

# Merton LBM – New Hospitals Programme

Independent Analysis

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## Introduction

### Background

As part of the New Hospitals Programme, Epsom & St Helier FT, serving both SW London & Surrey ICBs, has outlined plans to construct a new Specialist Emergency Care Hospital in Belmont by 2030. While this proposal aims to enhance specialised care, it raises concerns about the consequences for St Helier Hospital, which would lose its Emergency Department (ED) and relocate Paediatric and Maternity services.

Merton residents have voiced apprehensions about the potential impact of these changes on their community. Notably, there are concerns that accessing the new A&E facility might pose challenges, particularly from a perspective of travel time and addressing existing inequalities. Additionally, questions have emerged about the suitability of the original Business Case, developed in 2019 before the onset of COVID-19, and published in June 2020. It is being questioned whether this case relies on outdated data and fails to adequately address the evolving needs of Merton's residents, particularly those who are socioeconomically deprived.

In July 2023, the National Audit Office (NAO) released a report examining the status of the New Hospital Programme. The report highlighted that certain schemes initially promised for 2025 are now experiencing significant delays, casting doubt on their completion by the designated 2030 timeline. Moreover, concerns have been raised about the assumptions guiding the NHP's "model of care shifts," with potential ramifications for accommodating the rising demand due to an aging population, ultimately leading to a potential capacity shortfall.

This context calls for an Independent Analysis to critically assess the Business Case and address three key questions to ensure a comprehensive evaluation of the proposed Specialist Emergency Care Hospital and its implications for the local community.

### Scope of Independent Analysis

The purpose of the independent analysis is critically assessing the Business Case and address three key questions to better understand the implications of the proposed Specialist Emergency Care Hospital in Belmont for the local Merton community. The review team has been commissioned to:

- Review key documents including the Joint Strategic Needs Assessment (JSNA), Kings Fund report, and the business case. Evaluate how current the data used for the initial documents still is and ascertain whether it requires updating.
- Develop an understanding of the implications of the proposed changes (i.e., moving A&E, maternity, and paediatric services to Belmont) for Merton residents. The following three hypotheses were developed to investigate this, based on latest available data:
  1. Travel Times and Deprivation: Understanding how the proposed changes could impact Merton residents, in terms of travel times, particularly where this intersects with deprivation, and thereby anticipated demand on other local hospitals.

2. Care Quality & Volumes: Understanding how the proposed changes could impact the quality of care and experience of Merton Residents in accessing ED, Paediatric and Maternity services, given available data.
3. Merton's Changing Population: Building on the King's Fund report and Merton's story, understanding how Merton's population has changed since 2019 (latest available dataset at the time of drafting the business case). Including any key trends and accompanying link to potential demand impacts.

This report is a detailed compilation of findings from the above activities. The report also includes a description of the methodology, sources, and limitations of this review, as well as recommended next steps for further analysis. Notably, weekly collaboration sessions were held with Merton Council Staff members to ensure analysis was progressing in line with the agreed scope and to provide local context and understanding.

It is important to note that the purpose of this report is not to determine the appropriateness of the proposed changes. But to provide an updated information that can assist decision-makers in promoting and protecting the wellbeing of the local communities in which they serve.

# Executive Summary

## Background

- Epsom & St Helier FT is planning to build a new Specialist Emergency Care Hospital in Belmont by 2030.
- This proposal would mean that St Helier Hospital would lose its Emergency Department (ED) and relocate Paediatric and Maternity services. Other services would remain, and residents would continue using them.
- Merton residents have raised concerns about the potential impact of these changes, including travel time, quality of care, and the needs of socioeconomically deprived residents.
- Merton council has also raised concerns about the suitability of the original Business Case, which was developed using data ranging from 2011 to 2019 and before the onset of COVID-19.

## Scope of Independent Analysis

- The Independent Analysis will assess the Business Case and relevant key documents used as input for the business case, as well as address three key questions:
  - How will the proposed changes impact travel times for Merton residents, particularly those who are socioeconomically deprived?
  - How will the proposed changes impact the quality of care and experience of Merton residents in accessing ED, Paediatric and Maternity services?
  - How has Merton's population changed since the publication of the draft business case, and what could be the implications for demand for healthcare services?
- The purpose of the Independent Analysis is to provide updated information that can assist decision-makers in promoting and protecting the wellbeing of the local communities in which they serve.
- The report does not determine the appropriateness of the proposed changes, but it does highlight the need for further analysis and consideration of the potential impact on Merton residents.

## Summary of findings

### *Travel Times & Deprivation*

- Travel times to the nearest hospital are expected to increase by 2-6 minutes for driving and 2 minutes for public transport, on average across Merton borough (more detailed information at ward level found through the report).
- Three of the most deprived wards will see a > 5-minute increase in average public transport and driving travel time (with an upper range of 20 mins increase during heavier traffic for some wards like Ravensbury). People living in deprived areas are up to twice as likely to attend ED services.

## Care Quality and Volumes

- St. Georges, Kingston, and Croydon combined would likely serve ~50K additional Merton residents after proposed changes. Notably, this would just be expected for ED, Inpatient maternity and paediatric services no longer offered at St. Helier after changes. Further analysis is required to validate this and quantify expected net impact for neighbouring hospitals.
- Quality indicators for the hospitals expected to see an increase in demand are below national standards and, in some cases, performance is declining. ED attendance times remain below the 95% target for 4h performance. Waiting times from decision to admit to admission and bed occupancy rates appear to be increasing for most providers, indicating declining capacity.
- Attendance levels appear to be increasing (per latest reports for 21-22 year), slightly surpassing pre-COVID levels. Whilst overall admission levels appear to be decreasing, bed occupancy rates and average length of stay metrics appear to be increasing, suggesting additional capacity constraints.
- Following the March CQC inspection, St. George's has been downgraded to "inadequate" due to inadequate safety measures, including failure to address stillbirths and severe bleeding as "serious incidents," along with concerns about staffing, triage, and leadership.<sup>1</sup> An increased number of Merton residents would be expected to use St. George's maternity service after these services are relocated from St Helier.

## Merton's Changing Population

- Growth in populations considered to drive ED Demand (over 65, 6.85%) and maternity services demand (Female, 6%) is higher than overall population growth (5.8%).
- Growth in <16 population (2.9 %) for Merton is lower than expected (> 5.8%), and births are declining (from 1.8 to 1.5).
- No additional major changes from IIA analysis of Merton demographics were identified during this review.

## Implications

- The proposed changes are likely to have an adverse impact on travel times (+2 to 6 min on average) and hospital access for Merton's population.
- The impact of the changes on people living in deprived areas is likely to be more significant, as their increase in travel time is expected to be higher (up to +20 min, given traffic conditions) and they are more likely to use ED services.
- Quality indicators for hospitals expected to see an increase in Merton demand is below national standards and, in some cases, performance is declining. Merton experience and quality of care could be affected if appropriate mitigation actions are not taken.
- The changing population of Merton is likely to put further pressure on hospital and health care system.

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<sup>1</sup> <https://www.hsj.co.uk/st-georges-university-hospitals-nhs-foundation-trust/staff-let-down-by-leaders-as-chaotic-service-gets-double-downgrade/7035375.article>

## Recommendations

- Further analysis – building on this report – should provide more detailed understanding and validation of findings. Including:
  - Postcode level hospital usage and capacity modelling using more granular level data (e.g., postcode level hospital usage data).
  - Understanding the demand and capacity planning for in-scope services on a hospital-by-hospital level (this granularity of data was not available for this analysis)
- Undertake detailed work with neighbouring NHS providers to understand their ability to accommodate any changes in activity and the impacts for them.
- Work with neighbouring NHS providers to understanding the scope and status of investment plans discussed during the development of the original business case – which were deemed necessary at the time to successfully cope with increasing demand.
- Strategies should be developed to address the needs of the changing population of Merton.
- Consideration should be given to providing additional transport options to and from wards with expected higher travel times (e.g., Ravensbury, Cricket Green and St Helier), to mitigate the impact of the proposed changes. This could be a targeted initiative, considering a smaller proportion of residents are expected to experience a significant change in travel times.

## Methodology & Approach

To achieve the objectives of this independent analysis, the team performed an in-depth review of key documents related to the proposed £500 million investment, a data collection and analysis exercise, and collaboration sessions with key Merton Council Staff members. The approach involved the following steps:

### Key Documents Review

A comprehensive review to examine the following key documents<sup>2</sup>:

- IHT Decision-Making Business Case – version published June 2020
- IHT Integrated Impact Assessment
- IHT Equality Scoping Report/Joint Strategic Needs Assessment (JSNA)
- King's Fund Health Inequalities Review
- The Merton Story<sup>3</sup>
- Other relevant documents reviewed include:
  - Improving Healthcare Together 2020 - 2030 Impact on other providers<sup>4</sup>
  - Progress with the New Hospital Programme Department of Health & Social Care<sup>5</sup>

The primary objective of the key document review was to evaluate the original Business Case developed in 2019 (published in June 2020) and assess the assumptions and relevance of the data

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<sup>2</sup> <https://improvinghealthcaretogether.org.uk/important-documents/>

<sup>3</sup> Provided by Merton Council

<sup>4</sup> <https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/07/Impact-on-other-providers-a-summary-assessment.pdf>

<sup>5</sup> <https://www.nao.org.uk/reports/progress-with-the-new-hospital-programme/>

used considering the current context. It also helped the team identify knowledge gaps and inform areas for investigation in this and recommended subsequent analysis.

## Data Collection & Analysis

To address the three key hypotheses and evaluate the implications of the proposed changes, the team collected the most recent publicly available health and socio-demographic data for Merton's population and NHS providers. Sources include Merton Council, Greater London Authority, NHS Digital and The Office for National Statistics (ONS). This data was used to analyse trends in population changes, population size and key demographic factors, healthcare usage, and quality of care.

In addition, to enable the travel time analysis associated with hypotheses 1 & 3, the team used google maps travel API data and python programming language to quantify journey times (at postcode level and LSOA), primarily to the following hospitals:

- St George's Hospital (Wandsworth)
- St Helier Hospital (St Helier)
- Kingston Hospital (Kingston)
- Croydon University Hospital (Croydon)
- (Planned Belmont Hospital site)

Notably, analysis was primarily focused on the above location given their proximity to Merton residents and the services offered to the population (ED, Maternity, Paediatrics). Further analysis was conducted for other locations that also offer Maternity and Paediatrics services within a 10-mile radius Merton Park. A full list is included in the appendix section of this report.

## Limitations

There are data availability and approach limitations that are worth noting, as they limit the level of detail the analysis can reach and the certainty of some conclusions. However, with additional data, most of these limitations could be overcome in subsequent analytical work – building on this report. The main limitations are:

- No access to hospital level data. Implications include:
  - Limitation on travel time impact analysis. The team was not able to accurately analyse hospital level usage for Merton's population.
  - Limitations on hospital capacity and volumes. Without hospital and resident level information, it is not possible to confidently assess the potential increases in demand to hospitals adjacent to the Merton community after proposed changes. Analysis on this should be treated as estimates. Further analysis – building on this report – would provide more detailed understanding and validation of findings.
- Focus on Merton population:
  - Per the scope of work for this review, the analysis focused on the implications for the Merton population from the proposed changes. Notably, residents from communities outside of Merton are also likely to experience changes (whether positive or negative effects) from the proposed changes. This analysis has not investigated such implications, nor has it reviewed the other two options initially proposed in the business case (i.e., the St Helier and Epsom options).
- Unclear sources and qualitative statements in some key documents reviewed:



- In some instances, the source of information used in key documents is not clear, which limits the extent to which the team can validate and/or assess the current validity of the information.
- Some statements related to assumptions or impact assessment do not include quantitative information (e.g., “impact is likely to be moderate”). This limits the extent to which the team can assess the validity or magnitude of some implications.

#### Collaboration with Merton Council Staff

Throughout the review process, the team maintained close collaboration with Merton Council Staff members. Weekly engagements and review sessions were conducted to ensure analysis was progressing in line with the three hypotheses and to ensure local context and understanding.

#### Recommendations and Next Steps

Based on the findings, the report presents recommendations for further analysis or actions. These recommendations will be directed towards decision-makers and stakeholders to facilitate informed decision-making that promotes the wellbeing of the local Merton community.

It is important to reiterate that the primary aim of this report is not to determine the appropriateness of the proposed changes but to provide updated information that can assist decision-makers in making informed choices to serve the best interests of the communities they represent. The analysis aims to be comprehensive, transparent, and impartial in its approach to ensure the integrity of the findings and recommendations.

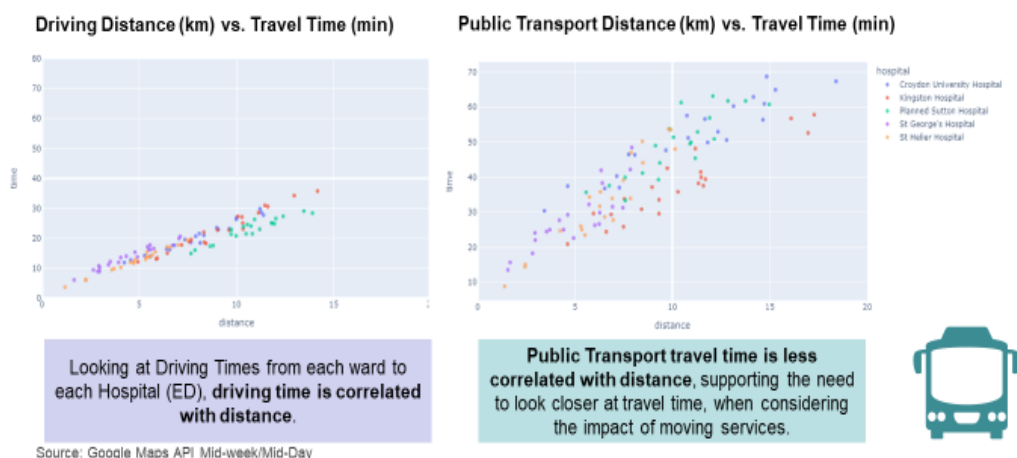
# Findings

## H1.1 Travel Time Implications

This section of the report focuses on understanding potential implications of proposed changes to Merton residents, in terms of travel times, particularly where this intersects with deprivation (and health inequalities). It also aims to understand potential implications for demand changes on hospitals adjacent to Merton.

Notably, previous Merton analysis has been based on understanding of distance to the proposed Belmont site “as the crow flies”. A correlation analysis between distance and journey time suggests that, while driving times are strongly correlated with distance, public transport travel times are not very strongly correlated. In addition, travel times (as opposed to distance) was used as input for the draft business case published in June 2020. Therefore, travel times have been used as the main metric for this section of the analysis.

### While driving travel time correlates with distance, public transport travel time is less correlated.



Source: Author calculation. Based on Google API travel time analysis

Noting that Merton residents use a mix of modes of transportation, we have analysed travel times for both driving and public transport.

## Noting that Merton residents use a mix of modes of transport, we've analysed travel times for public transport and driving

### Transport preferences vary

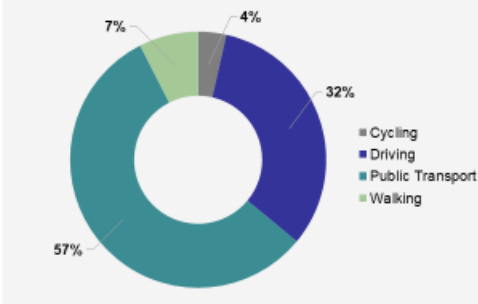
**32%** of residents **drive to work**

**33%** of Merton households **do not own a car\***

**57%** of people **prefer to use public transport**, when traveling to work.

Note: This will not necessarily be how they travel to hospital as individuals' preferences could be affected by a wide range of factors – time of day, convenience, direction etc.

### How do Merton Residents travel to work?



\*Source: LSOA level 2021 ONS



The approach involved: (i) identifying the shortest travel time to each hospital (a) before and, (b) after proposed changes for each postcode; (ii) for each location, travel times were retrieved for different times of the day (e.g., Mid-Day, 17:30 and 23:00) to account for different traffic and transport availability conditions; (iii) the travel time results were aggregated at Merton LSOA and ward levels to enable analysis and comparison of average travel to the most convenient hospitals.<sup>6</sup>

### What are the travel time implications for people traveling to their closest ED, and In-Patient Maternity or Paediatric services after the proposed changes?

On average, public transport and driving travel time to the nearest hospital is expected to increase by c. 2 minutes, and 2-6 minutes, respectively. From an average driving time of 10-20 mins before to 12-24 after proposed changes. And an average public transport travel time of 25 mins (from 23 mins before proposed changes). Notably some wards would experience higher increases in travel times (see table 1 and appendices 1A-1C).<sup>7</sup>

<sup>6</sup> Note: This analysis focuses on average travel time (at different times of day), and does not account currently for a wider range of factors affecting someone's transport use, e.g., number of changes, cost, reliability etc. In addition, a range is provided for driving time to account for low to heavy traffic conditions.

<sup>7</sup> Source: Google Maps API July 2023

Table 1 – Difference in average travel times before and after proposed changes

	Before	After	Difference
<b>Merton Average</b>	10 - 20 mins	12 - 24 mins	+ 2 to 4 mins
<b>Longest Raynes Park</b>	15 - 34 mins	18 – 40 mins	+ 3 to 6 mins
<b>Merton Average</b>	23 mins	25 mins	+ 2 mins
<b>Longest West Barnes</b>	42 mins	42 mins	None

The analysis suggests that for both travel methods (public transport and driving) average journey times are expected to be slightly higher for Merton residents after proposed changes – regardless of time of the day.

Transport Method	Metric	Scenario	Noon	Rush Hour	Night	Range	Diff (range)	Min Travel Time Impact	Max Travel Time Impact
Driving*	Average (average traffic)	Current	15.2	16.1	14.0	14.0 - 16.1	2.0	2.8	3.3
		After Proposed Changes	18.5	19.4	16.8	16.8 - 19.4	2.5		
	Max Travel (heavy traffic)	Current	29.2	34.3	25.6	25.6 - 34.3	8.8	5.9	6.4
		After Proposed Changes	36.9	40.7	31.5	31.5 - 40.7	9.3		

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Transport Method	Metric	Scenario	Noon	Rush Hour	Night	Range	Diff (range)	Min Travel Time Impact	Max Travel Time Impact
Public Transport	Average	Current	23.2	24.6	19.8	19.8 - 24.6	4.8	2.2	1.7
		After Proposed Changes	25.5	26.4	22.0	22.0 - 26.4	4.4		
	Max Travel	Current	36.2	41.9	33.9	33.9 - 41.9	8.0	None	None
		After Proposed Changes	38.2	41.9	33.9	33.9 - 41.9	8.0		

Implications of traveling at different times of days are similar before and after proposed changes (e.g., traveling on public transport during rush hours adds ~+4 min to journey, compared to traveling at nighttime. It is the same ~+4 mins difference before and after proposed changes)

<sup>8</sup> \*Note: Travel times for driving have been calculated with average and heavy traffic conditions

## H1.2 Travel time and deprivation

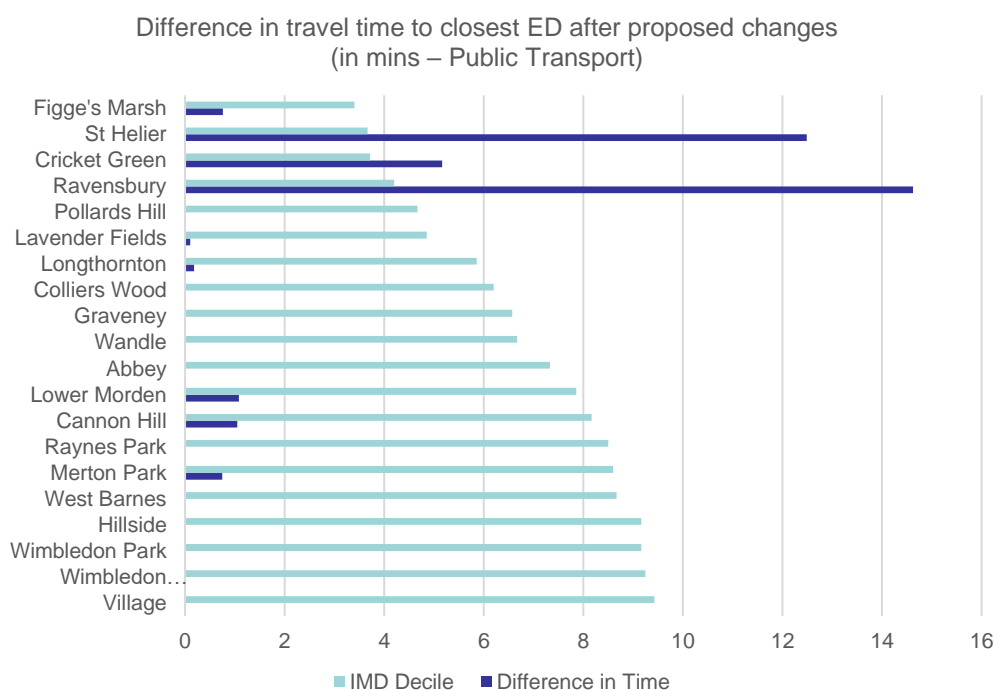
There are questions within Merton about the impact this could have on Merton residents – e.g., residents may face barriers to accessing the new A&E, with a particular consideration for potential implications from a health inequalities and deprivation lens.

*The Integrated Impact Assessment found that: “Moderate adverse - short increases largely linked to public transport travel for a large proportion of the population living across the study area. Will likely have a greater impact on deprived communities when traveling by public transport”.*

To explore this lens, the relationship between deprivation and travel time was investigated. Findings indicate that three of the most deprived wards in Merton (i.e., St. Helier, Cricket Green and Ravensbury) are likely to experience a higher increase in travel times than the rest of Merton residents:

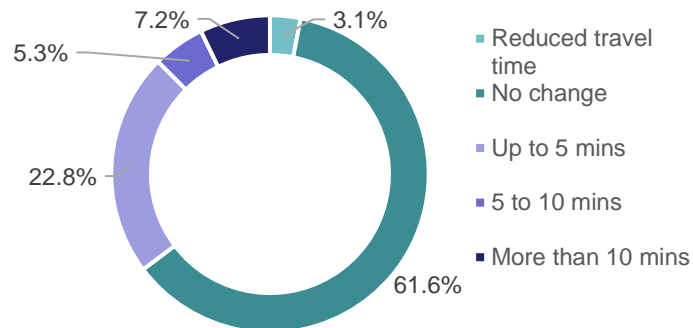
For public transport Ravensbury residents are likely to experience an average increase of 15 mins (from an avg. travel time of 14 to 29 mins), residents of St Helier an average increase of 12 mins (from an avg. travel time of 14 to 26 mins), and residents of Cricket Green an average increase of 5.5 mins (from an avg. travel time of 22.5 to 28 mins) compared to the average 2-4 min increase for Merton.

Figure 1 Difference in travel time to closest ED after proposed changes (Public Transport)



The affected population (>5-min travel time) across all wards is 26,900 (12.5%) people, compared to 165,000 (61%) who are likely to experience little to no impact.

Figure 2 – Public Transport time change, as percentage of Merton Population

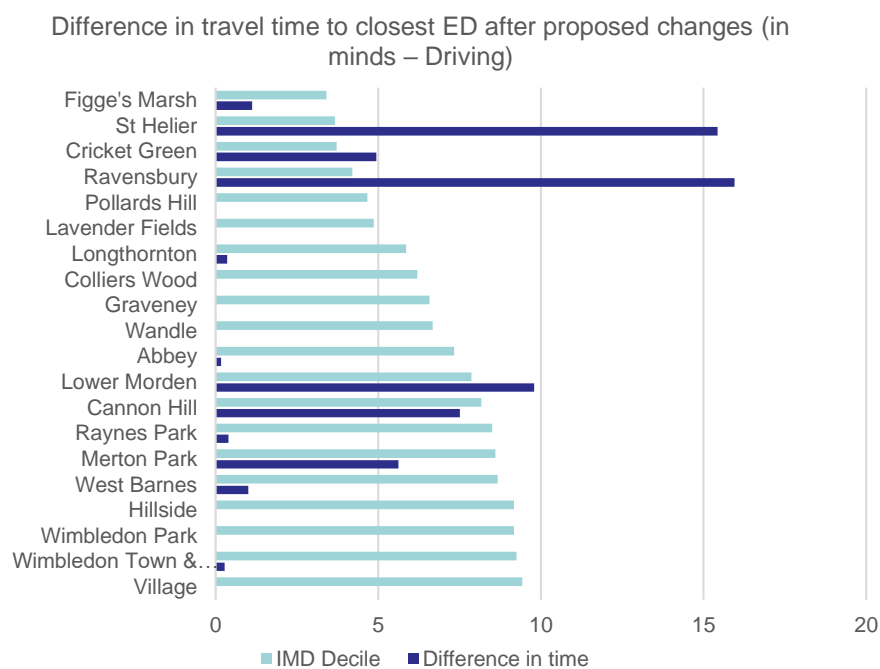


For residents traveling by car, 24% are likely to experience an increase of 5 mins or more in average driving time to their nearest ED, or in-patient Maternity and Paediatric services.

Like public transport travel times, three of the most deprived wards are likely to experience higher than average increases in travel time by car. Ravensbury residents are likely to experience an average increase of 16mins (from 8 to 24 mins), St Helier residents and average increase of 15 mins (9 –24 mins) and Cricket Green residents an average increase of 5 mins (from 15 to 20 mins). Other wards, with lower levels of deprivation are also likely to experience higher than average increases; namely Lower Morden (from 14 to 24 mins), Cannon Hill (from 18 to 25.5 mins) and Merton Park (16 to 21.5 mins).

The affected population (>5-min travel time) across all wards is 51k (24%) people, compared to 130K (60 %) who will experience no impact.

Figure 3 - Difference in travel time to closest ED after proposed changes (Driving)



*The fact that most deprived wards are likely to see a higher increase in travel times is important to note. Considering that:*

***“Analysis shows a clear and consistent association of higher rates of A&E attendance for those living in the more deprived communities” (Business case)***

***“There were around twice as many attendances to A&E departments in England for the 10% of the population living in the most deprived areas (3.0 million), compared with the least deprived 10% (1.5 million)” (Source: ECDS\*)***

**What are the potential implications for neighbouring providers after the proposed changes?**

Demand from Merton residents currently using ED, Maternity and Paediatric Services at St. Helier is expected to shift to neighbouring providers (e.g., St. George’s, Croydon, and Kingston Hospitals) as well as the proposed new site at Belmont.

To address this question in a comprehensive way, postcode level hospital usage data for Merton and non-Merton residents would be required – which for this analysis was not available. Therefore, publicly available data as well as google maps API travel time data was used to estimate demand shift from Merton residents to neighbouring providers.

The analysis assumes that each member of the population is “served” by their two closest hospitals. Notably, for this reason, the numbers below add up to twice Merton’s population size. Closest hospital was calculated using travel time analysis data at postcode level and population size was calculated using LSOA level (ONS 2021) population statistics. The intent being to give an indication if the change in Merton resident demand on each hospital.

Notably, NHS Maternity & Paediatric pathways enable more control over where this demand goes. Therefore, it is less likely that demand for these services will shift in the same way as ED services. However, residents may still experience longer travel times for all services.

Pre-liminary analysis indicates that St. Georges, Kingston, and Croydon combined would likely serve ~50-55K additional Merton residents (out of ~215K population) – for services moving out of St. Helier (i.e., ED, Maternity and Paediatrics). **Net impact to hospitals would need to consider changes in demand from non-Merton residents, this is not included in this analysis.**

*Figure 4 - Estimate of Merton population served by provider before and after proposed changes.*

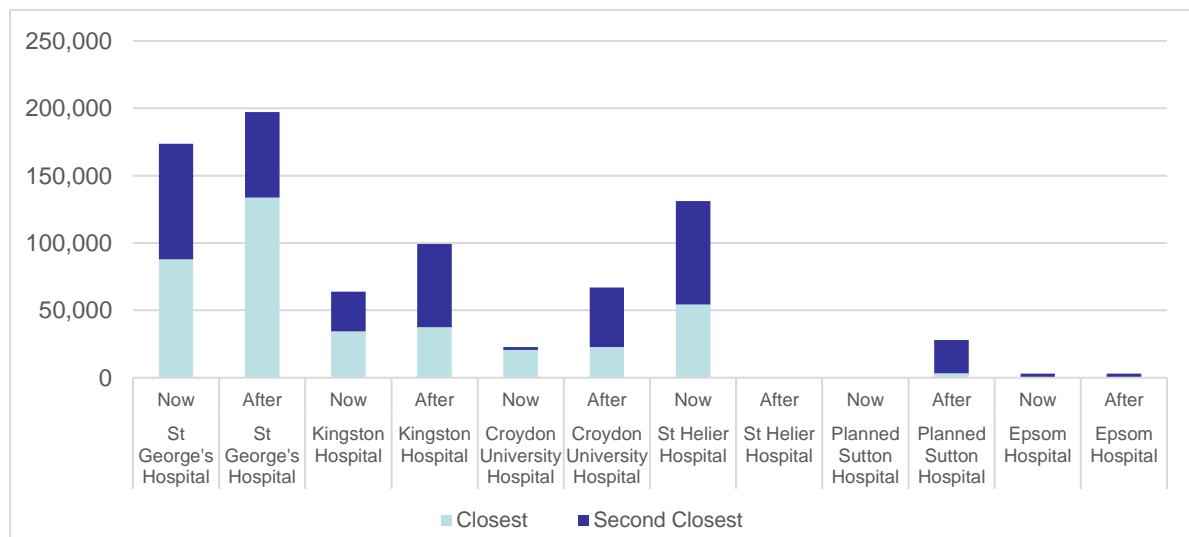


Table 2 - Estimate of Merton population served by provider before and after proposed changes.

	Merton population served now (estimate)	Merton population served after (estimate)	Difference # Merton residents	Difference % Merton residents
St George's Hospital	173,766	197,246	23,480	14%
Kingston Hospital	63,951	99,209	35,258	55%
Croydon University Hospital	22,657	66,977	44,320	196%
St Helier Hospital	131,078	-	- 131,078	-
Planned Belmont Hospital	-	28,020	28,020	-
Epsom	3,040	3,040	-	-

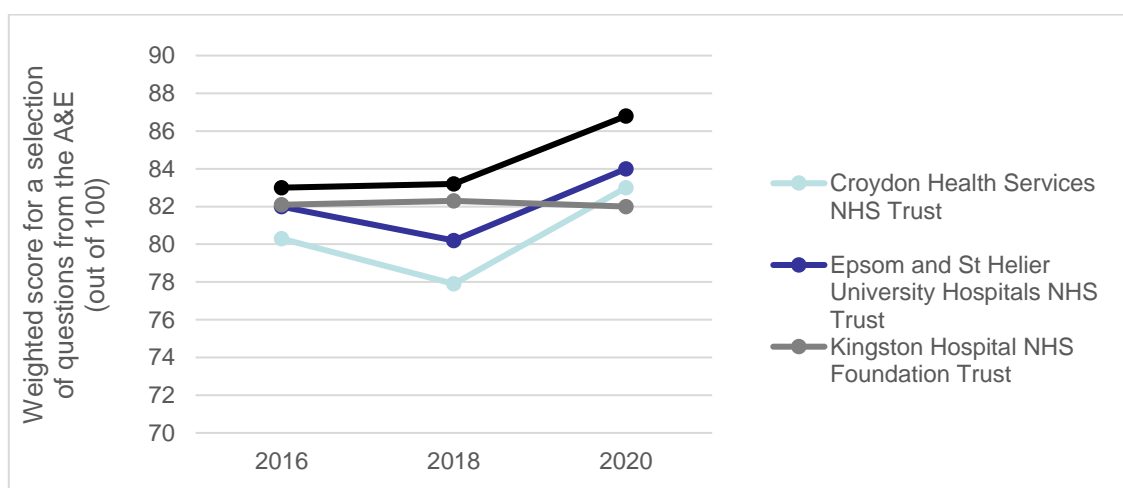
In addition to convenience based on travel times, resident preferences might also influence where demand will shift. For example, during consultation focus groups, some residents expressed a preference for St. George's over Croydon:

*[St Georges was perceived as having a better reputation] "If it moves from St Helier the majority of Merton will move to St Georges. Our local hospital will change and put a lot more pressure on St Georges" (Those from the two highest quintiles of deprivation focus group, Merton)*

Source: Improving Healthcare Together (2020-2030) Final Integrated Impact Assessment, June 2020

This is consistent with patient experience survey data, where St. George is reported to have the highest patient experience score.

Figure 5 - Patient Experience of A&E services by provider



Source: NHS outcomes framework indicator 4.3: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework> - Unit: the average weighted score for a selection of questions from the A&E (score out of 100)



***During the 2019 IIA - neighbouring providers believed they would be able to cope with additional demand under Belmont option – provided investments were made.***

*“Each provider has stated that all options would be deliverable with the right level of investment and mitigations, while noting the scale of the challenge and investment varies by option” (IIA 2019)*

*“[Under the Belmont option] Impacts are distributed more evenly across providers in both London and Surrey. This is driven by the location of the Belmont site, in between the Epsom and St Helier sites. There is also some additional activity currently at Croydon Hospital that would use the new Belmont Hospital as its nearest site. A small amount of additional capacity and associated capital investment is needed for each provider to accommodate additional demand.” (IIA 2019)*

<b><i>Provider</i></b>	<b><i>Provider board conclusions (Provider Impact Assessment – 2019)</i></b>
<i>St George’s</i>	<i>The Board believes all options are deliverable and identified that providing major acute services at Epsom would have a high impact, Belmont a high to medium impact and St Helier a low impact. The impact included a significant capital investment requirement for the Epsom option.</i>
<i>Kingston</i>	<i>The Board expects broadly consistent medium to low impacts across the three options, with limited differentiation between them.</i>
<i>Croydon</i>	<i>The Board identified a low impact for the St Helier option, medium for the Belmont option and a high impact for the Epsom option. It stated that while all three options are deliverable, there are challenges with the Epsom option, which would require significant capital investment.</i>

#### H1- Areas for further investigation

- ❖ Findings suggest there would be a shift in Merton resident’s demand to neighbouring providers. Conclusive numbers on net demand changes for each hospital is not possible without additional on hospital usage at postcode level. Further analysis – building on this report, and business case documentation –is recommended to update demand and capacity models for hospitals to ensure expected changes in demand (from Merton and Non-Merton residents alike) are accounted and mitigated, were possible.

## H2. Care Quality & Volumes

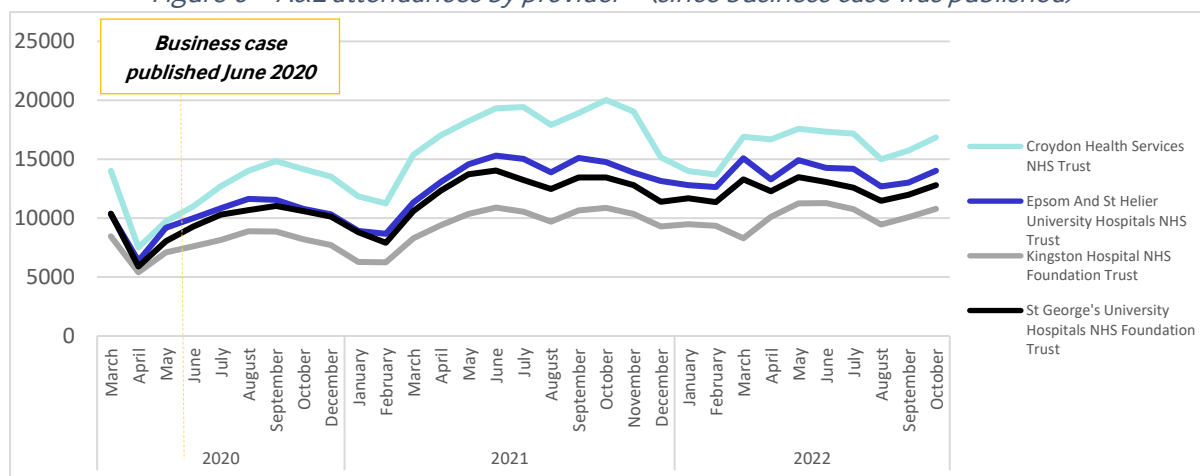
This section of the report focused on understanding how the proposed changes could impact the quality of care and experience of Merton Residents in accessing ED, Paediatric and Maternity services. The analysis investigated trends in A&E attendance and admission volumes, in-patient length of stay, as well as different metrics associated with quality of care and patient experience for hospitals that would expect to see increased demand from Merton residents, namely:

- St George’s Hospital
- Epsom & St Helier Hospitals
- Kingston Hospital
- Croydon University Hospital

Note that the analysis is based on Trust-level data, as Hospital-level data is not publicly available.

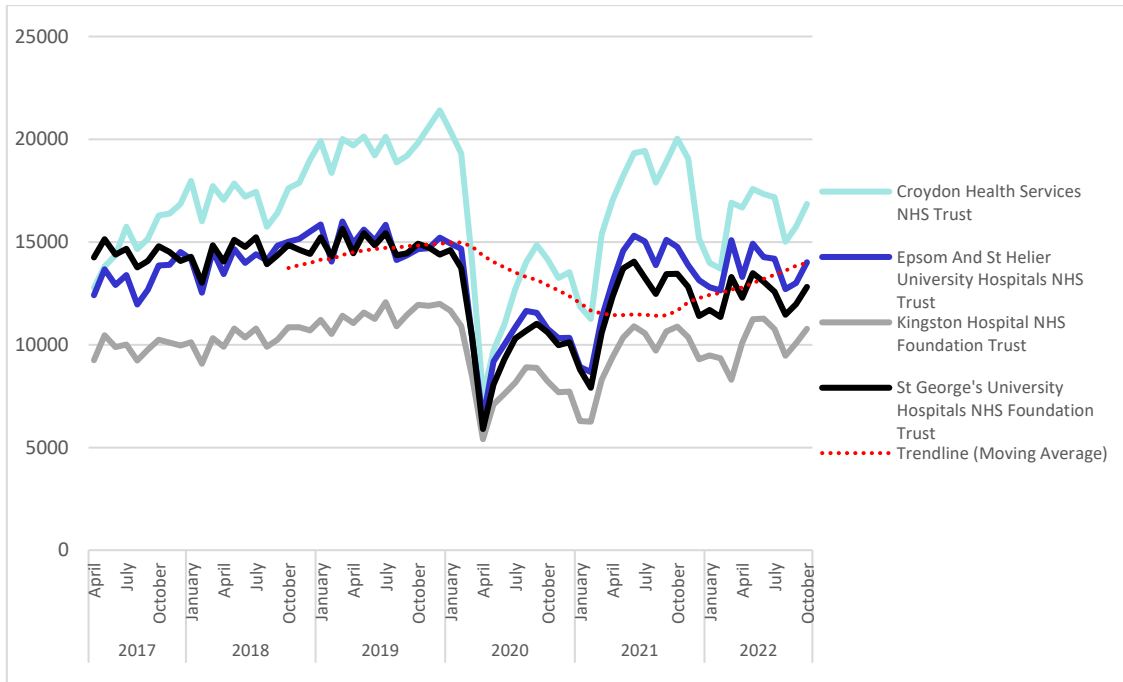
A&E attendance numbers since the development of the original business case (developed in 2019 and submitted in June 2020) indicate an increasing trend in A&E activity for all neighbouring providers (see Figure 6– attendances since business case submission). Notably, during Covid-19 A&E attendances decreased significantly – attendances have now surpassed pre-covid levels (~5% increase from 2018-19 levels) (see figure 7 below).

Figure 6 – A&E attendances by provider – (since business case was published)



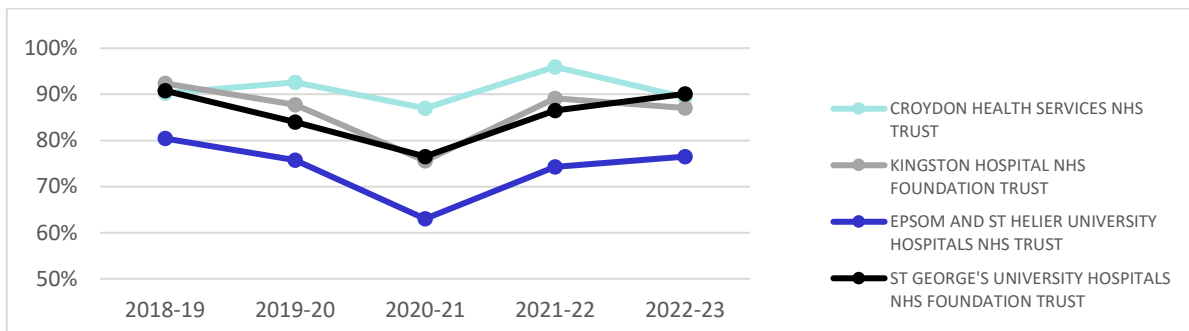
Source: NHS Digital, Emergency Care Data Set (ECDS) statistics - 1st March 2020 to 31st March 2022

Figure 7 - A&E attendances by provider – before and after COVID-19 pandemic<sup>9</sup>



In addition, bed occupancy rates for all providers have also increased, to levels above the national targets. Notably, a downward trend observed before the COVID-19 pandemic has mostly reversed.

Figure 8 - Percent of beds occupied (Total Beds) by provider.<sup>10</sup>



The analysis suggests that emergency total emergency admission volumes are decreasing, for all providers – see Figure 10 below. However, admission rates for specific conditions (e.g., admissions for children with lower respiratory tract infections) are increasing – see Figure 11 below. Furthermore, whilst admissions are decreasing, the average length of stay (LOS) for emergency admissions has increased significantly since the development of the business case – see Figure 12. This trend is relevant given that the business case ‘*bed modelling to 2029/30 [was] based on continuing trends in activity growth, QIPP and incremental length of stay reductions*’ – also see Figure 9 below.<sup>11</sup>

<sup>9</sup> NHS Digital, Emergency Care Data Set (ECDS) statistics - 1st March 2020 to 31st March 2022

<sup>10</sup> <https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy>

<sup>11</sup> June 2020 Version of Business Case – page 93.

Figure 9 - Business case reference (Care Model)

**“An effective consultant-led model of care has been shown to be more efficient in delivering care, with decreased length of stay, more efficient use of beds, decreased rates of readmission and decreased need for patient follow-up. Consultants are central to educating new doctors and developing research and innovation” (Business Case, June 2020)**

Figure 10 - Total Emergency Admissions by Provider

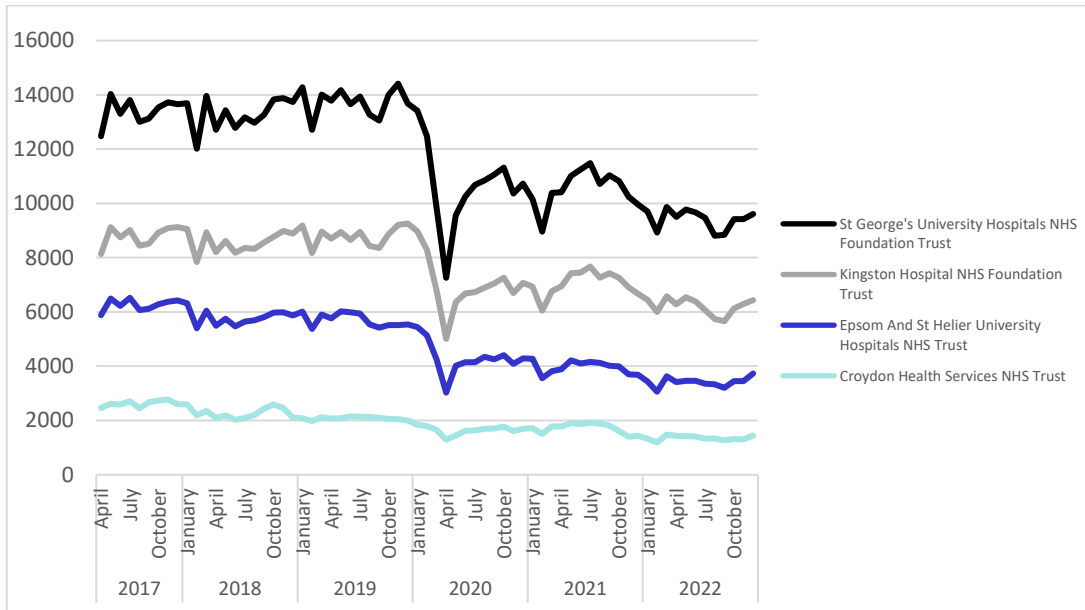
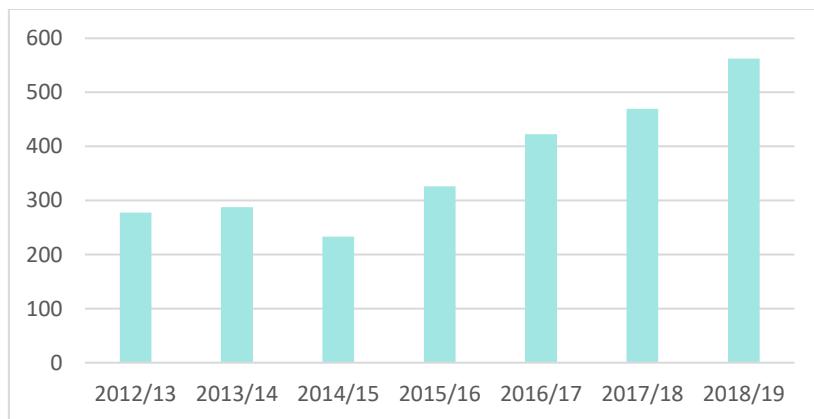
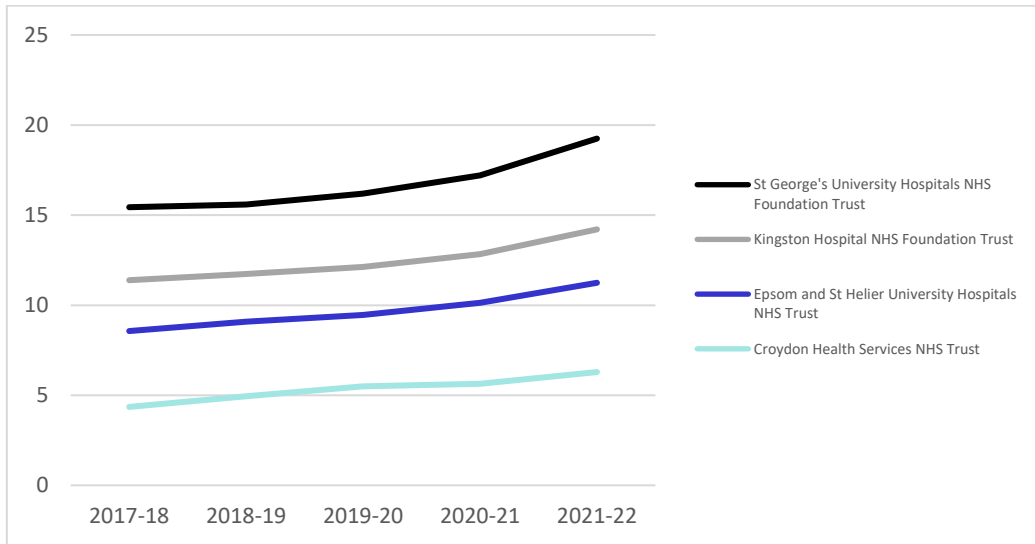


Figure 11 - Emergency admissions for children with lower respiratory tract infections (LRTI) - per 100k in Merton population.<sup>12</sup>



<sup>12</sup> <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-3---helping-people-to-recover-from-episodes-of-ill-health-or-following-injury-nof/3.2-emergency-admissions-for-children-with-lower-respiratory-tract-infections-lrtis>

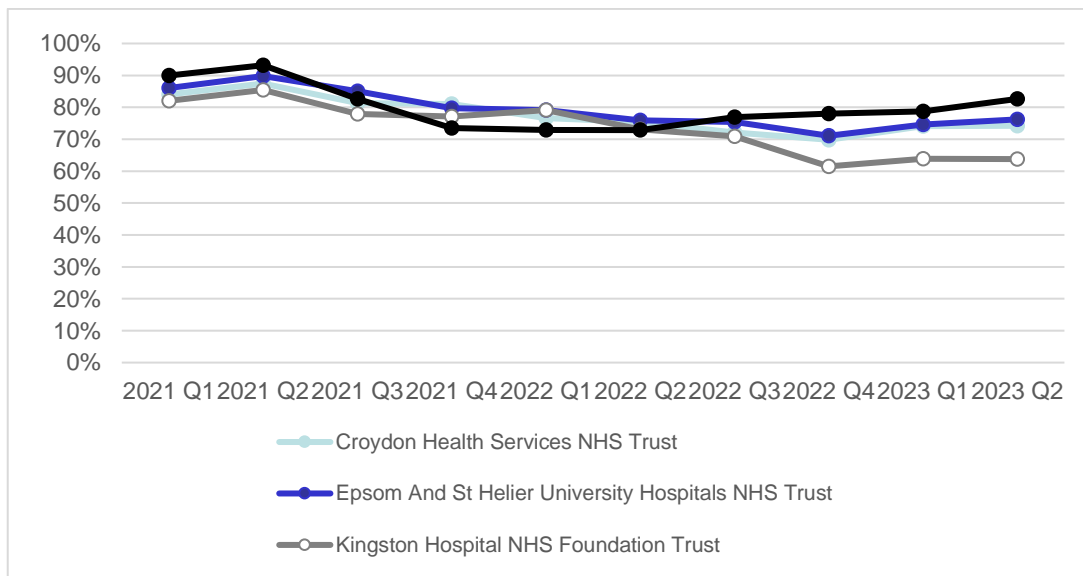
Figure 12 - Average LOS by Provider<sup>13</sup>



Overall, quality indicators for the hospitals expected to see increase in demand appear to be below national standards (on most indicators) and, in some cases, performance is declining. In the absence of investment in additional capacity, increases in demand on one or more of these hospitals, because of proposed changes could further exacerbate this trend.

For example, the number of A&E attendances seen, treated, admitted, or discharged within four hours, although appearing to be improving, remain below the 95% target for 4h performance.

Figure 13 - Percent of attendances under 4 hours by provider.



14

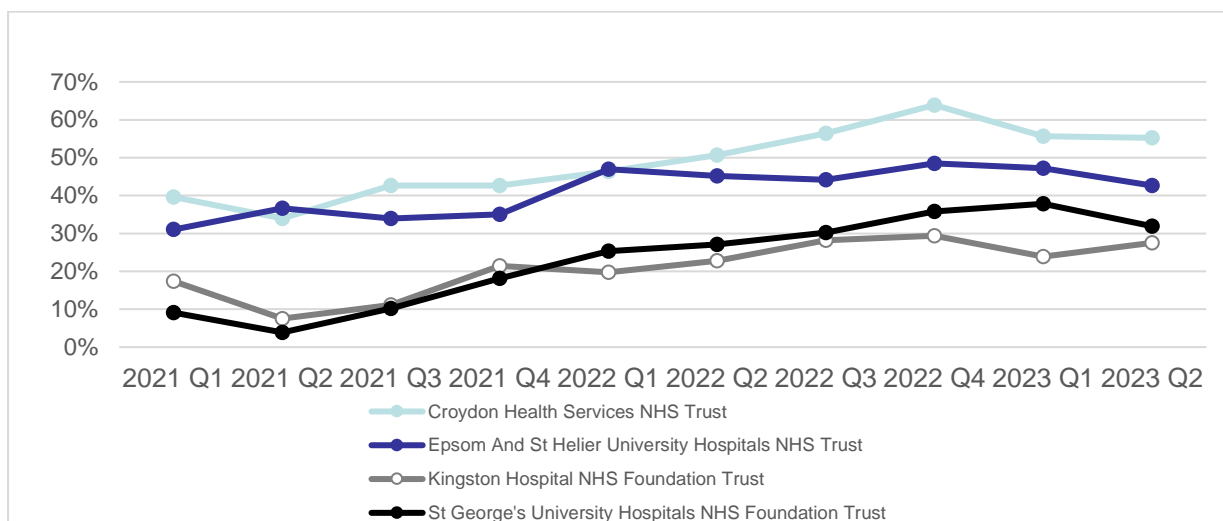
Further, waiting times from decision to admit to admission appear to be increasing for most providers, indicating decreasing capacity to deliver on national targets.

Waiting times before admission have risen across all four Trusts in the last three years. 30% to 55% of people must wait >4 hours from decision to admit to being admitted.

<sup>13</sup> <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/>

<sup>14</sup> Source: Data provided by Merton council – analysed by report team.

Figure 14 - Percent of people spending more than 4 hours from decision to admit to being admitted, by provider.



*“If the additional activity at neighbouring providers is not sufficiently provided for, there is the potential for patient outcomes and experience to be negatively impacted. This is applicable to both clinical services and clinical support services such as diagnostics.”*

**(IIA 2019)**

Between 30 – 50% of A&E attendances (depending on time of day) and 20% of non-elective admissions come in via ambulance services. This represents a significant percentage of all attendances and admissions to ED.

Increases in driving travel time due to proposed changes (average of 2-6 minutes) would have an impact on ambulance travel time as well, the extent of which is unknown with available data. However, analysis of current ambulance response and handover times suggest ambulance performance and handover times could be a bigger barrier to accessing emergency care in a timely manner (see Figure 15 & Figure 16 below) than increases in driving time to the nearest ED. In addition, between 20 -35% of the time, ambulances wait >30 minutes from arrival to ED to patient handover.

Figure 15 - Average C1 response time for London Ambulance Service

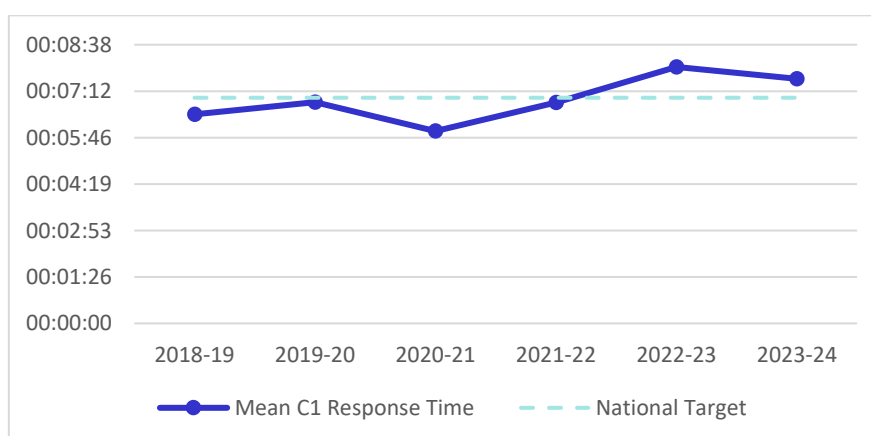
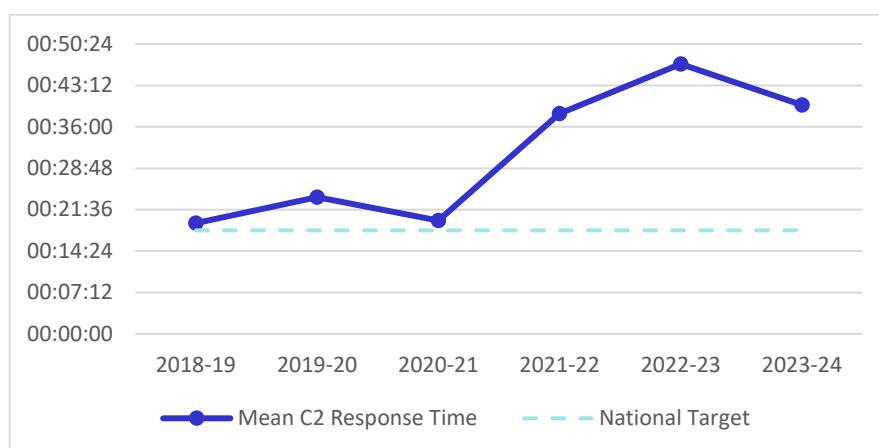


Figure 16 - Average C2 response time for London Ambulance Service



Bed occupancy rates and waiting times at neighbouring providers are below national targets.

In addition to

Lastly, following the March CQC inspection, St. George's maternity services have been downgraded to "inadequate" due to inadequate safety measures, including failure to address stillbirths and severe bleeding as "serious incidents," along with concerns about staffing, triage, and leadership.<sup>15</sup>

## H2. 2- Areas for further investigation

- ❖ The Integrated Impact Assessment references the need for neighbouring providers to invest to meet potential increases in demand resulting from the proposed changes. Given the current performance trends for neighbouring providers, a re-evaluation of potential demand increases, as well as providers ability to cope with and carry-out investment plans is recommended.
- ❖ Understanding the impact of proposed changes on ambulance services performance would provide more details into the impact on quality of care and timely access to emergency services for Merton residents. A 2022 paper, published by *The Health Foundation* found that increases in handover delays is largely being driven by the lack of hospital bed capacity and delays in discharging patients.<sup>16</sup> Between 20 -35% of the time, ambulances wait more than 30 minutes from arrival to ED to patient handover, due to bed and/or staff capacity at destination hospital. Given the current bed occupancy rates and waiting times at neighbouring providers, additional analysis, looking into the potential impact of proposed changes on ambulance performance is recommended.

<sup>15</sup> <https://www.hsj.co.uk/st-georges-university-hospitals-nhs-foundation-trust/staff-let-down-by-leaders-as-chaotic-service-gets-double-downgrade/7035375.article>

<sup>16</sup> Ambulance Handover Delays: A Major Contributor to the Decline in Ambulance Performance in England" by The Health Foundation, published in the British Medical Journal in 2022

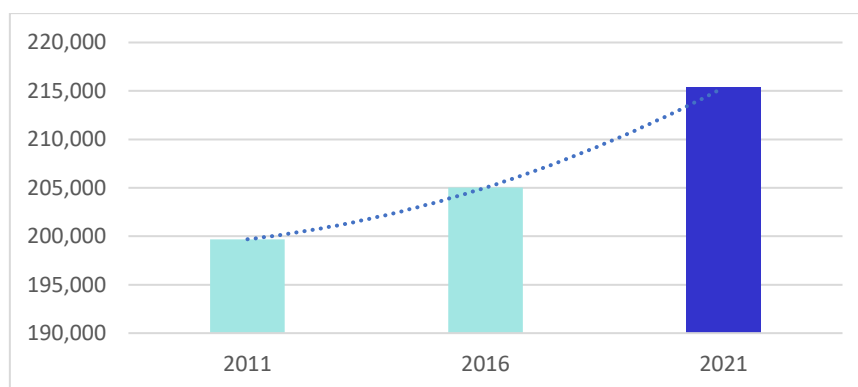
### H3 – Merton’s Changing Population

This section of the report builds on and complements the King's Fund report and Merton's story, by understanding how Merton's population has changed since 2019 – latest available datasets at the time of developing the draft business case ranged from 2011 to 2019. For due diligence purposes, the analysis focuses on key trends and demographic factors initially identified as part of the Initial Inequalities (JSNA) report. It aims to surface any significant variation in demographic indicators for Merton and were appropriate an accompanying link to potential demand impacts.

This section highlights current indicators and trends for population groups that are considered key drivers of health and social care demand, a list containing updated values for due diligence purposes (additional demographic factors included in the Initial Inequalities report) can be found in the appendix section.

According to the most recent 2021 Census, Merton has a population of 215,200. This represents a 7.8%, from around 199,700 in 2011 to 215,200 in 2021. This is higher than the overall increase for England (6.6%). Nearby areas like Belmont and Croydon have seen their populations increase by around 10.2% and 7.5%, respectively, while others such as Kingston upon Thames saw an increase of 5.0% and Lambeth saw smaller growth (4.8%).

Figure 17 - Population Growth - Merton



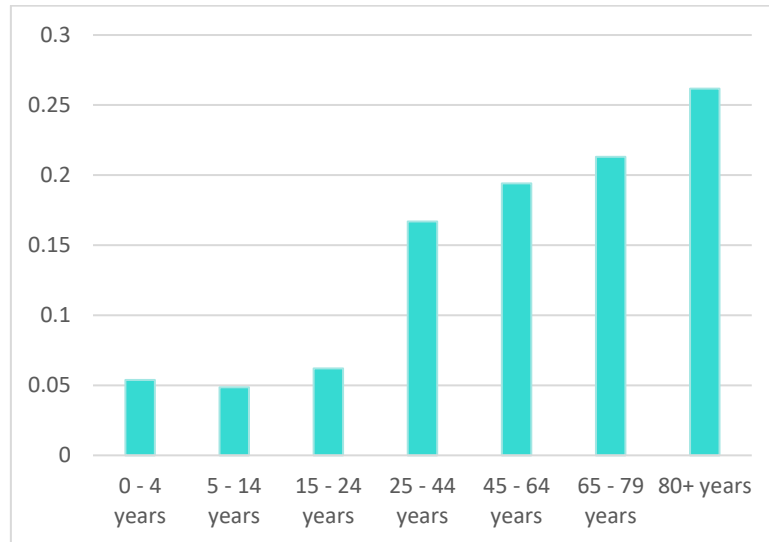
***From the Business Case – “Merton’s population has been projected to increase by around 6.45% between 2014 and 2020.”***

Merton’s population growth is slightly lower than initially projected. Actual growth from a similar period 2014 (204,598) to 2021 (215,200) was 5.8%.

Merton’s population is ageing (with population over 65 growing at a faster rate than the rest of the population). This is consistent with national trends. Across England, more than one in six people (18.4%) were aged 65 years and over on Census Day in 2021. This is a higher percentage than ever before. This is likely to have demand implications as the population over 65 is the largest driver of health and social care demand (20-25% of A&E attendances, and 42-53% of A&E admissions, from 12% of the population) – see Figure 18 below.

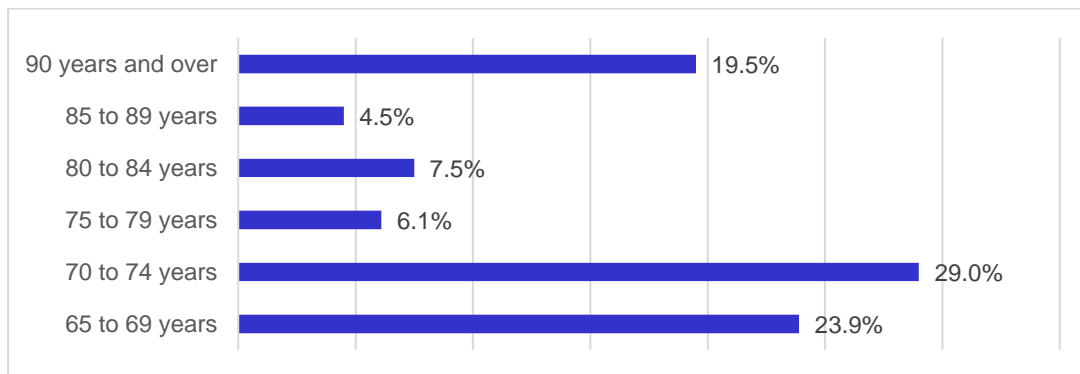


Figure 18 - Percentage of A&E admissions by age-group (four study providers)



The business case stated that: “significant growth is projected for population over 50”, with the following projection “[in the next 10 years] the 65-84 age group is projected to increase by around 22% and the 85 years and older group is projected to increase by 16%”. Like for like comparison is not possible to corroborate that projection, but latest census (2021) data indicates that growth is likely to be close to what was projected (see Figure 19).

Figure 19 - Over 65 Population Growth - Merton (from 2011 to 2021)



*“[Number of beds the Trust provides] should continue to be reviewed and refined as further population growth forecasts... are developed...” (Business Case)*

*“Older people tend to have a higher need for/use of emergency acute services” (Business Case)*

Female population growth of 6% (compared to JSNA report figures) is higher than male population of 3,9% (and overall Merton population, 5.8%) growth. Birth rates are declining compared to when the business case was developed– from 1.77 in 2019 to 1.49 in 2021 – no fertility rate projections were provided. Growth in female population could have implications for increased demand for Maternity and Paediatric services. However, this could be offset by declining fertility rates and a slower growth rate of population under 16 (2.9%) compared to the rest of the population (5.8%). Notably this is below, the business case “projected higher than average growth for population under

16”. Further analysis into current usage and capacity of Maternity and Paediatric services would provide better insights into potential implications.

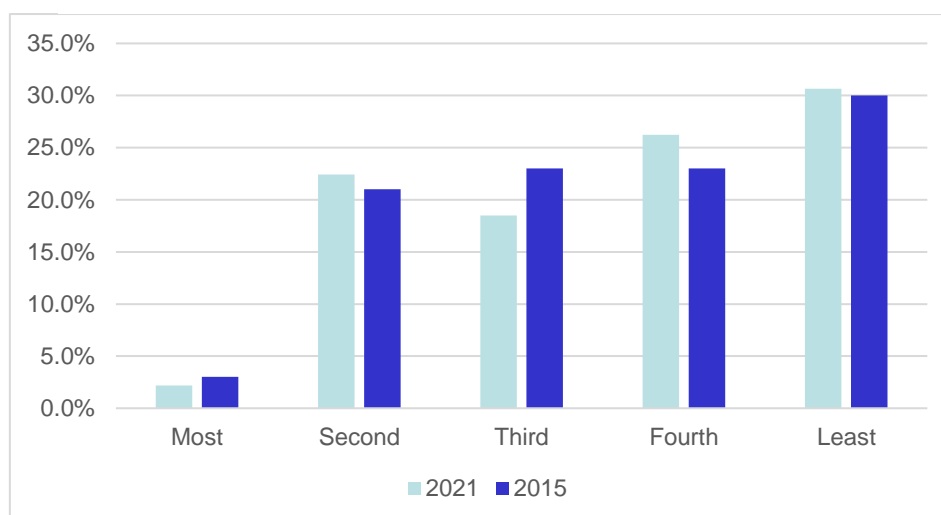
Fertility Rates - Merton Population

2018	2019	2020	2021
1.80	1.77	1.71	1.49

Source: ONS

Overall deprivation levels appear to have decreased slightly across Merton compared to when the original business case was developed (average IMD deprivation score decreased from 14.76 to 14.34). However, significant health and social inequalities remain between different wards (between the East and West of the borough).

Figure 20 - Merton Population by Deprivation Quintiles



An increase in prevalence of mental health disorders has been observed since the development of the original business case. Specific numbers for mental health prevalence in Merton are not included in the IIA – 2018. However, the analysis indicates that there is an increase in mental health prevalence (nationally and for Merton residents) after the COVID-19 pandemic (see Figure 21 below). This is relevant, as it is likely to increase demand for health and social care services. For example, a study found that patients with a mental health disorder were more likely than patients without a mental health disorder to have unplanned admissions (10.8% compared to 4.5%)<sup>17</sup>. Further, the Office for National Statistics (ONS) estimated that one in five adults experienced some form of depression during the pandemic, which is double the pre-pandemic rate.<sup>18</sup>

<sup>17</sup> Payne R. et al., (2013): 'The effect of physical multi-morbidity, mental health conditions and socioeconomic deprivation on unplanned admission to hospital: a retrospective cohort study'. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3602270/>

<sup>18</sup> <https://blog.ons.gov.uk/2021/05/05/are-we-facing-a-mental-health-pandemic/>

Figure 21- Mental Health Referrals - SW London ICB<sup>19</sup>



The analysis finds that broader population characteristics do not deviate vastly from when the business case was developed. However, some changes to population groups that are likely to drive demand for health services (population over 65, female population, mental health prevalence, fertility rates, and population under 16) were observed. In some case (e.g., population over 65 growth) there is alignment with business case projections. In the case of population under 16, the level of growth is below that projected in the business case. With the available data, it is not possible to determine the specific impact this could have on demand or healthcare experience for Merton residents. Further analysis, building on these findings is recommended.

### H3 - Areas for further investigation

Changes in population demographics are important to note – specifically when it comes to updating capacity models and demand-shift models.

- ❖ Growth in over 65 population could have implication for increased demand/cost of ED services for neighbouring providers – an updated demand model is recommended to ensure health needs would be met under current and planned investments.
- ❖ Growth in female population could have implications for increased demand for Maternity and Paediatric services. However, this could be offset by declining fertility rates and a slower growth rate of population under 16, compared to the rest of the population. Further analysis into current usage and capacity of Maternity and Paediatric services would provide better insights into potential implications.

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<sup>19</sup> <https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/mental-health-data-hub/statistical-publications>

## Appendix

Appendix 1A- Average (public transport) travel times at different times of day

Ward	Noon		Rush Hour		Night		Current Range		Post Range	
	Current Avg.	Post Avg.	Current Avg.	Post Avg.	Current Avg.	Post Avg.	Current Min	Current Max	Post Min	Post Max
Abbey	19.3	19.3	20.3	20.3	16.4	16.4	16.4	20.3	16.4	20.3
Cannon Hill	26.4	28.0	29.5	29.5	24.5	28.2	24.5	29.5	28.0	29.5
Colliers Wood	14.5	14.5	14.1	14.1	12.5	12.5	12.5	14.5	12.5	14.5
Cricket Green	24.2	30.1	25.5	30.3	18.6	24.3	18.6	25.5	24.3	30.3
Figge's Marsh	28.9	29.3	29.5	29.6	22.2	22.2	22.2	29.5	22.2	29.6
Graveney	21.9	21.9	22.0	22.0	17.2	17.2	17.2	22.0	17.2	22.0
Hillside	21.6	21.6	22.3	22.3	18.8	18.8	18.8	22.3	18.8	22.3
Lavender Fields	25.4	25.4	26.4	26.5	22.0	22.4	22.0	26.4	22.4	26.5
Longthornton	26.4	26.7	28.3	28.3	22.7	22.7	22.7	28.3	22.7	28.3
Lower Morden	29.4	32.7	33.2	35.2	25.0	26.6	25.0	33.2	26.6	35.2
Merton Park	23.0	25.4	25.0	25.4	19.1	24.1	19.1	25.0	24.1	25.4
Pollards Hill	28.0	28.0	30.5	30.5	26.7	26.7	26.7	30.5	26.7	30.5
Ravensbury	14.3	32.1	15.6	31.9	12.2	24.8	12.2	15.6	24.8	32.1

Raynes Park	21.6	21.6	22.6	22.6	19.3	19.3	19.3	22.6	19.3	22.6
St Helier	14.6	26.9	17.1	27.7	11.9	25.7	11.9	17.1	25.7	27.7
Village	28.9	28.9	29.6	29.6	23.7	23.7	23.7	29.6	23.7	29.6
Wandle	15.3	15.3	15.6	15.6	14.3	14.3	14.3	15.6	14.3	15.6
West Barnes	31.3	31.3	34.6	34.6	28.7	29.1	28.7	34.6	29.1	34.6
Wimbledon Park	24.5	24.5	24.5	24.5	19.2	19.2	19.2	24.5	19.2	24.5
Wimbledon Town & Dundonald	25.5	25.7	26.6	26.6	21.7	21.7	21.7	26.6	21.7	26.6

Appendix 1B- Longest (public transport) travel times at different times of day

Ward	Noon		Rush Hour		Night	
	Current Max	Post Max	Current Max	Post Max	Current Max	Post Max
Abbey	21.8	21.8	22.8	22.8	17.8	17.8
Cannon Hill	29.3	31.5	33.2	33.2	28.4	29.9
Colliers Wood	20.5	20.5	20.5	20.5	16.2	16.2
Cricket Green	29.2	38.2	30.9	40.0	23.1	31.3
Figge's Marsh	34.4	34.4	36.4	36.4	29.7	29.7
Graveney	27.6	27.6	26.6	26.6	21.6	21.6
Hillside	24.8	24.8	26.8	26.8	23.3	23.3
Lavender Fields	30.4	30.4	36.6	36.9	27.4	28.6
Longthornton	32.2	34.3	34.6	34.6	27.7	27.7
Lower Morden	36.2	36.2	37.4	37.4	29.9	29.9
Merton Park	31.5	32.2	28.9	29.3	23.6	28.3
Pollards Hill	35.2	35.2	38.2	38.2	31.7	31.7
Ravensbury	18.5	36.7	21.1	37.8	16.9	27.7
Raynes Park	27.1	27.1	28.1	28.1	23.6	23.6
St Helier	20.3	33.4	24.8	35.3	18.3	32.4
Village	35.7	35.7	36.7	36.7	29.9	29.9
Wandle	16.7	16.7	16.7	16.7	16.7	16.7
West Barnes	34.1	34.1	41.9	41.9	33.9	33.9
Wimbledon Park	34.5	34.5	33.5	33.5	25.5	25.5
Wimbledon Town & Dundonald	30.9	30.9	33.1	33.1	27.2	27.2

Appendix 1C- Average (driving) travel times at different times of day

Ward	Noon		Rush Hour		Night	
	Current Avg	Post Avg	Current Avg	Post Avg	Current Avg	Post Avg
Abbey	15.1	15.5	16.2	16.2	13.7	13.9
Cannon Hill	17.9	26.1	20.3	27.5	16.4	23.6
Colliers Wood	10.0	10.0	10.1	10.1	9.5	9.5
Cricket Green	14.8	20.1	15.3	21.1	13.8	17.6
Figge's Marsh	17.0	18.4	17.9	18.8	15.7	16.8
Graveney	14.1	14.1	14.5	14.5	13.4	13.4
Hillside	17.8	17.8	18.5	18.5	16.2	16.2
Lavender Fields	16.8	16.8	17.1	17.1	15.0	15.0
Longthornton	17.6	18.0	18.2	18.5	16.3	16.6
Lower Morden	14.2	23.9	15.2	26.1	13.2	22.1
Merton Park	15.8	22.0	18.0	23.7	14.6	19.5
Pollards Hill	14.9	14.9	14.9	14.9	14.1	14.1
Ravensbury	8.8	24.8	9.1	27.0	8.2	22.2
Raynes Park	18.5	19.0	19.5	19.8	17.0	17.4
St Helier	9.1	24.6	9.8	26.6	8.4	22.4
Village	17.7	17.7	18.6	18.6	16.5	16.5
Wandle	14.9	14.9	15.4	15.4	13.5	13.5
West Barnes	18.9	20.2	20.6	21.2	17.7	18.8
Wimbledon Park	13.6	13.6	14.2	14.2	12.4	12.4
Wimbledon Town & Dundonald	16.5	17.0	17.6	17.7	15.0	15.3

Appendix 1D- Longest (driving) travel times at different times of day

Ward	Noon		Rush Hour		Night	
	Current Max	Post Max	Current Max	Post Max	Current Max	Post Max
Abbey	22.2	22.2	23.7	23.7	19.3	19.3
Cannon Hill	27.8	36.9	33.2	39.6	24.3	31.5
Colliers Wood	17.3	17.3	17.6	17.6	16.5	16.5
Cricket Green	24.7	32.5	25.3	36.2	22.0	26.0
Figge's Marsh	23.1	27.9	26.4	28.8	21.0	24.3
Graveney	22.9	22.9	24.2	24.2	20.9	20.9
Hillside	27.6	27.6	29.4	29.4	24.2	24.2
Lavender Fields	24.6	24.6	25.6	25.6	20.9	20.9
Longthornton	25.9	27.7	28.2	27.9	23.4	25.1
Lower Morden	22.4	35.4	24.0	40.7	20.1	31.5
Merton Park	25.1	32.0	30.2	35.5	22.0	26.4
Pollards Hill	21.3	21.3	21.1	21.1	19.6	19.6
Ravensbury	15.5	35.2	17.2	39.7	13.8	30.1
Raynes Park	29.2	34.9	34.3	37.8	25.6	28.5
St Helier	15.4	36.8	16.8	40.5	13.9	31.4
Village	26.6	26.6	28.4	28.4	23.9	23.9
Wandle	21.2	21.2	22.1	22.1	18.1	18.1
West Barnes	27.9	33.2	32.5	34.7	24.7	28.7
Wimbledon Park	21.1	21.1	22.8	22.8	18.3	18.3
Wimbledon Town & Dundonald	28.1	30.9	33.2	33.1	24.8	24.9



Appendix 1E – Travel times Raw Data – Including Closest Hospitals by LSOA, Ward Pre and Post Proposed Changes



Merton Travel  
Times Raw Data

\*\*\* Data set embedded into document due to its large size.

Appendix 2A – A&E attendances by provider

Year-Month	St George's	Croydon	Epsom & St Helier	Kingston
<b>2019</b>	<b>141340</b>	<b>125912</b>	<b>122040</b>	<b>117964</b>
January	11306	10086	9755	9427
February	11070	9856	9525	9197
March	11754	10528	10197	9855
April	12062	10840	10509	10167
May	12372	11150	10819	10477
June	12860	11548	11217	10875
July	12558	11246	10915	10573
August	12256	10944	10613	10271
September	11774	10452	10121	9779
October	11492	10170	9839	9497
November	11109	9787	9456	9114
December	10727	9305	9074	8732
<b>2020</b>	<b>143425</b>	<b>126726</b>	<b>122742</b>	<b>118837</b>
January	11579	10338	10006	9764
February	11241	10017	9685	9442
March	11934	10606	10274	9932
April	12242	10895	10563	10221
May	12553	11184	10852	10510
June	13060	11673	11341	10999
July	12758	11352	11020	10678
August	12456	11041	10709	10367
September	11974	10529	10197	9855
October	11592	10118	9786	9444
November	11209	9697	9365	9023
December	10827	9276	8944	8602
<b>2021</b>	<b>137432</b>	<b>119157</b>	<b>115173</b>	<b>111170</b>
January	11135	9594	9262	8920
February	10807	9273	8941	8600
March	11494	9973	9641	9299

April	11802	10281	9949	9607
May	12110	10589	10257	9915
June	12518	11007	10675	10333
July	12216	10695	10363	10021
August	11914	10393	10061	9719
September	11432	9911	9579	9237
October	11050	9529	9197	8855
November	10668	9147	8815	8473
December	10286	8765	8433	8191
<b>2022</b>	<b>90125</b>	<b>77949</b>	<b>75233</b>	<b>72577</b>
January	10695	9173	8841	8509
February	10367	8845	8513	8181
March	10955	9433	9091	8759
April	11263	9741	9399	9067
May	11571	10049	9707	9375
June	12060	10538	10196	9864
July	11758	10236	9894	9562
August	11456	9934	9592	9260

Appendix 3A- Summary of review of Initial Inequalities (JSNA) report demographic indicators:

	<b>Previous Metric</b>	<b>Most Recent Metric</b>	<b>Comments</b>
Total Population	205,020 (2016)	215,324 (2021)	<ul style="list-style-type: none"> <li>• 5.8% Growth</li> <li>• Business case projection was higher (6.45% from 2014-2020)</li> </ul>
Age – specifically children (those aged 16 and under), young people (those aged 16-24) and older people (those aged 65 and over)	<ul style="list-style-type: none"> <li>• <b>Under 16:</b> 42,658 (2016)</li> <li>• <b>16-24:</b> 18,153 (2016)</li> <li>• <b>65 +:</b> 25,362 (2016)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Under 16:</b> 43,571 (2021)</li> <li>• <b>16-24:</b> 19,697 (2021)</li> <li>• <b>65 +:</b> 27,100 (2021)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Under 16:</b> 2.1% increase, proportion of population remains similar. Business Case: “<i>Merton is projected to see a notable growth in those under the age of 16 years</i>”</li> <li>• <b>16-24:</b> 8.5% increase, proportion of population remains similar.</li> <li>• <b>65 +:</b> 6.85% growth, proportion of population (12.6% from 12%) compared to 5.8% growth for Merton. Business case: “<i>Merton is projected to see a notable growth in those over 50 years</i>”</li> </ul>
Limiting Long-Term Illness (Used as metric for disabilities)	25,232 (2011)	25,902 (2021)	Proportion of population with LLTI decrease from 13 to 12%
Gender reassignment	1% of population (estimate)	0.7% of pop (2021 census)	• Previous census did not include question on gender identity – metric is new
Pregnancy and maternity	45,013 (2016)	47,685 (2021)	• 5.9% growth, proportion of total population constant (~22%)
Race and ethnicity	103,035 (2011) – BAME **	90,961 (2021)	** Comparison of statistics used in 2016 are not like for like. This is due to an Inequalities Commission report (2021) which found that aggregate terms like ‘BAME’ were no longer helpful and should be dropped
Sex	<ul style="list-style-type: none"> <li>• <b>Male:</b> 100,780 (2016)</li> <li>• <b>Female:</b> 104,249 (2021)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Male:</b> 104,700 (2016)</li> <li>• <b>Female:</b> 110,500 (2021)</li> </ul>	<ul style="list-style-type: none"> <li>• 6% growth in female residents</li> <li>• 3.9% growth in male residents</li> <li>• Proportion of total population female increased from 50.8% to 51.3%</li> </ul>
Carers	17,000 (estimate)	• 15,900 carers in Merton (2021 census)	• 7.4% of population reported providing some level of unpaid care
Deprivation	14.76 avg. deprivation score (2015)	14.34 avg. deprivation score (2021)	Average IMD deprivation score decreased slightly from 14.76 to 14.34 – suggesting a slight reduction in deprivation levels across Merton

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