Committees in Common Submission

July 2020

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"A reduction in the number of hospitals providing major acute services could potentially have a negative impact on the resilience of services, if for example, there is an unplanned event… on the single major acute hospital site which may restrict service delivery.

It is recognised that the likelihood of such a situation occurring is unlikely".

Improving Healthcare Together Integrated Impact Assessment, January 2020

Dear Committees in Common,

Please consider this evidenced submission in advance of your meeting on Friday 3rd July. In this response I will present a clear analysis of the Improving Healthcare Together 2020-2030 consultation responses, I will challenge a number of findings and gaps in the Integrated Impact Analysis and Decision-Making Business Case, and I will reiterate a number of previously stated questions and concerns that remain unaddressed by the programme. Given that there are two proposed sites in Sutton, I refer to the St Helier Hospital site as St Helier and the Sutton Hospital site as Belmont.

Consultation Responses

I turn first to the response to the consultation. According to the Decision-Making Business Case, "*Looking across all consultation strands, on balance Belmont (Sutton) received more support as a potential site for a new SECH, although views varied by where respondents lived."*

In all aspects of the consultation, it is unequivocally clear that this is not the case.

Responses to the consultation came in different forms: the consultation questionnaire, a resident survey, focus groups, engagement activities, listening events, written submission, social media engagement and petitions. I take each in turn:

1) **Consultation Questionnaire:**

   4,172 people responded to the consultation questionnaire. But the analysis is clear: "*Less than half of non-NHS respondents felt that building on the Sutton Hospital site would be a good or very good solution."*

   It is further noted that those who had most used the maternity services in the last year were more likely to view the proposals more negatively than other respondents.

   It is clear that the programme's proposals to move all acute services to Belmont were not supported in this form of the consultation responses.

2) **Residents Survey:**

   3,751 interviews were completed through the resident's survey. 59% thought that St Helier was a good or very good solution. Less (52%) thought the same for Belmont. More responses thought that Belmont was a poor or very poor solution compared with St Helier.

   Meanwhile, 58% thought that St Helier Hospital would be very or fairly easy for them to travel to, with just 44% for Belmont.

   Participants were also asked about the impact they think the new specialist emergency care hospital being based at each site would have on them and their families. St Helier (46%) is seen as the site which would have the most positive impact with Belmont at 32%.

   It is clear that the programme's proposals to move all acute services to Belmont were not supported in this form of the consultation responses.

3) **Written Submissions**

434 written submissions were made. The analysis states, regarding these submissions, that *“ultimately, repurposing St Helier as a district hospital was not considered acceptable, and many residents offered personal experiences to explain why it should retain all of its services”.*

In these written submissions, more contributions are said to support St Helier than Belmont.

It is clear that the programme’s proposals to move all acute services to Belmont were not supported in this form of the consultation responses.

4) **Listening Events**

Over 1,000 people attended listening events. I quote directly from the analysis:

“Attendees criticised the consultation for being a done deal; that the Sutton site had already been chosen. There were complaints that the site was actually in Belmont and not Sutton; that St Helier is actually nearer to Sutton than Belmont and that Belmont was relatively difficult to access. Some doubted whether the consultation would make any difference to the preferred site of Sutton; that people were not being heard and their opinions not considered.”… “*Moreover, there was particular support for investment at St Helier hospital”.*

It is clear that the programme’s proposals to move all acute services to Belmont were not supported in this form of the consultation responses.

5) Social Media Engagements

There were 1,730 social media engagements. In these, it is stated clearly that *“Residents took to Twitter and Facebook to express their disagreement with services being removed from their local hospitals”* and *“there was disappointment that much of the public campaigning and strength of feeling among the local population was being largely discounted.”*

It is clear that the programme’s proposals to move all acute services to Belmont were not supported in this form of the consultation responses.

6) **Petitions**

- 3,390 people signed a petition stating:

  “We the undersigned oppose any closure of St Helier’s A&E or Maternity services as proposed by NHS South West London. We oppose cuts to services that are much needed by the residents of St Helier, Morden, Mitcham and beyond”

- 6,069 people signed a petition stating:

  “We, the undersigned call on NHS England, The Secretary of State for Health and Social Care, all SW London & Surrey MPs, Councillors, GPs and all SW London and Surrey Downs CCGs to: Permit NO CLOSURES, NO CUTS TO SERVICES, NO PRIVATISATION OF OUR NHS … To protect, maintain and improve all existing NHS hospital services at St. Helier, Croydon, Kingston, Epsom, and St. George’s

Hospitals… To halt all hospital downgrades and closures… Keep all A&E, Emergency, Maternity and Paediatric services on all current sites… To cease all NHS land sales"

It is clear that the programme's proposals to move all acute services to Belmont were not supported in this form of the consultation responses.

7) 3,339 people responded to 2 third party surveys

- 1,210 people responded to a survey supporting any new hospital to be situated as centrally as possible, with emphasis on travel links and forward planning based on housing forecasts, with a new specialist centre based at Epsom.

- 2,129 people responded to a questionnaire with three questions to gauge agreement or disagreement with the need for emergency services, maternity services and paediatric inpatient services (Queen Mary's Hospital for Children) to remain at St Helier Hospital. There was overwhelming agreement (greater than 90%) in all three questions from the 2129 respondents

It is clear that the programme's proposals to move all acute services to Belmont were not supported in this form of the consultation responses.

8) Other engagement activities and meetings

I quote directly: *While some people supported Sutton for being central to the area and near a train station, more were concerned over accessing the site, which is actually in Belmont and 'off the beaten track'. The narrowness and layout of the roads was mentioned, as were infrequent bus links to the hospital site from areas like Morden, Mitcham, Worcester Park, Cheam and Epsom.*

What's more, *"During the events in Merton, a show of hands indicated participants' preferred site for the SECH which was: 70% for St Helier; 24% for Sutton and 6% for Epsom".*

It is clear that the programme's proposals to move all acute services to Belmont were not supported in this form of the consultation responses.

9) Focus Groups

11 focus were held and it is stated that many had arrived at the sessions with outright objections until representatives from the programme had had the opportunity to pitch their case.

The programme repeatedly stated that people could engage with the consultation in any form and their view would be heard equally. Tens of thousands of local residents had their say and have unequivocally voiced their opposition to these proposals.

The evidence could not be clearer.

Will you listen to the consultation?

Additionally, it was stated that 6,000 copies of the questionnaire and summary document in Tamil were sent to the MPs for Carshalton and Wallington & Sutton and Cheam to share with their constituents. Why didn't I receive the same documents? Why should the Tamil Community in my constituency have any less of a say?

Outstanding Questions, Comments and Concerns

As well as a consultation analysis, the programme has published a Decision-Making Business Case and an updated Integrated Impact Assessment. On 1st April 2020, I submitted a full evidenced piece to the consultation with clear questions, comments and concerns at the analysis undertaken so far. A significant number of the points raised are not addressed in any of these new documents. I take each in turn.

Deprivation

In my response to the consultation, I emphasised the negative and disproportionate impact that this proposal would have on the most deprived communities in the catchment. I gave clear evidence that this would be the case: of the 51 most deprived Lower Super Output Areas in the catchment area, 42 are nearest to the St Helier site.

The programme has consistently analysed deprivation by CCG area rather than proximity to each possible site. It is a misleading way to analyse this imperative factor. After all, none of the three possible acute sites are in Merton. Concluding that there are high levels of deprivation in Sutton should not be used as support for an acute site in Belmont given that St Helier Hospital is also in Sutton. What's more, analysing in this way masks the significant difference in deprivation within each CCG area. Most significantly, it underestimates the deprivation in Merton, as my constituency of Mitcham and Morden is statistically far more deprived than neighbouring Wimbledon. The proximity of deprived areas to the three proposed sites is far more significant than the CCG that they are in.

Similarly, as I have previously raised, your deprivation analysis concludes that age is the largest contributor to acute health need. But this ignores the link between 'old age' and life expectancy. Old age for a resident in Mitcham is likely to be lower than old age for someone in neighbouring Wimbledon where there is a significantly higher life expectancy.

Concerns about the impact on deprived communities were consistently raised throughout the consultation. I quote directly from the consultation response analysis:

"Concerns about potential impacts on individuals and families living in deprived areas as a result of the proposed model of care and, in particular, of the option of locating a new SECH in Sutton, were shared by respondents who opposed the changes completely, and those who agreed with the model of care and even with the preferred option"

Following the consultation, the Decision-Making Business Case finally addresses some of these strongly held concerns, with a data table showing service use by deprivation decile:

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**

The analysis states that this evidence does not prove the correlation between deprivation and acute service need. But the evidence could not be clearer to the contrary.

Regarding A&E attendance, the two lowest deprivation deciles are the two highest service users. The 9th and 10th deprivation deciles are the two lowest.

Regarding birth admissions, the bottom four deprivation deciles clearly have the highest service use. The 8th, 9th and 10th deprivation deciles are the three lowest (or joint lowest).

Regarding NEL Medicine Admissions, the highest service use is in the lowest deprivation decile.

This evidence is clear. It cannot be dismissed.

The Decision-Making Business Case suggests that a further focused deprivation review specific to East Merton and North Sutton will be undertaken to determine whether any additional services should be made locally. But it is fundamental that any and all analysis is completed in full before any decision is made to proceed.

There is a clear and consistent association of acute service use for deprived communities in the catchment. The updated Integrated Impact Assessment itself states:

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.

An Urgent Treatment Centre is not a substitute for A&E. Moving acute services away from St Helier Hospital will negatively and disproportionately impact the most deprived areas of the catchment. Your analysis indicates that just 20% of health outcomes are affected by hospital care. But this is the only 20% that you can affect. It is your responsibility to take this into account and influence it as best you can.

BAME Communities

We know that BAME residents are more likely to have underlying conditions such as diabetes, lupus and kidney failure, and are at higher risk of developing heart disease and hypertension.

We also know that black women are five times more likely to die in childbirth than white women and are more likely to require neonatal or specialist care baby units.

We also know that BAME residents are less likely to have a GP and if they do are less able to go to see them during opening hours.

Your own consultation response analysis is clear:

"It was again said that moving acute services from St Helier to Sutton (or indeed Epsom) would have a disproportionate impact on BAME groups, who disproportionately use A&E and experience barriers in accessing primary care".

And

"Furthermore, in the resident focus groups, black and minority ethnic participants, who tended to be present mostly in the Merton groups and workshops, had a slightly greater inclination towards St Helier than the overall response, due to a higher reliance on public transport and due to living further into central London".

But of the 66 Lower Super Output Areas across the catchment with the highest proportion of BAME residents just 1 is nearest to Belmont. Meanwhile, 64 of the 66 are nearest to St Helier. 32 of these are in the bottom two quintiles of deprivation, increasing their likely reliance on acute services. Your proposals would unequivocally negatively and disproportionately impact BAME residents in your catchment.

This evidence had already been presented to you in the consultation. But the world has fundamentally changed since the consultation closed on 1st April. We are facing a global pandemic, with tens of thousands of deaths in the UK alone.

We should all have been horrified at the evidence from the recent Public Health England report that highlighted the disproportionate impact that coronavirus is having on BAME communities. BAME residents are more likely to require admission to an intensive care unit once in hospital and are up to twice as likely to die than those from White British backgrounds.

But when the South West London and Surrey Joint Health Overview and Scrutiny Committee challenged the programme on the impact of the pandemic on their proposals, the programme released just a 5-page piece of analysis that did not even once mention BAME communities.

The impact on BAME communities must be heard.

What's more, it is absolutely imperative that these proposals are reconsidered and the analysis reviewed in light of coronavirus. January's Integrated Impact Assessment clearly stated an expectation that a pandemic was not expected by the programme when developing the proposals:

"A reduction in the number of hospitals providing major acute services could potentially have a negative impact on the resilience of services, if for example, there is an unplanned event… on the single major acute hospital site which may restrict service delivery… It is recognised that the likelihood of such a situation occurring is unlikely". This quote has since been updated to state that *"as we have seen with COVID-19, the preparedness of hospital systems to manage a surge in capacity is imperative".*

This was the foundation upon which the consultation was approved. Given all that has happened, it is vital that we understand in full the impact of coronavirus on these proposals before continuing.

The Decision-Making Business Case itself states that:

"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".

And

"Further analysis will need be undertaken as more information about impact and learning from COVID becomes available".

What's more, it brings a further warning that:

"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".

It is fundamental that the programme and the analysis undertaken is reviewed in full in light of the pandemic.

The updated Integrated Impact Assessment brings further warnings:

"With all major acute services being delivered from one hospital site, there is a risk that patient activity may be greater than capacity, which could have an adverse impact on the safety and quality of patient care".

And

"There is the potential for the quality and safety of patient care to be negatively impacted if: …

- *There is unanticipated increased use of the UTC which is co-located with the major acute hospital. It is possible that patients will choose to access the UTC which is provided at the major acute site where more facilities are available and there is perceived to be a greater level of care available".*

The coronavirus pandemic has pushed our national health service to its limit, with the urgent opening of a new Nightingale Hospital in London due to the extraordinary pressure our health service was has been under. How can it possibly make sense to commit to downgrading 2 of London's hospitals in the heart of a pandemic?

Bed Numbers and Impact on other Providers

Given the concerns noted above about bed numbers, I am very disappointed that my evidenced questions about bed numbers have been left unaddressed.

Currently, Epsom and St Helier NHS Trust has 1,048 beds. Under the no service change option, this is expected to grow to 1,082 beds by 2025/2026. Comparatively, under these proposals, Epsom and St Helier Trust would have 1,052 beds, regardless of where their acute site is based. To indicate that this is 4 more beds than present day disguises the reality that there would be 30 less beds under this programme for the Trust than there otherwise would be.

This does not even take into account the number of beds that would overflow to other providers. For example, under the Belmont option, 50 beds are stated to operate under other providers. Including the 30 beds already lost through this programme, Epsom and St Helier Trust would therefore have 80 less beds in their catchment area than they otherwise would have in 2025/2026.

To emphasise: under your preferred option, there would be a lower number of NEL overnight beds, EL overnight beds, maternity beds, critical care beds, district hospital beds, elective day beds and NEL day beds than the no service change option.

Furthermore, under the no service change option, the population size for the catchment is expected to grow to 505,000. If Belmont is chosen as the acute site, the catchment will fall to 422,000, a significant difference of 83,000 people. Given this huge fall in population size, why are just 50 beds accounted to move to other providers under this proposal?

Meanwhile, the consultation response analysis makes clear that "*St George's University Hospitals NHS Foundation Trust's backing for the Sutton option was contingent on investment in the services provided by St George's to mitigate the impact of moving major acute services on patient flows and activity*". Similarly, "*that of Reigate and Banstead Borough Council was subject to the retention of a full suite of local services at Epsom Hospital, including a 24-hour urgent care facility".*

Where is this funding coming from? What happens if this investment cannot be accommodated?

In my response to the consultation, I provided clear evidence on a ward by ward basis from my constituency that the fastest, cheapest, most accessible route to acute hospital services from every single ward would be to other providers and not to your proposed site in Belmont. Your updated analysis does not take this into account. Why?

Maternity Services

The updated Integrated Impact Assessment makes clear that district service developments will seek to increase the number of home births.

But, currently, only 2.5 – 3.5% of women in the catchment choose this option. Why do you expect this to change so significantly in the space of 5 years?

What's more, whether you can have a home birth at all is assessed based on the risk to you and your baby. An increased distance to hospital if something goes run must become a factor in this decision. If they need to get to the hospital as quickly as possible, the extra travel time for mother and baby will put them at increased risk. No wonder evidence from the public consultation shows that some patients "*may feel pressure to adopt a choice which they would have not previously considered nor feel comfortable with*".

Moving maternity services further away and assuming that women in my constituency will be happy to instead have a home birth is discriminatory and complete against their right to choose where to have their baby.

Travel

A second travel analysis has been undertaken by the programme. But the results are the still clear:

"Across all the options, patients are likely to see some addition to their current overall journey time."

…

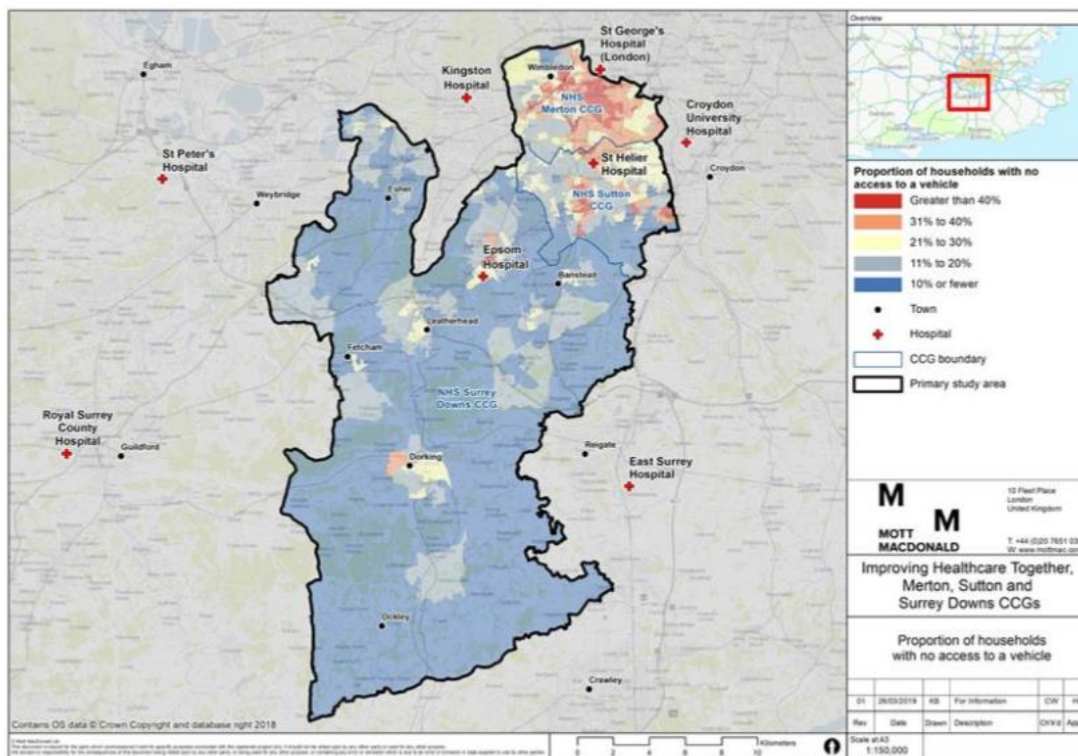
"The delivery of major acute services on a single site will have an impact on existing travel times for those travelling via blue light ambulance"

…

"The additional distance to travel to a consolidated major acute hospital service site is likely to result in additional costs for some residents travelling to the site."

Once again, this is a decision that would disproportionately and negatively impact those who live in the most deprived areas of the catchment. These residents are far less likely to have access to a car, as evidenced clearly in the programme's own analysis here, and are reliant on public transport to access their local acute hospital:

Figure 11: Car ownership



Source: Mott Macdonald based on Census 2011.

The map is clear that areas in my constituency, and around St Helier Hospital, are far less likely to have access to a car and so are more reliant on public transport.

Of the three hospitals sites, St Helier Hospital, has the greatest number of routes servicing it with the greatest frequency of services. This is a particularly important factor for those reliant on public transport.

Meanwhile, public transport to Belmont is said to be poor. Most buses do not run directly to the hospital and the train stations are a 10-20 minute walk from the site. Those most likely to need the acute services are those least likely to be able to walk a long distance. The programme's latest documentation considers mitigations to this problem, but the same mitigations are not considered for any negative factors associated with the other possible sites. Why? The analysis isn't an analysis of future routes, but present-day options that are available.

Additionally, the longer, more complex and more expensive a journey, the less likely friends and family are to be able to regularly visit. The evidence is clear that friends and family visiting can have a hugely positive impact on the recovery of a patient.

Once again, the decision to move acute services to Belmont would negatively and disproportionately impact BAME communities. I quote directly from the updated Integrated Impact Assessment:

As higher densities of the BAME community and those with a long term health condition/disability live within areas in the highest quintiles of deprivation, these groups may also be expected to be disproportionately impacted compared with others.

No wonder BAME residents are more likely to say it will be easy to travel to St Helier (69%, compared with 53% of residents from white backgrounds).

What's more, the argument consistently raised throughout the documentation about the travel-related benefits of the Belmont option for many residents simply does not stand. Residents who benefit from accessing a major acute service locally in Belmont would still be required to travel to Epsom or St Helier Hospital for their outpatient care. This is not reflected in the scoring or analysis. Why?

Longer journeys are not just an inconvenience. For patients requiring acute health services, they may be a matter of life and death.

Finances

The financial modelling produced by the programme takes Net Present Value as the key determining factor. However, the financial data clearly shows St Helier to have a higher return on investment, posing less risk with a significantly lower capital requirement.

Given that the Belmont site would require 22% more capital than the St Helier option, it would be expected to offer a higher Net Present Value. But despite this, the St Helier option has a higher return on investment than Belmont.

Moreover, the Pre-Consultation Business Case states that enabling capital (the broader changes that would be needed over the next ten years to support any incremental changes and need to be in place before the programme's options can be delivered) are not included in the financial modelling.

How can the financial cost of these proposals be accurately measured unless both the incremental and enabling capital required is calculated? Why is the amount of capital required not taken into account? Why is the return on investment not considered?

Royal Marsden

Throughout the programme's documentation, it is consistently argued that the Royal Marsden could bring additional benefits to the Belmont site option.

The financial section of the analysis states clearly that it is this factor that distinguishes the Belmont site from St Helier.

"The total income and expenditure position by 25/26 is greatest for the Sutton option. This is driven by the additional benefits (including co-locating with the Royal Marsden) outweighing the higher annual capital costs needed to pay for a new build facility".

and

The "greater benefits are driven by the greater economies of scale opportunities (£135m)" and *"additional co-location synergies are expected through joint working between Epsom and St Helier and the Royal Marsden".*

However, the updated Integrated Impact Assessment recognises that in light of coronavirus and the vulnerable condition of cancer patients, these co-location synergies may not be possible.

Does this change the financial merits of each option? If not, why not?

Similarly, it was stated clearly that an analysis of sensitivities which could change the ordering of the Net Present Value ranking was requested by regulators. The reason for this request, and the results of it, are missing from your documentation. If the economies of scale and Royal Marsden benefits are removed, the St Helier option would have the highest Net Present Value.

Why did regulators request this analysis? Where can the results be found? And why does the Improving Healthcare Together programme believe that these benefits are certain to be delivered? If they are not, the scoring should reflect this. This must be reviewed in light of coronavirus.

Model Assumptions

In my consultation response, I highlighted a number of further considerations and concerns with regards to the modelling that has been produced. The following points remain unaddressed and it is important that no decision is taken until they have been:

- The danger of transferring severely ill patients has not been tested. An overnight audit took place in October 2018 at Epsom to test the provision of overnight staffing but none of the calls resulted in the transfer of a patient to a higher acuity ward. The Trust appears to have had no practice for this likely scenario.

- There is an assumption regarding transfers that technological systems will be in place when the model initiates. One of the constraints of the current system is that some records (such as inpatient notes) are paper based. What if these systems are not in place by 2025? How could a patient be safely transferred from one site to another?

- The model assumes, through provider productivity improvements, that there will be an estimated 3% average annual reduction in acute activity and a further 3% annual length of stay reduction. But the aims and ambitions set out in these proposals are unproven and have not been achieved anywhere in the country.

- The programme argues on the one hand that Epsom and St Helier NHS Trust's buildings are not fit for purpose, but then goes on to indicate that they are adequate enough for 85% of services to remain at the sites. Are these statements not mutually exclusive?

- How or why the introduction of a new acute site in Belmont would solve the staffing issue for Epsom and St Helier NHS Trust. The proposals will simply move the staffing problem to another catchment area and, consequently, to another Trust. In the Integrated Impact Assessment, St Peter's Hospital clearly identifies that if Belmont is chosen as the acute site, workforce will be an area of high impact and that this could lead to an issue with regards to the deliverability of the proposals.

- If the Belmont option is chosen, there would be 33 less consultants, 64 less middle grade doctors, 3 less junior doctors, 29 less RNs/HCAs, 18 less midwives, 2 less OTs and 2 less physiotherapists. That's 129 less specialist staff. How is that a justifiable way to use a £500m investment in the NHS?

- The proposed service model is likely to have a negative impact on the capacity of the ambulance service. How would this be mitigated?

The Wilson

A new modelling assumption has also been made in the latest Decision-Making Business Case: that the Wilson Hospital in Mitcham will be fully operational.

But this has been promised time and time again and my community is still waiting. Discussions about it's opening together with the Nelson in wealthy Merton Park have been ongoing since 1998 with only the Nelson being progressed and opened in 2015.

3 years ago the walk-in centre in a portacabin at the front of the site was closed. In a public meeting attended by hundreds of local residents in March 2017, Dr Andrew Murray stated that a planning application had been submitted for the redevelopment of the site. It had not. The walk-in centre closed and no planning application or consultation on its reopening has ever happened. In 2019 the scheme collapsed entirely when the developer refused to provide the capital due to the risk involved.

How can the programme proceed with certainty that the Wilson will be open considering my community has been repeatedly let down in this regard?

Renal Services

Similarly, I am appalled to see that proposals to move Epsom and St Helier's renal services to St George's Hospital have been added to this programme at this stage of the process. At no point over the last 5 years has there been a public discussion about combining the renal services at St Helier at St George's at the latter site.

It has been obvious that they could not remain on the St Helier site if downgraded as there would not be the diagnostic and intensive care services required. The current services at St Georges cannot fit on site with intense scheduling pressures allocating dialysis sessions to patients. Just how

combined services would be placed on one of the most intensively developed acute hospital sites in London is not explained. Quite apart from how the funds would be found.

This appears to me to be a decision that should be completely separate from this programme. That it is being considered here strengthens my concern that St Helier Hospital will become nothing more than a glorified walk in centre.

Scoring

In my response to the consultation, I presented clear evidenced arguments to challenge the weighting and scoring of the criteria that determined Belmont as the programme's preferred site.

These arguments have not been addressed.

It is imperative that the scoring is reviewed in light of this clear evidence before any decision is made to proceed. These were scores decided in behind closed door workshops attended by a disproportionate number of Sutton attendees who were asked to anonymously score three hospital sites and were not asked to justify their decisions. Unsurprisingly, they chose Belmont, in the heart of Sutton.

It is imperative that these erroneous scores and weightings are reviewed before any decision is made to proceed. This includes, but is not limited to:

• **Accessibility**: Of the three hospital sites, St Helier has the greatest number of routes servicing it with the greatest frequency of services. Nearby is Morden tube station and Sutton, St Helier and Carshalton Rail Stations. There are roughly seven bus services to the hospital. Meanwhile, the Integrated Impact Assessment is clear that public transport to Belmont is poor and even states that "those who struggle with walking long distances may experience particular difficulties with accessing this site". Why does the Belmont option therefore score 6.17 whereas the St Helier option is significantly lower on 5.26 despite being described throughout the documentation as the most accessible? This is particularly important as any supposed transport benefit for residents near Belmont would be lost if they are moved to one of the district sites as an outpatient. This is not reflected in the scoring. Furthermore, why is the score even lower than Epsom?

• **Availability of beds**: Under all three options the bed numbers are repeatedly said to be the same, regardless of which is chosen. Why, therefore, does St Helier score 7.39 and Belmont 7.48?

• **Delivering urgent and emergency care**: As well as ranking the three options, the analysis also gives a rating for the no service change option. Why is the no service change option significantly lower than the score given to Belmont (6.36 to 7.00) considering the former includes two acute sites and has no transfer requirements?

• **Workforce safety, recruitment and retention**: The CAG concluded that "there is not expected to be a material difference in workforce experience across the options, as the clinical model is expected to be delivered in the same way, providing the same workforce benefits". The only difference described is births in Epsom. So why are scores given so different? Belmont received a score of 6.91 whereas St Helier scored 6.74. How is this justified?

• **Alignment with wider health plans**: The CAG stated that it "does not expect there to be a material difference in contribution across the options, as these aims are delivered by the consistent clinical model"? What justification is there, therefore, for these scores to be so different? Belmont scored 7.17 and St Helier 6.74.

• **Integration of care**: Similarly, there are only 4 and a half lines in the entire Pre-Consultation Business Case on the rationale for this score. This small amount of text is used to state that there are no material differences between the options. Why therefore do the scores differs so greatly? Belmont scored 6.74 and St Helier 6.17. Furthermore, integration of care is dependent on Local Authorities. The model makes this integration of care harder for those who are moving between acute and district sites – and so from one Local Authority to another. Given this, why is Belmont's score higher? Has the Royal Marsden been taken into account yet again?

• **Deprivation**: Of the 51 most deprived Lower Super Output Areas in the catchment area, 42 are nearest to the St Helier site. Why, therefore, does Belmont have a score of 5.57 compared to St Helier's 5.30?

• **Health Inequalities**: As with deprivation above, why does Belmont score higher given this new analysis? The deprivation and equalities analysis produced by the programme considers these factors by CCG area rather than by proximity to each of the three sites. The evidence is indisputable that moving services to Belmont would have a detrimental impact on health inequalities and deprived communities – and that they are nearest to St Helier Hospital. Why then does Belmont score 4.13 and St Helier 3.87? What's more, given the findings in the recently published Marmot Review, the weighting given to the deprivation and health inequalities scoring should be considerably higher.

• **Older People**: The analysis fails to take into account that old age is dependent on life expectancy. Epsom is given the highest score for old age, but also has a considerably higher life expectancy than significant areas of my constituency and the rest of the catchment area. To ensure accuracy, this measurement should not be taken by age alone, but by the life expectancy of each Lower Super Output Area in the catchment and by the percentage of people in each Lower Super Output Area who are in the final years of their life expectancy. Those people will be 'old' for their expected age. This score should be adjusted accordingly once this analysis has been undertaken. What's more, why does the Belmont site score higher than St Helier considering the programme's own Integrated Impact Assessment states that "those who struggle with walking long distances may experience particular difficulties with accessing (the Belmont) site"?

• **Safety**: The CAG states that it "does not expect there to be a material difference in safety across the options, as the clinical model is expected to be delivered in the same way, including meeting clinical standards and refurbishment is expected to be functionally the same as a new build, offering similar safety benefits". Why therefore does Belmont score 7.43 to St Helier's 7.39?

• **Patient experience**: Why is patient experience given a higher waiting than availability of beds? How can a patient expect to have a good experience if there is no bed available for them?

• **Staff Availability**: Considering staff unavailability is one of the defining reasons for the Improving Healthcare Together Programme taking place in the first place, why is this not considered to be a fundamental factor? St Helier scores highest.

In addition to the above, if the Belmont option is chosen as the acute site then there would be no district hospital alongside it. As such, patients would be required to travel to Epsom or St Helier for outpatient care. I do not consider this challenge to be reflected in the scoring for 'Accessibility', 'Older People', 'Patient Experience' or 'Safety', amongst other criteria. Any challenges faced by the Epsom or St Helier sites in regard to these factors will not be avoided if the Belmont site is chosen, with a significant number of acute patients accessing Belmont first before moving to one of the district hospital sites.

Conclusion

I wholeheartedly welcome every penny of investment in our treasured NHS. I do not for a second dispute the need for healthcare capital in our catchment area. I just ask that it's use does not discriminate against protected characteristic groups and that it is instead spent where it is needed most: at St Helier Hospital on its current site.

The consultation response is clear that there is overwhelming local opposition to the programme's proposals to move all acute services to Belmont.

It is fundamental that the views expressed in this consultation are heard and that the evidenced considerations in this letter are addressed in full before any decision is made to proceed.

Yours sincerely,

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Member of Parliament for Mitcham and Morden