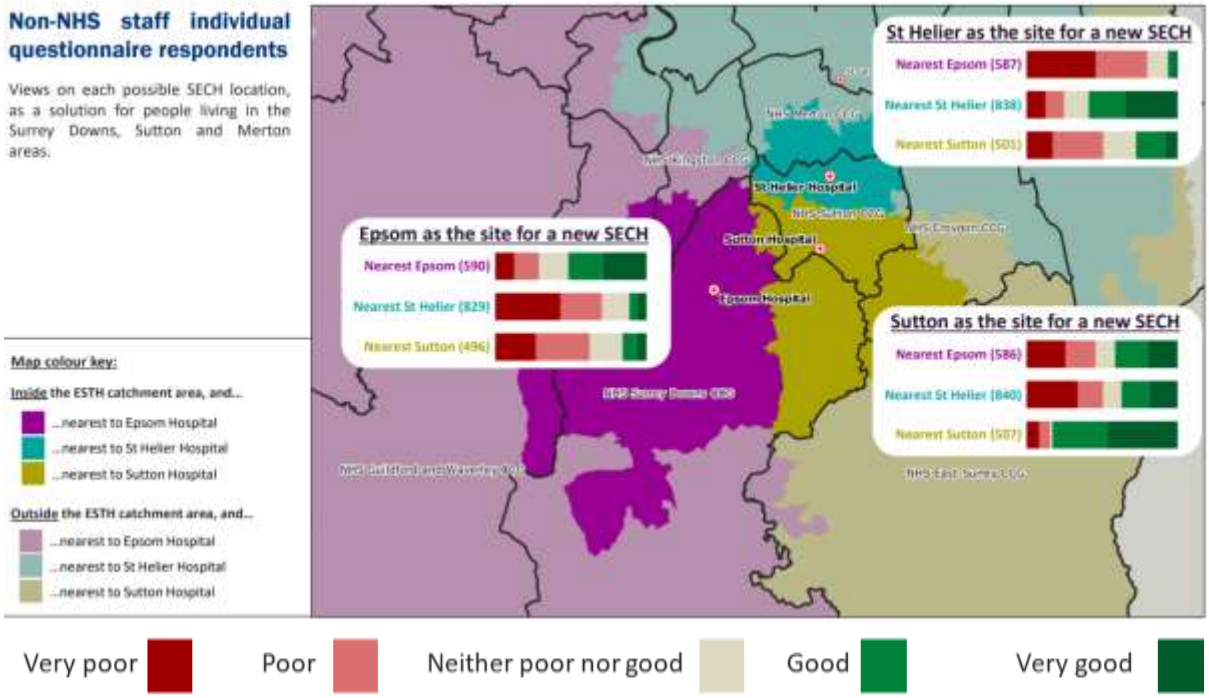
Overall, views on the options varied according to where the respondent lives, where those who live close to the proposed hospital site favoured this as the site for the new SECH. In the consultation questionnaire, this was true of both individual respondents and NHS employees, although more pronounced for the former. NHS employees tended to favour the new SECH on the Sutton site, with more than three quarters (77%) stating that would be a good or very good solution. Whereas only 24% and 15% and said that locating the SECH at St Helier or Epsom sites would be a good and very good solution, respectively.

Overall, non-NHS-staff individual respondents were also most positive about locating the new hospital at Sutton; however, views were less clear cut and varied considerably by geography. Almost half (48%) felt that building on the Sutton site would be a good or very good solution (52% of those living within the ESTH catchment), compared with just over a third for St Helier (37%) and just over a quarter for Epsom (27%).

The main reasons for the preference in location of the SECH tended to be their closest site, for example with those closest to Epsom having a preference for the Epsom SECH option.

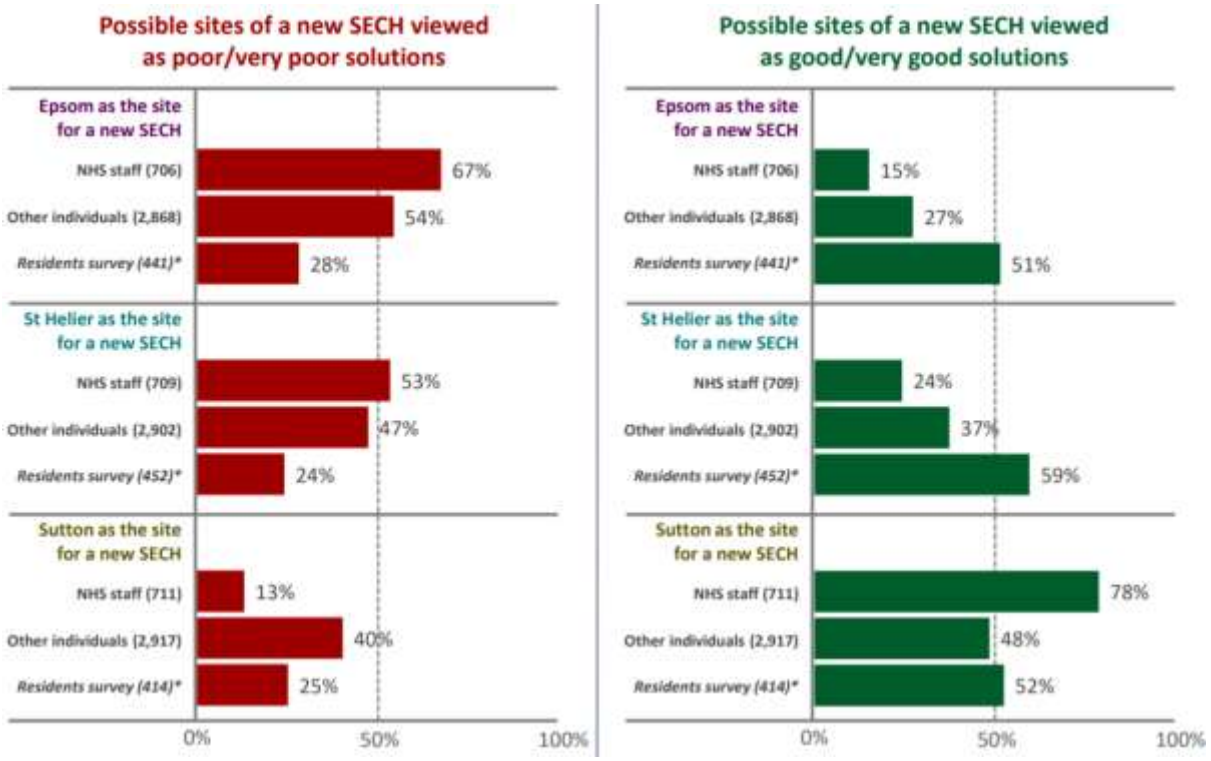
[24] https://improvinghealthcaretogether.org.uk/document/full-consultation-document/

Figure 12: Map illustrating the preferred sites of questionnaire respondents, with their location (based on individual respondents who indicated a clear preference and provided their postcode)



- **Epsom:** Some respondents considered that locating the new site at Epsom would be more beneficial for the older population to access treatment. However, respondents expressed a concern that this would be the worst option for residents of Merton CCG who would have long journey times; also the Epsom site posed constraints on size, although there was some support based on the lower capital costs of building the site.
- **St Helier:** There were mixed views on locating a SECH at St Helier. Positively, some people felt it could be more appropriate, due to the more deprived nature of the local population and the potential regeneration it might bring. However, there were concerns raised about the lack of facilities being able to accommodate the influx of new staff and concerns about travelling to the area for older people with longer journeys from Surrey. Some supported this option as it is the least expensive option.
- **Sutton:** The proposed location of the new hospital at Sutton was criticised for poor travel and transport access and for not being located in the most heavily populated area or closest to the most deprived communities, meaning that a high proportion of people would have to travel some distance. Supporters of the Sutton site for the new SECH, stated that building from the ground up means that there is much less disruption to existing hospital buildings, and that the build time is the shortest and that this option would result in three rather than two UTCs.

Figure 13: Views on the possible sites for the SECH from NHS staff, other individuals and the residents' survey



8.4 Crosscutting themes

When reviewing the feedback across all consultation strands, a number of broad themes emerged. This section summarises the responses into these themes.

8.4.1 Travel and Access

Access to care and transport to hospital sites is the most common concern raised by both those who oppose or support the proposals. Residents think that the distance people have to travel is the most important factor when deciding where the new site should be located (56%). Other important factors include around one in ten saying that it should be in a central location or close to where the population density is greatest (12%), that parking should be available (10%) and that there should be ease of access (10%). There are views that travel and access to a new SECH, wherever it might be built, would be difficult, time-consuming and expensive, with concerns about private and public transport, and parking provision at hospital sites.

Overall concerns were particularly centred around travel times and parking.

- **Access to the SECH**: The main concerns about access to the SECH site centred around the following points:
    - Some concern was expressed that the travel time could lead to poorer health outcomes and unnecessary risk to life, primarily as a result of longer journey times.
    - Confusion may arise as a result of having both a central A&E, and UTCs available locally, with public education needed on 'where to go for what'.
    - Fit for purpose public transport is needed, providing alternative modes including volunteer car schemes, shuttle buses, night buses, adapted vehicles for people with limited mobility
    - Separation of pre-natal, ante-natal and maternity care staff to different hospitals reduces consistency of care and support, and could potentially pressure some mothers into home birth, or conversely put off some mothers having home births who lived furthest from a new SECH.

- **Parking**: The provisions at the hospital sites was a key concern. Many believed that the current parking facilities are inadequate and wanted to know how the plans will provide affordable and accessible parking for all, including staff parking and better disabled parking facilities. There were concerns that there would not be adequate space to facilitate the parking needed. As it currently stands, all three sites were discussed as being too small and there were concerns that building expansions would further limit space for parking. Multi storey and underground parking was suggested to facilitate this. Reduced parking costs for all and subsidised parking was suggested for patients and carers, given current parking costs were seen as high.
- **Impact on deprived, older and BAME communities**: The overriding concerns both of, and about, individuals and groups with protected characteristics, related to concerns regarding loss of local services, and the potential challenges of travelling to a centralised SECH. The three protected characteristics groups most frequently mentioned across all consultation strands were older people, those with disabilities, particularly in relation to reduced mobility, and of pregnant women and those about to or having just given birth. In all three cases, increases in journey times (whether by public or private transport, or by ambulance) were cited as having potential for significant impacts.
- **Traffic and congestion**: Feedback received around traffic and congestion expressed concern that road improvements are needed. Respondents stated that there were already traffic issues and a new hospital (without sufficient planning for the right transport infrastructure) may add to these challenges.

8.4.2 Workforce

While there was some support for how the model of care will address the workforce issues currently faced, some concerns were expressed that can be broadly categorised into three areas:

- **There are alternative solutions for workforce challenges**: Some felt that workforce shortages are a poor justification for reconfiguration. They cited that there is a national shortage of staff and were concerned that the model would not solve this issue. However, others commented that the model of care was the only way of resolving staffing issues.
- **Availability of required skills**: A small majority could see the benefits of the clinical model and centralising specialist services. However, there was some concern that bringing together specialists, at the SECH, could increase the risk of district hospitals closing or not being able to provide the same level of care as acute hospitals if there are not enough generalist or training opportunities at the district sites. Similarly, there were concerns about sharing staff and facilities across three sites and the sustainability of this model. There were additional points raised that the current level of staff was already too low, and some were apprehensive of how the new hospital would be staffed.
- **Staff training**: Some comments received were positive, with respondents acknowledging that increased training will improve specialisms. However, it was noted that money needs to be invested into better training to ensure quality of care. Specifically, all staff need awareness of children with special needs training.

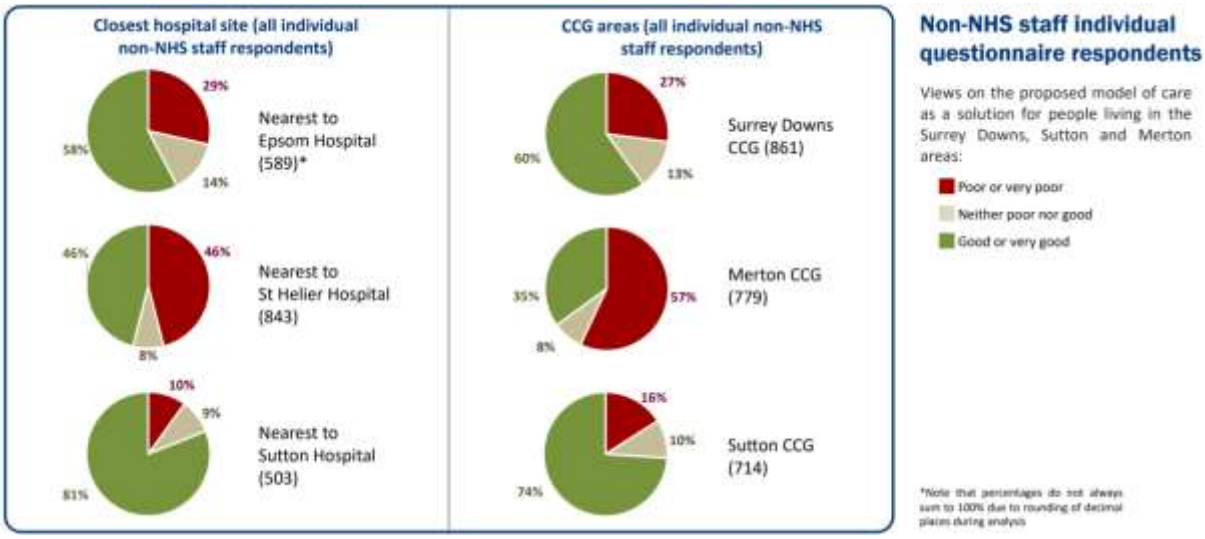
8.4.3 Clinical model

Overall, many consultees recognised the challenges facing the NHS nationally, and there was “widespread support” for the clinical model from respondents, and particularly from clinical stakeholders and NHS staff, on the basis that it addresses the case for change. However, levels of support varied by geography with more individuals living in the Merton area stating that the model of care is a poor or very poor solution.

Most organisations and those responding to the consultation questionnaire as NHS employees were very positive about the proposed model of care. For example, around four in five working in the NHS (81%) felt it is a good or very good solution. More than half (56%) of the other individual respondents to the questionnaire shared this view. However, a third felt the proposed model is a poor or very poor

solution (33%), and results varied by geography as indicated below, in particular respondents living in the Merton area stating that the model of care is a poor or very poor solution (57%). Results were slightly more positive among respondents to the telephone residents' survey[25], with just under two-thirds (63%) feeling that the proposed model of care is a good or very good solution, and just over a fifth (21%) considering it a poor or very poor one.

Figure 14: Consultation questionnaire responses from staff and other non-NHS staff individual respondents in response to the proposed model of care



There was support for the proposed model of care in the written submissions (particularly among NHS Trusts and professional/clinical groups) and at the focus groups with members of the public and residents' workshops, as well as among many attending CCG-organised events. There was also some support on social media and in the locally organised questionnaires, as well as at the Community and Voluntary Sector (CVS) meetings.

The vast majority of those consultees who viewed the proposed model of care negatively recognised many of the challenges facing the NHS nationally, and ESTH hospitals in particular. This led to strong advocacy among opponents for an enhanced 'status quo', in which any forthcoming financial investment should be used to renovate and upgrade the two existing hospitals.

8.4.3.1 Benefits of the clinical model

Some of the main reasons for supporting the clinical model were centred around the improved quality of care. For example, the respondents commented that the clinical model could:

- Improve standards of care and enable hospitals to meet quality standards;
- Help overcome long-standing staffing issues, especially among specialists;
- Ensure modern facilities for modern healthcare and better working conditions for staff;
- Increase efficiencies and place the Trust on a more secure financial footing; and
- Reduce waiting times.

However, there was apprehension that centralisation of services, as proposed, is a precursor to the closure of the two existing hospitals and/or privatisation of NHS services.

[25] In order to ensure closest comparability, where results from the residents' survey are contrasted against those from the consultation questionnaire, residents' survey results are based on those obtained from the ESTH catchment area, with 'don't know' responses excluded. A further explanation can be found in the full ORS report.

8.4.3.2 Impact on other providers

The impact on other local hospitals was a concern, particularly for St George's. There were comments made that changes to St Helier's A&E, maternity and other units would lead to a significant increase in demand at St George's Hospital, which would not have the capacity to cope. Respondents did recognise that work had been carried out with other local hospitals as to the increases in capacity that may be needed, but did not think this was necessarily sufficient.

8.4.3.3 Accessing the right service

A key concern was about knowing which hospital to go to in an emergency. Many participants said that there is work to be done around educating local communities on where their new emergency services will be situated and some were worried about the consequences of going to the wrong place. Participants, across all strands of the research conducted, shared concern about possible delays in getting the right treatment if they were to go to a UTC rather than the SECH.

8.4.3.4 Pregnancy and maternity

As with accident and emergency services, centralisation of maternity services (particularly hospital births) at a new SECH was raised across all consultation strands. These comments and concerns focused on:

- Longer travel times for mothers in labour, whether traveling by car or ambulance, leading to an increased risk of complications and negative outcomes as a result of delays;
- Separation of pre-natal, ante-natal and maternity care staff to different hospitals reducing consistency of care and support;
- The potential advantages of having all births located at a specialist hospital, with consultants and state-of-the-art emergency care available on location;
- The effective reduction of choice, in which some mothers might feel pressure to choose a home birth over travelling a further distance for a hospital birth;
- Conversely some mothers being put off home births, if living at a distance from a new SECH, due to concerns about what might happen if complications arose that required transfer from home to hospital; and
- Whether births should be considered as emergency or acute at all or should be excluded entirely from the proposed model of care.

8.4.4 Population and bed modelling

Across all consultation strands, one of the main concerns raised was that the proposals do not provide sufficient hospital bed numbers across Epsom Hospital, St Helier Hospital and a new SECH, particularly in light of the anticipated growing and ageing population.

There was a suggestion that the bed modelling should extend to 2029/30 to take into account large housing developments that are expected to impact on hospital demand. Some respondents were apprehensive about the proposed reduction in acute beds, stating that it is contrary to the most recent Planning Guidance from NHS England.

8.4.5 Deprivation and health inequalities

The overriding concerns both of, and about, individuals and groups with protected characteristics, related to concerns regarding loss of local services, and the potential challenges of travelling to a centralised SECH.

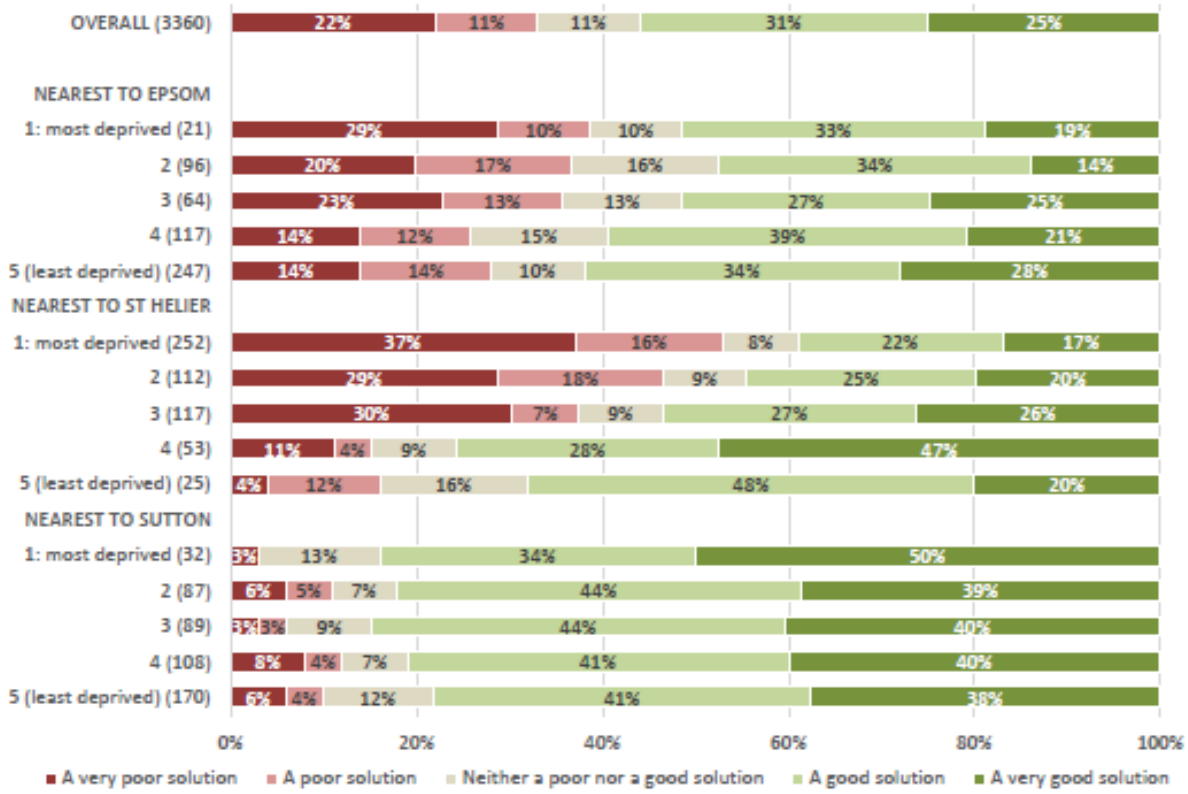
Health inequality was a key theme arising, particularly from those with serious reservations about the proposal to centralise specialist acute and emergency care at a single location. The potential for negative impacts from these changes on people living in socio-economically deprived areas of the ESTH catchment area were of concern to many respondents, with particularly strong advocacy for those residents living nearest to St Helier Hospital from some MPs, local councils and individual councillors, and campaign groups. The outcomes of these concerns ranged from outright opposition

to any centralisation or relocation of services, to support for the model of care on the proviso that it be built at the St Helier Hospital site.

The specific concerns raised in relation to the accessibility for protected groups include:

- Older members of traveller communities might find navigating to new and unfamiliar hospital locations particularly challenging;
- Some people with disabilities, particularly those who are blind or visually impaired, or who have sensory impairments as a result of neurological conditions or learning disabilities, could find accessing and navigating around unfamiliar hospital buildings particularly challenging; and
- As a consequence of the above, the need to include people with disabilities (including those with learning disabilities) in service and building development and design.

Figure 15: Views of other, non-NHS staff individual respondents on the proposed model of care, by IMD quintile and closest hospital (consultation questionnaire)



The deliberative work undertaken by YouGov, individual CCGs and CVS organisations to engage with seldom-heard and protected characteristics groups was able to identify some more specific potential equality impacts, and mitigations. These, along with more detailed equalities reporting, are covered in a dedicated chapter of the ORS report, as well as in those covering each individual consultation strand.

Further concerns that relate to deprivation and health inequalities considered how the proposals adversely affect protected groups. This included provision for mental health services – particularly in relation to attendance at emergency departments and acute admissions. There was also concern around the needs of BAME groups, who – particularly in deprived communities – disproportionately use A&E and experience barriers in accessing primary care, as well as experiencing higher rates of diabetes and heart and stroke problems compared to other groups.

8.4.6 Out of hospital and the district sites

A theme arising from consultation was whether out of hospital providers had the capacity and funds to support demand management and prevent hospital admissions. It was suggested that primary care was not sufficiently included in proposals. Further, there were concerns that there would not be sufficient funding, after building the new site, for the expansion of these services. It was suggested that the proposals are assessed against the needs of the wider area and the services provided.

There was some concern regarding the maintenance of district services at district hospital sites. Some respondents commented that existing NHS staff might be attracted to the acute hospital to the detriment of the proposed district facilities. Others were wary that the reduction in services at district hospital sites is a step towards future closures. However, some commented positively on the introduction of UTCs and the continuation of district hospital services. It was argued that given the majority of people will never need to use the SECH, it makes sense to have the most used services located nearby. The new model was therefore believed to take account of all levels of care needed in participants' communities.

8.4.7 Multi-site working

There were some site specific themes raised, primarily around multi site working.

- **Two levels of care provision**: There were concerns that multi-site working could result in two levels of care provision with local district hospitals providing only basic services compared to care delivered at the SECH and a divergence in care quality could develop over time.
- **Transfers**: Some commented that there could be increased transfers between two or three sites, requiring excellent communication and clear protocols to be established between the sites. It was further noted that increased patient transfers between three sites could be risky and place additional pressure on the ambulance service.

8.4.8 Additional feedback raised

In addition to the feedback themes, there are particular areas to consider where further feedback has been received. These include:

- **Digital:** Respondents also wanted to ensure that the three hospitals would include state of the art facilities and technology throughout.
- **Environmental considerations:** Across all the consultation strands, environmental concerns were expressed. These included the need to ensure high quality of build design incorporating environmentally sustainable features and having minimal impact on the environment. Given the main concerns over travel and congestion that was brought up throughout the feedback process, consideration was given as to the impact of increased traffic to sites on levels of pollution.
- **Familiarisation:** Given the extent in the change of services that has been proposed, it was suggested that open days for people to visit the new site could be planned.
- **Funding:** Some expressed concerns around the funding of the proposal. Assurances were needed that the sums allocated for build will not be diverted elsewhere. There were questions raised as to how three hospital sites would be maintained into the future given high costs of maintaining their buildings. Some were further concerned that funding had been awarded and then later withdrawn in the past and wanted a guarantee that this would not happen for this proposal.

8.4.9 Further areas of consideration

Further areas of consideration have additionally been identified through the consultation process. These include:

- Renal services
- Responding to Covid-19
- A letter received from Sutton and Merton councils

8.4.9.1 Renal services

As part of the consultation, the clinical leads for renal services at ESTH and St George's have proposed the consolidation of ESTH's and St George's tertiary renal services on a single site. They suggest that patient care could be improved if all tertiary renal medical and surgical practice were to be offered in one new purpose-built facility with its own identity and containing inpatient beds, dedicated operating theatres, high dependency care, patient training and outpatient facilities. Administrative facilities would also be housed there, and renal research facilities would need to be on the same site. The Renal Community believes it "*would be able to achieve all of the best practice indicators for both transplant, renal access surgery and inpatient nephrology if we were co-located [and that] there could be a revenue saving of several £million a year".*

The Renal Community seeks permission to undertake a future feasibility study around whether it can make an appropriate case for a single renal service. If this is successful, it would like to find a way of including this option in the Outline Business Case.

8.4.9.2 Responding to Covid-19

With the arrival of the Covid-19 pandemic in the UK, there were some respondents to the consultation who referred specifically to the virus and ongoing crisis in their submissions. Among individual respondents to the questionnaire who mentioned the virus, Covid-19 was viewed predominantly as a reason not to go ahead with the proposed changes by those who also objected on other grounds. By contrast, some NHS staff members, responding to the consultation questionnaire, shared the view that the proposals would strengthen the ability of health services to deal with major incidences like Covid-19.

8.4.9.3 Letter received from Sutton and Merton councils

Sutton and Merton council provided specific feedback around their wish for St Helier to remain at the heart of the community. In relation to St Helier, their response asked for:

- More community beds, including "discharge to assess" beds located in this accessible and visible location.
- A children's hub, meeting the needs of young people, dealing with child development and recognising that this is an area which would benefit from greater focus in Mental Health (CAMHS) and Safeguarding resources.
- Mental Health and Wellbeing services such as have already been planned for the Wilson hospital site in Mitcham. The councils state that the space on this site would present a real opportunity to provide services to ensure the wellbeing of the community and to address some of the deficits in mental health and counselling services from which the local community is suffering.

The letter states that primary care is under pressure throughout the boroughs, and the councils recognise that attempts that have been made to date to integrate primary and acute care on the St Helier site, but think that this needs to go further and that any new configuration needs to work to support primary care and community services so that hospital remains a resource to be accessed in times of need rather than the only visible source of help and advice.

8.5 Alternative suggestions to proposals

As described in the independent consultation report there were some suggestions made for variants on the short list of options. Most often, these focused on maintaining or improving local services, including:

- An enhanced 'status quo' – retaining and improving the current sites instead of building a new hospital;

- Building the new hospital in a different location (with various suggestions made as to the most suitable area or site, but the most common being the open space opposite St Helier Hospital, and the West Park and Headley Park locations in the Epsom area);
- Building the new SECH, but still retaining the full range of acute services at the remaining two sites (i.e. having three A&E departments, etc.);
- Having up to four smaller 'SECHs' to offer better coverage of the whole area; and
- More general alternatives, e.g. increasing funding to help the NHS meet the ongoing challenges and recruit more staff.

Other proposed alternatives were more radical in nature, and called for further redevelopment or centralisation, including:

- Building the new SECH at Sutton, but only retaining one of the other two sites;
- Demolishing the current Epsom and/or St Helier Hospitals, and starting them again (rather than trying to renovate older buildings that may be no longer fit for purpose); and
- Increased centralisation, i.e. focusing on just one 'super hospital'.

8.6 Continued public and stakeholder engagement

Following consultation, we have continued to test our understanding of the options and the impact of the consultation findings. This includes:

- The Integrated Impact Assessment Steering Group, on the 30th of April, which included a presentation on the consultation findings for inclusion in the final IIA
- The Consultation Oversight Group, on the 2nd of June, which included a presentation by Opinion Research Services on the key findings from the consultation
- The Stakeholder Reference Group (SRG) (on the 2nd of June), which included presentations from ORS on the consultation findings and Mott MacDonald on the phase 3 IIA and changes to the draft interim IIA report
- The Joint Overview and Scrutiny Committee (JHOSC), on the 4th of June, which included presentations from ORS on the consultation findings and Mott MacDonald on the phase 3 IIA and changes to the draft interim IIA report in support of a JHOSC response to the consultation; and
- The Surrey Adult Health Select Committee, on the 5th of June, which included a presentation from ORS on the consultation findings. This meeting was also attended by Mott MacDonald who addressed various travel and access concerns raised by the committee members.

This is in addition to continued engagement through IHT newsletters and social media.

9 ADDRESSING THEMES FROM CONSULTATION

This section sets out:

- How for each theme we have listened to the consultation feedback as set out in Section 8;
- How we have developed and assessed any new evidence or alternative options and its materiality as a result of this feedback; and
- How we have listened to this feedback and incorporated this into our decision-making.

This has allowed us to understand how the consultation feedback and evidence areas impact on the options and our understanding of how to deliver the best solution for our population.

This section sets out:

- How for each theme we have listened to the consultation feedback as set out in Section 8;
- How we have developed and assessed any new evidence or alternative options and its materiality, as a result of this feedback; and
- How we have listened to this feedback and incorporated this into our decision-making.

Our process therefore is to:

- **Step 1:** Assess whether the evidence from consultation was previously considered.
- **Step 2:** Assess whether the evidence from consultation impacts on our understanding of the option. That is, whether the new evidence from consultation affects our understanding of the differences between the options.
- **Step 3:** Assess whether the evidence from consultation is material to decision-making. That is, whether the evidence highlights enhancements for any option(s) that need to be managed through implementation. This can include areas for further work in subsequent business cases.

Details around how the consultation process and evidence has been brought into the decision-making process is set out in Section 11. This includes the changes we have made to our proposals and specific requirements around subsequent business cases.

9.1 Travel and access

The primary feedback we received regarding travel and access related to access to the SECH, parking, the impact on deprived older and BAME communities and traffic/congestion.

9.1.1 Accessibility to services

Evidence previously considered

In the PCBC, we undertook a comprehensive travel time analysis to understand the impact of the options on travel times for different populations.

This concluded that all options had an impact on travel times, including small increases, and that any consolidation of the SECH would require an effective travel strategy to reduce any negative impacts. This was balanced against the increased quality of care and benefits through the new clinical model. Across the options, the Sutton option had the smallest increase in average travel time and the least overall impact on travel for older people and people from deprived communities.

Table 14: PCBC travel time analysis

	Travel time (mins)			*Change from 'No service change' travel times (mins)*								
	No service change			**Epsom**			**St Helier**			**Sutton**		
Percentile	50th	80th	95th	50th	80th	95th	50th	80th	95th	50th	80th	95th
Car	10	14	18	+4	+3	+1	+2	+5	+5	+1	+1	+5
Public transport	23	34	53	+6	+4	0	+4	+12	+12	+3	+6	+7
Blue light ambulance	9	13	17	+3	+3	+1	+1	+5	+5	+1	+1	+4

This evidence was considered as part of the non-financial assessment of the options. This included specific criteria concerning access and impact on older people and deprived communities.

New evidence from consultation

The time and distance for patients and relatives/carers to access the new site was considered the most important factor. Some respondents asked for public travel information to be made available for access to specific sites, while others asked for fit for purpose public transport providing alternative modes including volunteer car schemes, shuttle buses, night buses, adapted vehicles for people with limited mobility. It was proposed that disability groups should be involved in site and management design to ensure easy access for all.

Detailed travel analysis in the interim IIA was undertaken in order to understand and plan for access to the SECH. The analysis assessed the extent to which patients, carers, visitors and staff members would be faced with longer and more complex travel times. Following this analysis, the IIA recommended working with local councils and transport providers to consider specific opportunities, such as subsidised travel for specific groups, and standardised fares across the study area (IIA Action 10).

Following the feedback received, refreshed travel analysis has been undertaken as part of the IIA. This further looks at the impacts on travel and access of the proposals, in light of new information available and the latest information on travel times across all modes of transport.

Table 15: Phase 3 IIA travel time analysis

	Travel time (mins)			*Change from 'No service change' travel times (mins)*								
	No service change			**Epsom**			**St Helier**			**Sutton**		
Percentile	50th	80th	95th	50th	80th	95th	50th	80th	95th	50th	80th	95th
Car	11	14	19	+3	+3	+1	+2	+6	+5	+2	+2	+5
Public transport	23	33	52	+6	+4	+4	+4	+15	+13	+4	+6	+8
Blue light ambulance	10	13	17	+3	+3	+1	+1	+5	+5	+2	+2	+4

Impact of new evidence on our understanding of the options

This new and updated information does not materially change the overall findings of the IIA, as travel times changed only marginally. This therefore does not materially affect our understanding of the impact of the options on access.

Table 16: Variance in PCBC analysis and phase 3 IIA by percentile

	Travel time (mins)			*Change from 'No service change' travel times (mins)*								
	No service change			**Epsom**			**St Helier**			**Sutton**		
Percentile	50th	80th	95th	50th	80th	95th	50th	80th	95th	50th	80th	95th
Car	+1	0	+1	-1	0	0	0	+1	0	+1	+1	0
Public transport	0	-1	-1	0	0	+4	0	+3	+1	+1	0	+1
Blue light ambulance	+1	0	0	0	0	0	0	0	0	+1	+1	0

How we have listened and the impact of new evidence on decision-making

Listening to the feedback from consultation has led to the development of this additional evidence. This helps provide further detail and develop a range of actions to support improved travel and access under each of the options.

The additional evidence from consultation, refreshed travel time analysis and integrated impact assessment provides further insight into how the different options could affect local people. While findings from the refreshed travel time analysis does not change the ordering of the options, additional action areas should be considered look to improve access to services when it comes to developing a travel and access strategy for implementation, which could include:

- Subsidised travel;
- Subsidised parking;
- Alternative modes of transport (e.g., shuttle buses); and
- Extensions/changes to existing public transport routes.

Given the consultation feedback, in this DMBC we commit to extending the H1 shuttle bus route to include stops in the Merton, Sutton and Surrey Downs areas by working in partnership with stakeholders and local transport providers (e.g. TfL in London). The H1 bus currently stops at Epsom Hospital, St Helier Hospital and Sutton Hospital. This could be further extended to Morden station, Sutton Town Centre and Leatherhead, as well as increasing the frequency of buses, to ensure that there is improved public transport to each of the sites at an early stage in the process to mitigate some of the concerns around future access.

9.1.2 Parking

Evidence previously considered

The PCBC set out that there is a need to consider the availability and capacity of parking, through the detailed estates planning later in the process. The pre-consultation engagement also raised that parking would be essential to ensure appropriate access to services.

The phase 2 IIA recommended that an appropriate level of parking would be required on the site chosen to host acute services. Action 6 in the IIA sets out that a full-scale parking review be undertaken, which considers on-site and off-site parking options, as well as related alternatives e.g. park and ride. This would ensure that each site should have an appropriate level of car park availability, with particular consideration for disabled visitors.

As all the options could offer sufficient parking, parking was not felt to differentiate the options for the purpose of decision-making and was identified as a requirement of implementation planning.

New evidence from consultation

Feedback from the consultation highlighted that sufficient parking is an important concern for the public. Further, the phase 3 IIA includes an action to ensure appropriate parking on the site. Specific details include:

- Implementing a full-scale parking review (including on-site and off-site parking options and other alternatives such as park and ride);
- Developing a car parking management strategy to increase parking capacity (e.g. double tier parking on the site); and
- Considering disabled visitors and ensure appropriate access to disabled parking.

Impact of new evidence on our understanding of the options

Some early work has already been undertaken to determine where this parking may be for each of the options, which found that all the options have the potential to offer sufficient parking for the SECH site and the district hospital(s).

How we have listened and the impact of new evidence on decision-making

Feedback from consultation reconfirms the importance of parking, which will need to be considered further. Parking will need to be part of the travel strategy, and an implementation plan will need to consider all options to ensure appropriate parking capacity is in place, allowing for good accessibility to the SECH and district hospitals.

9.1.3 Travel impacts on people with protected characteristics and vulnerable communities

Evidence previously considered

The impact on people with protected characteristics and vulnerable communities was considered as part of the PCBC and the IIA. This includes specific non-financial criteria considering the impact of the options on deprived and older people.

The interim IIA carried out an assessment of potential health inequality impacts, specifically it found:

- The geographical area of Sutton and Merton, which contains pockets of deprivation, is fairly concentrated resulting in a relative ease of access to major acute services. Initial proposals for any changes to locations of major acute services are likely to have relatively marginal impact on access. However, the interim IIA found that the Epsom option may impact on a greater proportion of deprived communities.
- For older people, the equalities impact scoping report[26] concluded that older people tend to have a higher need for/use of emergency acute services such as A&E, acute medicine and emergency general surgery. The interim IIA found that in the St Helier option, older people are expected to be disproportionately impacted by longer, more complex and more costly journeys. This is due to larger densities of this group being located in the more rural south of Surrey Downs.

Overall, previous evidence concluded that the Sutton option has the least overall impact on travel for older people and people from deprived communities.

New evidence from consultation

Some respondents expressed a concern that some protected groups would be adversely affected in terms of travel and accessibility. For example, some considered that accessibility is best in the St Helier option, whereas Sutton could disadvantage residents living in areas of deprivation. Respondents also wanted to determine whether older people, BAME communities and those living in rural areas had been given due consideration in the travel analysis. Feedback also highlighted the aging population, and that this group should be factored into travel and accessibility plans.

[26] Improving Healthcare Together 2020-2030 Initial equalities analysis of major acute services

In response to the feedback, we have refreshed the travel analysis and considered the impacts on the options. The phase 3 IIA builds on the interim IIA:

- Deprived communities are likely to be only marginally impacted by longer journey times under St Helier and Sutton hospital options. The Epsom Hospital option may have an impact on a greater proportion of deprived communities across the study area compared with the other options, resulting in longer, more complex, and costly journeys for these groups across all transport modes.

Table 17: Deprivation and service use

Deprivation decile	A&E	Birth admissions	NEL Surgery Admissions	NEL Medicine Admissions
1	48.3	1.2	1.5	3.9
2	48.7	1.4	2.6	3.3
3	47.8	1.6	2.7	3.2
4	43.8	1.5	2.6	3.3
5	34.6	1.0	2.1	2.9
6	35.6	1.3	2.3	3.2
7	34.4	1.2	2.0	2.8
8	32.9	1.0	2.0	3.3
9	30.5	1.0	1.8	2.9
10	**29.5**	**0.8**	**1.7**	**3.0**

- BAME:
    - Any improvement in clarity around patient pathways is particularly likely to deliver quality of care benefits for BAME migrant communities, especially those who are new to the country or new to navigating the healthcare system[27].
    - Evidence has indicated that members of minority ethnic groups disproportionately use A&E, as they experience or perceive barriers in accessing primary care services. Local audits have found that people from migrant communities were least likely to be registered with a GP and more likely to use A&E, even during normal working hours[28].
    - Any standardisation of care should help to enhance understanding of the services on offer and help patients engage with the system correctly to receive the best possible care. However, local community representatives and those who took part in focus groups at part of the IIA highlighted that this benefit is only likely to be realised alongside a strong communication plan.
- Older people: The additional deprivation study noted the increased rate of non-elective medical admissions for the Surrey Downs area per 1,000 residents in comparison to the Merton and Sutton areas. This was attributed to the higher proportion of elderly residents in the Surrey Downs area.

Impact of new evidence on our understanding of the options

The further analysis completed since the PCBC provides a more detailed understanding of the issues and mitigations for these communities. This includes:

- The additional deprivation analysis has shown that while those from areas of high deprivation do not necessarily have a disproportionate need for acute services, they do tend to have a higher usage compared to other groups.

[27] Gibin, P. et al. (2011): 'Names-based classification of accident and emergency department users'. Available at: https://pdfs.semanticscholar.org/7c53/2d61afaddf9c5140531528eadfdf8885fc8a.pdf

[28] HSJ (2012) 'How to reduce A&E use by targeting diversity'. Available at: https://www.hsj.co.uk/technology-and-innovation/how-toreduce-aande-use-by-targeting-diversity/5052217.article

- In terms of the association between lengths of stay in hospital and deprivation, there is no clear pattern.
- The IIA also highlights that the Urgent Treatment Centres at each hospital site will treat a significant proportion of those traditionally attending Emergency Departments; including those from deprived communities, who have increased use of these services.

The additional evidence from consultation and the phase 3 IIA further emphasises the importance of access for protected characteristics and vulnerable communities, with the Epsom option having the greatest increase in travel time for those from deprived areas, and the St Helier option having the greatest increase in travel time for older people.

How we have listened and the impact of new evidence on decision-making

The different impacts of the options on deprived and older communities were considered as part of the non-financial assessment of the options in the PCBC. The new evidence supports our previous understanding of the key issues.

Following consultation, we further understand the importance of ensuring appropriate access for protected characteristics, deprived communities and vulnerable groups to local people.

The IIA suggests several important enhancements to ensure that these groups are fully considered as part of travel and access. This includes:

- Effective communication of transport options and the travel plan to staff, patients and visitors (IIA Action 5)
- Supporting the development and capacity building of community transport options and making the community aware of the options available to them (IIA Action 7)
- Building site specific transport offerings such as Park and Ride scheme, shuttle bus scheme, or hospital carpool system (IIA Action 8)
- Exploring the possibility of ensuring more personalised support to patients in promoting clarity around transport options. For example, considering wayfinding technology for the chosen site, providing assisted support for people with disabilities, alignment with carers and patient passports (IIA Action 9)

Having listened to consultation feedback, we will ensure that implementation plans around travel and access specifically address requirements and enhancements for protected characteristics, vulnerable groups and deprived communities so that meaningful action can be taken after a decision on the site is made.

9.1.4 Keeping services local

Evidence previously considered

Bringing together our CCG strategies, objectives for the local health economy include:

- Delivering care closer to patients' homes.
- Ensuring high standards of healthcare across all providers.
- Maintaining the provision of acute services within the combined geographies.
- Greater prevention of disease.
- Improved integration of care.
- Enhanced standards for the delivery of major acute services.

In the PCBC, district services were included in the clinical model which will be maintained at Epsom Hospital and St Helier hospital regardless of the option. This means that the majority of patients will be treated in district hospital services at both Epsom and St Helier hospitals and integrated with other hospital services.

Table 18: District hospital services that will continue to be offered from Epsom Hospital and St Helier Hospital under all options

Category	Service
Urgent and emergency care	• Urgent treatment centre(s) • Ambulatory care • Frailty assessment unit
District beds	• 'District beds • Direct admission beds • 'Step down' beds • Rehabilitation • Imaging and diagnostics • End of life care
Integrated primary and community care	• Community beds • Proactive community services • Reactive community services • Primary care at scale
Planned care	• Day case • Elective surgery • Dialysis • Chemotherapy • Endoscopy • SWLEOC • Outpatients
Paediatrics	• Community paediatrics • Enhanced paediatric observation • Paediatric ambulatory care
Maternity	• Early pregnancy • Antenatal care • Postnatal care • Home births
Diagnostics	• X-ray • CT • MRI • Phlebotomy

The interim IIA suggested that district services should be aligned with local strategies (IIA Action 20). It found district services support accessibility to services, with local strategic priorities for the CCGs having clear alignment in seeking to reduce health inequalities through increased access to local primary or community care, a focus on prevention, as well as targeted initiatives to manage patients with risk factors around diabetes or high blood pressure and supporting behaviour change.

New evidence from consultation

The consultation highlighted the important role of district services and the place Epsom and St Helier hospitals have in local communities. This reiterates the importance of an integrated district hospital offering, aligned and supportive of the wider community, with good access to local services.

The Clinical Advisory Group reviewed the district services and their link with out of hospital initiatives to ensure appropriate local access to services for the population is maintained, given their importance. It confirmed the benefits of having local access to services, and integration of care with out of hospital initiatives.

Impact of new evidence on our understanding of the options

The feedback from consultation and further evidence emphasises that district hospital services are central to this model. As district services are consistent across all the options, the options are not further differentiated through the consultation feedback.

How we have listened and the impact of new evidence on decision-making

The feedback from consultation highlights that we need to enhance implementation plans associated with the district hospital model and the wider out of hospital system we are developing. This is explored more fully in Section 9.2, where we consider these services in greater detail.

Listening to consultation feedback, we understand that any implementation planning will need to ensure appropriate access to district services and out of hospital services in conjunction with local plans being developed by the CCGs.

9.1.5 Summary

The feedback we received, and the actions taken, are summarised below.

Table 19: What we did in response to this feedback

Subtheme	You said	We did
Accessibility to services	• There needs to be good access to services, including the SECH	• A refresh of the travel analysis with the latest data, a committed to extend the H1 bus route and further requirements of the travel strategy
Parking	• There needs to be sufficient parking at the hospitals for patients, visitors and staff	• A review of the parking capacity for each of the options and confirmed sufficient space is available to accommodate predicted numbers of staff, patients and the public
Travel impacts on people with protected characteristics, deprived communities and vulnerable groups	• There needs to be good access for protected characteristics, deprived communities and vulnerable groups to services	• Refreshed travel analysis and reviewed impacts on the options • Carried out an additional deprivation study • Updated information within the phase 3 IIA • Defined that as part of implementation plans requirements and enhancements for protected characteristics, vulnerable groups and deprived communities are specifically addressed • Responded positively to the suggestions from Sutton and Merton councils on increasing range of services that could be available as part of the District Hospital services at St Helier
Keeping services local	• There needs to be good local access to district services	• The CAG carried out a further review of district services and their link with out of hospital services. Additional work was carried out to establish how they are already integrated locally.

9.2 Clinical model

The consultation responses indicated that there is widespread support for the clinical model, particularly from clinical stakeholders and NHS staff, on the basis that it addresses the case for change. There were several areas where further queries were raised, as discussed in Section 8.

Within the PCBC, a detailed clinical model was developed across the SECH and district hospitals. Further analysis has been developed and reviewed through the CAG to understand how the feedback from consultation could be incorporated.

9.2.1 Evidence underlying and benefits of the clinical model

Evidence previously considered

The PCBC considered the evidence around the proposed clinical model, and specifically a number of benefits. These were considered in the non-financial appraisal of options, which concluded that all options would deliver improved quality of care.

New evidence from consultation

The CAG has reviewed the benefits of the clinical model in light of the consultation feedback.

Overall, the clinical model is expected to translate into improved clinical outcomes for patients, an improved way of working for staff, opportunities for the implementation of new technology, fewer patient falls and transfers, fewer adverse drug events and infections, an improved patient experience and shorter stays in hospital.

Aligned to the feedback received from consultation, the main benefits of the clinical model can be summarised across seven main areas:

1. **An effective consultant-led model of care and delivery of seven day services**: The achievement of workforce standards which promote consultant delivered care. The evidence is well established that consultant presence and seven day services improves care, quality and outcomes.
2. **Centralisation**: The clinical model allows for a critical mass of cases to be undertaken and provides greater opportunities for sub-specialisation.
3. **Maintaining service co-dependencies**: Timely and more efficient access to co-dependent services as a result of their co-location, bringing together multidisciplinary teams, in fit for purpose facilities – resulting in better outcomes for patients.
4. **Developing effective integrated care**: Integration of primary, community, social, mental and acute hospital care and strategies across the geography, resulting in improved pathways and a better experience for patients.
5. **Admission avoidance and early discharge**: Delivering patient benefits by providing care in the most appropriate setting.
6. **Workforce benefits**: A sustainable workforce impacts directly on the quality of care that is delivered and outcomes for patients.
7. **Estates and technology benefits**: There will be a positive impact on patient experience and outcomes as a result of fit for purpose facilities and integrated digital care records.

This is further described in sections 9.2.5,9.3 and 9.4.

Centralisation and co-location

Specialisation and centralisation of services has been raised in the consultation. Key evidence raised included:

- Harrison (2012): *Even if gains in outcomes are achieved by centralisation, the longer journey times entailed for some patients may offset the benefits to some extent.*[29]
- Kings Fund (2014): *those who are taking forward major clinical service reconfiguration do so in the absence of a clear evidence base or robust methodology with which to plan and make judgements about service change:*
    - *Evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking.*

[29] Harrison (2012). Assessing the relationship between volume and outcome in hospital services: implications for service centralization. Health Services Management Research. 25.1 pp 1-6. https://journals.sagepub.com/doi/abs/10.1258/hsmr.2011.011027?journalCode=hsma

- *Evidence on the impact on quality is mixed, being much stronger in relation to specialist services than other areas of care.*[30]

- The Monitor report (2014)[31]:
  - *We need to understand factors that are affecting change, such as workforce issues, clinical specialisation or increased staffing levels, and consider how best to balance competing objectives*
- The Nuffield Trust (2018)[32] finds in relation to smaller hospitals, but of relevance in examining the continuation of services at Epsom that:
  - *[T]here is limited evidence that these standards translate into improved outcomes. Smaller hospitals… need to be free to design the acute medical service in a less rigid way.*

To understand this further, the CAG has reviewed the benefits of centralisation, which also relate to co-location of services as discussed within the case for change.

Benefits of centralisation

For some services within the clinical model, consolidating services onto one site will allow for a critical mass of cases to be undertaken and this can be correlated to improved patient outcomes. For example:

- For complex or high risk elective surgery, evidence suggests better outcomes at high-volume hospitals.[33]
- Risk-adjusted peri-operative mortality and long term conditional survival[34] worsen as hospital surgical volume decreases.[35]
- For neonatal services, there is evidence that extremely preterm and very low-weight babies do better in specialist hospitals providing neonatal intensive care. Survival is further improved in units with higher volumes of activity.[36]
- In acute medicine, there is evidence that units and/or consultants undertaking higher volumes of care deliver better outcomes.[37]
- Trauma care in England was re-organised in 2012 with ambulance bypass of local hospitals to newly designated Major Trauma Centres. This whole system national change was associated with significant improvements in both the care process and outcomes of patients after severe injury. The analysis of trends in risk adjusted survival for study hospitals shows a 19% increase in the case mix adjusted odds of survival from severe injury over the 9- year study period[38].

[30] The reconfiguration of clinical services: What is the evidence?, The King's Fund, November 2014, p23

[31] Facing the Future : Smaller Acute Providers Monitor 2014 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_dat a/file/320075/smalleracuteproviders-report.pdf

[32] "Rethinking acute medical care in smaller hospitals" by Dr Louella Vaughan, Nigel Edwards, Candace Imison and Ben Collins . Nuffield Trust 2018

[33] 6 Begg CB, Cramer LD, Hoskins WJ, Brennan MF (1998) 'Impact of hospital volume on operative mortality for major cancer surgery'.; Dudley RA, Johansen KL, Brand R, Rennie DJ, Milstein A. (2000) 'Selective referral to high volume hospitals: estimating potentially avoidable deaths'.

[34] Five-year conditional survival was calculated as the time from surgery to death or last contact for patients who survived greater than 60 days after the index surgery. This conditional survival method excludes the effect of perioperative mortality when assessing long-term outcomes.

[35] Karl Y. Bilimoria, David J. Bentrem, Joseph M. Feinglass, et al. (2008) 'Directing Surgical Quality Improvement Initiatives: Comparison of Perioperative Mortality and Long-Term Survival for Cancer Surgery'

[36] Imison C, Sonola L, Honeyman M, Ross S (2014) 'The reconfiguration of clinical services: What is the evidence? The Kings Fund

[37] Imison C, Sonola L, Honeyman M, Ross S (2014) 'The reconfiguration of clinical services: What is the evidence? The Kings Fund

[38] Changing the System - Major Trauma Patients and Their Outcomes in the NHS (England) 2008–17, Moran et al, 2019

Patient outcomes may also be enhanced by sub-specialisation with regards to complex elective surgery. Specialisation of the surgical team is reported to have been recognised for some time in the elective performance of a number of surgical procedures[39], although it is recognised that surgeon and hospital volume also play an inherent role.

Benefits of co-location

The co-location of clinically interdependent services, and particularly critical care, will facilitate timely access to co-dependent services where required. These clinical interdependencies were considered as part of the clinical case for change, including for example that paediatric inpatient services should be co-located with obstetrics, neonatal, emergency surgery and critical care. There is evidence for benefits of co-location across a range of services:

- Readily accessible psychiatric expertise reduces admission and readmission rates in people with mental health problems. Evidence for co-location of liaison psychiatry shows that the most benefit is derived from services which are fully integrated with hospitals. Specialist teams offer increased benefits where they are focused on the emergency department and older people. The co-location and integration of psychiatric services will furthermore address the need for parity of esteem between physical and mental health care.[40] Core24 liaison psychiatry is currently available at St Helier Hospital, and will shortly be introduced at Epsom Hospital.
- Co-located emergency surgery and acute orthopaedics delivers rapid diagnosis, treatment and improved outcomes for adult patients with acute surgical and orthopaedic illness.[41] Emergency surgery is currently co-located at St Helier Hospital – patients requiring emergency surgery at Epsom are transferred to St Helier.
- Co-locating acute medicine with the emergency department delivers rapid diagnosis, treatment and improved outcomes for adult patients with an acute medical illness.[42] There are insufficient staff to maintain acute medicine and the emergency department to meet clinical standards.
- Evidence suggests that a lack of access to critical care beds for emergency surgery can be a key factor in perioperative death. The RCS also requires hospitals undertaking surgery to have the appropriate critical care provision to support emergency surgical workload. There is currently a shortfall in the number of critical care consultants at ESTH.

The CAG has considered the balance of evidence and agreed that the benefits of centralisation and co-location outweigh the risks.

Impact of new evidence on our understanding of the options

As the clinical model is implemented by all the short-listed options, this new evidence does not affect the relative position of the options.

How we have listened and the impact of new evidence on decision-making

The feedback from consultation emphasises that the clinical model should be underpinned by the most recent evidence, and that the delivery of the benefits of the clinical model should be monitored. The further consideration of the evidence has reconfirmed our understanding of the benefits of the clinical model, including centralisation and co-location of services.

We recognise that new evidence is being developed regularly – as plans progress, it will be critical to incorporate the latest evidence to ensure we maximise the advantages of the clinical model and mitigate any risks.

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[39] Paterson-Brown S (2014) 'Core Topics in General & Emergency Surgery: Companion to Specialist Surgical Practice'. Fifth edition

[40] *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

[41] *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

[42] *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* (2014)

9.2.2 Accessing the right services at the district site(s) and SECH, particularly EDs and UTCs

Evidence previously considered

The clinical model was developed to ensure that the services on district sites and the SECH provided the best possible care locally for the population.

The PCBC described district services and major acute services and how they would deliver the most appropriate care for different cohorts of patients. This included keeping care as local as possible, with UTCs located on district sites to treat patients with urgent health needs, and an ED at the SECH for emergencies.

The PCBC considered patient behaviour and flow within its analysis of the options, including patient expectations, presentations at emergency departments and UTCs, transfers between sites, and transitioning to the new system. This includes specific consideration of sites where the district hospital is not co-located with the SECH.

In addition, the IIA has identified the need for clear communication with the local population about changes to services and new patient pathways.

New evidence from consultation

The consultation raised concerns around how patients would know whether to access the district sites for care or the SECH. This includes the capability of UTCs to treat patients. This has been considered further by CAG and the wider programme.

Emergency department and UTCs

We have looked at UTC data to determine the transfers that occur between services. Data was provided with all UCC attendances at Epsom (41%) and St Helier (59%) from February 2019 to January 2020. This included all attendances, including those where the first attendances was not the UCCs (e.g. paediatrics, eyes, majors). The data shows a small number of referrals to A&E or wards from the UCCs to other services, with 3% being reviewed at A&E and 5% admitted to a ward.

End point of review	Number	Percentage
A&E review	1282	3%
Admitted to ward	2062	5%
Referred to fracture clinic	4654	12%
Referred to other service	2089	6%
Usual place of residence	26988	72%
Other	643	2%
Total	37718	

This indicates that for co-located UCCs, there is already a good level of understanding of access requirements. The future model for UTCs is over and above the national mandate, open 24 hours a day with access to a full suite of diagnostics. This will further give UTCs significant capability in the future to assess and treat patients effectively.

Accessing the right services

While there is good level of current understanding of services, in the future it will be essential to ensure that patients and staff are informed as changes are implemented. There are a number of

lessons learned from other areas to consider, including Northumbria which implemented its own Specialist Emergency Care Hospital in 2015.

There were initial challenges in Northumbria which were in part due to the local context.

- There were a high number of low acuity attendances.
- There were particular challenges around ambulance handovers:
    - Multiple 111 providers applying potentially inconsistent criteria, different clinical review protocol and conveyance rates to the SECH
    - A single portal for ambulance admission within the system at SECH may discourage crews taking some lower acuity patients to the Urgent Care Centres.
    - Despite this, benefits of the clinical model were seen and mitigating actions were taken to address the challenges. Overall A&E visits were 14.3 minutes shorter on average than would have been expected, and there was a 14% reduction in emergency admissions compared to the previous year

Impact of new evidence on our understanding of the options

The further evidence concerning access to the right services did not highlight any new differentiators between the options.

How we have listened and the impact of new evidence on decision-making

Feedback from consultation and associated evidence highlights that it will be critical when transitioning to any preferred option that patients, and staff, are directed appropriately. Whilst the evidence suggests this generally works well, it will require focused work as we move towards the new clinical model. This will therefore need to be fully managed throughout the implementation process with a robust communications and engagement plan.

9.2.3 Impact on other providers

Evidence previously considered

The impact on other providers was considered in detail in the PCBC. This included a specific non-financial criterion concerning impact on other providers and inclusion of providers' capital requirements in the financial analysis.

Providers have been involved in proposal development and are supportive of the IHT proposals with the right mitigations. As described in the PCBC, several areas of high impact were identified by providers.

For the Epsom option:

- **Capacity**: A high impact is expected by St George's and Croydon (due to increased non-elective demand). St George's impact is due to a number of estates costs including expansion of its emergency department
- **Estates and capital**: A high impact is expected by St George's (mainly linked to bed requirement) and Croydon (due to increased non-elective demand).
- **I&E**: A high impact is expected by Croydon and St George's (due to increased non-elective demand).
- **Workforce**: A high impact is expected by Croydon (due to increased non-elective demand).
- **Deliverability**: A high impact is expected by St George's and Croydon (due to increased non-elective demand).

For the St Helier option:

- **Workforce**: Ashford and St Peter's expect the required workforce to be above current plans and to not be available. This leads to an identified deliverability issue if TUPE is not available.
- **Capital**: East Surrey has estimated the capital costs needed to build a new ward, as well as an access road which will be needed to support the new block.

- East Surrey noted high risks across domains if ambulances did not cross geographical boundaries. Ambulance services currently cross boundaries to access the closest suitable hospital where relevant and it is expected that planning will support cross border ambulance flows in appropriate cases under any option.

For the Sutton option:

- **Estates and capital:** St George's expected a medium impact – due to a number of estates costs including expansion of its emergency department. East Surrey estimated the capital costs needed to build a new ward, as well as a road which will be needed to access the new block.
- **Workforce**: Ashford and St Peter's expect the required workforce to be above current plans and to not be available. This leads to an identified deliverability issue if TUPE is not available. St George's also expect a high impact. Workforce remains a shared concern across the 6 providers and across all types of staff.
- East Surrey notes high risks across domains if ambulances did not cross geographical boundaries. Ambulance services currently cross boundaries to access the closest suitable hospital where relevant and it is expected that planning will support cross border ambulance flows in appropriate cases under any option.

All providers stated that all options would be deliverable with the right level of investment (capital and revenue) and mitigations. Multiple providers expressed a requirement for capital and revenue consequences to be met by commissioners and this remains a clear expectation from providers.

New evidence from consultation

Feedback from consultation highlighted concerns about the impact on other providers and their ability to manage additional demand. However, this feedback did not suggest the impact would materially differ from the impact considered in the PCBC.

Impact of new evidence on our understanding of the options

Feedback from consultation highlight how critical this issue is to local people. While the feedback from consultation did not suggest the impact on specific providers will be materially different from the analysis included in the PCBC for the options, it is clear that providers will need to be closely involved in the implementation of any preferred option to ensure it remains deliverable..

How we have listened and the impact of new evidence on decision-making

We have reviewed the provider responses during consultation which confirmed previous analysis that all options are deliverable. As part of implementation we will look to work with providers in the future to ensure assumptions are reviewed and tested, and support all providers in ensuring they receive the appropriate investment as determined within the funding envelope confirmed by Department of Health / NHSE/I.

9.2.4 Maternity and paediatrics

Evidence previously considered

The clinical model included all relevant maternity and paediatrics guidance, including implementation of Better Births.

Better Births sets a vision for continuity of carer in maternity care - before, during and after the birth:

- Provide for consistency of the midwife and/or obstetrician who cares for a woman throughout the antenatal, intrapartum and postnatal periods
- Include a named midwife who takes on responsibility for co-ordinating a woman's care throughout the antenatal, intrapartum and postnatal periods
- Enable the woman to develop an ongoing relationship of trust with her midwife
- Where possible be implemented in both the hospital and community settings.

The two main models are:

- Team continuity whereby each woman has an individual midwife, who is responsible for co-ordinating her care, and who works in a team of four to eight, with members of the team acting as backup to each other.
- Full caseloading, whereby each midwife is allocated a certain number of women (the caseload) and arranges their working life around the needs of the caseload. The backup is provided by a core midwifery team whom the woman is unlikely to have met.

In line with the national agenda, continuity of care is a key part of the future model. Women will be looked after through the team approach, across their whole pathway with a named midwife. In the case of a home birth, women will be looked after via a caseloading approach.

The PCBC was clear that choice is being maintained across the geography in line with Better Births, ensuring that all women have access to a home birth, midwife-led birth or obstetrician-led birth. Antenatal and postnatal care will continue to be delivered from district sites.

New evidence from consultation

The impact of the clinical model on maternity services was highlighted as a concern, with continuity of carer through pregnancy seen as essential.

CAG considered this evidence and re-confirmed the importance of implementing Better Births.

ESTH is already working to implement this model of care through team working, with properly formed community hubs as the base site from which midwives can look after patients, further keeping care as close to home as possible.

Impact of new evidence on our understanding of the options

The consultation did not highlight any new differentiating factors relating to maternity and paediatrics. As the clinical model is consistent across the options the ranking of options is unchanged.

How we have listened and the impact of new evidence on decision-making

Feedback from consultation highlighted how important continuity of carer will be to local women; this therefore needs to form a central part of the implementation of the new maternity model. This includes implementing the continuity of care model for maternity through a team approach, to ensure each woman has a named midwife and continuity of carer from the first prenatal appointment to the last antenatal appointment.

9.2.5 Implementing the district hospital model to enable patient flow and operation of the SECH.

Evidence previously considered

Through the district hospital model, it is intended that patients who would benefit from a proactive approach to reducing their hospital stay are identified early on. This would be enabled by introducing a multidisciplinary approach early on in their stay. This is already being implemented at ESTH, where patients are identified at the acute medical unit ward round by the frailty team.

Keeping district hospitals local and supporting people to go home will be the default pathway. This is already working at ESTH, with more patients returning to their place of residence from the Croft Community unit with integrated care support wrapped around them.

To support this, the local CCGs have worked to establish their out of hospital initiatives over the past few years, and many of these are already delivering. This has not only resulted in improvements to overall system performance, but more importantly has resulted in improved care for patients (see Section 9.4.1.2).

New evidence from consultation

The consultation report identified that there were concerns around ensuring district services are fully operational prior to the SECH being completed, and that this will be central to patient care. This

largely reflects public concern about future changes in the model of care undermining the viability of the district sites and patient flow within the SECH.

Impact of new evidence on our understanding of the options

The district model is the same across the options. Therefore, this further feedback does not differentiate between the options.

How we have listened and impact of new evidence on decision-making

The feedback from consultation reflects the importance of the district model to our local communities and in meeting local care needs. District services will need to be fully implemented and in place to support patient flow and the operation of the SECH.

This will continue to be an important part of the clinical model. Within implementation, we will ensure district services will be further designed and embedded within our local ICS plans.

9.2.6 Summary

The feedback we received, and the actions taken, is summarised below.

Table 20: What we did in response to this feedback

You said	We did
There needs to be a robust evidence base for the clinical model and the benefits need to be continually reviewed so they are fully implemented.	• Further reviewed the evidence through CAG and confirmed the benefits within an updated paper, considering the balance of evidence.
There needs to be clarity on access for the SECH and district sites	• Reviewed the current level of understanding with CAG, building on the likely cohorts of patients as described at each of the sites within the PCBC.
Other local providers need to be supported if there are any impacts on the running of their service	• Reviewed the provider responses during consultation which confirmed previous analysis that all options are deliverable. • Confirmed that as part of implementation we will look to work with providers to ensure assumptions are reviewed and tested, and support all providers in ensuring they receive the appropriate investment to ensure delivery of the options
Continuity of carer model is key to the maternity and paediatrics model	• Reviewed the continuity of carer model through the CAG
Implementing the district hospital model	• Reviewed the district hospital model as an essential enabler to the clinical model

9.3 Workforce

The consultation raised a number of concerns relating to the availability of workforce, and its inclusion in the case for change as a reason to consider changes to the clinical model. The programme has reviewed these concerns and considered the further evidence, guided through the Clinical Advisory Group.

9.3.1 Workforce as a driver for change

Evidence previously considered

The PCBC considered the multiple workforce issues faced by ESTH, including some of the specific challenges relating to clinical standards.

The workforce challenges experienced at ESTH are reflective of a wider national challenge including expected gaps in the future skills mix for certain specialties without changes in ways of working – for example, in the Emergency Department and acute medicine.

Workforce is key for the sustainability of delivering acute service across the Trust and other solutions have been ruled out on the basis that clinical standards cannot be met in the future under the current ways of working by the current workforce establishment and expected future skills mix. Given national shortages in specific areas, it is expected that recruitment to additional posts that would be needed to meet standards would be challenging, and that cross-site rotas are unlikely to be attractive to the workforce.

New evidence from consultation

Following consultation, CAG has re-reviewed the workforce requirements to meet clinical standards (summarised in the table below).

The Trust has confirmed that the critical shortages for ED and acute medicine consultants driven by meeting clinical standards across two sites are ongoing. RCEM, NHSE, NHSI and HEE have collectively identified national workforce shortages in ED staffing across all grades. Therefore, the availability of new consultants itself may not close key gaps. Any potential solution would need to be met by the existing workforce at ESTH which is sufficient to staff a single rota in ED.

Table 21: Clinical standards gap analysis (consultants)

ESTH Service	Clinical Standards Requirement (two sites)	Gap to requirement
ED	24	10
Obstetrics	22	No gap
Em. general surgery	10	No gap
Paediatrics	24	No gap
Acute medicine	24	13
Intensive care	9	2

Impact of new evidence on our understanding of the options

This additional evidence does not materially affect our understanding of the impact of the options – which are expected to address these workforce challenges.

How we have listened and impact of new evidence on decision-making

Following on from consultation, and having reviewed our workforce challenge with CAG and the Trust, we have confirmed this is still a key part of our case for change. Further consideration since the PCBC has reconfirmed the workforce challenges that are central to the case for change. As the options all seek to address this, this does not affect our understanding of the relative merits of the options.

9.3.2 Workforce sustainability and training

Evidence previously considered

The PCBC explored the workforce available to deliver the clinical model. This considered the workforce requirements and skill mix to meet clinical standards on both the SECH and District Hospital sites for all the options. This was included in the non-financial assessment of options.

This analysis showed that the current two site model is not sustainable given the current workforce establishment and expected future availability of staff. However, all three of the proposed options for reconfiguration are expected to deliver clinical standards within expected available workforce, the vast majority of which will be met with the current workforce.

The PCBC considered how to make best use of the workforce. The clinical model is designed to:

- Decrease the unsustainable strain on clinicians by increasing the level of cover to recognised standards;

- Improve training opportunities for junior clinicians through greater access to specialists;
- Provide a wide range of career opportunities across all clinicians, including allied health professionals, doctors and nurses, with opportunities to take on new and evolving roles;
- Reduce sickness and absence rates with a decreased workload reducing stress and tiredness;
- Enhance attractiveness and recruitment through providing additional opportunities for training, a beneficial work environment and career opportunities;
- Reduce use of bank and agency through more effective cover of the rotas through existing staff; and
- Change the skill mix of the workforce by ensuring consultant cover meets major acute standards.

The clinical model will allow for workforce standards to be achieved. This is particularly with regards to ED and acute medicine, where – although services are currently safe – there is an insufficient number of staff to be able to maintain rotas at both Epsom and St Helier.

An effective consultant-led model of care has been shown to be more efficient in delivering care, with decreased length of stay, more efficient use of beds, decreased rates of readmission and decreased need for patient follow-up. Consultants are central to educating new doctors and developing research and innovation[43].

Workforce standards promote consultant delivered care (where there is 24 hour presence, or ready availability for direct patient care responsibility), because consultants "make better decisions more quickly and are critical to reducing the costs of patient care while maintaining quality"[44]. There are a range of further benefits to meeting standards and increasing the hours of consultant cover, including:

- Faster triaging of patients and improved decision making;
- More consistent care, seven days a week; and
- Ensuring that patients are seen in the right care setting at the right time, and by the most appropriate clinician.

Achieving workforce standards and addressing current workforce challenges will remove the variation in consultant presence that can exist, and the impact this can have on care. Greater levels of consultant staffing (through the achievement of workforce standards) are also associated with improved outcomes, such as fewer stillbirths and fewer readmissions[45].

Workforce standards are likely to enhance patient outcomes as they promote seven-day access and remove variation in outcomes and errors which can be experienced particularly at weekends. This is in line with guidance from NHS England and relevant Royal Colleges[46].

- Evidence is well established around the correlation of improved patient outcomes as a result of **consultant delivered care in emergency medicine**, with many studies providing evidence that patients experience increased morbidity and mortality when there is a delay in involvement of a consultant in their care[47].
- Patients who had their surgery out of hours have been shown to have higher predicted and observed 30-day mortality (13.5%) than those whose surgery was performed between 8.00 am and 6.00 pm (9.2%). This rate increased further to 17.4% for surgery after midnight, which

[43] Leading for Quality the foundation for healthcare over the next decade, Royal College of Physicians, 2010

[44] Temple J. (2010) 'Time for training'. Available at: https://www.londonmedicine.ac.uk/wpcontent/uploads/2016/11/Temple%20Report_Time%20for%20Training_%20May%202010.pdf

[45] Imison C, Sonola L, Honeyman M, Ross S (2014) 'The reconfiguration of clinical services: What is the evidence? The Kings Fund'.

[46] NHS England (2017) 'Seven Day Services Clinical Standards'; For example, that there should be minimum labour ward consultant presence throughout the working day, seven days a week. RCOG (2016) 'Providing Quality Care for Women; Academy of Medical Royal Colleges (2012) 'Seven Day Consultant Present Care'.

[47] Academy of Medical Royal Colleges (2012) The Benefits of Consultant-Delivered Care. London: Academy of Medical Royal Colleges.

is almost twice the risk of those whose surgery was performed in daylight hours. The typical (median) length of stay for all patients was the same in both groups, however the average (mean) length of stay of all patients was almost a day lower in the hospitals with twice-daily ward rounds (16.3 days compared to 17.2)[48].

- Consultant presence in the **emergency department** overnight can reduce length of stay and rates of admission.[49]
- In **acute medicine**, lack of consultant input has been found to be a contributor to poor-quality care. The Royal College of Physicians recommends early senior review of patients admitted as an emergency. There is a wide variation in the number of consultants per head of the population across the country, and the RCP has found a correlation between consultant staffing levels and hospital standardised mortality ratios[50]. A recent study by the Nuffield Trust recommended that as a core principle smaller hospitals will need to be able to deal with all types of emergency medical cases and need to have the capability to deal safely, quickly and expertly with all patients for at least the first 2 to 3 hours of their care.[51]
- For **critical care**, the evidence is more mixed, however there is evidence that mortality risk is sensitive to a strained intensive care unit capacity.[52]
- For **emergency surgery**, consultant-led emergency surgery has been associated with improved provision of care, resulting in timely management and improved clinical outcomes[53].
- Delivering standards for **obstetrician-led births** will mean emergencies can be responded to safely at all times. Obstetricians provide interventions in emergencies to ensure good outcomes for mother and baby, such as caesareans and instrumental deliveries.

While many acknowledge increased opportunities for training through specialisation enabled by consolidating major acute services, the PCBC sets out improvements to training opportunities through consolidation of services. Care of the Elderly consultants working on rotation across the SECH and District Hospital(s) on a rotational basis will provide oversight and will work with interface physicians to provide consistent integrated care across district and acute hospital services.

New evidence from consultation

The CAG has reviewed the benefits of the clinical model in light of the consultation feedback. A sustainable workforce impacts directly on the quality of care that is delivered and outcomes for patients. Our clinical model ensures that the workforce will be enabled to deliver the best possible care and thereby increase staff satisfaction.

The clinical model will enhance training opportunities resulting in improved skills across the workforce and improved recruitment and retention.

- There will be additional sustainable specialist 24/7 on call consultant rotas, that might include an acute physician medical take, emergency endoscopy, cardiology, paediatrics and critical care.
- The ongoing development of registered nurses as a member of the multidisciplinary team is vital to reducing unwarranted variation, and improving patient experience and outcomes.[54]
- There will also be larger teams with more opportunities for training and support, with higher activity levels on the major acute site for some services with a varied and specialist case mix.

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[48] Patient Report of the National Emergency Laparotomy Audit, 2017

[49] Knowles E, Shephard N, Stone T, Bishop-Edwards L, Hirst E, Abouzeid L, et al. *Closing five Emergency Departments in England between 2009 and 2011: the closED controlled interrupted time-series analysis.* Health Serv Deliv Res 2018;6(27).

[50] Royal College of Physicians. *Hospital Workforce. Fit for the Future?* London: RCP; 2013.

[51] *Rethinking acute medical care in smaller hospitals*, Nuffield Trust, October 2018

[52] Hall et al, *Association between afterhours admission to the intensive care unit, strained capacity, and mortality: a retrospective cohort study*, Crit Care. 2018 Apr 17;22(1):97.

[53] Shakerian et al, Outcomes in emergency general surgery following the introduction of a consultant-led unit, 2015 https://doi.org/10.1002/bjs.9954

[54] HEE, Facing the facts, Shaping the future, 2017

- As the clinical model progresses, and national guidance is established, nurses and AHPs will develop new ways of working and develop further competencies.
- The clinical model also describes new roles for physician associates and health care assistants
- Training opportunities from the Royal College would be improved with greater exposure to a larger take. This will improve the view staff have of the care they are delivering and work satisfaction rates.

The consultation raised concerns that there would be insufficient specialists and generalists to maintain services across sites, particularly under the preferred option with services delivered from three sites.

The workforce plan will need to continue to be developed during the implementation process. It will be important to ensure there are sufficient generalists and specialists to meet standards at both the SECH and District Hospital(s). However, the detailed workforce analysis in the PCBC shows that requirements can be met and are sustainable under the proposed clinical model including across three sites in the preferred option. In total across the options, c. 1,690 – 2,237 WTEs are needed for the model, the vast majority of which can be staffed from the current establishment. This has been reviewed and confirmed with CAG.

Impact of new evidence on our understanding of the options

Feedback from consultation highlighted the importance of a sustainable workforce – which our options are designed to deliver. The feedback from consultation highlighted the need to continue to work with local and national training partners to ensure the right workforce is available for the clinical model. The workforce plan including a training plan will continue to be developed during implementation. It will be important that plans are in place to ensure training is available to support staff development and maintain high standards of care as the new model of care is put into place.

How we have listened and impact of new evidence on decision-making

The feedback from consultation highlighted concerns about staffing; this was considered at length in the PCBC. Feedback reiterated the importance of workforce going forward, which will need to be part of implementation planning. This will require detailed workforce implementation plans, continuing to work in partnership with HEE, Royal Colleges, local clinicians and stakeholders.

9.3.3 Summary

The feedback we received, and the actions taken, is summarised below.

Table 22: What we did in response to this feedback

Subtheme	You said	We did
Workforce as a driver for change	There is public support for the case for change, however some stakeholders felt that workforce challenges should not be a driver of change.	Reviewed our workforce challenge with CAG and the Trust and confirmed this is still a key part of our case for change, with no other solutions available to address this challenge.
Workforce sustainability and training	The workforce model needs to be sustainable and deliver sufficient training	Reviewed the workforce and training requirements at CAG and confirmed that these are deliverable

9.4 Population and bed modelling

Feedback from consultation included that the public were concerned that the number of beds should be appropriate for the population, and should be considered in the longer term. We have therefore extended the bed modelling.

9.4.1 Ensuring the appropriate number of beds are provided for the population

9.4.1.1 Extending the bed modelling to 29/30

Evidence previously considered

The PCBC included bed modelling up to 2025/26. We expected to need 1,052 – 1,082 beds for the population in 25/26. Currently there are 1,048 at ESTH. All options in the PCBC provided 1,052 beds in the future other than the no service change option, which is expected to be less efficient than the other options and mean a requirement for 30 additional beds (1,082).

Table 23: Number of beds by option

Major acute site	Epsom	St Helier	Sutton	Other providers	Total beds needed for the population
Current beds	454	594	-	-	1,048
No service change (25/26)	470	612	-	-	1,082[1]
Epsom (25/26)	634	213	-	205	1,052
St Helier (25/26)	277	694	-	81	1,052
Sutton (25/26)	285	221	496	50	1,052

New evidence from consultation

There was suggestion that the bed modelling should extend to 2029/30 to take into account large housing developments and population growth that are expected to impact on hospital demand. In response, we have:

- extended this modelling to 2029/30 based on continuing trends in activity growth, QIPP and incremental length of stay reductions; and
- considered the impact of housing developments and alternative growth estimates.

This shows an additional 14 beds would be needed to meet population needs by 2029/30 under the options. Inpatient activity would also increase but A&E and outpatient attendances would fall as result of improvements driven by QIPP. This has a similar impact on all of the options as it increases the overall system bed requirements.

[1] The no service change counterfactual requires more beds as it is expected to be less efficient.

Figure 16: Total system bed requirements in 29/30

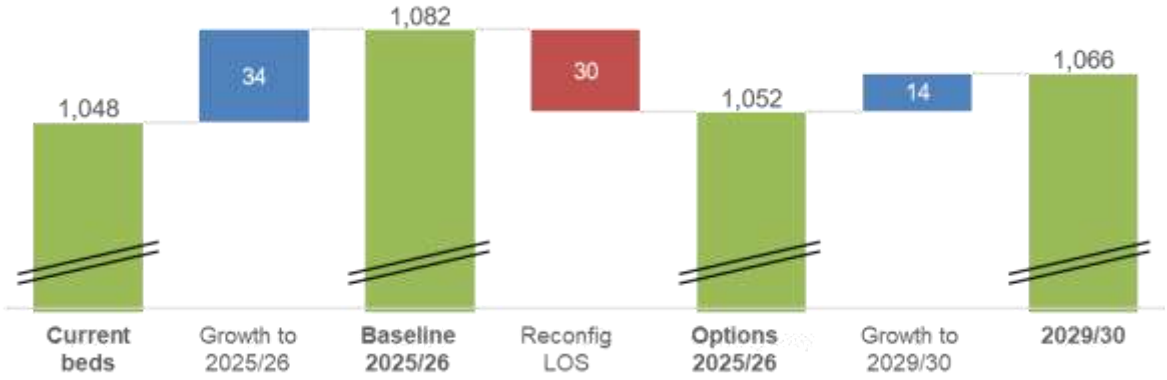


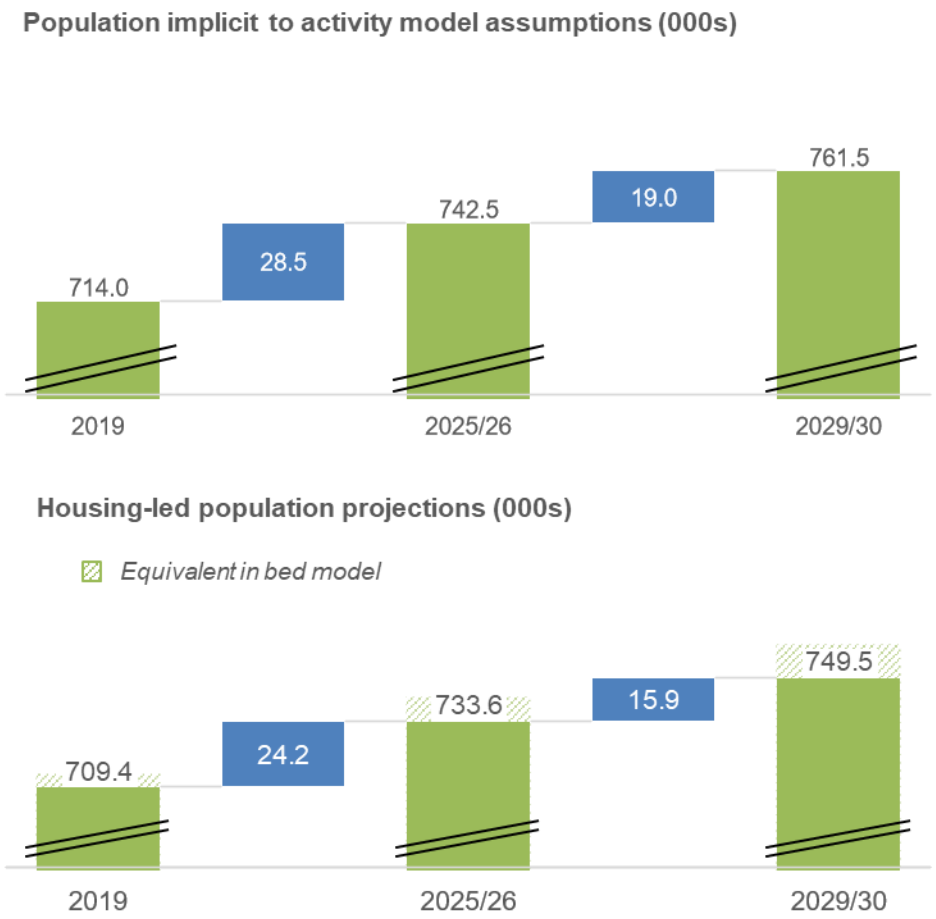
Table 24: Activity forecasts to 29/30

Activity	Current	25/26 (PCBC)	29/30 (DMBC)
Elective	48,001	51,374	53,407
Non Elective	47,593	50,375	52,044
Births	4,848	4,915	4,954
A&E / UCC	152,142	151,074	150,466
Outpatients	607,088	565,534	543,078
SWLEOC	4,576	4,898	5,091

To capture the impact of housing developments, we compared housing-led population projections developed by the Greater London Authority and Surrey County Council to the ONS trend-based population projections underpinning our activity assumptions in the bed modelling. Housing-led projections account for local housing plans including future developments and housing constraints.

Growth is lower for housing-led population than in our model across the forecast time periods. We have retained the higher ONS growth estimates in our bed modelling. This means our approach is more prudent in terms of projecting forward the possible impact of population size on bed numbers.

Figure 17: Comparison of population underpinning activity model against housing-led projections



Impact of new evidence on our understanding of the options

This bed requirement applies consistently across the options; it does not differentiate.

How we have listened and the impact of new evidence on decision-making

Based on this analysis, a small amount of additional capital will be required.

9.4.1.2 Benefits of developing integrated care out of hospital and their impact

Evidence previously considered

The PCBC incorporated our plans for out of hospital care, including significant investment in primary and community care.

There are a large number of schemes in place, and these are becoming more well developed. This includes in particular Merton Health and Care Together, Surrey Downs Health and Care and Sutton Health and Care.

Figure 18: OOH initiatives across the combined geography

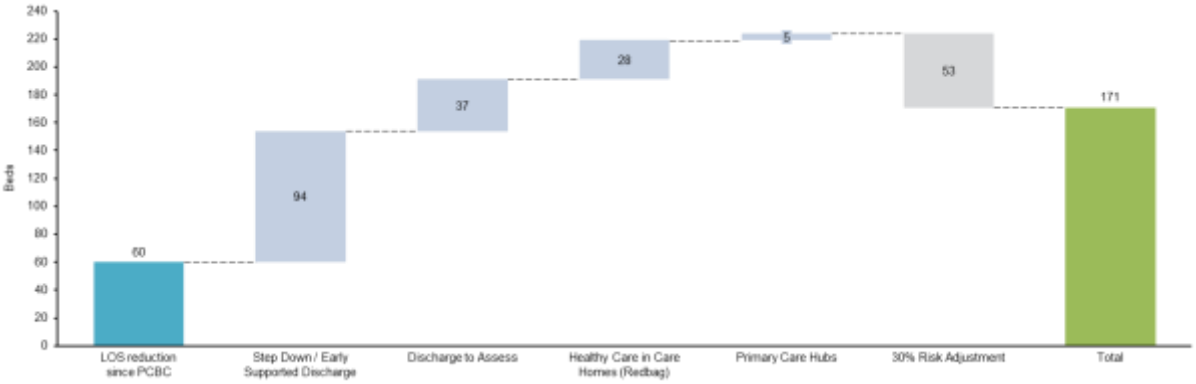
In addition, the district hospital site will be an appropriate facility for patients who live within the combined geography to be transferred to and from other providers in the local area. For example, this could include a patient local to Epsom who was initially treated at St George's Hospital for the major acute part of their stay, but who now meets the criteria for district hospital care and can be more appropriately treated closer to home.

New evidence from consultation

A key question within the consultation was whether there is sufficient primary and community care capacity to support demand on hospitals and the impact these schemes are having. We are seeing early evidence that our out of hospital plans are starting to change the balance of care locally.

Evidence suggests out of hospital initiatives being implemented could significantly reduce length of stay and bed demand. Across SWL and Surrey various out of hospital models are being implemented (see Section 3.2 and 3.3). Evidence and precedent suggest that these initiatives can significantly reduce length of stay, before considering improvements ESTH could make from purpose built facilities and internal efficiencies over the coming years. To be prudent, the impact of these initiatives has been risk adjusted down to moderate the impact.

Figure 19: Beds impact from local out of hospital initiatives[55]



Since the PCBC, length of stay improvements have already been achieved since the modelling was undertaken, with a fall in the average length of stay c. 7.6%.

Figure 20: Average length of stay (non-elective inpatients), ESTH, 2017 – 2020

This equates to a c. 60 bed reduction in demand for non-elective beds at ESTH.

There are many examples of how the out of hospital initiatives across the area are already delivering. For example:

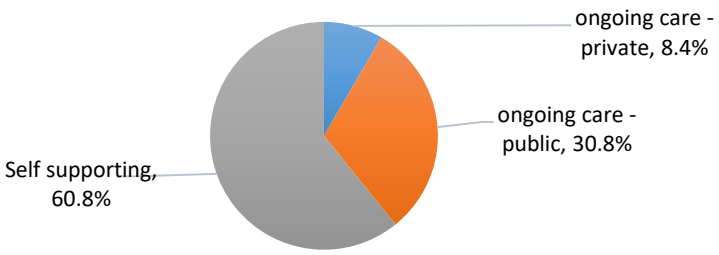
- Since October 2018, Surrey Downs Health and Care has run the Croft Community Unit on the Epsom Hospital site, including a new frailty pathway. Mean length of stay for these patients is now 7 days (vs. the hospital average of 12.3 days) and the readmission rate is 15.4% (vs. the hospital average of 23–29% and national average of 25%). This represents a c.40% lower length of stay for these patients than the ESTH average.

[55] *Sources: 60 days LoS impact delivered to date based on observed ESTH data since the modelling was undertaken; Step down / early supported discharge (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/459414/Moving_healthcare_closer_to_home_financial_impacts.pdf) (p.30); Healthy care homes (https://www.england.nhs.uk/2018/06/red-bags-to-be-rolled-out-across-englands-care-homes-getting-patients-home-from-hospital-quicker/) ; Discharge to assess (https://improvement.nhs.uk/resources/discharge-assess-home-day/); Primary care hubs (https://www.journalofhospitalmedicine.com/jhospmed/article/132088/hospital-medicine/impact-bedside-interdisciplinary-rounds-length-stay-and)*

- Surrey Downs Health and Care has achieved a 6% reduction in overnight NEL admissions at Epsom Hospital for patients over 65, in comparison with a 6% increase for the same cohort at St Helier hospital. A&E attendances for patients over 65 remained in line with expected demographic growth, and in comparison there was a 5% increase A&E activity at STH.

More people are receiving care in the community as an alternative to a hospital stay, as shown by the below figure. Within the 12 months up to July 2019, 97.6% of patients remain at home 91 days after commencement of care at home.

Figure 21: Outcomes for referrals completing reablement



Impact of new evidence on our understanding of the options

The out of hospital model applies to all options; therefore, this does not differentiate the options.

How we have listened and the impact of new evidence on decision-making

We heard from consultation that there needs to be sufficient capacity within out of hospital services and that integration of care is important to local people. The new evidence we have developed supports our plans for out of hospital care and reflects early delivery of these and how they support the bed base.

9.4.2 Summary

The feedback we received, and the actions taken, is summarised below.

Table 25: What we did in response to this feedback

You said	We did
Bed modelling should forecast to 2029/30 and account for housing growth	• We extended the bed modelling to 2029/30 and considered the impact of housing developments on population and activity growth. • Reviewed how the out of hospital initiatives are currently being implemented and how they support the current assumptions within the bed base

9.5 Deprivation and health inequalities

Evidence previously considered

We have extensively engaged pre-consultation and during consultation with the whole population, including targeted engagement with protected characteristics groups, hard to reach groups and areas of greater health inequality.

Health inequalities have been considered throughout the options consideration process. This has been covered in both the phase 2 and phase 3 IIA and detailed enhancements are described. There has been an independent comprehensive deprivation study and interim IIA of the impact on deprived

communities all LSOAs, across the whole combined geography for all of the options, including St Helier.

As defined in the deprivation study, a greater impact on health outcomes for deprived communities within the combined geographies would be likely to come from concerted effort earlier in health and care pathways prior to the need for major acute services. The deprivation study found that the geographical area of Sutton and Merton is fairly concentrated resulting in a relative ease of access to major acute services. It found that IHT proposals for any changes to major acute services are likely to have relatively marginal impacts on access.

As described in the PCBC, an independent review[56] found that decisions about the major acute service locations are likely to only have marginal impacts on health outcomes for deprived communities because:

- Health outcomes decline with increasing deprivation, but there is less evidence linking deprivation with the need and usage of the specific major acute services;
- The deprived areas within the combined geography are in relatively close proximity to the proposed solutions.

Evidence suggests that a greater impact on health outcomes for deprived communities would be more likely to come from concerted effort earlier in the health and care service pathways prior to need for major acute services.

The IIA assessed the impact of the proposed options on health inequalities. The ratings from this assessment are illustrated below.

Table 26: Assessment rating of the proposed options on health inequalities

Impact area	Option: major acute services at Epsom Hospital			Option: major acute services at St Helier Hospital			Option: major acute services at Sutton Hospital		
	Likelihood	**Magnitude**	**Duration**	**Likelihood**	**Magnitude**	**Duration**	**Likelihood**	**Magnitude**	**Duration**
Health inequalities	Medium	Minor beneficial - larger impacts experienced through other factors	Long term	Medium	Minor beneficial - larger impacts experienced through other factors	Long term	Medium	Minor beneficial - larger impacts experienced through other factors	Long term

New evidence from consultation

Deprivation and health inequalities was a key concern within the consultation. The programme has therefore carried out further work within the phase 3 IIA and as well as additional deprivation analysis to identify the impact of the proposals on areas of deprivation or those with greater health inequalities.

Additional deprivation analysis

An additional report was undertaken on the association between increased use and lengths of stay of hospital services for more deprived communities compared to the overall population.

[56] Deprivation impact analysis, independent report prepared by Cobic/Nuffield Trust/PPL

Table 27: Deprivation and service use

Deprivation decile	A&E	Birth admissions	NEL Surgery Admissions	NEL Medicine Admissions
1	48.3	1.2	1.5	3.9
2	48.7	1.4	2.6	3.3
3	47.8	1.6	2.7	3.2
4	43.8	1.5	2.6	3.3
5	34.6	1.0	2.1	2.9
6	35.6	1.3	2.3	3.2
7	34.4	1.2	2.0	2.8
8	32.9	1.0	2.0	3.3
9	30.5	1.0	1.8	2.9
10	**29.5**	**0.8**	**1.7**	**3.0**

This analysis shows a clear and consistent association of higher rates of A&E attendance for those living in the more deprived communities.

There is no clear association when assessing admissions rates for either non-elective medicine or surgical admissions; the only exception being the Sutton area where there is a slightly higher rate of non-elective medical admissions for those living in more deprived communities and a possible association in the Merton area for birth admissions and non-elective surgery admissions although this is less definitive.

When looking at lengths of stay for admissions, Table 28 shows the average length of stay for non-elective medical and surgical admissions by deprivation band. Overall, there is no discernible difference and hence no association that can be found between deprivation and length of stay of admissions.

Table 28: LOS by deprivation decile and area

	Combined		Merton		Sutton		Surrey Downs	
Deprivation decile	NEL Surgery LoS	NEL Medicine LoS	NEL Surgery LoS	NEL Medicine LoS	NEL Surgery LoS	NEL Medicine LoS	NEL Surgery LoS	NEL Medicine LoS
1	5.4	10.7	0.0	0.0	5.4	10.7	0.0	0.0
2	4.5	12.4	5.0	8.4	4.2	13.4	0.0	0.0
3	5.4	10.6	5.1	10.4	5.2	9.6	7.7	13.1
4	5.0	9.9	5.1	8.7	5.5	12.6	4.3	9.5
5	6.0	10.6	5.5	9.6	6.6	11.7	3.9	8.4
6	5.5	10.3	5.0	11.0	5.1	9.4	6.6	10.4
7	5.4	9.7	4.4	10.1	6.0	9.1	6.1	10.1
8	6.3	10.8	4.9	10.6	6.7	10.7	6.9	10.9
9	6.6	10.3	5.6	10.6	6.5	11.0	7.1	10.0
10	6.2	10.2	5.6	9.5	6.9	11.0	6.2	10.0

This analysis showed that there was limited evidence to suggest a disproportionate use of acute hospital services by those living in areas of higher deprivation compared with the overall population and those living in more affluent areas. The only exception to this was the use made of Emergency Department services. However, as the IIA notes, the role of the Urgent Treatment Centres at each hospital site will be able to treat a significant proportion of those traditionally attending Emergency Departments. We therefore believe that the change in services proposed will not disproportionality effect those living in areas of higher deprivation.

Integrated impact assessment

There are a number of key findings in the IIA relating to health inequalities:

- The IIA found that the impact on health inequalities comes earlier in the pathway prior to accessing IHT major acute services.
- The IIA found that the planned changes to district services may lead to the enhancement of local service offerings which may in turn lead to improved health outcomes for those from deprived areas and bring about changes which may help to reduce health inequalities.

The IIA identifies health inequalities and deprivation as a key area for consideration. Further detail on findings can be found in Section 10.1 and in the full report.

Access will remain in place for local services, with improved integration with community services, and refurbishment and new build will improve physical accessibility of sites.

Impact of new evidence on our understanding of the options

The further evidence considering deprivation and health inequalities provides further understanding about these issues. However, it does not materially affect the relative impact of the options and their ranking.

How we have listened and impact of new evidence on decision-making

The further evidence reconfirmed the importance of non-acute services on the health outcomes for deprived communities and health inequalities. This will continue to be a central theme of our integrated care model in the future, including access to local services through the district hospital model.

The consultation feedback has told us we need to ensure that the greater positive impact on health outcomes for all protected characteristics groups, deprived communities and seldom heard groups are realised early in the health and care service pathways.

This includes the implementation of district services, enhanced local services and the targeted local strategies developed by CCGs to reduce health inequalities through increased access to local primary or community care, with a focus on prevention, as well as targeted initiatives to manage patients with risk factors around diabetes or high blood pressure and supporting behaviour change.

We would also look to work with local partners to undertake a further focused deprivation review specific to East Merton and North Sutton residents to determine whether any additional services should be made available locally.

9.5.1 Summary

The feedback we received, and the actions taken, is summarised below.

Table 29: What we did in response to this feedback

You said	We did
There needs to be sufficient account taken on the impact of the option on deprivation and health inequalities	• Carried out additional deprivation analysis as part of the IIA and assessed the impact on health inequalities. Reviewed the district and out of hospital initiatives to understand how they are impacting earlier in the pathway on care provision

9.6 Multi-site working

9.6.1 Different types of care delivered from multiple sites and associated transfers

Evidence previously considered

The clinical model was designed to ensure a consistent, integrated care offering for the local population. The clinical model at the district sites and the SECH has been developed to deliver the most appropriate care for the population cohorts, and ensure that patients receive the best possible care for their needs.

The PCBC details a range of considerations around transfers (both step up and step down), noting there are currently effective transfer protocols in place between Epsom and St Helier Hospital given there is no general ITU at Epsom. The interim IIA further recommended the introduction of appropriate transfer protocols and action to reduce transfers (IIA Action 3).

Urgent, deteriorating cases are likely to be taken by ambulance, whereas PTS will transport stable patients. Depending on the case presented, it is likely that:

- Patients requiring step up services from a district site to the major acute site will require an ambulance – this number is expected to be low based on audits carried out to date
- Patients requiring step down services from the major acute site to the district site – this is expected to be carried out by Patient Transport Services (PTS).

While there may be additional demand on ambulances, transfers are likely to be low and transfer protocols are already in place for some services.

New evidence from consultation

In the consultation, there was concern about having a district hospital model and a SECH model implemented at different sites. We have explored this issue further with our CAG and reaffirmed the importance of a consistent, integrated model of care that is appropriate to the needs of the patient cohorts.

To understand if co-location with RMH will create an additional pressure on a Sutton site, we have reviewed transfer data to understand any potential demand.

At Sutton, RMH has 106 inpatient beds including two step up critical care level 2 beds, and 34 paediatric beds and 83 day case beds. Over a 12 month period RMH transferred 38 patients from the step up facility and a further 19 patients from Sutton wards to the Chelsea Critical Care Unit. Based on an average LOS of 5 days, this used up 285 bed days (less than one bed).

Based on this, there is unlikely to be a material demand for critical care from RMH if the SECH was built at Sutton.

Impact of new evidence on our understanding of the options

The number of transfers between sites were considered as part of the PCBC deliberations. The additional evidence does not suggest that there would be further changes to the ranking of the options.

How we have listened and the impact of new evidence on decision-making

We have listened to consultation feedback and have confirmed that the clinical model will be delivered in the setting most appropriate to patient needs. We have additionally reviewed likely numbers of transfers from RMH to supplement our understanding of the impact on working across three sites should a decision be made on the Sutton option.

To ensure a safe service, robust transfer protocols will need to be established in order to safely manage patients who require the SECH or district hospitals, with robust clinical governance in place. The workforce would be supported with clear guidelines on the transfer and transition between acute and district hospital sites. Protocols will include handovers, providing continuity of care, management plans and medication continuity. As we move to implementation, we will consider this feedback further and ensure transfer protocols are developed further, working with ambulance providers and the voluntary sector.

9.6.2 Summary

The feedback we received, and the actions taken, is summarised below.

Table 30: What we did in response to this feedback

You said	We did

The types of care delivered across different sites needs to meet patient needs, with a consideration of transfers	Reviewed the clinical model and the needs of the different patient cohorts for district services and SECH services.

9.7 Other feedback raised

9.7.1 Digital

Evidence previously considered

The PCBC included a significant investment in digital, including a new EPR to be implemented before the opening of any SECH.

ESTH is committed to delivering the significant digital enhancements in advance of, and as preparation for new ways of working that will be maximised in a new single acute facility. ESTH has modelled in its current draft five year plan, aligning with SWL Long Term Plan and Surrey Heartlands LTP and digital strategies, the delivery in a collaborative way a replacement Patient Administration System / Electronic Patient Record (EPR) during the next five year period. Through this route, ESTH aspires to attain HIMSS level 6 – a high standard of digital integration.

New evidence from consultation

Comments in the consultation feedback highlighted that state-of-the-art facilities and technology throughout all three hospitals is a key priority.

Since the PCBC, ESTH has progressed its digital plans. ESTH is in the process of deploying new clinical IT within Surrey Downs Health and Care to enable greater integration of primary and community care and is planning the same approach for Sutton Health and Care in 2020/21. This will enable GPs and community staff to view records seamlessly and have tasking functionality across different settings built in.

Impact of new evidence on our understanding of the options

Feedback re-emphasised the importance of digital to all options.

How we have listened and the impact of new evidence on decision-making

Feedback also emphasised how important digital transition will be. ESTH is developing a detailed business case for its digital implementation in advance of the SECH to provide assurance this will be effectively managed.

The Trust should continue to develop plans to implement EPR in advance of SECH implementation, and the implementation digital technology should be fully incorporated into the design of the hospitals and enable connectivity with wider healthcare providers.

9.7.2 Environmental considerations

Evidence previously considered

The PCBC considered a number of environment factors, including the expected benefits in terms of energy efficiency and water demand at any new or refurbished facilities and the relative environmental impacts of different options. This was considered as part of the benefits case and IIA.

New evidence from consultation

The feedback received in the consultations emphasised the importance of environmental considerations, including:

- ensuring high quality of build design incorporating environmentally sustainable features and having minimal impact on the environment; and
- considering the impact of increased traffic to sites on levels of pollution.

The quality and sustainability of the build is also reflected in recent guidance that new developments should aspire to be net zero and minimised their impact of the environment.

Impact of new evidence on our understanding of the options

Design and sustainability considerations apply to all options; this feedback re-emphasises their importance.

How we have listened and impact of new evidence on decision-making

The impact on travel and transport will continue to be an important consideration, as described in Section 9.1. Specifically, as we move towards implementation, the travel strategy for any preferred option will need to consider changing patterns of travel behaviour and impacts on local town centres.

For implementation we would look to move towards a carbon net zero building, and address sustainable green travel alternatives as part of the travel and access plan.

9.7.3 Funding

Evidence previously considered

The PCBC carried out extensive financial analysis to establish the funding required. This included securing agreement in principle (via the hospital infrastructure programme) for the funding required for the shortlisted options.

New evidence from consultation

Questions were raised during the feedback process which related to funding. These were related to the concern that the sums allocated for build will not be diverted elsewhere, how the ESTH will be maintained in the future given high costs of maintaining their buildings, and whether funding could be withdrawn. Agreement in principle to funding remains in place and we expect the Government to honour its commitments to local people.

Impact of new evidence on our understanding of the options

Funding is still available for all the options, as assessed within the financial model.

How we have listened and impact of new evidence on decision-making

Funding requirements will be further detailed as part of implementation, including further detail on costings and availability. This includes continuing to seek appropriate assurance from DH and NHSE/I to ensure commitments are honoured.

9.7.4 Summary

The feedback we received, and the actions taken, is summarised below.

Table 31: What we did in response to this feedback

Subtheme	You said	We did
Digital	• Ensure state of the art facilities and technology throughout all three hospitals	• Ensured EPR is incorporated as part of implementation with the necessary investment and that it will be delivered in advance of the SECH opening
Environmental considerations	• Hospital design needs to take into account environmental considerations	• Ensured that environmental considerations are incorporated as part of implementation
Funding	• We are concerned funding may not be available for the delivery of the IHT proposals	• Confirmed that ESTH remains one of the HIP1 schemes with an allocation of £500m

9.8 Addressing further impacts

While the above themes are collectively exhaustive of the main points raised in the consultation, we have also sought to address some further potential impacts that were raised by the respondents. These include:

- the impact of coronavirus (Covid-19);
- changes to renal services; and
- feedback from Sutton and Merton councils.

9.8.1 COVID-19

Evidence previously considered

When we wrote the PCBC, we did not anticipate the global COVID-19 crisis and associated national emergency response.

New evidence from consultation

While fewer than 2% of the questionnaire respondents mentioned Covid-19 in their comments, we understand the growing impact the pandemic has had on NHS services since the deadline for responses in late March. We are further aware that there are potential impacts in the delivery of healthcare both in response to the pandemic and in early efforts to recovery.

9.8.1.1 Context of COVID-19 in the NHS

COVID-19 has already brought learning as to how we may need to adapt delivery of care in the future.

In response to COVID-19, the following changes have been seen:

- creation of emergency capacity (Nightingale hospitals);
- reduction in emergency attendances;
- cancellation of elective work;
- virtual outpatient appointments;
- return to work of retired NHS staff; and
- enhanced discharge – low numbers of medically fit for discharge patients in beds

Many of these changes are likely to remain as the system begins to recover in the coming months. The recovery could include:

- splitting of COVID and non-COVID patients;
- system-wide management of ITU capacity;
- resumption of cancer and elective work where possible;
- backlog of urgent care – where individuals have not sought urgent care when needed; and
- new staffing models – adapting to high sickness absence.

9.8.1.2 The impact at ESTH

COVID-19 required ESTH to make a number of emergency changes to manage the crisis – as all acute trusts did. But at ESTH this was exacerbated by its long-standing structural issues, especially its ageing estate and challenges staffing two major acute sites.

Early lessons from the crisis include:

The estate cannot adapt to meet the challenges of a pandemic.

- **Limited critical care capacity at St Helier Hospital requiring Level 3 critical care to move to Epsom Hospital**. COVID-19 required an increase in Level 3 ITU beds from 7 to 38. This was not possible at St Helier Hospital (the current Level 3 site) due to the layout of the hospital and physical limitations in the oxygen supply. Therefore, the Level 3 site was moved to Epsom Hospital, requiring the conversion of the standalone South West London Orthopaedic Hospital into a Level 3 unit.
- **Insufficient single rooms meaning potentially infected patients could not be isolated**. Less than 20% of the beds at Epsom and St Helier are in single rooms. This was insufficient to isolate an average of 50 suspected COVID-19 patients each day at the height of the recent peak in April, requiring these patients to be cohorted on wards – meaning patients cannot be effectively separated (especially in specialist clinical areas). Moreover, the lack of patient

bathrooms and bed spacing also meant the Trust could not meet infection control standards for those patients on wards. The Trust also had to forego gender separation to protect patient safety.

- **Difficulties separating patients in emergency spaces, limiting infection control**. Due to the limitations of the existing emergency departments, ESTH has struggled to create separate COVID-19 positive and COVID-19 negative spaces and has not been able to separate patient flows. The only way on both sites to do this required the Urgent Treatment Centres to be converted into majors areas.
- **Planned care cannot be effectively separated from emergency care**. The design of Epsom and St Helier Hospitals makes separate spaces for planned and emergency care very challenging in their current configuration (e.g., eye theatres at St Helier are in the same wing as the ITU).

ESTH's people are stretched and under pressure, leaving limited capacity to respond to a crisis.

- **Pressures on already fragile staffing required rapid re-deployment and staff to go above and beyond**. Before COVID-19, ESTH had significant issues staffing its emergency departments and critical care sufficiently and was not meeting relevant standards.
- **This was exacerbated by the crisis**: more staff were needed to treat more patients, but staff sickness (staff sickness rose from 5% to 18%, meaning c. 500 staff were off sick at once) and our staff's own underlying health conditions meant fewer staff were available.
- **To manage this, ESTH had to retrain and redeploy hundreds of staff** (including doctors in ITU and acute medicine, as well as nurses) and **rely significantly on the goodwill of its people** to manage the demand. For example, intensive care consultants worked >70 hours a week; consultant dermatologists acted as junior doctors on medical wards; orthopaedic surgeons supported junior staff on ITU; audiologists supported dialysis units.

The model of care can be different – with less time in acute hospitals.

- **Significant numbers of outpatient appointments can be delivered virtually**. The crisis has forced all acute trusts to rethink outpatient care. ESTH has found multiple ways of delivering clinics differently without face-to-face interaction; it is currently running 500-1000 virtual outpatient appointments a week.
- **Patients can be discharged from acute care more quickly**. The crisis has required record numbers of patients to be discharged. This has accelerated significant improvements in length of stay.

9.8.1.3 Implications for the model

Our model of care is focused on care in 2025 onwards, whereas it may take several years before the policy is firmly established around meeting future pandemics and future requirements.

However, a joint letter from The Health Foundation, The King's Fund and the Nuffield Trust to the Health and Social Care Select Committee discussed five main challenges:

- appropriate infection prevention and control measures will need to be available;
- the need to understand the full extent of unmet need;
- the public's fear of using NHS and social care services needs to be reduced;
- looking after and growing the workforce; and
- wider reconfiguration and improvement of the health and social care system.

Our initial learning is that the case for change and need to consolidate major acute services is enhanced.

COVID-19 demonstrated the difficulties in responding to this crisis with split-site services, inadequate estate and a stretched workforce. Consolidating major acute service would mean responding to any future crisis with more robust services, in purpose-built estate and with an enriched and enhanced workforce.

However, more staff are still needed in key areas. The shortcomings exposed, especially in ITU, demonstrate a need for more medical staff. This would be eased by consolidating services to create critical mass and greater staffing resilience.

The district and out of hospital models need to work more closely together. COVID-19 demonstrated that the @Home service and Health and Care services can do more to support the district hospital model; this needs further embedding.

9.8.1.4 Possible design implications

Covid-19 has given us lots of insights into how hospital buildings need to be designed to make them better able to cope with diseases like this in the future.

- **Buildings need to be designed to be flexible**. To respond to future pandemics and/or changes in demand, healthcare buildings need to be designed so they can be used in different ways, including providing more ITU and/or ventilated capacity when needed.
- **Where possible, access and clinical spaces should be separate/segregated**. Planned care spaces should, where possible, be separate from emergency spaces, to support separation of patients – and this would be supported by the split of the SECH from the district hospital sites (meaning we could offer COVID-protected environments). Emergency spaces should also be designed to enable segregation when necessary (e.g., segregating emergency departments in COVID and non-COVID spaces). Departments should, as much as possible, have dual access and egress routes.
- **We need greater capacity and staffing resilience to support planned care**. In future pandemics, we would want to continue more planned care than during COVID-19. This requires better facilities and more resilient staffing, supported by consolidation.
- **Overall capacity needs to be reviewed**. The assumptions we previously made about critical care capacity and single room provision may need revisiting to create further capacity for pandemic response and/or surges in demand. We are already exploring scenarios where c. 20% additional capacity is required and confirming this can be accommodated on the proposed site(s).
- **Digital needs to be embedded in the hospital**. To maintain the shift to virtual care, dedicated facilities and systems will be needed alongside clinic rooms for face-to-face care – including the ability to review outpatient/ambulatory patients virtually and for staff to work remotely. Moreover, the facility should maximise the opportunity offered by digital.

These areas will be explored further through the business case process as plans develop into more detailed pathway and building designs.

These changes may create a pressure on the cost of any new hospital development, which may require a further case to be made to HM Treasury and the Department of Health and Social Care to ensure ESTH is equipped to respond to future pandemics.

Impact of new evidence on decision-making

At this stage, there is no evidence to suggest any of the options would be better prepared for a similar health crisis in the future.

Impact of new evidence on our understanding of the options

Our analysis of the impact of Covid-19 on the proposals in the Improving Healthcare Together programme has two conclusions:

- The need to consolidate acute services in a modern fit for purpose SECH is **even more important to do now**.
- We may need to **alter the design** of both the SECH and the district hospitals to reflect the learning from Covid-19.

To ensure we are ready for a similar challenge, we need to ensure that our workforce and estates are sustainable and can meet surges in demand. This will need to be considered going into any implementation stage, as part of the decision-making process.

9.8.2 Renal services

Evidence previously considered

The PCBC included inpatient renal services as part of the SECH (due to their dependency on major acute services) and dialysis as a district service.

New evidence from consultation

The clinical leaders for renal services at St George's and ESTH have proposed a consolidation of a single renal service as part of a consultation response.

The clinicians overall support the IHT proposals:

- Collectively support the case for change made by the CCGs, and the proposed clinical model for consolidating the acute services provided by Epsom and St Helier onto one site
- Agree that the preferred location of Sutton is the best option for Epsom and St Helier patients.

However, given increasing collaboration between the renal services over recent years and the associated benefits, the clinical leads view that:

- The services could make a further step change in improving care if St George's and ESTH renal services formally combine forces and locate all tertiary renal medical and surgical practice in one new purpose built facility with inpatient beds, dedicated operating theatres, high dependency care, patient training and outpatient facilities.
- The right place for a combined renal service should be at St George's, though they would be open to an option appraisal of the chosen SECH or St George's.

Impact of new evidence on our understanding of the options

This proposal is separate to the IHT process and does not affect our assessment of the options.

How we have listened and the impact of new evidence on decision-making

This was considered by Clinical Advisory Group which recognised the potential merit in the proposals and agreed that this should be considered separately from the IHT process following decision making.

It is therefore recommended this is considered fully at OBC stage and taken through the appropriate process.

9.8.3 Feedback from Sutton and Merton Councils

Evidence previously considered

The PCBC describes the district hospital model, including services that would remain at St Helier Hospital in all options and important developments in the clinical model.

This included:

- district hospital and community beds;
- development of a children's development centre and integration of community paediatrics, CAMHS and public health;
- access to psychiatric liaison; and
- opportunities for integrated care facilities and/or non-acute services on the site.

New evidence from consultation

Feedback from Sutton and Merton councils states that they wish to ensure that St Helier remains at the heart of the community. The response asks for specific services to be considered for St Helier Hospital if it is not the SECH:

- more community beds, including "discharge to assess" beds;

- a children's hub, meeting the needs of young people, dealing with child development and recognising that this is an area which would benefit from greater focus in mental health (CAMHS) and safeguarding resources; and
- mental health and wellbeing services such as have already been planned for the Wilson hospital site in Mitcham.

Initial analysis suggests there would be space on the St Helier Hospital site for primary care, a children's hub, additional CAMHS services and community services if it was not the SECH, however additional work may need to be undertaken in partnership with local authorities and the Trust to understand whether this is appropriate for local needs.

Impact of new evidence on our understanding of the options

The feedback focused on potential implementation of the preferred option rather than the assessment of options.

How we have listened and the impact of new evidence on decision-making

This feedback informs us that additional work may need to be undertaken in partnership with local authorities and the Trust to appraise the additional services that could be located on district site(s) or other local settings to best serve local community health needs.

If additional services are to be developed, they will need to be aligned to local needs, local plans for services (including the Wilson Hospital) and the clinical model (with consistency where appropriate).

Table 32: What we did in response to this feedback

Subtheme	You said	We did
Covid-19	• There needs to be a consideration of how changes related to Covid-19 may impact the clinical model and option	A interim review of the impacts and concluded that: • The need to consolidate acute services in a modern fit for purpose SECH is even more important to do now. • We may need to alter the design of both the SECH and the district hospitals to reflect the learning from Covid-19. • Further analysis will need be undertaken as more information about impact and learning from COVID becomes available. • We are requiring the Trust to demonstrate how the design of the hospital meets the learning from Covid as part of its Outline Business Case.
Renal services	• Consolidation of renal services currently delivered by St George's and ESTH could result in improved outcomes for patients.	• Considered the feedback with the Clinical Advisory Group which recognised the potential merit in the proposals and agreed that this should be considered separately from the IHT process following decision making.
Feedback from Sutton and Merton Councils	• Specific services should be considered for St Helier Hospital if it is not the SECH to ensure it remains at the heart of the community.	Considered their proposals and confirmed that space would be available on the St Helier site to deliver them. • Commissioned additional work to be undertaken in partnership with the local authorities, other relevant providers and the Trust on whether these services should be included in implementation planning.

10 FURTHER ASSURANCE OF PROPOSALS

Three key areas of further assurance have taken place following consultation. This includes:

- The phase 3 IIA which identified further enhancements to the proposals that could be made
- The Mayor's assurances.
- Feedback from the JHOSC

10.1 IIA phase 3

The below summarises the initial findings from the phase 3 IIA which built upon the analysis carried out in the phase 2 IIA.

10.1.1 Scope and purpose of the IIA phase 3

This final IIA report builds on the interim report and incorporates evidence gathered through:

- **Refreshed analysis with new data sources**:
  - Since the publication of the interim report, the government has released new data on the indices of deprivation.
  - New data is also now available on travel times for both public and private transport. For private car this is now based on 2018 and for public transport this is based on data released this year (2020).
- **Additional analysis on deprivation**: this considers the impact of proposed changes on those living in deprived areas compared with other areas of the impacted study area and the extent to which their use and experience of hospital services is different.
- **Review of the consultation responses**: This enabled the final IIA to incorporate any additional impacts or mitigating actions which had not been identified as part of the interim report. This review also considered responses from those in certain protected characteristic groups and/or living in particular areas where a potential disproportionate impact has been highlighted. The public consultation also included the targeted engagement of groups, including for example LGBTQ+ and the Gypsy/Roma/travelling community.
- **Covid-19:** it is acknowledged that the Covid-19 Pandemic may have implications for the way in which health services are planned and delivered in the future; although the learning associated with this may take some time to emerge. Relevant sections of the report have been updated with available evidence at the time of publication.

The IIA also carried out some further engagement in order to:

- Validate the findings of the scoping report.
- Obtain expert professional opinion on the evidence required for the full IIA assessment, ensuring that the baseline data is comprehensive and relevant.
- Ensure that the IIA draws attention to, and is based on, the most current and relevant evidence, statistics, and research nationally and locally.
- Provide an insight into the views on the current provision of acute services and obtain detailed views on possible impacts that could be realised from the adoption of any of the proposed options for change to acute services.

Supplementing this, within the phase 3 IIA, consultation responses have been reviewed and any additional impacts or mitigating actions which had not been identified as part of the interim report have been incorporated. The public consultation also included the targeted engagement of groups, including for example LGBTQ+ and the Gypsy/Roma/travelling community.

10.1.2 Summary of additions to the phase 3 IIA

The additional analysis on deprivation and travel times, the updated Indices of Deprivation and consultation feedback resulted in a number of additions to the IIA. The main areas are described below.

10.1.2.1 Maternity

Evidence from the public consultation highlighted that, for maternity services, there is also a perception by some, that patients may feel pressure to adopt a choice which they would have not previously considered nor feel comfortable with, for example a home birth. This change in choice also has the potential to adversely impact continuity of care for women on this maternity pathway, as a result of maternity services being provided across different sites.

10.1.2.2 Travel and access

Arising from the public consultation, the most common concerns shared by respondents across all consultation strands related to access, travel and transport to services. New data is also available on travel times for both public and private transport. For private car this is now based on 2018 and for public transport this is based on data released this year. A review was undertaken on the differences between the data originally used to inform the analysis and what is now available to assess its materiality. Overall, under the baseline, there is no difference to the overall proportion of the population who can access services within 30 minutes by private car and little difference to those accessing services within 45 minutes by public transport. There is a small shift in travel times for the population between travel time bands as shown below.

Table 33: Baseline data set in the phase 3 IIA (private car, Tuesday AM peak)

	< 15 minutes	< 30 minutes	< 45 minutes	Total
Population	556,736	136,835	1,877	695,448
% of population	80.1%	19.7%	0.3%	

Table 34: Updated data in the phase 3 IIA (private car, Tuesday AM peak)

	< 15 minutes	< 30 minutes	< 45 minutes	Total
Population	531,090	162,481	1,877	695,448
% of population	76.4%	23.4%	0.3%	
Difference from existing analysis	3.7%	-3.7%	0.0%	

There is less of a perceived shift for public transport, as shown below.

Table 35: Baseline data set in the phase 2 IIA (public transport, Tuesday AM peak)

	< 15 minutes	< 30 minutes	< 45 minutes	< 60 minutes	Over 60 minutes	Total
Population	136,233	342,694	161,484	43,059	11,708	695,448

	< 15 minutes	< 30 minutes	< 45 minutes	< 60 minutes	Over 60 minutes	Total
% of population	19.6%	49.3%	23.2%	6.2%	1.7%	

Table 36: Updated data in the phase 3 IIA (public transport, Tuesday AM peak)

	< 15 minutes	< 30 minutes	< 45 minutes	< 60 minutes	Over 60 minutes	Total
Population	135,756	334,023	165,907	43,844	15,918	695,448
% of population	19.5%	48.0%	23.9%	6.3%	2.3%	
Difference from existing analysis	0.1%	1.3%	-0.6%	-0.1%	-0.6%	

In summary, for each of the options:

- **Epsom**: This option is predicted to result in the greatest reduction in accessibility for all residents across both car, ambulance and public transport travel for journeys lasting under 30 minutes. People living in deprived areas are expected to be disproportionately impacted by the Epsom Hospital option in relation to changes in journey time as these individuals are more densely located in Sutton and Merton.
- **St Helier**: This option would likely offer the second best option in terms of accessibility for residents in accessing acute services for journeys lasting under 30 minutes by car and by public transport. For ambulance journey times, older people are expected to be disproportionately impacted. This is due to larger densities of this group being located in the more rural south of Surrey Downs. For public transport due to reduced transport provision connecting Surrey Downs with Sutton and Merton, residents in the south of Surrey Downs would likely see the most significant changes to travel times. As such this option, when compared with the other options, is likely to result in the highest proportion of those who will not be able to travel to acute services within 45 minutes.
- **Sutton**: Where major acute services move to Sutton Hospital, this would likely give the greatest accessibility to the local community of the three options for journeys lasting under 30 minutes by car by public transport. Areas which are more densely populated across Merton and Sutton would likely experience a greater proportion of residents, compared to the rest of the study area, who would be able to access Sutton Hospital or an out of area hospital within 15 minutes by car. The majority of residents are expected to be able to travel to acute services within 45 minutes via public transport.

10.1.2.3 Resilience of services

The phase 3 IIA describes that a reduction in the number of hospitals providing major acute services could potentially have a both a negative and positive impact on the resilience of services, if for example, there is an unplanned event such as and electronic virus affecting the hospital system, a fire or an outbreak of a virus on the single major acute hospital site which may restrict service delivery. Whilst it is recognised that the likelihood of such a situation occurring is unlikely to be a frequent

occurrence, as we have seen with COVID-19, the preparedness of hospital systems to manage a surge in capacity is imperative.

A single site solution for major acute hospital services could, depending on the situation, result in the some or all the services on this site being unable to treat and accommodate patients. In these circumstances, the district hospital site(s) could potentially be temporarily re-purposed to accommodate these services. In addition, the close proximity to other neighbouring major acute services will also provide added protection against this risk.

In contrast, having a single site solution for major acute hospital services with a single, expanded team on a larger hospital footprint can result in greater adaptability and flexibility in the use of space and resources to respond to difficult and unplanned situations, including surge capacity and the separation of services and patient flows. This is likely to provide increased resilience in terms of staffing, leadership and management of care.

The IIA added an additional action as a result for the programme to consider: Ensure flexibility and adaptability in the design for the new major acute hospital (action 20).

As evidenced through COVID-19, hospitals need to be responsiveness to unplanned changes in demand. As such the overall design of the new major acute hospital needs to consider how it will respond to surges in capacity as well as to the rapidly changing ways in how care is delivered through advancements in technology and medicines to ensure its fitness for the future. As such, the new hospital should ensure that it complies with new national guidance and sufficient adaptability has been incorporated in its design to facilitate flexibility in how the clinical and non-clinical space is used and re-purposed over time.

10.1.2.4 Health inequalities and deprivation

Deprivation is a key factor linked to health inequalities and any changes to the health outcomes for those from deprived areas, as a result of the proposed options for change, may likely affect health inequalities across the authorities. The additional deprivation analysis has shown that while those from areas of high deprivation do not necessarily have a disproportionate need for acute services they do tend to have a higher usage compared to other groups which is linked to poor health behaviours. It is clear that there is a strong association between deprivation and the use of A&E departments while for births and admissions the pattern of use linked to deprivation is less discernible.

Of note within the analysis overall is the increased rate of non-elective medical admissions for the Surrey Downs area per 1,000 residents in comparison with either the Merton area and Sutton area. This is largely attributable to the higher proportion of elderly residents in the Surrey Downs area. In terms of the association between lengths of stay in hospital and deprivation, there is no pattern of consistency.

The IIA also notes that the role of the Urgent Treatment Centres at each hospital site will be able to treat a significant proportion of those traditionally attending Emergency Departments, including those from deprived communities making increased use of these services; therefore negating travel to the major acute hospital site. Under the Sutton option, three UTCs are proposed, thereby providing increased availability of UTC services locally, compared to the Epsom and St. Helier options.

10.1.3 IIA enhancements

The below table represents the enhancements identified within the phase 3 IIA.

Table 37: IIA mitigations and DMBC / OBC

Area		Action
Patient experience, outcomes and choice	1	Ensure workforce requirements are met
	2	Provide clear communication about patient pathways and undertake an awareness raising campaign

	3	Introduce appropriate transfer protocols and action to reduce transfers
	4	Monitoring
Travel and access	5	Effective communication of transport options to staff, patients and visitors
	6	Ensure appropriate parking capacity on the site chosen to host acute services
	7	Support development and capacity building of community transport options and make the community aware of the options available to them
	8	Building site specific transport offerings
	9	Explore the possibility of ensuring more personalised support to patients in promoting clarity around transport options
	10	Work with local councils and transport providers
	11	Continuous review of service model
Health inequalities	12	Review district service provision against local health inequalities
	13	Re-assess accessibility issues for deprivation groups for preferred option
Impact on service delivery	14	Ensure district service enhancements and sufficient lead in time
	15	Develop a clear workforce plan
	16	Support patient clarity on accessing district services
Workforce	17	Understand clinical training and supervision needs at district sites
	18	Undertake workforce analysis and engagement and explore travel impact of preferred option
	19	Ensure staff are involved in the design of consolidated services
Resilience of services	20	Ensure flexibility and adaptability in the design for the new major acute hospital
Physical accessibility of services	21	Ensure district services are joined up with local strategies
	22	Ensuring accessibility to hospital site
	23	Continuously review needs of equality groups
Impact on other providers	24	Continued work with neighbouring providers
Wider impacts	25	Introduce and encourage more sustainable/green travel
	26	Seek to implement carbon offsetting strategies across the Trust
	27	Further air quality and carbon assessment following selection of preferred option

10.2 Mayor's tests

Following recommendations from the Nuffield Trust and King's Fund the Mayor of London has sought a greater role in providing oversight of the NHS's future plans. The Mayor has set out six key assurances needed from Government to ensure Londoners get the best healthcare possible. Given a

potential gap of £4.1billion in NHS finances in London by 2021, the Mayor has asked that the Government must provide six key assurances before the Mayor can give support for any changes to NHS services in London.

1. **Impact on health inequality** – The impact of any proposed changes to health services in London must not widen health inequalities. Plans must set out how they will narrow the gap in health equality across the capital.
2. **Hospital capacity** – Given that the need for hospital beds is forecast to increase due to population growth and an ageing population, any proposals to reduce the number of hospital beds will need to be independently reviewed to ensure all factors have been taken into account. Any plans to close beds must be an absolute last resort, and must meet at least one of the NHS' 'common sense' conditions.
3. **Sufficient investment** – Proper funding must be identified and available to deliver all aspects of the ICS plans.
4. **Impact on social care** – Proposals must take into account the full financial impact any new models of healthcare, including social care, would have on local authority services, particularly in the broader context of the funding challenges councils are already facing.
5. **Patient and public engagement** – Proposals must show credible, widespread and ongoing patient and public engagement including with marginalised groups.
6. **Clinical Support** – Proposals must demonstrate improved clinical outcomes, widespread clinical engagement and support, including from frontline staff.

Prior to the DMBC, following on from the publishing of the PCBC, the Mayor has assessed the work the IHT programme has undertaken against the first four of the six tests, as outlined below. The following two tests will follow after the publication of the DMBC. The CCGs confirm that if further information or recommendations are received from the Mayor's Office after the Improving Healthcare Together Committees in Common meeting on 3rd July 2020 these will be reviewed as part of any further implementation planning.

10.2.1 Mayor's tests findings

The letter from the Mayor[57] stated his support for investment, subject to considerations within his tests:

"The Government's capital allocation will allow significant facilities to be provided at all three hospital sites: St Helier Hospital, Epsom Hospital and Sutton Hospital. Continuing to provide district hospital services as well as providing a new acute hospital is critical to maintaining access for the diverse populations served across the combined geographies."

The Mayor considered the work against the tests and made specific considerations.

10.2.1.1 Impact on health inequality

The Mayor stated:

- *I would like the DMBC to provide further detail about how you plan to reduce health inequalities. The DMBC should also include analysis of how the different options would impact the diverse populations across the combined geographies, with a specific focus on East Merton.*
- *The DMBC should also include a detailed analysis of the potential impact on access for people in deprived communities, including analysis of increased travel times for the many people in these communities who rely heavily on public transport. If the shift in acute hospital location might disadvantage deprived communities, e.g. those in areas surrounding St Helier*

[57] Mayor's Office initial response to the Improving Healthcare Together 2020-2030; Accessible at: https://www.london.gov.uk/what-we-do/health/champion-and-challenge/mayors-six-tests#acc-i-61199

Hospital, I expect further assurance of plans to mitigate the risk of decreased access to both the district and acute hospital settings.

The IIA details how the different options impact on the population of the combined geographies in terms of health inequalities, deprived communities and people with protected characteristics. This is detailed in Section 10.1.2.4. This includes travel times, including public transport and describes mitigations on how to address any adverse impacts.

The IIA found that it is likely that making changes to the way acute services are commissioned will accelerate the growth of district services within both the Epsom and St Helier hospital sites. District services can play an important role in reducing health inequalities. Locally, this includes the development of strategies and services focused on:

- Enhanced prevention
- Primary care at scale
- Integrated locality teams
- Integrated or reactive urgent care
- Proactive care (including community hubs and locality teams)

These local strategic priorities have clear alignment in seeking to reduce health inequalities through increased access to local primary or community care, a focus on prevention, as well as targeted initiatives. As such, the developments to district services proposed as part of the service redesign may result in improved health outcomes for those from areas of high deprivation, helping to tackle health inequalities.

There are a wide number of initiatives outside of the scope of the IHT programme across the combined geographies that are looking to deliver health and care as close to people's homes as possible, with primary care, community care and prevention initiatives working in conjunction to address health inequalities, which includes specific initiatives for East Merton. This is detailed below.

1. Prevention initiatives:

    - **Merton**: Strategies in Merton identify that disease prevalence in specific areas needs to be addressed by integrated locality teams, led by primary care, and supported by other partners. This is at the heart of our partnership strategy across the borough and will be pursued regardless of changes in the healthcare infrastructure in the locality. It also stresses the importance of transforming how health care is delivered, with less reliance on hospital services and more effective use of community-based approaches. Specific prevention initiatives include the integration of health and wellbeing services, particularly around the Wilson Hospital in East Merton; the implementation of the Diabetes strategy, agreed at the Health and Wellbeing Board in 2019, which resulted from community co-production work called 'Diabetes Truth'; and the implementation of improved access to psychological therapies and emotional wellbeing support for both children and adults. East Merton GPs have also led the way in the development of a comprehensive social prescribing offer, which has been demonstrated to reduce A&E attendance and repeat GP attendance, and is working with the local voluntary sector to improve access to funding in support of this.
    - **Sutton**: The Joint Strategic Needs Assessment shows that Sutton ranks as one of the healthier boroughs in England, with mortality rates lower than the averages for England and for London. There are strategies in place to strengthen the focus on prevention and reducing health inequalities, and keeping people healthy at home by treating them earlier. Specific prevention initiatives include enhanced patient education, social prescribing, screening and early intervention, and health visiting.
    - **Surrey Downs**: Surrey Heartlands ICS places preventing ill health and disability at the heart of the health system, through the delivery of interventions to improve and maintain people's physical and mental health. The delivery of this vision will improve experience and outcomes for citizens of all ages and abilities and reduce variation

and health inequalities and deliver and scale at pace. Specific prevention initiatives include social prescribing, care navigation, risk stratification, patient activation and improving population health management.

2. Enhanced primary care networks
    - **Merton**: At the core of the Wilson Hospital will be an enhanced East Merton Primary Care Hub for GPs working at scale for the whole population of East Merton.
    - **Sutton**: Greater use of networks, shared workforce and shared clinical services to enhance the scale and scope of primary care
    - **Surrey Downs**: Development of federations, PCHs, community service mobilisation, extended access and new types of care
3. Integrated community care
    - **Merton Health and Care Together**: Proactive care for those at highest risk, improved response to crises, reablement, Integrated Locality Teams
    - **Sutton Health and Care**: Red bag scheme, homefirst, risk stratification, locality hubs
    - **Surrey Downs Health and Care**: Integrating into ESTH wards, homefirst, enabling early discharges

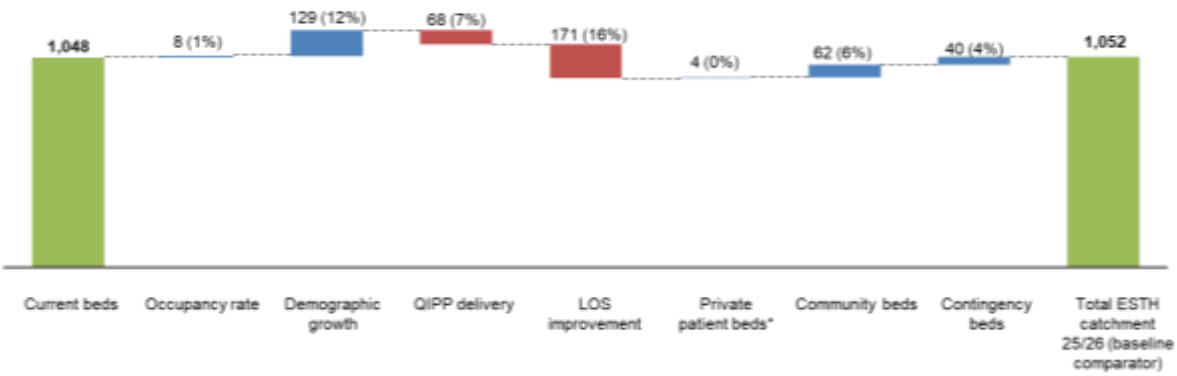
10.2.1.2 Hospital capacity

The Mayor stated:

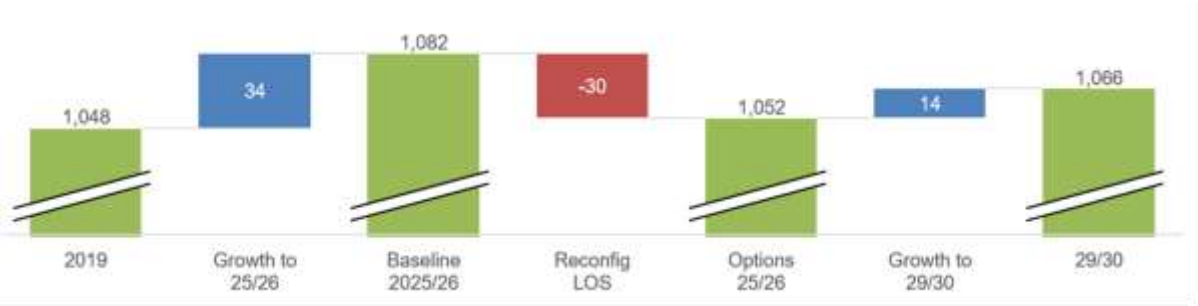
- *There is limited detail provided in the PCBC about how you will achieve the anticipated length of stay reductions and the 'Quality, Innovation, Productivity and Prevention' ('QIPP') savings. I expect to see further evidence explaining how you will achieve these efficiencies presented in the DMBC, and what contingencies you will put in place to ensure adequate bed numbers across both the acute and district sites.*
- *I note that the draft final integrated impact assessment (IIA) includes the risk that neighbouring providers may not be able to accommodate the expected additional activity, and that this could impact the quality of care and patient safety. I ask that you include further modelling, forecasting and sensitivity analysis in the DMBC to demonstrate a full understanding of this risk. I also expect to see your plans for how the risk will be mitigated to ensure the quality of care and patient safety is not compromised.*

Length of stay reductions and QIPP efficiencies

We are expecting to require more beds in the future, where the PCBC included a need for 1,052 beds in 2025/26.



Following feedback from consultation, we have extended the bed modelling to 2030, requiring an additional 14 beds.



. If bed demand is higher than expected, there are a number of possible mitigations:

- **Utilising contingency in the model**: There are 40 contingency beds included within the current bed estimates to allow for under-delivery of QIPP and LOS – these would be built but are not expected to be needed if the bed reductions are achieved. These would be utilised if the actual reduction in beds is lower than expected.
- **Utilise mothballed capacity at district sites**: In the Sutton option, there will be existing capacity at Epsom Hospital and St Helier Hospital that is not needed for the district hospital model. If additional beds were required – beyond the contingency – additional district beds could be opened to cope with demand.
- **Create additional SECH capacity**: The design of the build would have flexibility to increase the number of beds if needed. If bed demand outstrips all the above mitigations, additional capacity can be planned on the SECH.
- **Refine and enhance the OOH model**: Many OOH models require refinement as changes are embedded. While many of our OOH initiatives are already delivering, and our expectations are prudent, it is well recognised that changes often need to be introduced to enable further integration of care. If schemes were underdelivering, they would be refined and adapted to overcome implementation challenges and achieve the expected reductions.

Other providers impact

As described in Section 9.2.3, all providers have agreed that each of the options are deliverable with the right mitigations. The impact on other providers was considered in detail in the pre-consultation business case, with an analysis of workforce, estates and capital, bed capacity and income & expenditure impacts. This included a specific non-financial criterion concerning impact on other providers and inclusion of providers' capital requirements in the financial analysis.

As per the IIA mitigations, we will continue to work with local providers to ensure they are supported throughout any changes and receive the investment as detailed within the costing of the options.

10.2.1.3 Sufficient investment

The Mayor stated:

- *The current coronavirus pandemic has had, and will continue to have, far-reaching implications – many of which are not yet well understood. I would like the DMBC to reflect changes to the economic and health climate due to Covid-19, and your consideration of the likely long-term financial impacts. This should include the availability of the funds that have been committed.*

As described in Section 9.7.3, the PCBC carried out extensive financial analysis to establish the funding required. This included securing agreement in principle (via the hospital infrastructure programme) for the funding required for the shortlisted options. Agreement in principle to funding remains in place and we expect the Government to honour its commitments to local people. The OBC will need to reconfirm funding is available for the implementation of the SECH and we will continue to seek appropriate assurance from DH and NHSE/I to ensure commitments are honoured.

10.2.1.4 Social care impact

The Mayor stated:

- *I would like to see further detail about the impact of the proposals on community services and local authorities included in the DMBC. I support your vision of integrating care closer to home; however, any plans must be supported with sufficient investment in social, community and primary care. As you continue to develop new models of care for the new facilities within the context of the wider South West London Integrated Care System, it will be important to understand any financial impact on local authorities.*
- *In addition to the system wide impact on social care, you should consider the specific impact of the changes on the two proposed district hospital sites. I would like you to ensure that services currently provided in the community (both physical and mental health services) are reviewed to ensure that provision is enhanced and integrated around and on the St Helier site.*

As described in the PCBC, the c. 2-3% increase in funding to ESTH p.a. compares to the c. 4% increase p.a. in allocations. The c. 1% p.a. of additional growth will be used to support other priorities including out of hospital investment. This work is ongoing as the target operating models are refined as part of the ICSs' Long Term Plans. As a result, there will be a growing share of revenue allocated to out of hospital services and a declining share in acute services. Initial analysis indicates this would continue to be affordable to the CCGs.

Table 38: Affordability analysis

Sutton area spend, £m (nominal amounts)	Community	ESTH acute
19/20 plan recurrent spend	**21**	**123**
- Avg. activity growth + inflation p.a. (%)	*5%*	*3%*
Growth + inflation 6 years (£m)	**7**	**24**
- Agreed avg. QIPP p.a. (%)	*2%*	*1%*
- Agreed avg. QIPP 6 years (%)	*12%*	*7%*
Agreed QIPP 6 years (£m)	**(3.0)**	**(8.9)**
QIPP re-investment (£m) at 60% of total acute QIPP	**9**	**0**
25/26 indicative spend	**34**	**138**
Growth + inflation, less QIPP p.a. (%)	*3%*	*2%*
Growth + inflation, less QIPP p.a. (£m)	*0.6*	*2.1*

As described in Section 9.8.3, the feedback from Sutton and Merton councils informs us that additional work may need to be undertaken in partnership with local authorities and the Trust to appraise the additional services that could be located on district site(s) or other local settings to best serve local community health needs.

If additional services are to be developed, they will need to be aligned to local needs, local plans for services (including the Wilson Hospital) and the overall clinical model (with consistency where appropriate).

10.3 JHOSC

The South West London and Surrey Joint Health and Overview Scrutiny Sub-committee for Improving Healthcare Together 2020-2030 (JHOSC) reviewed our work as it relates to the planning, provision and operation of health services in their local area. This is set out in legislation that commissioners must consult the local authority when considering any proposal for a substantial change in health provision. As part of this process, the JHOSC will engage interested parties and take into account

relevant information available, including that from local Healthwatch. This therefore enhances public involvement in the commissioning process.

The programme engaged with the JHOSC while work and evidence development progressed. The table below provides an overview of the meetings and items for discussion.

Table 39: JHOSC meetings

	Meeting date	Items for discussion
1	16 October 2018	• Scrutiny issues: the approach of the Improving Healthcare Together subcommittee • Improving Healthcare Together 2020 -2030 progress update • Q&A / discussion of progress update • Dates for future meetings of sub-committee
2	28 November 2018	• Overall briefing report and verbal update on engagement • Deprivation Impact Analysis • Provider Impact Analysis • Independent review by the Campaign Company into Improving Healthcare Together Engagement
3	7 February 2019	• Programme update • A Report on the Options Consideration Process by Traverse • Response from Epsom & St Helier NHS Trust to the report on the Options Consideration Process by Traverse • Reports from local Healthwatch on focus groups with protected characteristic groups • Programme Equalities responses to Healthwatch reports
4	30 April 2019	• Programme update • Consultation plan update • SRG review report to JHOSC, prepared by the SRG Independent Chair, David Williams • Interim Integrated Impact Assessment - emerging findings presentation by Mott MacDonald
5	4 July 2019	• Programme and consultation planning update
6	30 July 2019	**South West London and Surrey County Council Joint Health Scrutiny Committee:** • Programme update • Impact on other providers report
7	26 September 2019	• Programme update • Consultation planning update • Draft consultation plan
8	4 June 2020	• Programme update • Independent analysis of feedback from consultation report and presentation of key findings by Opinion Research Services • Integrated Impact Assessment update by Mott MacDonald • Draft final Integrated Impact Assessment report • Consultation proposals presentation and consultation questions

10.3.1 JHOSC response to the proposals

Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 Regulations provides for the JHOSC to respond to the proposals. In

responding, the JHOSC may make formal recommendations to the CCGs. However, the JHOSC has not made any formal recommendations in its response to the IHT proposals.

The JHOSC supports the case for change:

It is acknowledged by the JHOSC that without significant capital investment the model for acute hospital provision within the borough is currently unsustainable and needs to change. Whether this investment needs to include a new third site is the subject of this consultation.

The JHOSC summarises the matters which it asks commissioners to consider across five main areas:

- Commissioners to provide further explanation of what they will do to provide better access and transport services; how they will work with relevant partners to deliver and; how funding will be secured to deliver;
- Commissioners to further address actions to minimise impact on deprived communities;
- Commissioners provide further information on the impact of Covid-19 in particular addressing implications for bed numbers and infection control; deprivation and; the impact on BAME communities (both patients and staff);
- Commissioners to work with relevant Local Authorities regarding the wider impact on the local economies of both the chosen Specialist Emergency Care Hospital (SECH) site and the District Hospital sites; and
- Commissioners ensure that development of the wider community based services and facilities happens before or in parallel with move to the new clinical model.

The JHOSC could not express a consensus view on the location of the SECH due to varying local ambitions, but has some areas of broad agreement.

10.3.1.1 The model of care

The JHOSC raised some areas of concern relating to the clinical model, in response to the consultation question around our model of care.

The JHOSC stated: *"Whilst the committee welcomes some aspects of the new model of care, most members believe that there are also a number of areas of concern where we have not been able to get the assurance we would need to fully support these ideas."*

Table 40: JHOSC comments on the model of care

#	Comment	IHT response
1	The fact that the new model will both be new and unique in London	Similar models are in place across the country, with Northumbria being the most notable example.
2	The extent to which preparations would be in place to ensure patients, families and carers understood the effect of the new 'architecture' of care	The majority of services are staying at Epsom Hospital and St Helier Hospital. Within our recommendations and within the IIA enhancements, commissioners will ask that as part of implementation a robust communications and engagement strategy is developed.
3	The extent to which the companion community-based service changes and facilities would be ready in time and sufficiently bedded-in	We are clear that our OOH services are already delivering and integrating with district hospital services. An additional recommendation will ensure this is considered as part of implementation.
4	The implications for existing users from deprived communities resulting from changed locations of provision	The majority of patients (85%), will continue to be seen at district hospitals. Through the deprivation impact assessment, IIA and extensive engagement with people in deprived communities we have listened to the feedback and considered the impact on deprived communities. We have developed recommendations and enhancements to address this.

#	Comment	IHT response
5	The travel, transport and accessibility (public and private) issues arising from the changes	As part of implementation, commissioners will scrutinise the Trust to ensure that a robust transport and access strategy is developed.
6	The impact on staff and the ease with which new or replacement staff can be recruited to work for the Trust, particularly at the site(s) which are not chosen to be the major centre.	Most of the staff working at Epsom and St Helier hospitals on the district services will remain where they are in the proposed clinical model. There is widespread support for the clinical model, particularly from clinical stakeholders and NHS staff. In addition to the work already undertaken, commissioners will ask the Trust will develop a detailed workforce implementation plan, including recruitment and retention plans, continuing to work in partnership with HEE, Royal Colleges, local clinicians and stakeholders.
7	The costs and complexity of district hospital services and major acute services being on different sites requiring inter-site patient transfers	We have considered the likely number of transfers required, and as part of implementation will require the Trust to develop detailed protocols to manage transfers, including strengthening of patient transport services (PTS) to support non-emergency patient transport.

10.3.1.2 The location of the SECH

The JHOSC could not express a consensus view on the location of the SECH due to varying local ambitions, but has some areas of broad agreement.

Table 41: JHOSC individual local authority views on the location of the SECH

#	Local authority	LA preferred option / response
1	Croydon	N/A
2	Kingston	Sutton (with essential actions and mitigations to ensure those “patients” and “non-patients” in the more deprived areas can access the new SECH site via bus or tram link).
3	Merton	St Helier
4	Surrey	Supports the new model of care but has not received the assurances needed to give its support to a specific location.
5	Sutton	St Helier
6	Wandsworth	Sutton

10.3.1.3 Transport and travel

The JHOSC responded to the consultation question on what would help improve transport and travel and what would improve public transport and travel to the new specialist emergency care hospital for any of the three options.

Table 42: JHOSC comments on transport and travel

#	Comment	IHT response
1	The IIA notes that some people from deprived communities and older people are disproportionately affected by the increased travel times. These disparities are accentuated when public rather than private transport needs to be used as is often necessary for these groups of people.	In the PCBC, we undertook a comprehensive travel time analysis to understand the impact of the options on travel times for different populations. Overall, under the baseline, there is little difference to the overall proportion of the population who can access services within 30 minutes by private car and little difference to those accessing services within 45 minutes by public transport. Through the IIA and deprivation studies we have considered the impact on deprived communities, and developed recommendations and enhancements to address this. Having listened to consultation feedback, we will ensure that implementation plans around travel and access specifically address requirements and enhancements for protected characteristics, vulnerable groups and deprived communities so that meaningful action can be taken after a decision on the site is made. The additional evidence from consultation, refreshed travel time analysis and final IIA provides further insight into how the different options could affect local people. While findings from the refreshed travel time analysis does not change the ordering of the options, additional action areas should be considered look to improve access to services when it comes to developing a travel and access plan for implementation
2	Regarding the transport considerations for each site this needs to include more detail on those groups whose travel times are lengthened by the Sutton site option and link this to higher historic use of A&E by these groups, which will not necessarily be mitigated by a UTC at St Helier.	
3	It is also not clear that any required additional funding would be provided for the relevant transport providers, the committee's understanding being that the £500M relates to hospital spend only. It is not clear whether the mitigations for adverse impacts proposed in the IIA final report are feasible or affordable.	As per recommendation 5 for implementation, and the IIA enhancement 10, further work will need to be undertaken in conjunction with partners (incl. TfL and local authorities) to ensure that the travel and access plan is delivered to ensure public and private transport needs are implemented. Furthermore, feedback from consultation reconfirms the importance of parking, which will need to be considered further. Parking will need to be part of the travel plan, and an implementation plan will need to consider all options to ensure appropriate parking capacity is in place, allowing for good accessibility to the SECH and district hospitals.
4	The JHSC notes that further work will be needed to improve transport access, both public and private, to the new SECH and ensure that these improvements are in place by the planned opening date in 2025. The JHSC expects the design and implementation of this improved public transport and road network will be carried out in conjunction with local authorities and will address issues and concerns raised by the JHSC relating to travel times, transport costs, parking and other access issues impacting on residents, particularly those in areas of high deprivation. The JHSC calls on NHS commissioners to work closely with the relevant local authorities to make the case to the Government to give assurance that sufficient funding is available to deal with transport issues arising from the anticipated increased population of the wider catchment area, together with the impact of the implementation of the IHT programme.	

#	Comment	IHT response
5	We also believe that the impact of longer journey times, poor bus connections and insufficient train routes and car parking are inter-related risk factors which require further mitigation. Some of the evidence presented in the Deprivation Analysis indicates greater healthcare usage by deprived communities. We note that a key concern from the formal consultation has been about poor health outcomes as a result of longer journey times.	As stated within the IIA, the developments to district services proposed as part of the service redesign may result in improved health outcomes for those from areas of high deprivation, helping to tackle health inequalities. Given that all communities are likely to engage more frequently with district services, the changes these services may bring in terms of reducing health inequalities may go some way in reducing any potential negative impact from deprived communities having to travel further to access acute services. In addition, we have developed detailed recommendations as part of implementation.
6	Longer journey time concerns have repeatedly surfaced throughout the process and in particular in the consultation process. The YouGov and Ipsos MORI findings support this feedback. The London Borough of Merton St. Helier Survey results also refer to longer journey times. Importantly, across the entire formal consultation exercise, concerns were raised about longer travel times, separation of services/maternity services and pathways and patient flow.	We will continue to work with the JHOSC across all the areas of concern that have been described. The recommendations that we have developed will ensure the Trust is required to carry out the additional work relating to their concerns, including any enhancements as described in the IIA
7	A potential risk to parking capacity at the preferred acute site may also materialise if “non-patient” usage exceeds expectation. Parking capacity at Sutton hospital is currently well below that of Epsom and St. Helier. Considerable investment would be required to allow for increased number of visitors at the preferred site, especially in acute maternity/birthing and paediatrics.	

10.3.1.4 Procedural considerations

The JHOSC make a number of observations on the evidence provided to them during the scrutiny process

Table 43: JHOSC comments on procedure

#	Comment	IHT response
1	The JHOSC does not believe it has been presented with the information needed to effectively carry out its scrutiny in a timely manner. Reference was made to the final IIA not being made available prior to the 4th June meeting	The IHT programme has worked in conjunction with scrutiny officers to agree a timetable for sharing key evidence for scrutiny, as shown in Table 39. The DMBC identifies evidence shared and scrutinised by the JHOSC. At the time of the publication of JHOSC papers the IIA final report was in draft as it was subject to review and approval by the IIA Steering Group. Mott Macdonald attended the meeting and presented its updated IIA findings to Members on the 4th of June.

#	Comment	IHT response
2	The JHOSC and some of the individual councils raised concerns towards the end of the period of public consultation when the lockdown effects of Covid-19 were introduced and caused face-to-face elements in the remaining consultation period to be cancelled. Whilst recognising that online paths did remain open, members were concerned that people would not have the opportunity to respond and would rightly be prioritising themselves and their families health rather than participating in a consultation.	The 12 week IHT consultation plan, was designed to deliver the majority of face to face engagement during the first 10 weeks of consultation (due to the planned Mayoral Elections). This plan was co-developed and supported by the JHOSC. During week 10 of consultation, COVID-19 and requirements for social distancing; the consultation continued online and through social media for the remaining two weeks, which involved continuing to encourage resident involvement, maintaining a profile to counter any criticism of the consultation process. One of the nine listening events was cancelled and one of the deliberative events took place virtually (rather than f2f). The large response to the consultation questionnaire in the final week of consultation (both online and via paper versions) demonstrates that stakeholders were still able to participate and provide feedback throughout the consultation period, up to and including on, the consultation closing date. tCI endorsed the mitigation plans and supported the changes to the planned engagement which included additional social media advertising. On this basis, and in discussion with tCI, it was agreed that the consultation could close as planned. Under its Consultation Quality Assurance Scheme, tCI confirmed that the IHT consultation fully met the requirements for best practice. In addition, as highlighted by COVID-19, it is of importance to conclude the consultation and enable decision-making on the proposals in order to be able to implement changes that address the clinical case for change without further delay.
3	The JHOSC is disappointed that requests either for an extension to the consultation or a pause were rebuffed. The committee has not seen any evidence to support the stated view that the impact of Covid-19 was minimal and is concerned that this demonstrates a continuation of approach whereby the IHT programme presses ahead on the basis of its own timetable with little or no thought for the impact on wider stakeholders	
4	At the JHSC meeting on 4 June the committee heard that the programme was undertaking work to inform itself of potential issues arising from the recent and ongoing Covid-19 pandemic. This is to be welcomed. Members were very concerned to hear that the information, which would be being shared with the CCGs, would not be available to the JHSC to help inform their considerations to this written response	Following the JHOSC meeting on the 4th of June, the Chair requested additional information on the impact of COVID-19. A copy of the CCGs interim assessment of the potential impact and influence of COVID 19 was shared with the JHOSC on the 10th of June.

11 DECISION-MAKING

The purpose of this document is to make a decision on the future site of the specialist emergency care hospital. The process for considering all the available evidence – including further evidence identified during consultation – and the outcome of this is detailed in this Section.

The evidence set out within this DMBC is one of the factors the Committees in Common will consider as part of their decision-making process.

No decision has been made.

The purpose of this document is to make a decision on the future site of the specialist emergency care hospital.

The process for considering all the available evidence – including further evidence identified during consultation – and the outcome of this is detailed below.

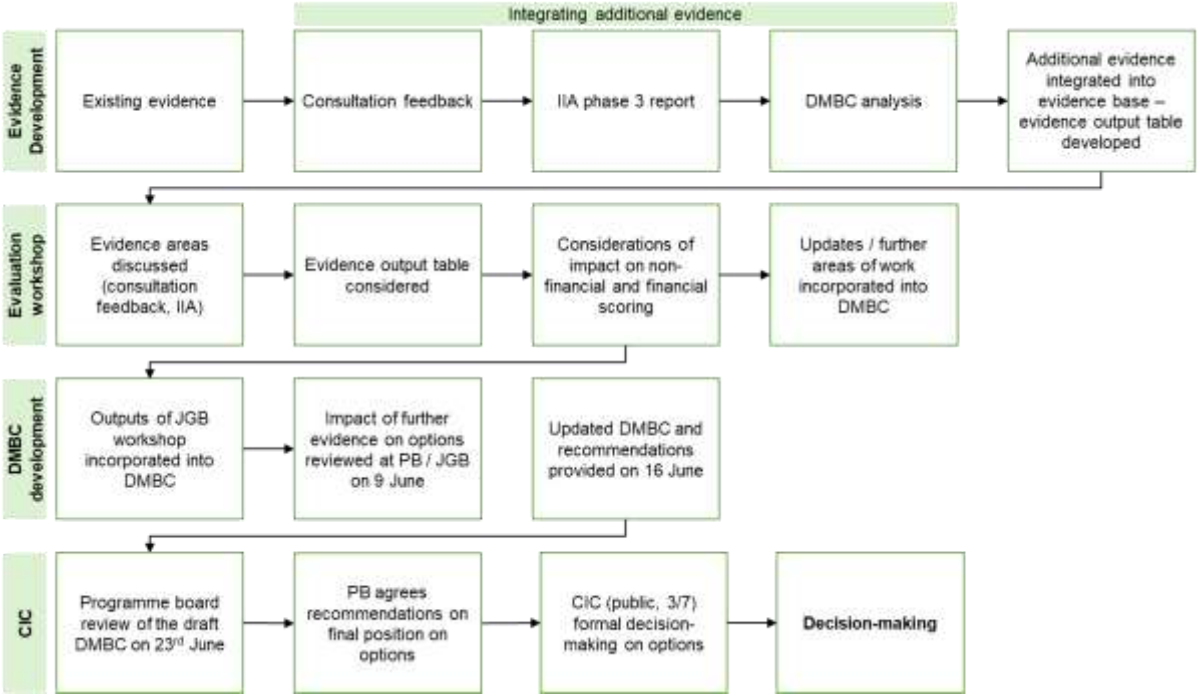
We have also identified a number of critical issues for implementation. These will need to addressed as the SECH is designed and built. We will ensure this is delivered through clear governance (see Section 12).

11.1 Process for decision making

Throughout the development of the DMBC, we have been through a process to:

- Collate and review the findings from consultation;
- Scrutinise the findings from consultation and identify areas for further evidence development;
- Develop additional evidence to further deliberate on and inform the findings from consultation; and
- Understand how the findings from consultation and the additional evidence changes the previous ranking of the options.

Figure 22: Process of deliberation



There have been dedicated deliberation sessions for Programme Board and the Joint Governing Bodies to review this evidence.

Table 44: Deliberations by Programme Board and Joint Governing Bodies

	Meeting date	Body	Items for discussion
1	30 January 2020	JGB	• Consultation update and evaluation framework
2	27 February 2020	JGB & PB	• Interim analysis of emerging findings from consultation
3	23 March 2020	PB	• Programme update • Consultation update
4	29 April 2020	JGB & PB	• Consultation findings from focus groups and deliberative events • Consultation findings from the residents' telephone survey • Analysis of emerging findings from consultation
5	18 May 2020	PB	• Draft consultation analysis report • Final report on findings from focus groups and deliberative events (YouGov) • Final residents' survey report (Ipsos Mori) • Update on draft IIA phase 3 development
6	21 May 2020	JGB	• Key messages from consultation • Review of actions by consultation theme
7	9 June 2020	PB & JGB	• Summary of consultation feedback • Final IIA
8	16 June 2020	JGB	• Recommendations and evidence by consultation theme
9	23 June 2020	PB	• JHOSC update • Draft DMBC • Draft recommendations
10	3 July 2020	CiC	• Draft DMBC

This allowed the Programme Board and Joint Governing Bodies to deliberate on the consultation findings and deliberate the evidence and its impact.

11.2 Impact of consultation feedback on decision making

11.2.1 Previous ranking of the options

The Committees in Common considered all the evidence and established a preferred option.

The Committees in Common considered all the evidence set out within the PCBC and concluded that:

- The three options are viable and should be included in any public consultation.
- The options continue to be ranked as:
    - Sutton as the top ranked and, on this basis, the preferred option;
    - St Helier as the second ranked option; and
    - Epsom as the lowest ranked option.

Following from consultation, the feedback has been considered and further evidence deliberated on, to understand how the ranking of the options is impacted.

11.2.2 Summary of additional evidence developed

The consultation themes and additional evidence have been considered in detail through the process described above.

We have considered all this evidence during the development of this DMBC and addressed the points raised.

This is summarised in the table below.

Table 45: Consultation themes

Theme	You said	We did
Travel and access	There needs to be good access to services, including the SECH	A refresh of the travel analysis with the latest data, and committed to extend the H1 bus route into Merton and South of Epsom Hospital.
	There needs to be sufficient parking at the hospitals for patients, visitors and staff	• A review of the parking capacity for each of the options and confirmed sufficient space is available to accommodate predicted numbers of staff, patients and the public
	There needs to be good access for protected characteristics, deprived communities and vulnerable groups to services	• Refreshed travel analysis and reviewed impacts on the options • Carried out an additional deprivation study • Updated information within the phase 3 IIA • Defined that as part of implementation plans requirements and enhancements for protected characteristics, vulnerable groups and deprived communities are specifically addressed • Responded positively to the suggestions from Sutton and Merton councils on increasing range of services that could be available as part of the District Hospital services at St Helier
	There needs to be good local access to district services	The CAG carried out a further review of district services and their link with out of hospital services. Additional work was carried out to establish how they are already integrated locally.
Clinical model	There needs to be a robust evidence base for the clinical model and the benefits need to be continually reviewed so they are fully implemented.	Further reviewed the evidence through CAG and confirmed the benefits within an updated paper, considering the balance of evidence.
	There needs to be clarity on access for the SECH and district sites	Reviewed the current level of understanding with CAG, building on the likely cohorts of patients as described at each of the sites within the PCBC.

Theme	You said	We did
	Other local providers need to be supported if there are any impacts on the running of their service	• Reviewed the provider responses during consultation which confirmed previous analysis that all options are deliverable. Confirmed that as part of implementation we will look to work with providers to ensure assumptions are reviewed and tested, and support all providers in ensuring they receive the appropriate investment to ensure delivery of the options
	Continuity of carer model is key to the maternity and paediatrics model	Reviewed the continuity of carer model through the CAG
	Implementing the district hospital model	Reviewed the district hospital model as an essential enabler to the clinical model
Workforce	There is public support for the case for change, however some stakeholders felt that workforce challenges should not be a driver of change.	Reviewed our workforce challenge with CAG and the Trust and confirmed this is still a key part of our case for change, with no other solutions available to address this challenge.
	The workforce model needs to be sustainable and deliver sufficient training	Reviewed the workforce and training requirements at CAG and confirmed that these are deliverable
Population and bed modelling	Bed modelling should forecast to 2029/30 and account for housing growth	• We extended the bed modelling to 2029/30 and considered the impact of housing developments on population and activity growth. • This increased the number of beds needed by 14 which we have factored into the model. Reviewed how the out of hospital initiatives are currently being implemented and how they support the current assumptions within the bed base
Deprivation and health inequalities	There needs to be sufficient account taken on the impact of the option on deprivation and health inequalities	• Carried out additional deprivation analysis as part of the IIA and assessed the impact on health inequalities. Reviewed the district and out of hospital initiatives to understand how they are impacting earlier in the pathway on care provision
Multi-site working	The types of care delivered across different sites needs to meet patient needs, with a consideration of transfers	Reviewed the clinical model and the needs of the different patient cohorts for district services and SECH services.
Digital	Ensure state of the art facilities and technology throughout all three hospitals	Ensured EPR is incorporated as part of implementation with the necessary investment and that it will be delivered in advance of the SECH opening
Environmental considerations	Hospital design needs to take into account environmental considerations	Ensured that environmental considerations are incorporated as part of implementation

Theme	You said	We did
Funding	We are concerned funding may not be available for the delivery of the IHT proposals	Confirmed that ESTH remains one of the HIP1 schemes with an allocation of £500m
Covid-19	There needs to be a consideration of how changes related to Covid-19 may impact the clinical model and option	A interim review of the impacts and concluded that: • The need to consolidate acute services in a modern fit for purpose SECH is even more important to do now. • We may need to alter the design of both the SECH and the district hospitals to reflect the learning from Covid-19. • Further analysis will need be undertaken as more information about impact and learning from COVID becomes available. • We are requiring the Trust to demonstrate how the design of the hospital meets the learning from Covid as part of its Outline Business Case.
Renal services	Consolidation of renal services currently delivered by St George's and ESTH could result in improved outcomes for patients.	Considered the feedback with the Clinical Advisory Group which recognised the potential merit in the proposals and agreed that this should be considered separately from the IHT process following decision making.
Feedback from Sutton and Merton Councils	Specific services should be considered for St Helier Hospital if it is not the SECH to ensure it remains at the heart of the community.	Considered their proposals and confirmed that space would be available on the St Helier site to deliver them. Commissioned additional work to be undertaken in partnership with the local authorities, other relevant providers and the Trust on whether these services should be included in implementation planning.

The options and the impact on the clinical model have been further considered based on the consultation feedback and further evidence.

11.2.3 Impact on the ranking of options

Within Section 9, each theme is considered as to its impacts on the option ranking and the impact on decision making.

Impacts on the option ranking are material for this DMBC, which will determine the preferred site option to be implemented.

Impacts and considerations for implementation are material to further business cases (see Section 12), which will determine how this site option is designed and implemented. However, this DMBC will ensure these are implemented through the ongoing IHT governance.

Section 9 describes for each theme how and why the additional evidence and consultation feedback considered impacts on the option ranking. The PCBC options appraisal considered the vast majority of the themes raised, with any updated evidence or analysis (e.g. travel times), having only a marginal change, with no impacts on the option rankings.

Table 46: Impact of the consultation feedback and further evidence on the option ranking and consideration within implementation

Area	Impacts on the option ranking?	Should be considered as part of implementation?
Accessibility to services	×	✓
Parking	×	✓
Travel impacts on people with protected characteristics, deprived communities and vulnerable groups	×	✓
Keeping services local	×	✓
Clinical evidence base	×	✓
Clarity on site access according to needs	×	✓
Local providers	×	✓
Pregnancy and maternity	×	✓
District services	×	✓
Workforce as a driver for change	×	✓
Workforce sustainability and training	×	✓
Population and bed modelling	×	✓
Deprivation and health inequalities	×	✓
Multi-site working	×	✓
Digital	×	✓
Environmental considerations	×	✓
Funding	×	✓
Covid-19	×	✓
Renal services	×	✓
Feedback from Sutton and Merton Councils	×	✓

11.2.4 Decision-making

The Programme Board has reviewed the feedback from consultation and the additional evidence developed as part of this DMBC.

The Programme Board has considered the impact of the feedback from consultation and additional evidence on the proposed clinical model, the ranking of the options, and the recommendations for implementation. The feedback from consultation and additional evidence has not materially impacted on the relative ranking of the options.

Therefore it is the Programme Board's recommendation to the Committees in Common that the following resolutions should be considered for agreement and approval, taking into account all the evidence that has been made available, on the basis that they represent the best solution to address the case for change:

- To agree and adopt the clinical model for the delivery of district hospital services and the SECH;
- To agree that the preferred option for the location of the SECH is Sutton, with continued provision of district hospital services at Epsom Hospital and St Helier Hospital.
- To agree and adopt the recommendations for implementation; and
- To establish a Strategic Executive Group and Strategic Oversight Group to monitor the delivery of the recommendations throughout implementation.

In their decision-making, the Committees in Common will consider:

- All available evidence previously considered prior to consultation, which lead to the ranking of the options for consultation, with the Sutton option ranked highest;
- The consultation responses; and
- Subsequent to consultation, the evidence within this DMBC and its supporting appendices, including:
    - The consultation analysis report;
    - Supporting analytical reports of the consultation, such as the IPSOS Mori and YouGov reports; and
    - The phase 3 IIA.

The evidence set out within this DMBC is one of the factors the Committees in Common will consider as part of their decision-making process.

No decision has been made.

11.3 Recommendations

As part of implementation of the preferred option, considering all the feedback received from consultation and the evidence developed, commissioners have developed the following recommendations for the Trust to deliver as part of its implementation planning. This includes the actions arising from the IIA.

These recommendations will need to be met for commissioners to provide formal support to any future business cases related to IHT.

Table 47: Recommendations

#	Area	Recommendation	Relevant IIA enhancement
1	Preferred option	The Trust should implement the preferred option as decided by commissioners.	
2	Assurance and implement ation	The Trust will report on the delivery of the recommendations and implementation of the OBC and FBC to commissioners. This includes reporting through the establishment of a Strategic Executive Group and Strategic Oversight Group.	
3	Travel and access	A full travel and access strategy should be carried out, including additional access roads and public transport routes, and review of any subsidised travel and parking	Effective communication of transport options and travel plan to staff, patients and visitors (IIA Action 5)

		The Trust should establish a Travel and Transport Working Group and Travel and Transport Reference Group to ensure local communities inform these plans The Trust and the CCGs will publish the travel action plan.	Build site specific transport offerings (IIA Action 8) Explore the possibility of ensuring more personalised support to patients in promoting clarity around transport options (IIA Action 9)
4	Travel and access	The Trust will develop plans/proposals for car parking at the SECH and district sites, and ensure appropriate parking capacity and site accessibility is available for our local population, including staff, patients and visitors.	Ensure appropriate parking capacity on the site chosen to host acute services (IIA Action 6)
5	Travel and access	Access to services for protected characteristics and vulnerable groups should be specifically addressed within the travel and access strategy to meet the needs of these groups including older people. The Travel and Transport Working Group should: • Explore and make recommendations to improve existing transport opportunities to/from the hospital sites. • Explore new transport links in particular new bus routes connecting Surrey (i.e. Leatherhead, Banstead, Epsom) to the SECH. • The Travel and Transport Reference Group should review and recommend potential alternative travel solutions for vulnerable groups for example (and not limited to): the good neighbour car scheme (operating in Surrey), Dial-a-ride, and services provided by the Merton and Sutton Community Transport.	Support development and capacity building of community transport options and make the community aware of the options available to them (IIA Action 7) Work with local councils and transport providers (IIA Action 10) Ensuring accessibility to hospital sites (IIA Action 22)
6	Travel and access	The design work within the OBC and the implementation of the clinical model should ensure appropriate access to district services and out of hospital services in conjunction with CCG and other stakeholder plans There should be representation from system partners in the further design of pathways, including primary care, community care and patients.	Continuous review of service model (IIA Action 11) Ensure district services are joined up with local strategies (IIA Action 21)
7	Workforce	In addition to the work already undertaken, the Trust will develop a detailed workforce implementation plan, including recruitment and retention plans, continuing to work in partnership with HEE, Royal Colleges, local clinicians and stakeholders.	Ensure workforce requirements are met (IIA Action 1) Develop a clear workforce plan (IIA Action 15) Understand clinical training and supervision needs at district sites (IIA Action 17) Detailed workforce analysis on staff groups affected by change,

			understanding their demographics and the impact on travel (IIA Action 18)
8	Workforce	The Trust carries out further staff (including clinical) engagement to develop the design and implementation of the SECH and district hospital clinical models.	Ensure staff are involved in the design of consolidated services (IIA Action 19)
9	Multi-site working	Transfer protocols are developed for implementation, working with ambulance providers and the voluntary sector.	Introduce appropriate transfer protocols and action to reduce transfers (IIA Action 3)
10	Clinical model	The clinical model should continue to be developed based on the latest evidence. The Trust should report regularly on implementation of the benefits realisation and evaluation plan.	Continuous review of service model (IIA Action 11) Develop an evaluation plan (IIA Action 4)
11	Clinical model	A communications and engagement plan will be developed to ensure clarity for the public on when to attend a SECH or District Hospital.	Provide clear communication about patient pathways and undertake an awareness raising campaign (IIA Action 2) Support patient clarity on accessing district services (IIA Action 16)
12	Clinical model	The Trust should implement the continuity of care model for maternity through a team approach, to ensure each woman has a named midwife and continuity of carer from the first prenatal appointment to the last antenatal appointment.	
13	Clinical model	The Trust should establish joint arrangements with local providers as part of the OBC to ensure patient flow assumptions are tested and reviewed as implementation plans are developed, including supporting them in their capital requirements.	Continued work with neighbouring providers (IIA Action 24)
14	Clinical model	The Trust should ensure district services are fully implemented and in place to support patient flow and the operation of the SECH.	Ensure district service enhancements and sufficient lead in time (IIA Action 14) Ensure district services are joined up with local strategies (IIA Action 21)
15	Population and future bed requirements	The Trust should provide the 1,066 beds to reflect the bed requirements to 29/30. This should continue to be reviewed and refined as further population growth forecasts, housing growth forecasts, and demand management initiatives are developed and delivered.	

16	Deprivation and health inequalities	It is a key requirement that the Trust, working with other partners ensures the implementation of district services, enhanced local services and the targeted local strategies developed by CCGs to reduce health inequalities through increased access to local primary or community care are realised, with a focus on prevention, as well as targeted initiatives to manage patients with risk factors around diabetes or high blood pressure and supporting behaviour change. See also recommendation 23.	Review district service provision against local health inequalities (IIA Action 12) Re-assess accessibility issues for deprivation groups for preferred option (IIA Action 13) Continuously review needs of equality groups (IIA Action 23)
17	Deprivation and health inequalities	NHS South West London CCG will work with local partners to undertake a further focused deprivation review specific to East Merton and North Sutton residents to determine whether any additional services should be made available locally.	
18	Digital	The Trust should continue to develop plans to implement EPR in advance of SECH implementation. Digital technology should be fully incorporated into the design of the hospitals and enable connectivity with wider healthcare providers.	
19	Environmental	The Trust should work towards implementation of a carbon net zero building. The Trust should address sustainable green travel alternatives as part of the travel and access plan.	Introduce and encourage more sustainable/green travel (IIA Action 25 Seek to implement carbon offsetting strategies across the Trust (IIA Action 26) Further air quality and carbon assessment following selection of preferred option (IIA Action 27)
20	Funding	The Trust should develop an Outline Business Case keeping within the funding envelope as confirmed by Department of Health / NHSE/I	
21	Covid-19	The Trust should ensure there is future capacity within the hospital design to incorporate flexibility to respond to future surges in demand across inpatient beds and ITU. The local health and care partners should monitor the latest guidance on implementing the response to COVID-19, including any further requirements for protected characteristics (e.g. BAME), deprived communities and vulnerable groups.	Ensure flexibility and adaptability in the design for the new major acute hospital (IIA Action 20)
22	Renal	The Trust should undertake a further appraisal of the options for renal services. Should	

		significant service change be proposed, this will require further consideration by commissioners.	
23	Primary and community services	Commissioners should undertake further work in partnership with local authorities and the Trust to appraise the additional services (including community beds, primary care, CAMHS, mental health, and a children's hub) that could be located on district site(s) or other local settings to best serve local community health needs.	
24	Social care	Working in partnership with local authorities, any potential financial or non-financial impact on social care and community services should be taken into account in implementation planning, both system wide and for the district hospital site(s).	

12 IMPLEMENTATION

The IHT Programme Board, which has representation from CCGs, regulators and ESTH, has provided strategic oversight to the Programme to date. During implementation, the Programme Board will become the Trust IHT Implementation Board with responsibility for overseeing the development and implementation of the programme.

Commissioners would have oversight of the implementation of the recommendations set out within this DMBC and the implementation of the OBC. This would be in the form of a Strategic Oversight Group, consisting of the two CCGs and regulators. This group would meet on a bi-monthly basis as a forum to report progress. On the intervening months, the Strategic Executive Group would meet, consisting of the two CCG accountable officers and the Trust Chief Executive.

To secure funding for the preferred option, ESTH will need to:

- Develop an outline business case; and
- Develop a full business case.

As part of this process, ESTH will need to secure commissioner support for its outline business case and full business case. This support will be contingent upon meeting the expectations defined in Section 11.

12.1 Overview of implementation

Following decision-making, it is expected that some transition time would be required to set up governance arrangements and finalise plans to progress implementation, but this time will be kept as short as possible to support early implementation.

The key considerations to ensure successful implementation of the plans are securing the capital monies, temporary / decant capacity during refurbishment, the lead time for capital developments, the availability of the workforce to staff the sites and developing locally agreed mitigations to the areas identified in the Integrated Impact Assessment (Section 10.1.3).

Given the scale of capital requirements, securing capital monies will require trust-led business case processes dependent on the outcomes of decision making.

To secure funding for the preferred option, ESTH will need to:

- Develop an outline business case:
  - carry out a refresh of the strategic rationale and benefits of the investment
  - align of the scheme to clinical strategy and commissioning intentions;
  - define the design and plans for the hospitals;
  - define the commercial strategy for securing a developer;
  - assess the overall impact, financial and non-financial (including full quality impact assessments); and
  - provide a clear statement of affordability and funding sources is provided for capital and revenue.
- Develop a full business case:
  - confirm the outcome of the commercial strategy;
  - finalise financials, including the final price of the build; and
  - be clear of affordability and funding sources are provided for capital and revenue
  - Following this process, ESTH can sign a contract and work can commence.

As part of this process, ESTH will need to secure commissioner support for its outline business case and full business case. This support will be contingent upon meeting the recommendations defined in Section 11.3.

The build of a hospital is complex and takes many years. The number and sequencing of moves, and the breadth of refurbishments necessary impacts on the complexity of the build and the time taken to build. Any significant new hospital build or refurbishment may need patients and/or services to be relocated (this is also known as a decant). Some options may require temporary accommodation to provide services while other spaces are redeveloped. Refurbishment of sites can only begin once new areas are available due to space requirements.

12.2 Approach and methodology

12.2.1 Key implementation activities

As part of the trust business case processes and to progress implementation, a number of workstreams will be vital to ensure a coordinated approach:

- **Clinical.** Leading development of the detailed clinical model and design to feed into the Estates workstream. Additionally, identifying the clinical benefits and risks associated with the design and developing the transition plan to the new clinical model.
- **Estates.** Developing a fully costed estates design for the SECH and District Hospitals based on the clinical model and design requirements, and developing all the requirements for an outline business case including Outline Planning.
- **Other Providers.** Leading engagement with other providers to ensure the impact of the scheme is agreed, and that capital schemes are sufficiently developed.
- **Commercial.** Developing and delivering the commercial strategy.
- **Finance and Economic.** Developing and refining finance and activity forecasts and leading development of the Finance and Economic cases.
- **Strategic.** Developing the strategic case, options appraisal and management case
- **People.** Leading workforce modelling to define future requirements and identify people change requirements. This will involve working closely with the clinical workstream to ensure that all people impacts of the programme are captured and an effective transition period is planned and delivered.
- **Stakeholder engagement.** Managing ongoing stakeholder engagement as plans progress, and developing and delivering a communications and engagement plan.
- **PMO.** Leading programme management activities to support implementation and development of business case.
- **Technology.** Developing technology requirements for the SECH and District Hospitals to feed into design requirements and developing the EPR business case and options appraisal.

Each of the ten workstreams will deliver multiple packages of work to develop the trust-led business cases, summarised in the table below. Further activities will be identified as the programme progresses.

Figure 23: Key implementation activities by workstream

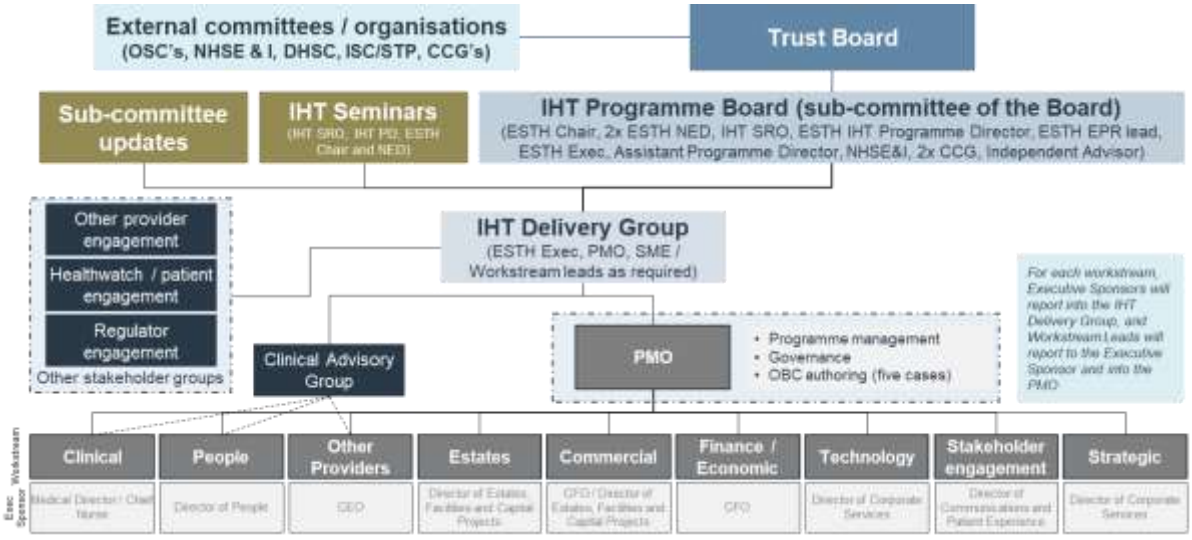
Workstreams	Work packages				
Clinical	Clinical model	SECH – design rqmts	District hospitals – design rqmts	Benefits / risks	Transition planning
Estates	Local planning (incl. Travel strategy)	SECH – design & costing	District hospitals – design & costing	Net-zero carbon commitment	Non-clinical rqmts
Other Providers	IHT Capital	Renal services	Revised flow modelling	Agree impact with providers	
Commercial	Procure support for OBC	Commercial strategy	Property / Legal	Market engagement	EPR procurement
Finance / Economic	Activity model	Overall model (CIA Model)	Options / criteria / scoring	Economic assessment	Affordability assessment
Strategic	Delivery planning (management case)		Options appraisal		
People	Workforce modelling	People change			
Stakeholder engagement	Healthwatch / patient engagement	Comms and engagement			
PMO	Programme management	Governance	OBC authoring (five cases)		
Technology	Technology requirements	EPR business case			

12.2.2 Governance arrangements for implementation

Clear, consistent and effective governance arrangements at all levels across the system wide implementation will be key to manage risks and dependencies across the system. The governance arrangements will build on the governance structures and processes that have been in place for the development of the PCBC and DMBC, but will pass over to the Trust rather than continuing to be the responsibility of commissioners.

A draft programme high-level programme governance structure is shown below.

Figure 24: Proposed draft high-level programme governance



The IHT Programme Board, which has representation from CCGs, regulators and ESTH, has provided strategic oversight to the Programme to date. During implementation, the Programme Board will become the Trust IHT Implementation Board with responsibility for overseeing the development and implementation of the programme.

The Implementation Board will oversee several workstreams. These workstreams will be established to lead on both the planning and development required to support changes to service provision. Each workstream will have an Executive Sponsor. The workstream leads will report to the relevant Executive Sponsor and into the PMO.

A Delivery Group chaired by the ESTH IHT Programme Director will oversee and drive progress and delivery of the IHT programme, facilitating alignment on key decisions across workstreams. The Clinical Advisory Group will continue to provide clinical leadership and oversight to the programme and will make clinical recommendations to the Programme Board / Implementation Board.

12.2.2.1 Commissioner scrutiny requirements

Commissioners would have oversight of the implementation of the recommendations set out within this DMBC and the implementation of the OBC. This would be in the form of a Strategic Oversight Group, consisting of the two CCGs and regulators. This group would meet on a bi-monthly basis as a forum to report progress.

On the intervening months, the Strategic Executive Group would meet, consisting of the two CCG accountable officers and the Trust Chief Executive.

12.2.3 Implementation risks

The consolidation of clinical services across sites brings risks which will need to be carefully managed throughout implementation and beyond. Risks are identified at all levels within the programme and are noted on a central risk register, held by the PMO. Risks are then rated based on their probability and impact. These are combined into an overall risk rating as shown below.

During implementation, the IHT Implementation Board will take responsibility for managing risks supported by other groups who will regularly review risks to delivery.

Figure 25: Risk rating matrix

Overall Risk Rating

Impact						
	5	A (5)	A/R (10)	A/R (15)	R (20)	R (25)
	4	A/G (4)	A (8)	A/R (12)	R (16)	R (20)
	3	A/G (3)	A (6)	A (9)	A/R (12)	A/R (15)
	2	G (2)	A/G (4)	A (6)	A (8)	A/R (10)
	1	G (1)	G (2)	A/G (3)	A/G (4)	A (5)
	Score	1	2	3	4	5
		Likelihood				

The table below sets out the risks identified to date. They have been reviewed by the Programme Board. The risks are regularly reviewed and are updated when new risks are identified or amendments are required.

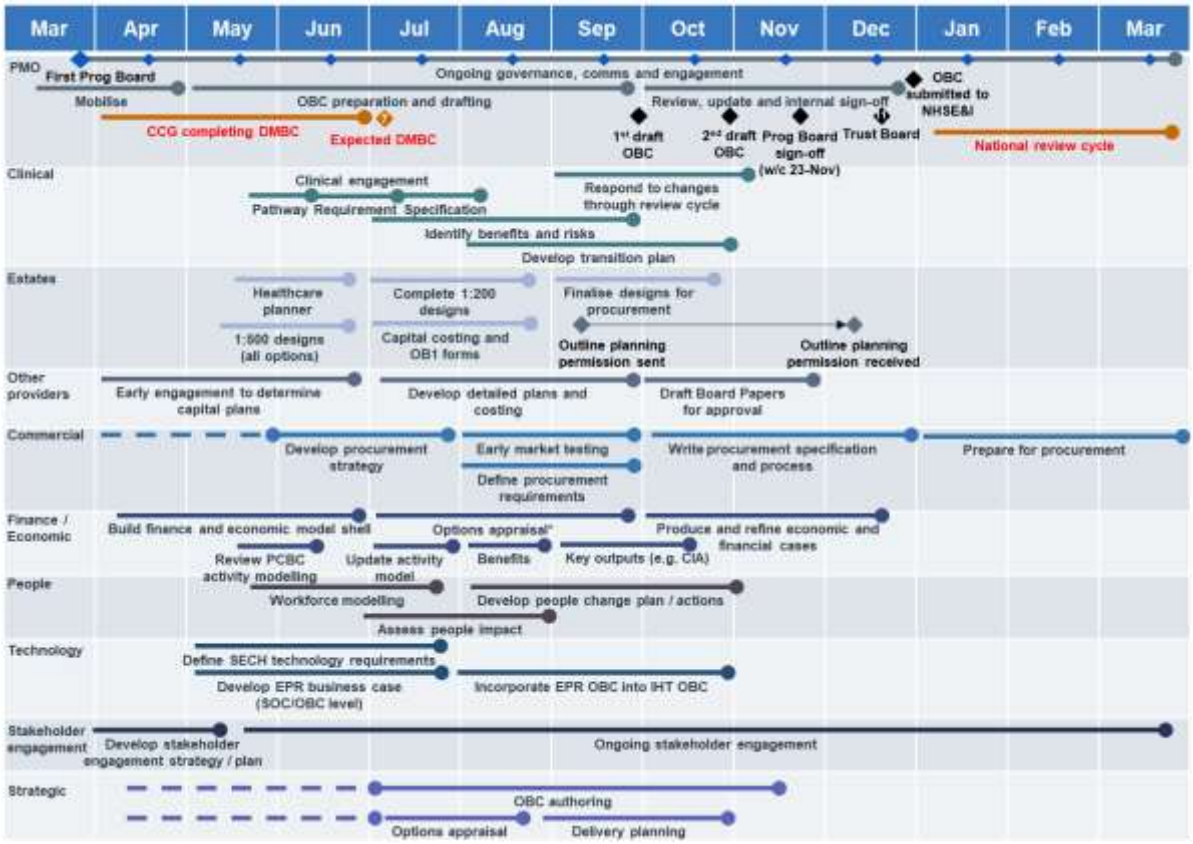
Table 48: Risks identified to date

Risk	Category	Risk Rating	Avoidance / Mitigation Action
The required response to the outbreak of COVID-19 limits the time that leading trust clinicians have to support the programme, delaying the development and agreement of the clinical design	**Engagement**	15	• Utilise existing meetings to engage clinicians • Develop a streamlined workshop plan, focusing on the minimum input requirements from clinicians
Changes required of other providers are not agreed in time to align with the sign-off for the ESTH capital funding	**Other providers**	8	• Early engagement with other providers to agree scheme and business case requirements
Uncertainty around the approach, funding and timescales for EPR impact the hospital design and implementation planning	**Technology**	6	• Begin development of the business case now, and engage with NHSX on funding options.
The governance and sign-off process is not expedited, resulting in delays to the OBC, procurement, build and completion	**Time**	4	• Early engagement with NHSE&I and agreement to a set timescale

12.3 Implementation timetable

A programme plan has been developed incorporating the key implementation activities to secure capital monies and progress towards build stage. The draft programme plan is shown below.

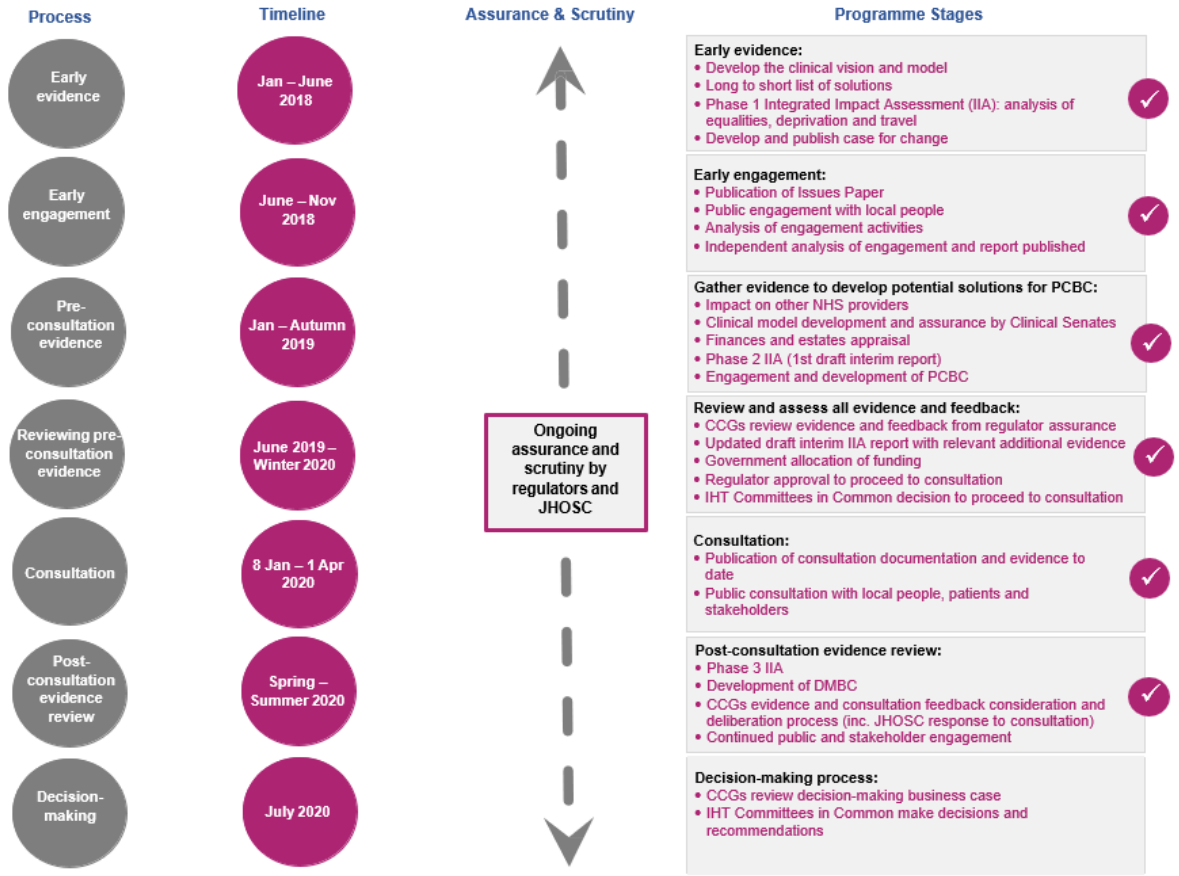
Figure 26: Draft implementation timeline



13 CONCLUSION AND NEXT STEPS

This DMBC is the result of almost three years of evidence development, assurance and review of proposals to deliver a solution that addresses our case for change and delivers our clinical model.

Figure 27: Process of the IHT programme



The feedback from consultation has shown that there is clear public support for our case for change and proposed clinical model.

As commissioners, we believe we have identified the best solution to deliver healthcare for our local population, and have tested this with the public through consultation. Further work has been undertaken to ensure that we have understood the themes from public consultation, and how this affected the ranking of the options and how the preferred option should be implemented.

The Trust will now be asked to implement the preferred option, as per our first recommendation. We will continue to have a role in ensuring that the Trust implements all the recommendations as developed through our review of the consultation feedback, as well as the IIA enhancements, through the Strategic Oversight Group and Strategic Executive Group.

14 APPENDIX

The documents below have been published on the Improving Healthcare Together website (https://improvinghealthcaretogether.org.uk/), and are available for reference in support of this DMBC.

Please visit www.improvinghealthcaretogether.org.uk and type in the search box the appendix name as captured below to view the relevant document(s).

- Pre-Consultation Business Case and associated appendices
- Independent analysis of feedback from consultation (by Opinion Research Services)
- Independent analysis on feedback from deliberative focus groups, workshops and depth interviews report (by YouGov)
- Independent analysis of feedback from the residents' telephone survey (by Ipsos MORI)
- Final Integrated Impact Assessment report (by Mott MacDonald)
- Interim review of the impact of COVID-19 on the clinical model briefing paper
- Clinical Commissioning Groups legal duties briefing paper