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Background Briefing for the Greater London Authority: Proposed Hospital Reconfiguration Proposal by Surrey Downs, Sutton and Merton CCGs

Final Report

NICK HEX, Associate Director
HAYDEN HOLMES, Project Director
HANNAH WOOD, Senior Information Specialist
AYEDA NADEEM, Research Assistant

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Prepared by YHEC

Overview of process

This document serves as a briefing paper for the Greater London Authority to help inform its advice to the Mayor of London regarding the proposed hospital reconfiguration plans by Surrey Downs, Sutton and Merton CCGs.[1] The document provides a high-level summary of the processes through which the recommended option for the reconfiguration was decided with overall commentary on those processes. It then goes on to provide more detail on how the process addressed each of the Mayor's six tests along with commentary on the extent to which each test was addressed.

The 3 CCGs have established the Improving Healthcare Together 2020 – 2030 programme (IHT). The main acute provider hospital trust in the area is Epsom and St Helier University Hospitals NHS Trust (ESTH) but ESTH has faced challenges in delivering acceptable levels of clinical quality, providing healthcare from modern buildings and achieving financial sustainability. The CCGs have developed a case for change, which includes 3 options, plus a default 'no service change' option:

- The 'no service change': Continuing current services at ESTH.
- 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 4 options were assessed using both a financial and non-financial ranking system. The financial ranking process found that the Sutton option offered the best value for money (measured in terms of net present value), followed by the St Helier, Epsom and no change options. The non-financial ranking process weighed the options against a set of criteria and also found that the Sutton option was also the best, followed by the St Helier, Epsom and no-change options. On the basis of these 2 processes the Sutton Hospital option has been recommended as the best option. The processes are summarised and described in the pre-consultation business case (PCBC) which has been reviewed along with supporting and other related documentation, such as the draft final Integrated Impact Assessment.

Key briefing findings

Process
The process of deciding on the reconfiguration options involved developing a long list of 73 options before reducing this to a short list of 4 options. One of the tests involved in developing the short list was whether or not the option could deliver major acute services. This would appear to rule out most of the long list options immediately so it would be valid to question whether the process of arriving at the short list was genuine.

The process used for the financial ranking of the options appears to be reasonable with estimates of the capital investment required carried out using robust methods, but there is a lack of detail which makes it hard to establish how the preferred financing options were determined. It is not clear whether all of the financing

[1] Since 1st April 2020, Surrey Downs CCG has joined other CCGs in Surrey to create the Surrey Heartlands CCG. Similarly, CCGs in South West London, including Sutton and Merton CCGs, have combined to form South West London CCG. The IHT programme addresses the reconfiguration of six major acute services within the former combined geographies of the Surrey Downs, Sutton and Merton CCGs. This report continues to refer to the three CCGs that were in place prior to 1st April.

will need to be found through borrowing and all options will need to be reassessed following the Covid-19 crisis.

The process used for the non-financial ranking of the options (a multi-criteria decision analysis) was appropriate for setting and assessing the inputs to be used in making the decision. However, the description of the methods used was unclear in some places, meaning we are less confident in whether or not bias may have been introduced in the resulting decision. For example, the people who scored the different criteria were not aware of the weighting of each criterion, which could lead to some criterion being scored lower than might have been the case if the weightings were transparent. The option scores did not present ranges or indicate the extent of uncertainty so greater transparency would be helpful.

Test 1 – Health Inequalities

In relation to health inequalities and prevention of ill health, the PCBC describes an approach involving an integrated impact assessment and a deprivation impact analysis but the overall weight of health inequalities is small in terms of the non-financial ranking process. The PCBC provides some analysis of the impact of the different options on health inequalities, such as the impact on travel times. But more detail could be provided to show the impact of the options on areas of deprivation, for example East Merton, and for people with protected characteristics. Some very general assumptions were made, such as the statement that the choice of the recommended acute site would have only marginal impact on health inequalities, but no analysis of the impact of these options on health inequalities is provided. There is little specific content about how the proposals will prevent ill-health. It would be helpful to provide some sub-group analysis on the different options for travel, for example GIS analysis of the impact on average travel times from home to hospital broken down by neighbourhood deprivation group, as the underlying assumptions and potential impact on diverse populations are unclear.

Test 2 – Hospital Beds

The PCBC describes the way in which the number of hospital beds required by 2025/26 has been calculated, including forecasts for bed increases due to demography and bed reductions due to efficiency. This shows a net increase in beds from 1,048 to 1,082 by 2025/26, assuming no service change. However, the calculations for the numbers of beds required under each of the 3 site options assumes that fewer beds will be required in the ESTH area because of changes in the catchment area meaning that net bed reductions are forecast for each option. Little detail behind these figures is presented in the PCBC, for example, the length of stay efficiency estimates are derived from a benchmarking exercise and there is no detail on what initiatives will enable the reduction in anticipated average bed stays. IHT has subsequently provided more in-depth analysis of the bed estimates to the GLA team and this analysis should be publicly presented in the next stages of the preparation of the decision-making business case. Although out of hospital and community initiatives are reported they are not explicitly linked to the efficiency estimates that support the bed estimates. There appears to be no uncertainty or risk analysis to account for the potential for underlying assumptions to be inaccurate, so the process would benefit from the presentation of sensitivity analysis on the baseline assumptions.

Test 3 – Financial Investment and Savings

In relation to financial investment and savings, the PCBC sets out the approach to the estimation of the capital requirements, the funding requirements and the expected cost savings reasonably well. The process used for estimating the capital investment required appears to be robust. It is not clear how the expected sources of financing were arrived at. The PCBC does not detail the amount of funding that will be expected to be found through borrowing or the amount that could be generated through capital released within ESTH (e.g. through capital receipts) or any funding provided by the Government for capital purposes. Efficiency savings plans need to be described in greater detail to show how they have been calculated, to help people to understand how realistic they are likely to be. The financial analysis was carried out in accordance with relevant guidance, such as the HM Government Green Book. The use of sensitivity analysis to test assumptions is good practice but there is a lack of detail on the results of this analysis. Although the PCBC

mentioned them, more detail could be provided on the expected investment in primary and community care, and in health prevention programmes.

Test 4 – Social Care Impact

In relation to the impact on social care, the PCBC does not include detailed information on the impact of the proposals on any of the organisations providing health and social care services outside of acute hospitals in the area, i.e. primary care; adult social care; mental health services; and community services. There is no clear calculation to show how the reported benefits of integrated care initiatives contribute to the 'overall systems impact' and the estimated impact does not include reference to lengths of stay, which is a key component of the estimated ability to reduce beds in the area by 2025/26. Demographic factors are referred to in relation to plans for social care but they focus primarily on older people and there is no description of mitigation plans should demographic forecasts not come to pass. There is no detail in the PCBC about potential challenges to service integration that may impact on how successfully these initiatives can reduce the need for acute care. There is no mention of potential financial pressures that might affect the ability for integrated and out of hospital initiatives to expand to support the clinical model. There is little mention of the pressures on workforce in London in relation to social care, which is also an important factor in the delivery of out of hospital and integrated care services.

Test 5 – Clinical Support

The PCBC sets out the clinical case for change clearly, including a description of the clinical model and some high-level patient benefits that are expected to accrue from the model. The Consultation Report shows very high levels of approval for the clinical model among NHS staff but there is no reference to whether other staff from related disciplines, such as social care, were consulted and whether or not they approve of the proposals. NHS staff also expressed approval for the preferred option of the Sutton site for the acute centre. The Joint Clinical Senate reviewed the proposed clinical model and made 94 recommendations, most in relation to the way in which the district hospital model will operate. The PCBC reports that the recommendations were considered and addressed in developing the proposals. It will be important that NHS England assurance processes are satisfied that its recommendations have been addressed during the implementation of the business case, if it is approved.

Test 6 – Patient and Public Engagement

At the pre-consultation stage patients, the public and Healthwatch, including people with protected status and those hard to reach were consulted on the plans and they were involved in the option appraisal process for non-financial considerations. They were also involved in developing the formal consultation approach. The consultation was well publicised and made widely available to people in a wide range of formats. The formal consultation was open for 12 weeks, which coincided with the outbreak of Covid-19. Although some consultation events and processes were not fully completed, IHT was able to mitigate this through online activities. Consultation with people with protected status and those hard to reach was planned through a wide-ranging series of activities. IHT reported that The Consultation Institute has approved the consultation process as meeting the requirements for best practice.

Test 1: Health inequalities and prevention of ill health

The impact of any proposed changes on health inequalities has been fully considered at an STP level. The proposed changes do not widen health inequalities and, where possible, set out how they will narrow the inequalities gap. Plans clearly set out proposed action to prevent ill-health

Background	Commentary

Do the proposals set out health inequalities issues in their local population?
 	
• The introduction to the draft final Integrated Impact Assessment (IIA) report [1] states that its aim is to explore the positive and negative consequences of different scenarios and produce a set of evidence based, practical recommendations. The analyses should "highlight if and where certain sections of the population will be affected, either geographical communities or certain socio-economic or equality groups". The scope of the impact assessment covers health, equality, travel and access and sustainability.
• The IIA is made up of three phases: a first scoping phase including a Deprivation Impact Analysis (DIA) to provide a focused exploration of the potential impact the proposed options for change may have on deprived communities in the local area; a second more focused phase scoping health and equality impacts and reported in the interim IIA; and a third final phase post public consultation which has incorporated the findings into the final draft IIA report.
• The pre-consultation business case (PCBC) reports the details of the second phase interim IIA as well as results from the Joint Health and Wellbeing Strategies and Joint Strategic Needs Assessments (JSNA) for Surrey Downs, Sutton and Merton, which highlight health inequalities issues in each area.
• The PCBC highlights important health inequality issues in the area, which include:
  ○ Pockets of deprivation, particularly in parts of Sutton and Merton. These are more deprived communities, including the areas around St Helier Hospital, where around 5% of lower-layer super output areas (LSOAs), small sub-areas within a council area, are in the most deprived 20% of all LSOAs in England [2].
  ○ There are 23,000 children in Surrey living in poverty [3].
  ○ Disadvantaged electoral wards in Sutton tend to have higher mortality rates [4].
  ○ The Slope Index for males in Sutton is 7.4 years. This is the range in years of life expectancy across the social gradient within the borough, from most to least deprived [4].
	• Health inequalities issues are reported in the PCBC, which refers to a range of supporting documentation, including the interim IIA, the DIA and the local JSNAs. The geography has low levels of deprivation in the national context, but does have pockets of deprivation, particularly in the Sutton and Merton CCG areas. These are described adequately at the LSOA level.
	• While health inequalities issues are described adequately, it is worth noting that the health inequalities criterion contributed only 6% of the overall non-financial consideration. While we acknowledge that some of the other 16 categories[2], e.g. deprivation, may have some overlap with health inequalities, the specific criterion of health inequality seems low at 6.0%. We acknowledge that the criteria and weightings were determined by representative groups, including the public, drawn from across the three CCGs.
	• Throughout the PCBC many numbers are provided without accompanying confidence intervals or interquartile ranges. There must be many variables that have driven conclusions and they should be varied and different scenarios discussed.
	• Specific, measurable goals for prevention are not set out in the PCBC or the draft final IIA.

[2] The non-financial criteria (and weightings) were: Access (8.4%); Availability of beds (5.0%); Delivering urgent and emergency care (8.6%); Staff availability (7.1%); Workforce safety, recruitment and retention (6.9%); Alignment with wider health plans (3.9%); Integration of care (6.8%); Complexity of build (5.0%); Impact on other providers (5.3%); Time to build (3.0%); Deprivation (6.3%); Health inequalities (6.0%); Older people (6.0%); Clinical quality (7.8%); Patient experience (6.6%); Safety (7.3%).

○ The eastern half of Merton has a younger, poorer and more ethnically mixed population. These people have worse health and shorter lives than the western half who are whiter, older and richer [5]. ○ A health report for East Merton highlights the issue of chronic disease management in primary care and states that health care should be more focused on community-based approaches in order to provide people with more accessible care [6]. ○ According to the Office for National Statistics, the 90+ age group in Surrey Downs, Sutton and Merton CCG is expected to grow by an average of 127% across the CCGs by 2041 [7]. • Access was one of the criteria in the non-financial analysis and is an important aspect in considering health inequalities. The PCBC acknowledged that there were small changes to travel times as a result of the updated analysis, but that this did not affect the rankings for accessibility [2]. In the final draft IIA there is an analysis of the impact on average travel times from home to hospital broken down by deprivation status for the 3 options. • One key theme emerging from community engagement was the concern regarding the transport and accessibility between the different sites, such as from St. Helier to Epsom and vice versa. This feedback included the need to consider bus routes, the impact of traffic on travel times and the cost and availability of parking [2]. • The draft final IIA found that the Epsom option may result in longer journey times for patients from deprived backgrounds and longer, more complex or costly journeys, which may exacerbate existing health inequalities, arising from factors such as housing, income, education, social isolation and disability [1]. • The draft final IIA found that for the St Helier option, older people are expected to be disproportionately impacted by longer, more complex and more costly journeys [1]. This is due to larger densities of this group being located in the more rural south of Surrey Downs. The Epsom and Sutton options are therefore more favourable for older communities. • Time and distance for patients and their family/carers to access the new Specialist Emergency Care Hospital (SECH) site was considered the most important factor in the consultation responses. Refreshed travel analysis, reported in the Decision-Making Business Case (DMBC), has led IHT to commit to extend 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 [20]. • The DMBC reiterates that parking arrangements at both the SECH and district hospital sites will be part of the travel strategy in the implementation stage of the proposals, if they are approved. *<u>Do the proposals consider the impact on health inequalities in a systematic, documented way?</u>* • The draft final IIA assesses that the deprivation of the combined area is comparatively limited when viewed in the national context. It does, however, report that there are pockets	• There was a lack of sub-group analysis on the impact of different options for travel on diverse populations in the PCBC. This has been analysed in the final draft IIA for the 3 options for which there is a disproportionate impact on the two most deprived quintiles across the CCGs. • Another issue highlighted in the DIA was that people may not be willing to travel if their journey involved changing two or more buses. This is something which has not been analysed in the PCBC but should be taken into consideration. • Following feedback from the formal consultation and the IIA, the IHT has committed to extending bus routes and to ensure hospital parking is part of the travel strategy in implementing the proposals, if they are approved. • The PCBC reports that while the overall catchment area of the 3 CCGs is not particularly deprived there are pockets of

in Sutton and Merton that are in the most deprived quintile nationally and these data are presented at LSOA level [1].

- The mapping of deprivation in the geographies was discussed at the South West London & Surrey JHSC sub-committee for Improving Healthcare Together 2020-2030. Members of the JHSC raised concerns that the work was completed too quickly and does not provide sufficient detail, particularly variations in levels of deprivation within the boroughs and individual wards. They suggest that pockets of deprivation may be overlooked as a result [8]. The Leader of Merton Council has written to the IHT programme about concerns that a "deeper deprivation analysis" which had been agreed, has not been presented [8].
- The DIA [9] concluded that decisions about the location of major acute services would have a limited impact on addressing health inequalities for the deprived in the geography of ESTH because:
    - The geographical area of Sutton and Merton containing the pockets of deprivation is fairly concentrated resulting in a relative ease of access to major acute services. Any of the proposed options for the siting of major acute services are therefore likely to have relatively marginal impact on access.
    - Whilst the link between poorer health outcomes and deprivation is well evidenced, there is less evidence linking deprivation with the need for and use of the specific acute services that are being considered within the IHT programme.
    - The greater impact on health outcomes for deprived communities within the combined ESTH geographies would be more likely to come from concerted effort earlier in the health and care service pathways prior to need for major acute services [9]. This links to Test 4 around the clarity of the impact of the proposals on social care and other integrated and out of hospital services.
- In the draft final IIA further analysis was carried out which shows that those from areas of high deprivation tend to have a higher usage of acute services compared to other groups, which is linked to poor health behaviours.
    - The DMBC reported the concerns articulated through the formal consultation around the impact of the proposals on deprivation and health inequalities [20]. Further analysis has been carried out showing that people from more deprived areas in the geography are higher users of A&E services but do not use other forms of acute care more or stay in hospital longer than those from less deprived areas.
    - This further evidence and findings in the final IIA, indicate that to achieve better health outcomes for protected characteristics groups, deprived communities and seldom heard groups, it is important to invest in early stages of health and care pathways.

deprivation, and associated health inequalities, in each area. The PCBC describes East Merton as an area with higher levels of deprivation, which is linked with higher rates of health inequality. However, the PCBC does not provide comment on whether the geographically closer option of St Helier would have an impact on reducing health inequality in the more deprived East Merton population.

- The PCBC and the DIA report conclude that areas of deprivation within Sutton and Merton will continue to have relatively easy access to major acute services regardless of the chosen option. We cannot say whether this conclusion is reasonable without seeing more detailed evidence to support it. At the margin, there will be some negative and positive effects of the short-listed options which may affect people living in deprived areas. These should be discussed fully and where there are negative effects, especially in deprived communities, there should be a greater attempt to quantify this impact. If the bulk of the analysis is focussed on the population group without health inequalities across the combined geographies, those deprived communities may be at risk of being marginalised. Specifically, there should be some consideration of whether reconfiguration implies cutting workforce capacity, and how this might impact on disadvantaged people.
- The IHT is exploring mitigations in respect of the future use of St Helier Hospital and Epsom Hospital if they are not the selected option, as part of its ongoing work in developing the business case.
- It is not clear what specific impact there will be on reducing health inequalities in specific areas where there are higher reported levels of deprivation. It is important to note that a health improvement in the combined geographies may actually lead to a widening of the inequality gap depending on who receives the benefit. The PCBC should go into further detail about how health inequalities will be reduced and how the different options will interact with a diverse population spread across the combined geographies.
    - IHT has reiterated its commitment to addressing health inequalities through the new model of care by emphasising access to primary and community care and

	focusing on prevention. There is also a commitment 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.
Do the proposal ensure that services do not become less accessible to vulnerable groups? • The draft final IIA anticipates positive impacts for vulnerable groups through the reconfiguration and they are reported to be equally applicable to all 3 options for change. The IIA refers to 'disproportionate positive effects' for protected characteristic groups for a number of the anticipated benefits of the reconfiguration. The protected characteristic groups include children and young people; older people; people with a disability; gender assignment; pregnancy and maternity; race and ethnicity; sexual orientation; and people living in deprived areas. The IIA anticipates that all or some of these groups will benefit disproportionately from the impact on: 1. **Patient outcomes** due to their disproportionate or differential need/use of acute services. Improved outcomes are described as arising from better workforce standards and staffing levels; reduced variation in staff across shifts and days; higher levels of specialisation; co-location of services; and a model that allows for a critical mass of cases to be undertaken and provides opportunities for sub-specialisation. 2. **Patient experience.** For all options the long-term patient experience will be enhanced through "consistent and integrated pathways, reduced variation and fragmentation of services, as a benefit of consultant delivered care and as a result of access to services delivered from fit for purpose buildings". These longer-term benefits are seen as offsetting the medium-term adverse impact of patients having to access services which may look and feel different and unfamiliar from the current site layout [1]. 3. **Service delivery.** Across the options for change, developments have the potential to improve patient flow and will enable resources to be utilised more efficiently [1]. 4. **Accessibility of the district health service** due to protected groups' disproportionate or differential need/use of acute services. Across the options for change this impact will be achieved through providing "different defined points of access to urgent care and choice in modes of contact". It should also allow for both clearer signposting and more integrated and responsive district services [1].	• The IIA refers to vulnerable groups benefitting disproportionately from some of the anticipated benefits of the reconfiguration, but these conclusions appear to be generalisations. The benefits referred to are those arising from reconfiguration in general rather than specific options and it would be helpful to see more specific evidence about how each option impacts on specific vulnerable groups. It appears that the benefits of the proposals have been linked to people with protected characteristics and people who live in deprivation on the assumption that improvements will disproportionately benefit them, rather than considering the specific needs of these people. It would be helpful to have a clearer analysis of the evidence base for the assumptions around how the benefits affect vulnerable groups, particularly relating to the drivers for the inequalities they face. • It would be useful for the PCBC to go into further detail about why the positive effects anticipated for vulnerable groups apply equally to each of the three options for change. The location of acute services can have a profound impact on health inequalities, and as such, it would be appropriate to provide a separate impact assessment for each of the options. Alternatively, they could provide a plausible rationale for their assumption, i.e. why these are equally applicable. • Following publication of the interim IIA, the IIA Steering Group recommended that further engagement was carried out with specific community groups, i.e. Carers; Gypsies, Roma and Travellers; Those with a Learning Disability; and the LGBT+ Community. The IIA team was only able to carry out a focus group with people with Learning Disabilities, their carers and local advocates in Surrey Downs, and so further

5. **Health inequalities.** The draft final IIA states "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 help to reduced health inequalities" [1]. 6. **Physical accessibility of health services.** All 3 options will result in improved buildings that are fit for purpose [1]. The PCBC suggests that existing buildings in the district hospital sites will be refurbished as well as the construction of a new acute hospital [2]. The draft final IIA also anticipates some negative impacts of the reconfiguration: 1. Children and young people, and people living in deprived areas are likely to be disproportionally negatively affected by the impact on air pollution caused by changes in travel as patients travel to other hospitals outside the catchment area. The IIA states that "Depending on location, the delivery of acute services on a single hospital site will likely have an impact on air quality, with the Sutton Hospital option the only option to offer potential improvements." [1]. 2. Older people, people with a disability, pregnancy and maternity, race and ethnicity, and people living in deprived areas are likely to be disproportionally negatively affected by transportation costs and accessibility of services on a single site as they are more likely to struggle to afford and/or manage more complex journeys [1]. • The DMBC reports the consultation response about the importance of ensuring appropriate access for people with protected characteristics, deprived communities and vulnerable groups [20]. • It also reports the suggested enhancements reported in the final IIA around effective communication of transport options and the travel plan; supporting the development and capacity building of community transport options; building site specific transport offerings; and exploring the possibility of ensuring more personalised support to patients in promoting clarity around transport options. *<u>Do proposals ensure that unwarranted variations in outcome do not worsen?</u>* *<u>Do proposals set out specific, measurable goals for narrowing health inequalities and mechanisms for achieving this?</u>* • The PCBC reports a range of activities, initiatives and strategies that are already being undertaken to integrate services from hospital, community, social and primary care in the geography [2]. Planned changes to district services in the proposals that continue this	engagement with the other protected characteristics groups will be sought during the period of public consultation. • The statements and analysis in the IIA do not provide clarity on whether all of the options would have a worse impact on air quality than no service change. The Sutton Hospital option would offer better air quality for the areas around the other 2 sites but it is not clear whether air quality in the ESTH area as a whole would be better or worse than with no service change. • In the DMBC, the IHT reports a commitment to ensure that implementation plans around travel and access specifically address requirements and enhancements for protected characteristics groups, vulnerable groups and deprived communities so that meaningful action can be taken after a decision on the site is made. This is in response to concerns over access raised in the Consultation Report and recommendations made in the final IIA. • The health outcomes relating to these activities and how they might change are unspecified. There is little specific content about how the proposals will prevent ill-health and this also

work, are described in the draft final IIA as something that may lead to the further enhancement of local service offerings which "may in turn lead to improved health outcomes for those from deprived areas and bring about changes which help to reduced health inequalities" [1]. • The district health model that is already being implemented is described in the draft final IIA as something that can "creating a proactive focus on wellbeing and prevention and will help to target efforts to support patients to change behaviours linked to poor health outcomes" [1]. The PCBC states that district services will build on local priorities and strategies to increase access to local primary or community care, focus on prevention, manage patients with risk factors around diabetes or high blood pressure, and support behaviour change [2]. o Surrey Downs has been identified in the DIA as having a particularly rural, elderly population [9]. Members of the South West London & Surrey JHSC sub-committee for Improving Healthcare Together 2020-2030 have suggested that access to acute care services should be considered for aging populations in the more rural areas of the geographies [8]. o The draft final IIA highlighted potential solutions that the CCGs could take to lessen the impact on their local populations [1]. For travel and access, these included clear communication with people; raising awareness of transport options; ensuring sufficient parking capacity; continuously reviewing the service model; and introducing emergency transfer and handover protocols.	has relevance for the beds and social care tests. There is no analysis presented about how the options will prevent the inequality gap from increasing. There could be analysis presented to show how this has been considered and mitigated against. For example, if more deprived communities have worsening access to major acute services how will the options deal with this to ensure there is no negative effect on the health in deprived communities? This is particularly relevant where cost could become a barrier to access such as through more complicated or expensive transport costs. The PCBC often refers to the combined geographies. It should be noted that a net improvement in health across the combined geographies does not equal a decrease in the inequality gap. This could be measured separately and commented on. • The PCBC reports that overall the decision to choose a particular acute site will have a 'marginal impact' on access but community groups disagree with this. We understand that views from the public and community groups have been captured in a consultation analysis report which will be considered during the next stages of the development of the business case.
<u>Independent analysis from Siobhain McDonagh MP [10]</u> Siobhain McDonagh MP has reported the results of her analysis of a 1-mile radius surrounding each of the three proposed sites for the hospital catchment area's acute services. Ms McDonagh reports the following as evidence for retaining acute services at St Helier: • A higher proportion of people in "bad" or "very bad" health, higher A&E attendances, and higher demand for maternity services within a mile radius of St Helier, compared with the population living an equivalent distance from Sutton and Epsom. • 38% of the neighbourhoods within a mile of St Helier are considered to be in the 40% most deprived neighbourhoods for health across the country. In contrast, there are no such neighbourhoods an equivalent distance to Epsom Hospital and 13% of neighbourhoods are considered as deprived for health around Sutton. • The population of over 60s and dependent children is higher within a mile radius of St Helier than the equivalent distances around Sutton and Epsom Hospitals. Ms McDonagh states that children and elderly are most in need of quick and easy access to acute services	• Ms McDonagh's analysis reports that there is a greater proportion of deprived populations and people with protected characteristics around the St Helier site compared with the other 2 sites. The implication is that deprived populations and people with protected characteristics around the St Helier site will be disproportionately affected by the chosen option. This appears to contrast with the conclusion in the PCBC that areas of deprivation within Sutton and Merton will continue to have relatively easy access to major acute services, regardless of the chosen option. We cannot form a conclusion on which argument is likely to be correct without seeing more detailed evidence to support the conclusion in the PCBC.

• Ms McDonagh concludes that moving St Helier Hospital's acute services to Epsom or Sutton would be "moving them from a considerably more deprived area to a considerably less deprived area"	

Test 2: Hospital beds
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 scrutinised for credibility and to ensure these demographic factors have been fully taken into account. Any plans to close beds should also meet at least one of NHS England's newly introduced 'common sense' conditions.

Background	Commentary

Do the proposals maintain/increase current bed capacity?
 	
• All 3 options presented in the PCBC forecast a lower number of beds in the ESTH catchment area compared with the baseline for 2019/20. For Sutton the forecast number of beds is 1,002, for Epsom 848 and for St Helier 971.
• The modelling of the total number of beds required across the area for the 'no change option' predicts a net rise of 34 beds overall by 2025/26 from 1,048 under the baseline position to 1,082 in 5 years' time. Bed number forecasts are estimated by taking the baseline number and adding additional beds required to increase the capacity for community care provision (to enable the district hospital model); changes in the occupancy rate; growth in the numbers of private patients; and activity growth due to demographic factors. The calculation then subtracts assumed reductions in demand due to QIPP (Quality, Innovation, Productivity and Prevention)[3] efficiency and length of stay (LOS) improvements [2]. The following table shows how these figures are calculated in the PCBC, based on the assumption of achievement of the national target of 85% bed occupancy:
 	
Bed forecast for ESTH for 2025/26 assuming no service change
 	
Factor / **Beds**
Baseline (2019/20) / 1,048
Community and contingency sub-acute beds / +102
Occupancy rate change / +8
Private patient growth / +4
Demographic growth / +129
Reduction due to QIPP efficiency / -68
Reduction due to length of stay improvement / -141
Beds required by 2025/26 assuming no service change / 1,082
	• The 3 proposed options, aside from the 'no service change' option, do not maintain or increase bed numbers as they forecast a lower bed capacity by 2025/26 than the baseline of 2019/20.
	• Bed modelling in the PCBC indicates a net increase of 34 beds by 2025/26 compared to the baseline for the 'no service change option'. This includes growth in bed numbers due to demographic factors and the need for additional community beds to provide the district hospital model, but it also factors in anticipated reductions in beds through increased efficiency and improved lengths of stay as a result of the new model. This seems reasonable.
	• Without the anticipated efficiency savings expected from QIPP and length of stay, the number of beds required by 2025/26 would be 1,291. Little detail is provided on the efficiency savings in the PCBC:
	  ○ The QIPP savings are only referred to in vague terms, for example, demand management schemes are referenced but no detail of those schemes is provided.
	  ○ Length of stay improvement is estimated through benchmarking of the ESTH area with other comparative areas, i.e. the associated reduction in bed numbers relates simply to a target. No detail is provided of how that target will be reached.
	  ○ IHT has informally provided the GLA with more detailed analysis on the anticipated lengths of stay improvement and this analysis should be provided in future business case publications.

[3] QIPP – Quality, Innovation, Productivity and Prevention – is a large scale transformational programme for the NHS that began in 2010. It was designed to improve the quality of care the NHS delivers while making efficiency savings to be reinvested in frontline care. https://webarchive.nationalarchives.gov.uk/20130104162058/http://www.dh.gov.uk/health/category/policy-areas/nhs/quality/qipp/

• The predicted need for more beds is offset by forecasts of reductions in beds driven by QIPP efficiencies (68 beds) and reductions in lengths of stay (LOS) (141 beds) [2].
  • In response to consultation concerns, the DMBC provided further detail on the estimates of the potential benefits associated with out of hospital initiatives [20].
• If no changes are made, a slight increase in required bed capacity is projected for ESTH from the current 1,048 beds to 1,082 in 25/26.
	• The 'overall systems impact' estimates for the out of hospital and community initiatives described in Test 4, do not include any estimate of impact of lengths of stay, which is a key component of the estimated ability to reduce beds in the ESTH area by 2025/26.
	• The PCBC refers to modelling that has been done around demographic forecasts but there are no details provided. The length of stay efficiency measures are derived from benchmarking data rather than specific proposals for how length of stay issues can be addressed. It would be helpful to see more detailed evidence of how reductions in lengths of stay will be achieved.
	  • As part of the further detail on the out of hospital initiatives, more detail has been provided on the potential for reductions in lengths of stay through these initiatives.

<u>Does revised bed modelling take full account of the latest demographic projections?</u>
 	
• Demographic forecasts for demand for healthcare project that 129 additional beds will be required by 2025/26 [2]. The Joint Clinical Senate Review recommended more planning clarity and detail on the expected demographic changes, for the catchment population of each shortlisted option to be clearly stated, and for the analysis to be extended to 2030 [11]. The Joint Clinical Senate Review also requested the inclusion of birth rate ranges in the context of modelling future maternity bed requirements [11]. The bed modelling projections only go as far as 2025/26 and it is not clear whether birth rate ranges have been included.
  • The DMBC reported that bed-modelling estimates have been extended to 2029/30 in line with the recommendation of the Joint Clinical Senate Review [20]. This has showed a further 14 beds estimated to be needed for the area population by 2029/30.
• For the 3 options presented, different numbers of beds are required depending on the outflow and inflow of patients from other areas. What this means is that whichever option is chosen, some people in the ESTH area will opt to attend hospital outside the ESTH area, and some people outside the ESTH area will opt to attend the new acute site. This may be because they prefer to attend another site or another site is more convenient. The following table shows the PCBC estimates of bed numbers under each of the options:
	• We cannot conclude on whether or not the bed modelling takes account of the latest demographic projections without further clarity and detail, as recommended by the Joint Clinical Senate Review.
	  • IHT extended bed modelling to 2029/30, as requested by the Joint Clinical Senate. Provision of further detail by IHT on the impact of out of hospital initiatives on beds and metrics such as average length of stay has provided further assurance of the bed modelling estimates.
	• It would be helpful for a list of detailed assumptions to be provided about the way in which the anticipated efficiencies will be achieved. This should include scenario and sensitivity analysis that has been carried out and some additional modelling to measure probability assumptions and uncertainty. For example, what are the community health workforce assumptions to achieve these efficiencies? What is the probability that these workforce assumptions are correct? Will they be affected by external factors such as immigration changes following Brexit?

Bed modelling estimates for the ESTH area for the 3 options

	Epsom	St Helier	Sutton
Baseline (no service change)	1,082	1,082	1,082
LOS improvement through redevelopment	-30	-30	-30
Outflow to other providers	-242	-81	-119
Inflow from other providers	+37	0	+69
Total beds required (2025/26)	848	971	1,002

- For all 3 options, the number of beds required is projected to be lower than the no service change counterfactual, due to additional relocation efficiencies of another 30 beds [2]. As with the other efficiency estimates, it is not clear on what basis this estimate is derived.
- Each option allows for 1,052 beds but for all 3 options there is a net outflow of beds to providers other than ESTH. This involves some outflow and inflow of beds to and from other providers due to changes in catchment areas for major acute services. This is because when acute services are reconfigured, there are changes in catchment areas for acute trusts resulting in more or fewer beds being required in a particular area. Local provider assessments have been undertaken that include the potential impact of the required inflow of beds to other local hospitals. Options that result in patient inflows would require capital investment for the impacted Trusts.
    - Sutton option: 1,002 beds provided in the ESTH area. £39m capital investment required by other providers receiving in-flowing patients.
    - Epsom option: 848 beds provided in the ESTH area. £174m capital investment required by other providers receiving in-flowing patients.
    - St Helier option: 971 beds provided in the ESTH area. £44m capital investment required by other providers receiving in-flowing patients.

- The Sutton option results in the fewest beds outflowing to other providers and the highest number of beds remaining within the ESTH area.
- The draft final IIA identifies the Epsom option as resulting in the greatest level of outflow to neighbouring providers, with a particular impact on St Georges Hospital (estimated additional 10,200 A&E attendances and an additional 108 beds by 2025/26) and Croydon

Does this consider seasonal events such as ward shut-downs from influenza?

- The draft final IIA notes that there are risks that neighbouring providers may not be able to accommodate expected additional activity. It is not clear whether this risk has been considered in the modelling for the 3 options or what the implications of this would be. There is no discussion of the mitigation strategy for these risks and whether there are greater risks depending on the short-listed option selected.
    - In the DMBC, IHT committed to working to review and test assumptions made about the impact on other providers as part of the implementation of the plans, if they are accepted.

- The draft final IIA has raised concerns about risks to the quality of safety and patient care if the preferred site faces higher activity than anticipated. The PCBC does not outline any measures of uncertainty or sensitivity analysis that

University Hospital (estimated additional 7,200 A&E attendances and an additional 105 beds by 2025/26) [1].
• St. Helier and Sutton hospitals see a smaller number of outflows, with greater impact at sites such as St Peters and Kingston Hospitals [1].
  • The DMBC reported concerns raised in the formal consultation about the impact of the new model of care on other providers [20]. Provider responses during consultation confirmed previous analysis that all options are deliverable.
 	
• The draft final IIA identifies potential risks to the quality and safety of patient care associated with the capacity of services at the chosen major acute site. Patients may not be able to "step down" to the district hospital and so tie up acute beds, or may choose to access urgent treatment centres or emergency departments at the major acute hospital when the district hospital is more suitable to their needs [1]. The Joint Clinical Senate Review states that steps to anticipate and avoid the risk of increased LOS arising from transfers of care between the acute hospital and the district hospital should be taken and clearly described [11].
  • The DMBC provides more detail on the proposed mitigation on the risk of excess activity which focuses on the provision of 40 contingency beds; using mothballed capacity at district hospital sites; creating additional capacity at the SECH if required; and refining and enhancing the out of hospital model.
• The Joint Clinical Senate Review identified issues around demographic change and activity and bed modelling to be one of the key themes in their report [11]. They have recommended:
  ○ that the modelling distinguishes between the LOS reductions that would occur in acute beds and district hospital beds separately.
  ○ clarity on the methodology and assumptions of how the ratio of acute to district hospital beds has been arrived at, specifically projections of the number of step up, step down and direct admission to the district hospital beds.
  ○ providing more specific modelling for the impact of community-based care and community beds on the district hospital bed numbers required.
  ○ that required future paediatric bed capacity is disaggregated from the adult bed requirements and the impact on increased activity on neighbouring trusts in terms of paediatric beds and ED made clearer.
  ○ a review of projections for future ED activity, including more detail as to what proportion of the projected reduction comes from shifting attendance to an urgent care centre as opposed to demand reduction.
  ○ clarification over the reason for the disparity between elective and non-elective activity and beds across the four options.
	have been carried out to test the assumptions about the numbers of acute and community beds required under the district hospital model.
	  • The DMBC has addressed the concerns about how problems caused by higher than anticipated activity would be mitigated.
	
	• It is not apparent that the recommendations from the Joint Clinical Senate Review have been taken into account. It would be helpful for the PCBC to clarify whether the recommendations have been adopted and if not, for what reason.

• The Joint Clinical Senate Review also suggests the consideration of evidence from Northumbria, which has a similar model of district hospital beds off site from the acute hospital. The Review notes that an analysis of the first year of Northumbria implementation showed an increase in A&E attendances, and an uncertain impact on admissions and lengths of stay [11]. The Review suggests there should be careful application and drawing of conclusions from the developments in Northumbria when included in the PCBC Siobhain McDonagh MP has stated her constituents will use acute services at St George's and Croydon hospitals if these services are moved from St Helier to either Sutton or Epsom. She states this is a particular concern as St George's has recently been under a CQC warning notice and has relied on St Helier to act as a "safety valve" when under pressure [10].	• IHT analysis of the Northumbria model has been carried out, although it is not included in the PCBC. This analysis should be provided in future business case publications.
<u>Do any proposed bed closures meet at least one NHSE common sense condition?</u> • The PCBC states that, where appropriate, service change which proposes plans significantly to reduce hospital bed numbers should meet NHS England's test for proposed bed closures and commissioners should be able to evidence that they can meet one of the following three conditions: o Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and the new workforce will be there to deliver it; and/or o Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or o Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting It Right First Time programme) • The PCBC states that for all options the bed provision will be increased across the system and that out of hospital initiatives such as Surrey Downs Health and Care will reduce pressure on beds [2]. As a result, it does not refer to how any of the conditions for bed closure will be met.	• The PCBC does not engage with any of the common sense checks because it does not consider that there is a loss of beds for any of the options. This is based on the premise that the net number of beds rises to 1,082 (from the 1,048 baseline number of beds for 2019/20) for the 'no service change' option, and for each of the 3 options there is then an additional 'efficiency saving' of 30 beds, resulting in 1,052 beds for each option. This would equate to a small net rise in beds from the baseline number of beds. It does not, however, factor in the reality of the net outflow of beds to other areas which is reported in the bed modelling estimates. The PCBC should justify why it has not included net outflow in its calculations or provide detail of how it meets at least one common sense condition for proposed bed closures.
<u>Have proposals used the NHS bed capacity modelling tool?</u>	• We cannot find any reference to the use of the NHS England bed capacity modelling tool, or any detailed information about any other modelling methodology in the PCBC.

Test 3: Financial investment and savings
Sufficient funding is identified (both capital and revenue) and available to deliver all aspects of plans including moving resources from hospital to primary and community care and investing in prevention work. Proposals to close the projected funding gap, including planned efficiency savings, are credible.

Background	Commentary
Are plans to make efficiency savings sufficiently detailed and credible?	

• The PCBC states that by 2025/26, Epsom and St Helier (the current main acute provider) may need around £23m of additional funding above that which is likely to be available, based on no change to current services [2]. Financial sustainability is an important part of the case for change.
• The estimated financial benefits of the 3 options, compared to the baseline of no change to current services, are:
  ○ Epsom: £32.9m
  ○ St Helier: £39.1m
  ○ Sutton: £49.1m
• The clinical model for the reconfiguration (i.e. the out-of-hospital model) drives the financial benefits for the 3 options. The benefits measured include some specific aspects such as reduced workforce turnover; avoided adverse events; and reduced staffing levels through consolidation. Other benefits described are more general, such as use of technology or other economies of scale.
• The PCBC states:
"The changes in … medical staffing associated with consolidation of acute services to care for the sickest patients on a single acute site could result in reduced workforce costs, particularly thorough the avoidance of the increased cost of meeting clinical standards that a single consolidated acute site allows. Additional savings may be had in the Sutton option where urgent treatment centres savings are adjusted for the three-site model" [2].
• The reduction in medical staff costs through consolidation is the largest element of the savings associated with all 3 options. For consultants, the financial savings for all 3 options would be £11.3m. For junior doctors, the savings are as follows:
  ○ Epsom: £5.8m
  ○ St Helier: £6.4m
  ○ Sutton: £6.6m
	• The efficiency savings plans are broken down into different categories but there are no details of how the individual savings lines are calculated. This makes it hard to judge whether they are credible.
	• Some aspects of the efficiency savings plans are not described in detail. For instance, one line refers to 'use of technology' but there is no description of what technology will be used or how it will generate efficiency savings.
	  • There were no further substantive changes to proposals for funding and efficiency savings in the DMBC. IHT committed to reconfirm that funding is available for the implementation of the SECH and will continue to seek appropriate assurance from the Government to ensure commitments are honoured.
	• The expectation that the largest component of cost savings will be generated through the consolidation of medical staffing by providing a single acute site appears to be reasonable. Staff make up around 70% of NHS costs and the consolidation of acute services would be expected to reduce medical staff costs.

Have plans secured capital and revenue investment to deliver in full, and are the sources of funding credible?
 	
• The PCBC states that a large capital investment in the hospital sites is required to deliver the benefits expected for all 3 options. This is capital investment after accounting for financing already secured (including existing loans and sales of surplus land) [2].
  ○ No service change - £225m
  ○ Epsom - £292m
  ○ St Helier – £386m
  ○ Sutton - £472m
• These include the costs required for new buildings and any refurbishment needed, across all relevant sites.
• These costs were calculated by expert estates advisors based on best practice and relevant standards and guidance (e.g. DHSC Health Premises Cost Guides).
• The PCBC states that additional funding has been made available to support the system through a 'sustainability and transformation fund', which aims to help local health economies transform and return hospitals to financial balance. It also highlights the 2017 Autumn Budget, which announced £6.3bn of new funding for the NHS in England, including £3.5bn of capital investment by 2022/23 [12]. It is not clear how much funding has been made available for the reconfiguration from either source,
• The PCBC describes an initial appraisal of potential financing sources, which considered advantages and disadvantages as well as testing the affordability of a short list of potential financing scenarios. The main financing scenario explored, as the preferred financing route, was drawing on public dividend capital (PDC), based the concept that this is simple, affordable and available, in comparison with other options.
• As an alternative, should public financing routes be unavailable, the PCBC also considered a mixed financing approach. This would draw on a number of sources, including leveraging local authority (LA) financing; energy efficiency financing; land receipts and internal financing; and charitable donations. The PCBC claims that initial analysis suggests that all financing scenarios can help to drive a positive income and expenditure for the options.
• The PCBC considers that other potential sources of capital are not likely to make a large contribution to capital requirements. Examples given include energy efficiency schemes, land receipts, charitable donations and NHS Digital sources [2].
 	
• The PCBC includes details of the financial analysis that was conducted. This includes estimates of activity, capital investment required, financing (including income and expenditure and any loan requirements), and the return on investment (ROI) and net present value (NPV) for the system.
• The table below shows the ROI and NPV by 2025/26 for the different options:
	• Robust methods appear to have been used to calculate the estimates of the capital investment required and these are set out in the PCBC.
	• The approach taken to exploring the financing options is less transparent, with no detail on how the preferred option was arrived at. The potential source of finance (PDC), as well as the alternative (local authority financing) may not be available following the Covid-19 crisis, so these options will need to be reconsidered in any case.
	• It is not clear whether the any of the capital commitments are accounted for in the Government's announcements on capital funding for the NHS more broadly, or whether all of the funding will need to be found from borrowing.
	
	• The key financial measures used, NPV and ROI, are consistent with advice in the HM Government Green Book. The recommendation of the Sutton option is consistent with the methods used, as it had the highest NPV. This option does, however, have the highest capital cost so there is

	No change	Epsom	St Helier	Sutton
ROI	-	5.3%	7.4%	7.3%
NPV (£m)	50	354	487	584

Do plans include increased investment in primary and community care, including moving resources from acute care where appropriate?

- The PCBC includes an affordability analysis showing the workings for anticipated changes in community and acute spend under the Sutton option only. This shows the nominal amounts of indicative spend in each sector.
- The PCBC states ESTH considers that the revenue costs of the service transition are likely to be affordable within existing plans. As such, ESTH does not expect that additional revenue funding will be required to finance the transition of services into the new clinical model. ESTH will ensure that finances across the health system are re-organised to ensure that these costs are funded.

Do plans include specific, increased investment in the prevention of ill health?

- The PCBC highlights plans to enhance prevention in Surrey Downs, Sutton and Merton, as preventable ill-health accounts for an estimated 50% of all GP appointments, 64% of outpatient appointments and 70% of all inpatient bed days. For example, there are plans to enhance social prescribing and to implement immunisation and vaccination programmes but it is not clear whether these plans are part of the reconfiguration or other initiatives within the CCGs.

some risk associated with this option, but a detailed sensitivity analysis was applied to the financial modelling to test the robustness of the NPV. The estimated ranges for the NPVs should be presented in the PCBC.

- The PCBC does not show the affordability analysis for options other than Sutton. This additional detail would aid transparency.
- The PCBC is uncertain about how much recurrent money will be provided to the NHS between 2021 and 2026, and so has assumed that current trends are likely to continue. Financial forecasts could, therefore, change if the government makes significant changes to the way that the NHS is funded in the future, particularly following the Covid-19 crisis. Funding for the reorganisation will, therefore, need to be reconsidered before it is started to ensure that the agreed financing options remain the best and is still viable. This will need to include consideration of how revenue is apportioned between the various services and sectors in the new model.
  - The DMBC acknowledged the concerns raised during consultation about the ongoing impact of Covid-19 and considered the implications for the new model of care. It will be important that these considerations are kept in mind when the new model is implemented, if the plans are approved.

- The PCBC does not describe prevention plans in detail but just states that plans are in place. It would be helpful to have a more detailed breakdown of the investment in those plans and on what basis the benefits are expected. It would also be helpful to know if these are ongoing programmes or whether they are new.

Test 4: Social care impact
The proposals take into account a) the full financial impacts on local authority services (including social care) of new models of healthcare, and b) the funding challenges they are already facing. Sufficient investment is available from Government to support the added burden on local authorities and primary care.

Background	Commentary

Do plans include a full and credible assessment of the financial impact on social and community care?
 	
• The clinical model described in the PCBC is based around a district hospital model of locality-based care. This means that major acute services are reserved for the most unwell patients. Other services can be co-ordinated by district and non-acute hospitals. These services, which are designed around keeping people well, maintaining their independence and avoiding the need for hospital treatment are delivered by community and social care teams [2]. They are integral to the estimates of the number of beds required for the proposed options, because they are made using assumptions about reductions in lengths of stay and other efficiencies driven by social and community care initiatives (Test 2).
• The PCBC describes a range of activities, initiatives and strategies that are already being undertaken to integrate services in the geography, independently of current proposals. These reflect alignment with the NHS 5-Year Forward View, the NHS Long Term Plan, the priorities of the South West London and Surrey Heartlands STPs, and the strategies of individual CCGs [2].
• The PCBC reports the impact of existing individual integrated care schemes in terms of fewer admissions, reduced length of stay, reduced A&E attendance, and improved patient experiences for each CCG [2]. These impacts are extrapolated to show what the expected impact on the system will be by 2025/26 in terms of percentage changes in elective and non-elective hospital admissions, outpatient appointments and A&E visits, but not in terms of lengths of stay.
• Some examples of key achievements for current initiatives are reported, such as:
  ○ the removal of all escalation beds in ESTH due to improvements in lengths of stay, avoidable admissions and accelerated discharge
  ○ c.30% reduction in stranded and super stranded patients across ESTH [2].
• The Joint Clinical Senate Review recommended that the proposals should "provide more confidence in the timeline for the impact of new community care initiatives on demand [11].", i.e. demonstrate the effect of those initiatives on health care demand and activity and when this will happen. The Review further states that capacity of community-based services is a key consideration and adequate funding and workforce will be required to ensure this.
	• The PCBC does not included detailed information on the impact of the proposals on any of the organisations providing health and social care services outside of acute hospitals in the area, i.e. primary care; adult social care; mental health services; and community services.
	• The proposals only describe a continuation and consolidation of existing measures to integrate services and provide "out of hospital care". It would be helpful for more detail to be shown on how the integration of care outside hospital will result in the reduced number of hospital beds required under the chosen options. Bed number estimates are based on the premise of efficiency savings (such as reduced length of stay) but there is no clear link between the benefits derived from the out of hospital initiatives and those efficiency savings.
	• The PCBC only presents limited data on the impact of out of hospital initiatives. It presents a small number of initiatives in the form of case studies, such as a description of the impact of Surrey Downs Health and Care on A&E attendances and lengths of stay. But these are only provided as examples and there is no detail provided on how the impact of out of hospital initiatives specifically supports the district hospital model. It would be helpful to demonstrate specific detail on how these initiatives contribute to the improvements in lengths of stay and other measures that support the district hospital model.
	• There is more detail in the Clinical Model section of the PCBC on how integrated care initiatives are expected to benefit the health system. However, there is no clear

• The PCBC outline of the clinical model also proposes the district hospital model will be further developed to provide district hospital beds to support people who do not require acute 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 [2]. • As currently happens at ESTH, under the new model social care will be part of multi-disciplinary care at district sites, for effective planning for hospital discharges and to speed up transfers of care. The PCBC states that it is expected that by the time the clinical model comes into effect the collaboration between health and care services "will have been further enhanced and well established" [2]. • Integration of care was one of the non-financial aspects that the 3 proposed options for reconfiguration were scored against during the options consultation process. The PCBC states that it was expected that there would be little difference between the scores for the different options, as integration of care is taking place outside the hospital setting and is not site dependent. The Sutton option scored the highest (6.74 out of 10), with Epsom and St Helier both scoring slightly less 6.17. The no service change changed scored the lowest with 5.30. *<u>Does this assessment take account of future demographic changes, especially an ageing population?</u>* • The overall financial model in the PCBC considers demographic changes and growth in the older population, but there are no detailed calculations to show how demographic factors are taken into account in considering the impact on community and social care. • The PCBC states that demographic changes, such as an ageing population, and associated increase in demand for hospital services will be off-set by efficiencies in the community keeping people out of hospital. The PCBC notes that this approach is consistent with current shifts towards more integrated care and more efficient use of district hospitals. *<u>Does this assessment take account of the impact of new social care provision and funding models set out in the adult social care green paper?</u>* • There are few detailed references to social care in the PCBC. Where social care is mentioned, it is referred to in general terms, for example, Section 1.5.4 refers to the importance of social care, its integration with health services and provides some high-level	calculation to show how the reported benefits of these initiatives contribute to the 'overall systems impact'. • The 'overall systems impact' estimates do not include any estimate of impact of lengths of stay, which is a key component of the estimated ability to reduce beds in the area by 2025/26. • There were no further substantive changes reported in the DMBC in relation to the social care impact of the planned reconfiguration. IHT acknowledged that additional work may need to be undertaken in partnership with local authorities and the Trust to appraise the additional services to best serve local community health needs as the plans are implemented, if they are approved. • The PCBC should include a commentary on what may happen if the strategies of the STP or individual CCGs do not progress as expected. This could create increased demand for hospital services that are then pushed back to the community. • Although the draft final IIA has considered the impact for all ages, much of the evidence cited in the PCBC is specific to over 65s. This may be relevant evidence for areas with older populations within the geography but may not be valid when applied to areas with younger populations. This is particularly relevant for the younger, more ethnically diverse and more deprived population of east Merton. • There is no detail in the PCBC about potential challenges to service integration that may impact on how successfully these initiatives can reduce the need for acute care. The

examples of initiatives in the area. There are no details provided of how the proposed reconfiguration will impact on these initiatives or how they will assist with the reconfiguration.	cuts to local authority budgets in the last decade have resulted in reduced spending on social care services by councils whilst demand increases. It is unlikely that funding issues will be resolved in the short-term. The expected government green paper on adult social care is yet to be published and it has been reported it will be scrapped [13]. Moreover, the 2020 budget has been criticised by the social care sector for not addressing social care [14]. The potential risk of lack of investment in out of hospital initiatives seems inconsistent with the PCBC vision that increasing demand for provision of hospital services will be met through increased service provision in the community. • Linked to the point above, the social care workforce challenge (high vacancy rates and turnovers in social care roles. which are higher in London than nationally) is only mentioned in the introduction section of the PCBC and the impact on the proposed model is not explored.
<u>Are there credible, funded, joint NHS/LA plans to meet any additional costs?</u> • The PCBC states that as the out of hospital schemes are already being delivered and the demand is being met, no additional incremental capital is required to support them. Further developments will be managed "within existing capacity or are covered by separate business cases". [2]	• As has been stated in other sub-questions for this test, there is no detail in the PCBC on the sources of funding for expansion of out of hospital and integrated care initiatives.
<u>Do plans fit with local health and wellbeing board strategies?</u> • There are no explicit references to health and wellbeing board strategies in the PCBC. Out of hospital schemes are referred to as a mechanism for helping to reduce acute care bed numbers, but there is no reference to how the reconfiguration fits with health and wellbeing board strategies.	• The out of hospital and community initiatives described in the PCBC are largely independent of the reconfiguration process, i.e. they would have been happening anyway regardless of these plans. It is implicit, but not clearly stated, that out of hospital schemes are part of health and wellbeing board strategies and it would be helpful for that point to be made in the PCBC.

Test 5: Clinical support The proposals demonstrate widespread clinical engagement and support, including from frontline staff.	
Background	**Commentary**

Do plans include a demonstrable, robust clinical case for change, including an improvement in both quality of care and outcomes?
 	
• The clinical case for change is based on the vision for future healthcare based on the principles of preventing illness, integrating care and ensuring high quality major acute services [2]. The barriers to achieving the vision are workforce shortfalls, which hinder the ability to deliver clinical quality; acute care buildings that need to be upgraded; and the need to achieve financial sustainability.
• To address the issue of clinical quality, the clinical model is described in the PCBC as a district hospital model of locality-based care [2]. This consists of a "community-facing, proactive health, wellness and rehabilitation service" for people with lower levels of health acuity, centred around prevention and the provision of services via community and social care and district hospitals. This is combined with a single site where major acute services are co-located. The integration of out of hospital care is essential to the model. The vision for the clinical model is "to ensure the very best quality of care is available to our populations…".
• 3 main clinical benefits of the proposed clinical model, affecting quality of care and outcomes, are described:
  • Improved patient experience, leading to improved patient satisfaction and a reduced number of complaints
  • Improved patient access, leading to meeting NHS Constitution targets and improved support for patients with mental health co-morbidities
  • Decreasing unwarranted variation in quality, safety and outcomes leading to reduced mortality and morbidity rates and reduced lengths of stay.
• The DMBC highlighted issues raised in the formal consultation about specialisation and centralisation in the new clinical model, and how there may be a lack of evidence of improved outcomes [20]. As a result the Clinical Advisory Group (CAG) reviewed the benefits of centralisation. The review suggested that there was a positive correlation between consolidation of some services on to a single site and the sub-specialisation of some elective services with improved patient outcomes. The DMBC also reported the CAG's reiteration of the view that co-location of services leads to benefits across a range of services.
• In the light of concerns expressed in the formal consultation about how patients would know whether to access district sites or the SECH, the CAG carried out further analysis. This showed that people in the catchment area have a good understanding of the role of
	• The proposals clearly set out the clinical model, with some high-level clinical benefits along with more detailed analysis of how the model is expected to improve patient experience and access and reduce unwarranted variation. It will be important to ensure that, as the plans are implemented, the expected clinical benefits and outcomes are closely and robustly linked to the practical changes in the clinical model detailed in the outline business case.
	• In response to consultation concerns about the likelihood of benefits accruing from the centralised model of care, IHT has emphasised the need to incorporate the latest evidence to maximise the advantages of the clinical model and mitigate any risks, but they have not said how this will be done.
	• The DMBC also emphasised the importance of a robust engagement and communications plan in the implementation phase to ensure people are directed to access care in appropriate settings.
	• The DMBC reported that workforce implementation plans will be important to ensure there are sufficient generalists and specialists to meet standards at both the SECH and district hospitals. IHT will work with Health Education England, Royal Colleges, local clinicians and stakeholders to develop these plans.

urgent treatment centres (UTCs) and that lessons from other areas that have implemented a similar model of care will be considered to direct people to appropriate care settings. • The CAG reviewed the workforce model in response to concerns raised during the formal consultation about the availability of staffing. The CAG has reiterated its view that the sustainable workforce model designed to underpin the clinical model will promote better outcomes for patients, for example through greater specialisation, and will also promote efficient delivery of care through achievement of workforce standards. *Do plans have the support of local primary and secondary care clinicians, including but not limited to those whose services/patients will be directly affected?* • The clinical model was developed with oversight from a Clinical Advisory Group which was made up of the chairs of the CCGs and local GPs, although there were various sub-groups set up to consider secondary care issues. • The Consultation Report states that 81% of NHS staff surveyed viewed the proposal for the new model of care as a good or very good solution for people living in the CCG areas, and only 10% viewed it as being poor or very poor [15]. • 77% of NHS employees felt that building the new specialist emergency care hospital on the Sutton site would be a good or very good solution, with 13% feeling it would be a poor or very poor solution. • Most staff were supportive of the proposed model of care, irrespective of where they live, but there was slightly lower support amongst staff who live in Merton CCG area. *Do plans have the support of pan-London clinical bodies – Londonwide LMCs, London Clinical Senate?* • The Joint Clinical Senate for London and the South East reviewed the clinical aspects of the PCBC, focusing primarily on urgent and emergency care, paediatrics, maternity and planned care [11]. • The Joint Clinical Senate stated that the proposals outline "an innovative model for reconfiguration, where very careful planning, and anticipation of the challenges to ensuring safe and high-quality care, is required prior to implementation". The review made 94 recommendations, many of which relate to the District Hospitals and the patient pathways into and out of them. The overall conclusion of the review was that while there were strong arguments to centralise services to one acute site, the proposals "raise a number of issues about admission criteria, clinical competencies required, and clinical pathways for more acutely ill patients, at the District Hospitals. These need to be considered in more detail to ensure that safety and quality of care would be maintained."	• The clinical model will need to be carefully developed and well-articulated throughout the next stages of planning, should the proposals be agreed. • Note that the London Clinical Senate is an independent body within NHS England. They support the development of London's health and care services by providing independent, strategic advice to commissioners and help them make the best decisions about the populations they serve. The Senate's advice is independent, impartial and informed by the best available evidence [4].

• The PCBC reports that the recommendations made by the Joint Clinical Senate were considered and addressed by IHT's Clinical Advisory Group in designing the version of the clinical model reported in the PCBC. • There is no reference to Londonwide local medical committees in any of the proposal documentation. • The DMBC reported consultation responses which stressed the importance placed on ensuring the continuity of carer model for pregnancy is implemented as part of the new model of care [20].	• IHT has reiterated its commitment to implementing the continuity of carer model for pregnancy through the Team Continuity approach, as part of the new model of care.
Do plans have the support of local authority social care and other professionals? • The Consultation Report does not report responses specifically from local authority social care and other professionals [15]. Written responses to the consultation were provided by local authorities but there are no substantive references to social care.	• It is not clear whether the proposals are supported by local authority social care and other professionals. Views of these stakeholders should be sought as the IHT further develop and implement the clinical model and proposed changes.

Test 6: Patient and public engagement The proposals demonstrate credible, widespread, ongoing, iterative patient and public engagement, including with marginalised groups, in line with Healthwatch recommendations.	
Background	**Commentary**
Did patients/the public/the local Healthwatch influence proposals before they were published for formal public consultation? • The PCBC describes the pre-consultation engagement with local residents, patients, carers and groups of people with protected characteristics [2]. The process was informed by the Consultation Institute and involved a Stakeholder Group (consisting of the voluntary and community sector, patient, carer and equality groups) and Merton, Sutton and Surrey Downs Healthwatch. Engagement tools and materials were developed and used in a series of engagement activities between June and October 2018. • Views were sought from 'seldom-heard' groups of people with protected characteristics including older people (>65); the BAME community; people with learning difficulties and physical impairments; people in poor mental health; the LGBT+ community; carers; children and young people; the Gypsy, Roma and Traveller community; pregnancy and maternity; and deprived communities. • Views were fed into the proposals including the development of the clinical model and the non-financial options consideration process. This process consisted of pre-consultation engagement to capture public priorities, followed by 3 workshop groups including clinicians, members of the public and professionals. The first workshop group agreed a set of 16 non-financial criteria. The second workshop group agreed a set of weightings for the non-financial criteria. The third workshop group scored the four options against non-financial criteria, 'blinded' to the weightings set by the second group, i.e. they were not aware of the weightings when carrying out their scoring. The proposals presented for consultation included 3 options for the site for the SECH and indicated the preferred option.	• The process of pre-consultation appears to have been carried out appropriately with sufficient engagement and the involvement of groups with protected characteristics. • Patients/ the public and Healthwatch were involved in the non-financial options consideration. The PCBC does not describe how the non-financial criteria were established (e.g. was every issue raised developed into a criterion?), the way in which weightings were applied to the criteria, or the way criteria were scored based on responses from people in the workshops. Transparency on these processes may provide greater assurance on the approach taken.
Did patients/the public/the local Healthwatch advise on the consultation plan? • A detailed Consultation Plan was published by IHT on 7 January 2020 [16]. The Plan describes the consultation aims and objectives, approach and principles, as well as the consultation process and methods. • A stakeholder analysis was carried out to identify specific groups to be consulted including traditionally under-represented or seldom-heard groups. The Consultation Plan includes a detailed description of how the plan was developed through pre-consultation engagement. This describes the Stakeholder Reference Group (SRG) which was set up to reach out to community members. The SRG provided advice, direction and assurance to the	• Patients, the public and Healthwatch were well represented on the advisory process for the development of the Consultation Plan.

programme on the engagement plan and co-designed and assured the engagement strategy. The plan also describes the Consultation Oversight Group (COG) which was set up to ensure seldom heard and marginalised communities were supported to participate in the consultation process and partners from the combined geographies. The COG comprised representation from Merton, Sutton and Surrey Healthwatch, and other voluntary sector organisations, representing a number of protected characteristic and equalities groups across the CCG geographies. The COG made suggestions, offered advice and looked for evidence of compliance with good practice consultation principles set out in the IHT consultation plan. • Healthwatch was asked by IHT to conduct discussion events around the proposals and supported the consultation in this way. *Did proposals set out sufficient, easily understandable information about, and reasons for the proposals to enable an informed response?* • The full Consultation document provided a summary of the proposals in an accessible format. The document includes references and links to the PCBC, the Deprivation Impact Analysis and the Integrated Impact Assessment [17]. • This background briefing has referred to a lack of detail in regard to the specific *impact* of the proposals on health inequalities (Test 1) and the calculations of estimated hospital beds under the proposed options (Test 2). *Was the formal consultation well-publicised throughout the geographical and other communities in which affected people live, work and spend their time?* • The formal consultation was promoted through a public launch, press releases, advertorials, the IHT website, and door-to-door leafleting across the 3 CCGs and wider catchment area. Paper copies of the Consultation document were provided in public places such as GP surgeries, pharmacies and libraries. Copies of the consultation materials were made available in accessible formats and in the 3 most common other languages (Tamil, Urdu, Polish). • Listening events and other public meetings were held in a targeted way to try to access the views of people with protected characteristics, in response to findings reported in the DIA and IIA. *Were local networks used to promote engagement?* • Local and community organisations were used to identify protected characteristic groups and hard to reach communities. The organisations included residents' associations, groups involving people with various disabilities, long term conditions or learning	• The full Consultation document presents a fair and accessible representation of the reconfiguration proposals. Additional detail has been provided on the impact of the proposals on health inequalities and hospital beds in the DMBC. • The consultation was well publicised and made widely available to people in a wide range of formats. The consultation was made available in 3 languages other than English and there was a Browsealoud support tool on the IHT website which reads aloud, magnifies and translates all consultation website content. This was aimed at people where English is a secondary language or people with a visual impairment or learning disability.

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 low-income communities; homeless people; housebound people; migrants, refugees, asylum seekers; and Gypsy, Roma and Travellers.
 	
Was the consultation available via a range of mediums including online and hard copy?
 	
• Copies of the consultation could be requested in large print, easy read or in the 3 most common other languages including Tamil, Urdu and Polish. 3,000 copies of the questionnaire and summary document in Tamil were distributed to MPs in Sutton to share with their local Tamil community. The vast majority of respondents – regardless of their ethnicity – chose to respond in English. 2 responses to the consultation questionnaire were received in Tamil and Urdu and were translated and included in the feedback.
 	
Was it possible to comment verbally via telephone and face to face meetings, as well as in writing?
 	
• The consultation methods used were:
  • A structured open consultation questionnaire
  • A telephone residents survey
  • A series of focus groups and in-depth 1:1 interviews with people with specific protected characteristics
  • A series of larger deliberative forums with a randomly selected cross-section of the general public
  • Public listening and mobile roadshows designed to reach out to the wider public as well as hard to reach and deprived communities
  • Meetings and events carried out by each of the CCGs with hard to reach and protected characteristic groups
  • Meetings with community groups and people with protected characteristics via a Community Voluntary Sector Scheme, led by the three Councils for Voluntary Services in each of the CCG areas
• Consultees could also submit feedback to IHT's helpline in writing or by email, via SMS and by telephone, as well as commenting on social media.
 	
Was the formal public consultation open for a sufficient period of time?
 	
• The formal public consultation was open for 12 weeks from January 8th to April 1st 2020. The pandemic lockdown in response to the Covid-19 pandemic was put in place on 23rd March but the consultation period had been designed to deliver many activities in the first
	• The consultation methods allowed for verbal and telephone comments, as well as those provided in writing.
	
	• Although the formal consultation was open for 12 weeks, the lockdown had an inevitable impact on IHT's ability to carry out their full programme of activities. Comments on the appropriateness of carrying out the consultation during this period were reported but The Consultation Institute

10 weeks because of the pre-election period requirements for the planned Mayoral election. • During week 10 of consultation and due to Covid-19 requirements for social distancing, the consultation continued online and through social media for the remaining two weeks. One listening event and 1 deliberative event were cancelled but were mitigated through virtual rather than face to face contact. • A third of responses were received in the period after lockdown began on 23rd March [15]. The Consultation Institute endorsed the mitigation plans and supported the changes to the planned engagement. On this basis, and in discussion with The Consultation Institute it was agreed that the consultation could close as planned. The Consultation Report states that The Consultation Institute confirmed that the consultation fully met the requirements for a best practice consultation. • Some respondents, several councils and political organisations responded with requests ranging from extensions to the consultation period to complete cancellation of the consultation and the reorganisation process. • Members of the South West London & Surrey Joint Health Overview & Scrutiny sub-committee for Improving Healthcare Together 2020-2030 felt that the changes caused by the current situation (COVID-19) required that the programme be paused and that the decision should not be made on 3 July, but that there should be a short delay [18].	provided assurance that the consultation could close as planned due to mitigation strategies put in place by IHT.
Were proactive steps taken to engage patients and the public, especially harder-to-reach groups and communities, and those particularly affected by proposals – both directly and through representative groups? • The IHT programme and its consultation partners attempted to engage with protected characteristics groups and hard to reach communities by deploying wide ranging consultation approaches. The Consultation Institute confirmed that the IHT consultation fully met the requirements for a best practice consultation. • Protected and hard to reach communities were identified through a stakeholder mapping exercise, which was quality assured by The Consultation Institute as part of their assurance process. This process gave assurance that all protected characteristic groups, deprived communities and hard to reach groups potentially impacted by the proposals had the opportunity to engage in the IHT consultation by the most appropriate methods of engagement. • Three of the consultation methods (focus groups and in-depth 1:1 interviews; CCG meetings and events; and meetings held via a Community Voluntary Sector Scheme) were targeted specifically at people considered hard to reach and those with protected characteristics. • Eleven focus groups were held for recent users of maternity services, people aged 65+ (and people aged 55+ with long-term conditions), parents of children aged 16 and under,	• IHT carried out a systematic stakeholder mapping exercise and used innovative and wide-ranging approaches to identify hard to reach and protected characteristic group. IHT report that this approach was endorsed by The Consultation Institute. • Although engagement took place with hard to reach groups and people with protected characteristics, for some groups there appears to have been minimal specific engagement, for example the LGBT+ community.

and young people up to age 24. IHT conducted 6 individual depth interviews, including 5 with Gypsy Roma Travellers and one with a person who identified as transgender. There were also 3 all day deliberative workshops with a representative sample of the local population [15].
• The CCG meetings and events engaged some hard to reach groups and people with protected characteristics [19]. Data for the Merton CCG engagement were not recorded in a way that enabled this to be analysed, but reports on the engagement by CCGs for Sutton and Surrey Downs indicate that activities were held with protected characteristic groups with the exception of the LGBT+ and Gypsy, Roma and Traveller communities.
• For the Community Voluntary Sector Schemes, Central Surrey Voluntary Action consulted carers; low income households; older people, people with mental health needs; and people with learning difficulties. Community Action Sutton consulted with adult and mental health carers; BAME/refugees; parent carers; people with learning disabilities; and people with mental health issues. Merton Voluntary Services consulted with BAME communities; carers; deprived/low income communities; maternity service users; people with mental health needs; older people; and young people. This approach was supported by the COG which included representation from Surrey, Sutton and Merton Healthwatch.
 	
Did the consultation yield widespread, detailed public/patient feedback, especially from equalities and hard to reach groups, and those particularly affected by the changes?
 	
• Although not all of the planned engagement with hard to reach groups was carried out due to the pandemic, as described above, IHT mitigated this through online activities.
• The rest of the consultation appears to have yielded plenty of feedback. The consultation questionnaire received 4,172 responses; 751 interviews were carried out as part of the residents' survey; 8 listening events were held attracting more than 1,000 attendees; there were 434 written submissions and 1,160 social media posts; and there were two petitions (organised by Siobhan McDonagh and Keep Our St Helier Hospital), two third-party surveys and seven comments via Sutton Healthwatch.
 	
Have the final proposals been demonstrably modified following patient/public feedback?
 	
• The key findings from the formal consultation were:
  • Consultees recognised the need for change and supported the proposed clinical model.
  • Although there was more support for the Sutton option, people's views on the options varied depending on their proximity to existing services.
  • People were concerned about access to services and the impact on local communities and travel. There was concern that longer travel times could lead to poorer health outcomes and specific concerns about the potential for fragmentation of
	• Lots of feedback was received through the formal consultation, and although it is difficult to judge whether the level of feedback was what was expected, it allowed the researchers to develop thematic findings.
	
	• In addressing the key findings from the formal consultation, the DMBC reports that none of the work done has changed the result of the options appraisal, i.e. the option to site the SECH at Sutton Hospital is still preferred. There were no changes to the overall proposal for the new model of care but concerns raised during the consultation period and through other forms of scrutiny were noted and are being addressed. For example, concerns about access will be

maternity services. There was also concern about health inequalities and the impact on deprived communities. • Aside from inequalities, people also expressed concerns about the 3 hospital system and the impact on other providers/hospitals, bed numbers and the potential for future privatisation. • The DMBC has reported in detail how the key findings from the formal consultation have been addressed. *Do the final proposals set out plans for ongoing dialogue with patients and the public as detailed delivery plans are developed and service changes are implemented?* • The DMBC refers to ongoing stakeholder engagement and the involvement of Healthwatch and patients as the plans move into the implementation stage, if they are approved. There is no detail provided on what form this consultation will take.	picked up as part of the implementation as IHT develop access strategies with better bus routes. • As implementation plans are developed, a detailed consultation strategy will need to be developed.

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