South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030

30 April 2019

10.30 am at the

Surrey County Council County Hall, Penrhyn Road, Kingston upon Thames, KT1 2DW

To all members of the South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030:-

Chair:	Councillor Colin Stears
Vice-Chair:	Councillor Zully Grant - Duff
Councillors:	Councillor Peter McCabe

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Helen Bailey
Chief Executive
18 April 2019

Enquiries to: Cathy Hayward: Committee Services Officer Tel.: 020 8770 4990, Email: committeeservices@sutton.gov.uk

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A G E N D A

1. Welcome and introductions

2. Apologies for absence

3. Declarations of interest

4. Minutes of the previous meeting 1 - 4

To approve as a correct record the minutes of the meeting held on 7 February 2019.

5. Improving Healthcare Together Programme Update 5 - 12

The Improving Healthcare Together programme office provides an update report on the various activities undertaken and outlines future plans.

6. Consultation plan update

An update on consultation planning.

7. Stakeholder Reference Group (SRG) update 13 - 26

The report attached explains the role and responsibilities of the Stakeholder Reference Group (SRG) and provides an update on the work it has conducted and will be doing in the future.

8. Integrated Impact Assessment (IIA) - emerging findings 27 - 60

Mott Macdonald has been engaged by the Improving Healthcare Together 2020-2030 (IHT) programme to conduct an Integrated Impact Assessment of their developing plans. The covering report and summary report provide Mott Macdonald's emerging findings at this stage of their work.

9. Any urgent business

To consider any items which, in the view of the Chair, should be dealt with as a

matter of urgency because of special circumstances (*in accordance with S100B(4) of the Local Government Act 1972*).

10. Date of next meeting

The date of the next meeting is to be confirmed.

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SOUTH WEST LONDON & SURREY JHSC SUB-COMMITTEE - IMPROVING HEALTHCARE TOGETHER 2020-2030
7 February 2019 at 7.30 pm

MEMBERS: Councillors Zully Grant-Duff, Peter McCabe and Colin Stears

21. WELCOME AND INTRODUCTIONS

The Chair, Councillor Colin Stears, welcomed those present.

22. APOLOGIES FOR ABSENCE

There were no apologies for absence.

23. DECLARATIONS OF INTEREST

Councillor Colin Stears, Non Pecuniary, his wife works for the Epsom and St Helier Trust
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24. MINUTES OF THE PREVIOUS MEETING

RESOLVED: that the minutes of the meeting held on 28 November 2018 be agreed as an accurate record.

25. IMPROVING HEALTHCARE TOGETHER PROGRAMME UPDATE

Andrew Demitiades, Programme Manager, Improving Health Care Together presented the report.

Members asked about the response to the letter regarding the impacts on other hospitals in the area from the Programme Director and expressed concerns that it had not been shared with Members of the Committee. Sarah Blow, Accountable Officer, NHS SW London Alliance explained that the response had been provided to Merton Council as the sender of the original letter, but that the response letter could be shared with the Committee.

The Programme Manager confirmed that a work programme with dates and milestones would be refreshed and provided to Officers and Members of the Committee.

Members asked about the attendance criteria for members of the Programme team to these meetings, and requested that representatives from relevant local Commissioners attend.

26. A REPORT ON THE OPTIONS CONSIDERATION PROCESS BY TRAVERSE

Andrew Demitiades, Programme Manager, Improving Health Care Together presented the report.

Members expressed concern that none of the workshops had been held in Surrey, although noted that there had been one at Bourne Hall in Ewell, Members also noted that only one workshop had been held in the evening. It was noted that the same workshops had been repeated in each of the CCG areas, and a cross section of residents invited, the split of

attendees was 60% from the community and 40% staff, people had generally preferred to attend their nearest event.

Daniel Elekes, Chief Executive Epsom and St Helier Trust, mentioned that the workshops completed so far, will be become part of the work used by each CCG to develop a view and will support future work.

Members reported that residents have expressed concerns about accessibility of proposed sites, and held the view that they would need to be able to park any site chosen. The Programme Director assured Members that all comments made at workshops are being logged, and information about parking and transport concerns will be included.

The design for each of the sites being considered includes a multi storey car park, the cost of the car park in the design at each site is similar. Bus services paid for by the Trust will start next week, the H1 bus from St Helier hospital to Epsom hospital and the 293 route being diverted to pass close to St Helier hospital.

27. RESPONSE FROM EPSOM & ST HELIER UNIVERSITY HOSPITALS NHS TRUST TO THE REPORT ON THE OPTIONS CONSIDERATION PROCESS BY TRAVERSE

Daniel Elekes, Chief Executive Epsom and St Helier Trust presented the report.

It is recognised that capital investment is required in order to progress any of the options. The process of securing the capital investment required will be completed before public consultation begins. As the patient numbers is the same for each of the options the capital funding required for each of the options is also the same.

The completion of this project is some way ahead, and therefore the Chief Executive, Epsom and St Helier Trust suggests the process does not affect staff recruitment and retention. However, the investment being completed on buildings at the moment which is improving working conditions is making recruitment easier.

28. REPORTS FROM LOCAL HEALTHWATCH ON FOCUS GROUPS WITH PROTECTED CHARACTERISTIC GROUPS

Matthew Parris, Healthwatch, Surrey and Pete Flavell, Healthwatch, Sutton presented the reports.

In discussion it was noted that urgent care treatment and the ways in which people present for urgent care is changing and will change in the future. Use is being made of Local Plan, and best evidence available of Community and long term plans to understand the changes to urgent care provision and use.

The Chair informed a local resident who asked, that nothing has been agreed to date and that residents will be able to share their views when the formal consultation of options becomes available.

Healthwatch (Sutton) confirmed that they would carry out further resident engagement when more information about the options becomes available. This engagement work will be used by the CCGs.

29. IMPROVING HEALTHCARE TOGETHER (IHT) PROGRAMME EQUALITIES RESPONSES TO HEALTHWATCH REPORTS

Dr Russell Hills, Clinical Chair Surrey Downs CCG presented the report.

The initial work for phase 2 will be starting next month, which will develop the initial work further, the scope of this phase is included in the report.

Members asked about the recruitment process to the post of Independent Chair of the IIA Steering Group, and heard that the standard recruitment process had been used and the selection panel included the Chair of the Programme Board and The Managing Director of a CCG.

30. ANY URGENT BUSINESS

There was no urgent business.

31. DATE OF NEXT MEETING

The date of the next meeting is to be confirmed.

Chair: .....

Date: .....

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Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:** 30 April 2019	
Report title:	Improving Healthcare Together Programme Update		
Report from:	David Olney, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author(s)/Contact Number(s):	David Olney, Statutory Scrutiny Officer, 020 8770 5207		
Corporate Plan Priorities:	• Being Active • Making Informed Choices • Living Well Independently • Keeping People Safe		
Open/Exempt:	Open		
Signed:	David Olney	**Date:**	16 April 2019

1. Summary

1.1 The Improving Healthcare Together programme office provides an update report on the various activities undertaken and outlines future plans.

2. Recommendations

The South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030 is recommended to:

2.1 Note the report.

3. Background

3.1 The Improving Healthcare Together 2020-2030 programme uses an update report to provide sub-committee members with a summary of the recent activity undertaken by the programme and to indicate future activity in the workplan.

4. Appendices and Background Documents

Appendix letter	Title
A	Improving Health Care Together 2020- 2030 - briefing Paper

Audit Trail		
Version	Final	Date: 16 April 2019

Background documents
None

Joint Health Overview Scrutiny Sub-Committee

Improving Healthcare Together 2020 – 2030

Briefing Report

30th of April, 2019

1. Introduction

The following briefing paper has been prepared for the Improving Healthcare Together (IHT) 2020 – 2030 Joint Health Overview Scrutiny Sub-Committee (JHOSC). It includes updates as requested by the Sub-Committee on the:

- Improving Healthcare Together programme update, including a revised programme timeline (Appendix 1)
- Outline consultation plan (see section 2d included in the briefing report)
- Integrated Impact Assessment emerging findings by Mott Macdonald (Attachment 1)

2. Improving Healthcare Together programme update

a) Programme process and timelines

The revised programme timeline has been shared with Scrutiny Officers on the 15th March 2019 which has been developed with input from our regulators NHS England and NHS Improvement which aims to achieve programme readiness for consultation. A proposed IHT JHOSC workplan was also shared for Member consideration for the time period June to August 2019.

Members are asked to note that all programme timelines are subject to change and Committees in Common approval. We will only proceed to consultation when our plans have been assured and we have secured the support in principle for the capital investment needed to make our plans a reality.

A draft pre-consultation business case (PCBC) has been submitted to our regulators, NHS Improvement (NHSI) and NHS England (NHSE), and the Joint Clinical Senates of London and South East have completed the assurance of all our work and evidence gathered to date to ensure that the proposed plans are financially and clinically viable for patients and the public.

An update on the clinical model and Clinical Senate report will be shared with the IHT JHOSC in May as per the proposed workplan.

The programme is progressing a number of key areas of work through 2019. These include exploring further evidence on the impact on providers, phase 2 of the Integrated Impact Assessment and the co- production of a draft consultation plan.

Any further evidence that will come out of this work, alongside the feedback from NHS regulators, and the Clinical Senate in conjunction with the JHOSC Sub-Committee and any new/additional information received, which may impact on the options, will be considered before determining our readiness to proceed to a public consultation on any proposals.

No preferred option(s) have been decided at this point or any decisions made. No decisions will be taken until after a public consultation.

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b) Engagement and outline consultation planning

As part of the Programme's ongoing engagement activity it continues to engage with the health, community and patient forums across the combined geographies to: provide updates on the programme's work, gather feedback and identify further engagement opportunities.

The Stakeholder Reference Group (SRG) continues to meet and last met on March the 7th 2019. The key focus of the meeting included:

- a presentation on the Integrated Impact Assessment work (phase 2)
- feedback following a review of the SRG as requested by the SRG Chair, David Williams and,
- a review of the draft Terms of Reference for the Consultation Oversight Group (COG).

David Williams, (SRG Chair) will provide feedback on the SRG review at the IHT JHOSC meeting on the 30th of April.

c) Consultation Oversight Group

As the programme moves from pre-consultation engagement towards planning for a public consultation it will begin to develop a draft consultation plan. To support this process, a small forum tasked with oversight of the public consultation exercise is required. Working on a best practice approach, a small, working group – known as the IHT Consultation Oversight Group (COG) will be established to represent seldom heard communities which rarely participate in consultations, provide input into the development of consultation material and contribute to the stakeholder mapping exercise.

Using the expertise, knowledge and insights of the community representatives who sit on the Integrated Impact Steering Group will help to enhance the work of the COG and ensure appropriate representation. The Group will convene in May, 2019.

d) Outline consultation plan

The consultation plan will set out an approach to formal, public consultation and how communities, key interest groups and stakeholders will be further involved and engaged for the period up to, during and after consultation. All methods and engagement activities will be determined and designed in line with evidence of effectiveness and best practice in conjunction with advisory support by The Consultation Institute.

The development of the plan is an iterative process which will be shared and tested with the IHT JHOSC, key partners and members of the Consultation Oversight Group to support the development of the plan and ongoing programme of engagement.

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The proposed sections below include key components of the draft consultation plan:

1) Aim and purpose of the plan
2) Aim and objective of the consultation
3) Principles of consultation
4) Legal requirements for consultation
5) Updated findings of pre-engagement and pre-consultation engagement activity
6) Consultation approach: how we will reach all stakeholders to ensure our methods are inclusive and tailored to each stakeholder group
7) Consultation Mandate (a document agreed by consultors on the clarity and purpose of consultation)
8) Existing mechanisms for consultation (e.g Health and Wellbeing Boards, Patient and Public Participation Groups)
9) Stakeholder mapping
10) Consultation activities
11) Communication materials
12) Communication channels
13) Mechanisms for reporting consultation feedback and presentation of findings
14) High level timeline for preparation of consultation materials
15) Consultation timeline to include key dates for deliberation of findings up to decision making point.

The following table below confirms the proposed timetable for sharing components of the draft plan with the IHT JHOSC.

May 2019	June 2019	August 2019
Update on: 1. Aim and purpose of the plan 2. Aim and objective of the consultation 3. Principles of consultation 4. Legal requirements for consultation	Update on: 1. Consultation approach 2. Consultation Mandate 3. Existing mechanisms for consultation 4. Stakeholder mapping 5. Communication channels 6. High level timeline for preparation of consultation materials 7. Consultation timeline	Update on: 1. Updated findings of pre-engagement and pre-consultation engagement activity 2. Consultation activities 3. Communication materials 4. Mechanisms for reporting consultation feedback and presentation of findings

Members are asked to note the key components of the draft plan and proposed timetable for sharing further content between June – August 2019.

e) Impact on other providers

The IHT Programme are is continuing to work with all providers to understand the impact of each option. This work is primarily being undertaken through a specific Provider Impact Technical Group, comprising provider Directors of Strategy from each Trust. The group has developed and agreed a shared set of working principles and an overall process.

This group is considering the activity impact on affected Trusts including bed, theatre and diagnostics capacity and the resulting requirements for estates, finance (revenue and capital) and workforce. The work involves quantifying the potential impacts as well as considering deliverability.

It is recognised that this is a complex piece of work which needs to satisfy the needs of a number of boards. Providers are aiming to take analysis and impacts through their boards – using a consistent and standardised template and series of methods – in late May early June.

The provider impact analysis will support the PCBC and comparison of options when CCG governing bodies consider how to take this work forward, including any submission of a draft PCBC and any subsequent decision-making.

f) Finance, Activity and Estates

The IHT Programme is continuing to develop our financial analysis and this will be informed by feedback received as part of the assurance process. We are also updating our work for the latest planning round (19/20).

The programme is developing a proposition for how the capital needed will likely be sourced, for example how much money from central government will likely be needed, and how much could be available from other sources. This proposition continues to be tested and refined with regulators. The programme will need to determine the most appropriate financing route as well as secure in due course the capital investment needed prior to launching any formal public consultation.

g) Integrated Impact Assessment

The IHT programme has commissioned independent specialists Mott Macdonald to undertake an Integrated Impact Assessment (IIA) to understand the full range of potential impacts that proposals could have on the local population and potential solutions. A copy of the IIA scope was shared with Members at the IHT JHOSC Sub-Committee on the 7th of February 2019.

Brian Niven, Director at Mott Macdonald will present emerging findings to the IHT JHOSC. Attachment 1 includes Mott Macdonald's covering report and presentation.

Further information regarding Improving Healthcare Together 2020-2030 can be accessed via the website: https://improvinghealthcaretogether.org.uk/contact/.

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NHS Surrey Downs, Sutton and Merton CCGs

Appendix 1: Outline IHT Programme Timeline

	Phase	Outputs	Governance route	Decision point
1	Pre-consultation engagement	• Early engagement on *Issues Paper*, including case for change, emerging clinical model and provisional solutions development framework • Phase 1 Integrated Impact Assessment (IIA) scoping: initial equality analysis and baseline travel analysis	June 2018 **Committees in Common in public**	**Decision to engage on *Issues Paper***
2	Initial option consideration	• Public and stakeholder feedback on engagement activities • Co-production of non-financial criteria, weighting and scoring of options	June – November 2018	
3	Regulatory assurance	• Draft Pre-Consultation Business Case submitted to NHS regulators • Provider impact analysis and Phase 2 IIA development • Regulator review of PCBC and Clinical Senate review of clinical model • Development of consultation plan in conjunction with JHOSC and SRG	December 2018 – June 2019	**WE ARE HERE**
4	Review of assurance and consultation planning	• Further consideration of evidence by Governing bodies • Public engagement on further evidence • Feedback from NHS regulators • Approvals from National oversight (OGSCR) and Investment Committee	June – August 2019	
5	Decision to proceed to consultation	• Final PCBC approval with preferred option(s) identified for consultation • Approval of consultation plan • Governing bodies decision to proceed to consultation	September 2019 **Committees in Common in public**	**Decision to proceed to consultation**
6	Consultation	• Consultation	September 2019 – January 2020	
7	Consideration of consultation outputs & decision making	• Independent review of consultation responses • Consideration of full post-consultation IIA (Phase 3) • Decision on agreed option • Development of decision-making business case for approval by regulators	Spring 2020 **Committees in Common in public**	**Decision to proceed with agreed option**

ALL TIMINGS ARE SUBJECT TO CHANGE AND COMMITTEES IN COMMON APPROVAL

Improving Healthcare Together 2020-2030

NHS Surrey Downs, Sutton and Merton CCGs

NHS

Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:** 30 April 2019	
Report title:	Stakeholder Reference Group update		
Report from:	David Olney, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author(s)/Contact Number(s):	David Olney, Statutory Scrutiny Officer, 020 8770 5207		
Corporate Plan Priorities:	• Being Active • Making Informed Choices • Living Well Independently • Keeping People Safe		
Open/Exempt:	Open		
Signed:	David Olney	**Date:**	16 April 2019

1. Summary

1.1 The report attached explains the role and responsibilities of the Stakeholder Reference Group (SRG) and provides an update on the work it has conducted and will be doing in the future.

2. Recommendations

The South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030 is recommended to:

2.1 Note the report.

3. Background

3.1 The SRG was established in the summer of 2018 to provide a mechanism to help ensure appropriate stakeholder involvement in the development of the plans for local health services under the Improving Healthcare Together 2020-2030 programme. Members act as ambassadors for the programme and representatives of their organisation.

3.2 The report attached from the independent Chair of the SRG explains the work which has been undertaken and plans for what will be undertaken in future as the Improving Healthcare Together 2020-2030 programme develops.

4. Appendices and Background Documents

Appendix letter	Title
A	Report on the Stakeholder Reference Group (SRG)

Audit Trail		
Version	Final	Date: 16 April 2019

Background documents
None

Improving Healthcare Together 2020 – 2030

Joint Health Overview Scrutiny Sub-Committee

Report on the Stakeholder Reference Group (SRG)

David Williams, Independent Chair of SRG

1. Purpose

This paper has been prepared by David Williams, Independent Chair of the Stakeholder Reference Group and Chair of Sutton Healthwatch, for the Improving Healthcare Together 2020 – 2030 JHOSC Sub-Committee. The paper aims to capture the key findings of an internal review of the work of the Stakeholder Reference Group to date and outline next steps in terms of the programme's proposed engagement activity.

2. Background and context

As part of the Improving Healthcare Together programme's governance structure, a Stakeholder Reference Group (SRG) was convened in May 2018 to act as a critical friend to the IHT programme and create a space for wider conversation and offer views, suggestions and opinions on:

- The plans for public engagement, including pre-consultation engagement and any subsequent consultation activities that may be undertaken.
- The language, tone and style of public consultation materials including, for example, consultation documents and leaflets.
- Which seldom-heard groups should be consulted and what forms of consultation would be most appropriate for these groups.

Appendix A outlines the Terms of Reference for the SRG.

SRG includes representation from over 100 voluntary, community, patient, carer and equality groups in addition to Healthwatch, local authorities, campaign groups and housing associations.

To date the SRG has met eight times across each CCG locality on the following dates:

- 15th May 2018, at Epsom Hospital, Surrey
- 13th June 2018, at Raynes Park Library, Merton
- 18th July 2018, at Sutton Life Centre, Sutton
- 15th August 2018, at St Mary's Church, Stoke D'Abernon, Surrey
- 19th September 2018, at Sutton Life Centre, Sutton
- 17th October 2018, at Lantern Art Centre, Raynes Park, Merton
- 27th November 2018, at Dorking Halls, Surrey
- 7th March 2019, at Sutton Life Centre, Sutton

Agendas for each meeting are constructed around SRG member requests and agreed with the Chair.

Attendance of SRG members at meetings has varied from 13 to 5 attendees. All invited representatives receive copies of the papers from each meeting and are given the opportunity to provide feedback outside of the SRG meeting. In addition, the IHT newsletter is sent to every invited SRG member/organisation to provide regular updates outside of the meeting.

SRG members are given the opportunity and encouraged to share news and information about the programme with their partners, networks, groups and service users.

To date the SRG has been involved in the following ways:

- As a sounding board for the programme;

- Review and input into the programme's plan for public engagement including the production of the programme's website, subtitled animation video and mobile engagement work. For example, following the feedback at SRG, an animation video with subtitles was produced. This has been reviewed by and agreed with the Surrey Coalition for Disabled People (an SRG member).

- Reviewed and made recommendations in relation to the programme's options consideration process and Terms of Reference for the evaluation workshops. Members of this group were also involved in the latter process in an observer capacity.

- Feedback on key findings such as the pre-engagement analysis report and the Integrated Impact Assessment (phase 1 and phase 2).

- Review of the proposed process for consultation planning and development of the Consultation Oversight Group (COG).

3. Evaluation and feedback

As the pre-engagement phase of the programme has drawn to a close, by way of good practice the programme has taken the opportunity to review the SRG as requested by the Chair. The review aimed to capture SRG members' views and reflections in relation to the:

- SRG's role and objectives
- Expectations of the group
- What has worked well and recommendations for the future structure of SRG meetings
- The effectiveness of the group and member engagement methods; and
- Whether SRG members feel they have been meaningfully involved

The Chair suggested two sample questionnaires should be developed tailored to members' level of involvement in this group:

1) A questionnaire for frequent SRG members who have attended this group's meetings at least once
2) A questionnaire for members who haven't attended any SRG meetings

Interviews were conducted via telephone.

The programme reached out to 18 SRG participants from the voluntary sector for the purpose of this review.

The following organisations were contacted:

- Heathwatch Sutton
- College Ward Residents Association
- Surrey Coalition of Disabled People
- Age UK Surrey
- Age Concern
- Merton Mencap/HW

- Keep Our St Helier Hospital
- Stroke Association
- Sight for Surrey
- African & Caribbean Heritage Association
- Homestart Merton
- Alzheimer's Society
- Fibromyalgia Group
- Sight for Surrey
- Surrey Community Action
- Wayside Keychange Charity
- YMCA East Surrey

Six SRG members participated in this exercise. These included four frequent attendees at SRG meetings and two members who only attended meetings once. No response was received from SRG members who had not previously attended any meetings.

Because of the number of people/organisations who chose to take part in the review, the following responses captured provide a snapshot of opinion and a partial picture of perceptions and views.

The summary below outlines key findings from the feedback:

- **Terms of Reference and objectives of the group**: Most respondents found the Terms of Reference and objectives of the group to be clear. Half of the participants felt the aims of the group had been achieved while two respondents were unsure and one disagreed.

- **SRG attendance:** A mixture of reasons regarding respondents' attendance at meetings were provided. These included: being passionate about the discussions, wanting to contribute and ensure that different equality groups are represented and the opportunity to network with peer organisations.

- **Expectations from the group:** Most SRG members attended the group as they wanted to learn more about healthcare developments and services in their local areas and ensure that the views of the voluntary sector and/or needs of different local groups were heard and represented. There was also a view and expectation around the CCGs response to the feedback provided and issues raised at the meetings.

- **SRG format:**
  - The need to use more plain English at the meetings.
  - The potential for the SRG to be seen as a 'tick-box' exercise.
  - The presence of people with strong feelings with particular interests for whom the aims of SRG might come second.
  - The group sometimes functions only in an advisory capacity being more of a 'discussion' rather than an 'action forum'.

- **Format of SRG meetings:** It was felt that the engagement methods used generally worked well. These included holding the meetings at different times in the day and in different areas, the notes, recommendations log, programme updates and the invites.

- **Impact of SRG:** It was felt by members that they were able to contribute to discussion and that their contribution to SRG has had an impact on the programme. In this sense, all SRG members felt that the process was worthwhile.

Recommendations for future SRG meetings included:

- **Agenda structure**: a view was expressed around the high number of agenda items to be covered in the time available

- **Content**: Some respondents felt that some of the updates and reports presented were long.

- **Engagement with the group – membership and attendance:**
  - Some people felt that attendance at meetings by the same people or organisations sometimes resulted in the discussion and questions sessions being influenced by the same people. One view highlighted that this limited other people's ability to input at meetings.
  - The number of questions raised at the meetings sometimes meant the meetings overran which meant some agenda items did not receive full coverage
  - One respondent identified that further consideration could be given to how the recommendations made and questions raised by SRG members could be addressed
  - A respondent felt that the way in which the comments and recommendations were considered by the CCGs is not clear.

- **Administration of meetings:** SRG members highlighted the need for more parking availability for attendees and longer lead in times for papers and meeting notes.

- **SRG format:**
  - Respondents suggested taking a thematic approach to workshops with further sub-group opportunities, to adopt a more tailored approach for each CCG area and different local groups, as well as approach organisations on an individual basis with tailored programme updates.

This survey findings was shared with SRG members at the meeting on the 7th March to ensure that the needs of members are met moving forward. SRG members generally responded positively and agreed with the findings.

4. Next steps

a) Next steps for SRG following the review:

SRG will continue to play a vital role in supporting the work of the programme. The next SRG meeting is currently being planned for May. This will focus on reviewing the clinical model and the draft findings of the Phase Two Integrated Impact Assessment interim report.

In addition to SRG proactive outreach activity will carried out to ensure there is continued information-sharing and communication with the community through local forums and networks.

b) Development of a Consultation Oversight Group (COG)

As the programme moves from pre-consultation engagement to planning for a potential public consultation, a small forum tasked with oversight of the public consultation exercise is also required. The COG will include representation from seldom heard communities which rarely participate in consultations. This group will aim to input into the consultation planning process, assure consultation materials and contribute to the stakeholder mapping exercise.

The Terms of Reference for this group are detailed in Appendix B.

A date for the first meeting of the COG will be scheduled for the end of May following recruitment to the group which is on-going and being pursued actively.

Some of the local groups approached to date which is by no means exhaustive include:

Sutton: Sutton Mental Health Foundation, Sutton Womens Centre (support for women experiencing domestic violence), The Inspire Partnership (drug and alcohol abuse support group with access to service user forums plus an outreach team based at St Helier) and Sutton Night Watch (reach to homeless community).

Merton: Merton Voluntary Services Council, AFC Wimbledon (football club for reach to young men and the working well), Inner Strength Network (for reach to women and girls who have experienced significant life challenges), Commonside Development Trust (for reach to deprived groups), Evolve Housing (reach to young mothers) and SPEAR (reach to homeless community).

Surrey Downs: Surrey Coalition for Disabled People, Surrey Gypsy Forum (representative recruited), LeatherHEAD start (reach to the homeless community), AFC Banstead (local football club with reach to young men and the working well) and Voluntary Action Mid-Surrey (reach through community networks).

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NHS

Appendix A:

Surrey Downs, Sutton and Merton Clinical Commissioning Groups Stakeholder Reference Group (SRG) Terms of Reference

(13 June 2018)

Preamble

The Stakeholder Reference Group has been set up to help ensure appropriate stakeholder involvement in the development of local health services.

Work being undertaken by the Improving Healthcare Together 2020- 2030 programme may result in formal public consultation at some point in the future.

The membership of the SRG will comprise a number of representatives from different communities of interest in the local area including patient groups, community groups, voluntary groups etc. who indicate that they wish to be involved in the programme.

Members will be encouraged to bring the views of their communities to the table rather than their own personal views. They will also be encouraged to share the thinking of the SRG with their respective communities between formal SRG meetings.

Objectives

The SRG will offer advice, views, suggestions or opinions on:

- The plans for public engagement, including pre-consultation engagement and any subsequent consultation activities that may be undertaken.
- The language, tone and style of public consultation materials including, for example, consultation documents and leaflets.
- Which seldom-heard groups should be consulted and what forms of consultation would be most appropriate for these groups.

(Note: People in seldom-heard groups face multiple barriers affecting access to public consultations. The term ‘seldom-heard groups’ refers to under-represented people who use or might potentially use health services and who may be less likely to be heard by decision-makers.)

Principles

The programme is committed to a best practice, transparent approach which engages and involves local people and communities at every step of the programme. NHS England recommends an approach based on co-production with patients and the public.

Our communications and engagement will follow the six principles of:

1. Transparency: information about the programme will be freely available online
2. Inclusivity: we will seek to involve local people and stakeholders at every stage
3. Listening: considering all feedback, publishing it and responding to it
4. Partnership: all partners in the programme will work to an agreed protocol
5. Meeting best practice: we will meet and where possible exceed our legal responsibilities under the Health and Social Care Act and the Equality Act.

Chair and format

The SRG will be independently chaired.

The format of the meeting will vary depending on the size of the membership, which may change as the programme progresses. The format will be decided by the chair.

Working groups

A number of working groups may be formed to discuss specific elements of the programme.

The SRG chair will suggest a chair for each sub-group. All sub-group chairs will report to the SRG chair.

The sub-groups will follow the same objectives, matters for consideration and process described on this document.

Matters for consideration by the SRG

Advice, views, suggestions or opinions from SRG will take full account of the following established criteria:

- Engagement and/or consultation should include some traditional activities (e.g. drop in events) and some more innovative activities.
- Engagement and/or consultation should be proportionate (i.e. neither excessive nor modest in scale).
- Consultation communication should be clear, concise and as easy to comprehend as possible.
- Documents intended specifically for the public should be jargon free and couched in plain English.
- Any public consultation document should be accessible and not too long.
- Any more detailed information should be published on the consultation website.

Process

- The SRG will meet every four to six weeks through to the end of any public consultation period.
- Meetings of the SRG will be supported by the Improving Healthcare Together 2020- 2030 programme which will provide secretariat support, circulate agendas and take minutes for approval by the SRG.
- Any advice, views, suggestions or opinions expressed by the SRG will be presented to the Improving Healthcare Together 2020- 2030 programme.
- The Improving Healthcare Together 2020- 2030 programme will respond to any SRG recommendations in writing in order to establish a clear two-way audit trail.

- The SRG may call upon independent experts to provide evidence or advice if required, through its Chair, as well support from the programme, in order to ensure it fulfils its obligations.

Outputs

The SRG has an extremely important role in being an independent voice in any potential changes to services.

The SRG will be encouraged to submit advice, views, suggestions or opinions on how high quality, safe and sustainable healthcare services can be delivered to local people in the years ahead.

It might also include how the Programme can work as effectively as possible with its residents.

Through the process outlined above, this feedback will inform into the development of the emerging thinking of the Programme and the resulting scenarios.

Constitution, decision making and behaviours

Members act as ambassadors for the programme and representative of their organisation. They are responsible for engaging with colleagues within their constituent organisation.

Where possible, the Group will reach consensus in deciding recommendations and will act in an advisory capacity. The Group will have no powers other than those included in this Terms of Reference.

Members will be expected to provide information as required to support accurate analysis and decision making.

Members will be expected to respect different views, speak through the independent Chair and allow everyone to have their say.

Attendance is by invitation only. It is not a meeting in public, nor a public meeting. There will be no recording, audio or visual, at the meeting.

Conclusion

The role of the SRG is to offer advice, views, suggestions or opinions on the matters described in these terms of reference.

Consideration of any options for change that may be taken to public consultation in due course is a matter for local health commissioners. Individual members will be free to express their own personal views.

Document last reviewed: At the SRG meeting on 19th September 2018

Improving Healthcare Together 2020-2030
NHS Surrey Downs, Sutton and Merton CCGs

NHS

Appendix B:

Improving Healthcare Together 2020 – 2030

Consultation Oversight Group

Terms of Reference

Purpose:
The purpose of the Consultation Oversight Group is to help ensure an Improving Healthcare Together 2020 - 2030 consultation on proposed improvements to emergency services at Epsom and St Helier Hospital makes every effort to reach communities who do not usually engage in public consultation exercises.

Seldom heard communities include (not exhaustively):

- The working well
- Children and young people in the care system
- People who are homeless
- Young men
- People with substance and/or alcohol abuse needs
- Refugees, migrants and asylum seekers
- The Gypsy, Roma and Traveller community
- Male / female victims of rape, sexual abuse, domestic violence and trafficking
- Domestic servants
- People who are HIV+
- People disadvantaged by poverty
- People who are housebound
- People with mental health needs

As a group we will make suggestions, offer advice and look for evidence of compliance with the following consultation principles set out in the IHT consultation plan to ensure the above:

- Are seldom heard communities being provided with a range of opportunities to be involved regardless of who they are and where they live?
- Is the information being provided in consultation materials clear, concise, honest and accurate so that people can make an informed decision based on a full understanding of the proposed options?
- Is information being provided in a variety of formats to ensure that everyone has the opportunity to access it?
- Is the consultation process open and transparent?
- Do the methods being used to consult suit the needs of a range of audiences?
- Has the actual engagement activity conformed to the planned activity?

- Have we captured key seldom heard communities in situ across the three CCG localities?

Facilitation:
The group will be chaired by David Williams, Chair of Sutton Healthwatch.

The day to day management and administration of the group will be hold by the IHT programme team.

Membership:
Attendance is by invitation only. The Consultation Oversight Group is not a meeting in public, nor a public meeting. There will be no recording, audio or visual, at the meeting. Membership will include a maximum of 10 voluntary, community or patient representatives.

The role is not an individual one but rather to bring the views of the community they represent to the group and to share the thinking of the group with that community between meetings.

Internal:

IHT consultation lead
IHT Patient and Public Engagement Lead (Secretariat)
Sutton CCG PPE Lead
Surrey Downs CCG PPE Lead
Merton CCG PPE Lead

External
Voluntary Action Mid-Surrey
Merton Voluntary Service Council
Community Action Sutton
Others – e.g. gypsy representative from Surrey Downs, Refugee and Migrant Network

Frequency of meetings:
Meetings will be interactive and last no longer than one and a half hours. Wherever possible the meeting format will be adjusted to facilitate attendance and meet participant needs such as holding meetings via Skype, teleconference and in rotation across the three CCG areas.

The group will meet monthly in the run up to public consultation and then at two or three weekly intervals during the life cycle of the consultation until the closing date of the consultation period.

These Terms of Reference will be reviewed upon conclusion of the public consultation taking account of feedback provided by the Group.

Agendas and papers:
The Group will be supported administratively by the IHT Team whose duties in this respect will include:

- Agreement of the agenda with the Chair, liaison with attendees and distribution of papers for each meeting sent out at least three days in advance.
- Taking notes, keeping a record of matters arising and issues to be carried forward
- Advising the Group on pertinent areas

Minutes:

A set of formal minutes will not be produced for these sessions - however a summary of discussions will be provided following each meeting. The notes of each meeting will be published on the IHT programme website.

Scope:
The role of the Consultation Oversight Group is to offer advice, suggestions, views and opinions on the matters described in these Terms of Reference.

Consideration of the option or options that will be taken to public consultation is a matter for Surrey Downs CCG, Merton CCG and Sutton CCG. The Consultation Oversight Group will not be required to advise on the options to be consulted upon. This means that individual members of the Consultation Oversight Group will be free to express their own views on the option(s) and / or the views on any organisation they represent in any way they wish.

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Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:** 30 April 2019
Report title:	Improving Healthcare Together Programme: Integrated Impact Assessment - emerging findings	
Report from:	David Olney, Statutory Scrutiny Officer	
Ward/Areas affected:	Borough Wide	
Chair of Committee/Lead Member:	Councillor Colin Stears	
Author(s)/Contact Number(s):	David Olney, Statutory Scrutiny Officer, 020 8770 5207	
Corporate Plan Priorities:	• Being Active • Making Informed Choices • Living Well Independently • Keeping People Safe	
Open/Exempt:	Open	
Signed:	David Olney	**Date:** 16 April 2019

1. Summary

1.1 Mott Macdonald has been engaged by the Improving Healthcare Together 2020-2030 (IHT) programme to conduct an Integrated Impact Assessment of their developing plans. The covering report and summary report provide Mott Macdonald's emerging findings at this stage of their work.

2. Recommendations

The South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030 is recommended to:

2.1 Note the report.

3. Background

3.1 As part of a range of activities being undertaken by the IHT programme Mott Macdonald has been engaged to conduct an Integrated Impact Assessment (IIA). The IIA is an ongoing process

with a number of phases taking place across the course of the development of the plans and consultation processes. The reports attached provide a briefing on the emerging findings at phase 2 of this work.

4. Appendices and Background Documents

Appendix letter	Title
A	Cover report IIA emerging findings
B	Mott Macdonald Integrated Impact Assessment – draft findings Phase 2

Audit Trail		
Version	Final	Date: 16 April 2019

Background documents
None

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Joint Health Overview Scrutiny Sub- Committee

Improving Healthcare Together 2020 – 2030

Integrated Impact Assessment

Briefing Paper

30th of April 2019

1. Context

The IHT Programme have commissioned independent specialists Mott Macdonald to undertake an Integrated Impact Assessment (IIA). Full details of the scope of this work can be found in Appendix 2.

Mott MacDonald are preparing an interim draft report for review by the Integrated Impact Steering Group. The following, briefly outlines their methodological approach and provides an indication of the early findings, drawing on the discussions which came out of their engagement with protected characteristic and equalities groups in the local communities.

The IIA is designed to be an iterative process that can be revisited over the course of the proposal development and consultation processes. The work has been structured around three phases (see below). We are current completing phase 2 of the work.

Table 1: IIA Phases

Phase	Activities	Outputs	Status
✓	**Phase 1: Baseline** The work undertaken in phase one is to investigate the current situation (the baseline) and to identify what needs to be considered going forward.		
1.a	✓ Initial equalities analysis to identify which protected characteristic groups may have a disproportionate need for services. • It identifies and separates differing profiles of people and their experiences, including equality characteristics, those from areas with health inequalities and, by implication, low income households and others that suffer deprivation. • As part of this process strategic stakeholder engagement with clinicians and community groups took place. • The purpose of this engagement was to gather evidence on the need for acute services and any potential impacts. ✓ Baseline travel analysis presenting the current travel times to hospitals for car, public transport and blue light ambulance	✓ Initial equalities analysis ✓ Baseline travel analysis	✓ The reports have been published on the IHT website.
1.b	✓ Deprivation impact analysis • This includes a baseline study of where there is health inequality, why it exists and with whom. ✓ Stakeholder engagement with protected characteristic groups was undertaken by Traverse, Healthwatch and IHT programme	✓ Deprivation impact analysis ✓ Summary of all equalities engagement report	✓ The reports have been published on the IHT website.
	Phase 2: Interim IIA report Phase 2 is an exploration with (i) people that need to travel to services, (ii) people from areas where health inequality has been identified or is suspected, and (iii) people with protected characteristics and their representatives as identified through the pre-engagement phase to identify what they think should be considered by those undertaking option development and appraisal.		
2.a	• Further engagement through focus groups and interviews with local people to understand potential impacts. □ To sense check the perceived needs and impacts from phase one and to determine any unconsidered impacts or potential impacts. □ Full impact assessments produced for equality, health, travel and sustainability.	• Interim IIA report which brings together the evidence collated in phases 1.a and 1.b and 2.a.	• Work to commence in January 2019. • Stakeholders to review the IIA report in spring 2019. • Report to be published before the public consultation.
	Phase 3: Final IIA report This final report takes into consideration all of the evidence from phases one and two and the public consultation. It presents a comprehensive assessment of the positive and negative impacts and provides suggested mitigation and enhancement measures.		
3.a	• Review public consultation outputs.	• Final IIA report.	• Work to commence once the public consultation has closed. • Stakeholders to review the IIA report in Autumn 2019. • Report to be published afterward stakeholder feedback.

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2. Methodological approach

In order to undertake phase 2 of the IIA, Mott MacDonald have undertaken the following methodological approach across the four assessment areas:

- **Health and equality** – The stakeholder engagement process alongside the desk review of equality, service planning and clinical literature has been used to allow for a detailed appraisal of the potential health and equalities impacts of the proposed options for change to acute services.
- **Travel and access** – In undertaking an assessment of the potential travel impacts, analysis has been undertaken to explore the travel impact across three modes of transport: car, blue light ambulance, and public transport. For each option the analysis explored travel times on a Tuesday and Sunday at defined periods; AM peak, interpeak, PM peak and off-peak. The central point of a Lower Super Output Areas (LSOAs), a small area of between 1,000 and 3,000 residents,[1] was used as the origin and the hospital sites as destinations to determine travel times across time periods and for all modes of transport. The analysis used 2011 census data, 2015 Index of Multiple Deprivation data and 2016 mid-year population estimates to determine the number of people from the overall study area population and protected characteristic groups who reside within each travel time band. It is important to note that the analysis used historical observed speed data and public transport timetables[2] and therefore does not represent all potential journey's and is instead a snapshot of average journey time for each travel mode. Individuals may therefore experience different travel durations.
- **Sustainability** – A qualitative assessment of the operational air quality impacts has been undertaken for each option for change considering the baseline environment surrounding each of the acute hospital sites and the potential changes in patient numbers which could influence the number of vehicles driving to or near the site. A qualitative assessment has also been undertaken of the operational impacts of CO_2 emissions resulting from potential changes in additional traffic and increased journey times to acute services.

Governance

This work is being overseen and scrutinised by an Integrated Impact Assessment Steering Group (IIASG) which has had oversight of the delivery of the work programme, including scope and deliverables and approval of the interim draft and final report (post any potential consultation).

In addition, to the IIASG, a Travel and Access Working Group (TAWG) has also been convened. The membership of this group is made up of experts within the local transport sector. The group has meet at regular periods throughout the IIA process and have provided oversight and scrutiny of the travel and access analysis methodology and have assisted in identify local data and evidence to support both the qualitative assessment and identification of mitigation action. The TAWG reports into the IIASG.

[1] Office for National Statistics (2019) *Census geography https://www.ons.gov.uk/methodology/geography/ukgeographies/censusgeography*

[2] Real time data was not available for all public transport options but was reviewed where possible in order to verify results.

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3. Findings from engagement

Full details on the approach to engagement can be found in the engagement plan in appendix 3.

Engagement was undertaken for both the initial scoping exercise and for the full IIA:

Initial scoping engagement

- Qualitative in-depth telephone interviews were undertaken with 18 individuals. These individuals described the ways in which services are currently used. They also reflected on the potential impact any service change could have on the local community, specifically those who fall under protected characteristics. These interviews were undertaken with:
    - 12 clinicians and CCG representatives who described the local context and provided their experience on delivering services.
    - 6 representatives of key user groups who discussed the potential impact of any changes to acute services for those they represent.

Engagement for the full IIA

- To support the full IIA, additional engagement has been undertaken to explore with (i) people that need to travel to services, (ii) people from areas where health inequality has been identified or is suspected, and (iii) people with protected characteristics and their representatives as identified through the scoping phase, what they think should be considered by those undertaking option development and appraisals.
- Twelve focus groups were undertaken with local equality groups. Those chosen to engage was intelligence led and based on the initial scoping work. The focus groups consisted of 7-12 participants and covered a range of protected characteristics covering those who have been identified as having a particular or disproportionate need for acute services. Recruitment to the groups was targeted at the highest density areas within the study area for each target group. Following feedback from the IIASG, the engagement plan was reviewed and agreed.

The discussions with both stakeholders and local equality groups has assisted in the identification of potential key impact areas. The below outlines the key thematic areas which were identified through engagement and have been covered in detail within the IIA report. Please note that quotes used on the presentation slides are used to provide insight on a point and do not reflect the views of all participants. Further, comments may not always be factually accurate, but they represent the truth to the individual.

Positive impacts resulting from the consolidation of major acute services:

- Potential to bring about health and service improvements through a more joined up approach which may also lead to a reduction in waiting times.
- Potential to save money through centralising resources.
- Potential to result in improved buildings which allow for a safer service.

Negative impacts resulting from the consolidation of major acute services:

- Longer travel times when accessing acute services which could be potentially life threatening.
- Reduced accessibility of acute services if consolidation results in longer journeys, requiring more complex and costly travel. Particularly likely to affect visitors and those who are older, disabled or have a mental health condition.
- Potential to increase waiting times from greater proportions of patients accessing the service, particularly if the reputation of the site improves as a result of the change.
- Potential to put pressure on other services as a result of a lack of clarity around where to access services, a preference for other sites and difficulties with traveling to the location.
- Potential to lose other health services to accommodate increasing capacity requirements for consolidated major acute services.
- Potential to lead to worsening health outcomes if patients are put off from accessing major acute services.

Suggested mitigation action:

Following a recommendation from the Travel and Access Working Group, a solutions workshop was held on the 8th of April comprising a range of stakeholders to highlight the range of potential impacts resulting from potential travel time changes and to explore and discuss potential solutions; either already being planned or new mitigating actions they felt was pertinent.

Additional equality groups still to be considered:

Through discussions with stakeholders and the equality groups, there has been further agreement with the IHT Programme to undertake additional engagement. This includes the following groups who may be potentially disproportionately affected by the impacts:

- Older people
- Disabled people
- People with a mental health condition or learning disability
- BAME groups
- Gender reassignment/sexual orientation.

4. Contact details

If you require any further information on the IIA work please contact:

Brian Niven: Brian.Niven@mottmac.com

Hattie Fowler: Hattie.Fowler@mottmac.com

Improving Healthcare Together 2020-2030

Integrated impact assessment – draft findings

Phase 2

All findings outlined in these slides are subject to change and review

Phases of the IIA

Phase	Activities	Outputs	Status
✓	**Phase 1: Baseline** The work undertaken in phase one is to investigate the current situation (the baseline) and to identify what needs to be considered going forward.		
1.a	✓ Initial equalities analysis to identify which protected characteristic groups may have a disproportionate need for services. ▪ It identifies and separates differing profiles of people and their experiences, including equality characteristics, those from areas with health inequalities and, by implication, low income households and others that suffer deprivation. ▪ As part of this process strategic stakeholder engagement with clinicians and community groups took place. ▪ The purpose of this engagement was to gather evidence on the need for acute services and any potential impacts. ✓ Baseline travel analysis presenting the current travel times to hospitals for car, public transport and blue light ambulance	✓ Initial equalities analysis ✓ Baseline travel analysis	✓ The reports have been published on the IHT website.
1.b	✓ Deprivation impact analysis ▪ This includes a baseline study of where there is health inequality, why it exists and with whom. ✓ Stakeholder engagement with protected characteristic groups was undertaken by Traverse, Healthwatch and IHT programme	✓ Deprivation impact analysis ✓ Summary of all equalities engagement report	✓ The reports have been published on the IHT website.

Phases of the IIA

Phase 2: Interim IIA report

Phase 2 is an exploration with (i) people that need to travel to services, (ii) people from areas where health inequality has been identified or is suspected, and (iii) people with protected characteristics and their representatives as identified through the pre-engagement phase to identify what they think should be considered by those undertaking option development and appraisal.

2.a	• Further engagement through focus groups and interviews with local people to understand potential impacts.
	  o To sense check the perceived needs and impacts from phase one and to determine any unconsidered impacts or potential impacts.
	  o Full impact assessments produced for equality, health, travel and sustainability.
		• Interim IIA report which brings together the evidence collated in phases 1.a and 1.b and 2.a.	• Work to commence in January 2019.
			• Stakeholders to review the IIA report in spring 2019.
			• Report to be published before the public consultation.

Phase 3: Final IIA report

This final report takes into consideration all of the evidence from phases one and two and the public consultation. It presents a comprehensive assessment of the positive and negative impacts and provides suggested mitigation and enhancement measures.

3.a	• Review public consultation outputs.	• Final IIA report.	• Work to commence once the public consultation has closed. • Stakeholders to review the IIA report in Autumn 2019. • Report to be published afterward stakeholder feedback.

Update on progress

- Equality, Health, Travel and Access and Sustainability assessments have been completed.
- Initial engagement to support the assessments has been undertaken will local protected characteristic and equality groups.
- Following discussion with the Integrated Impact Assessment Steering Group, some additional engagement has been requested and is being organised at this time. The findings of this engagement will be fed into the report ahead of any potential public consultation.
- Preparation of the first draft of the Interim IIA report will be shared with the IIA Steering Group at the end of April
- A process of review of all findings is currently ongoing.

Focus of analysis

Equality impact assessment – Phase 2

Equality impact assessment

Protected characteristics

The EqIA has consider each of the nine protected characteristic groups as defined by the Equality Act 2010 as well as considering deprived communities and carers.

Although deprived communities and carers are not legislated within the Act, it is best practice to consider these groups.

Last year, IHT also commissioned PPL to undertake a specific piece of work on deprivation entitled 'deprivation impact analysis'. This is accessible here.

The findings from the deprivation impact analysis have been used as evidence in the IIA. Based on its findings, the IIA has included a focus on the LSOAs identified in the top two most deprived quintiles, according to the Indices of Multiple Deprivation (IMD). This largely covers areas to the north of the study area such as Pollards Hill. The top two quintiles of deprivation have been chosen to reflect relative deprivation across the whole study area.

Equality impact assessment – phase 2

Scope of work

PPL's deprivation impact analysis made a number of recommendations for the IIA to assess how the proposals for change to major acute services could potentially impact on people living in the LSOAs in the most deprived quintile. In particular, they recommended:

- an assessment of health inequalities and deprivation as part of the Health and Equality Impact Assessments
- review of health need through assessing potential links identified in national evidence; and
- Exploration of health usage through analysis of patient flows and catchments for hospitals.

They also recommended undertaking a travel time analyses to assess the impact on travel times for different communities to and from different service locations, by different means of transport ('blue light', public transport and car), to understand if there are material and disproportionate changes to those in deprived communities as a result of any changes of locations to major acute services (this may include analysing the impacts on travel times for communities in areas of high deprivation who may typically have low levels of car ownership).

The Interim IIA report will identify, with reference to the PPL/Nuffield report, how each of the recommendations in relation to analysis of deprivation have been addressed.

Equality impact assessment – data sources

Desk research: Provides a baseline of issues relating to services under review and allows the identification of population groups vulnerable to service changes. Sources include but are not limited to:

- **Previous equalities assessment** work undertaken by and for IHT including the deprivation analysis published here
- Existing reports on **activity and access**, for example, patient activity datasets and performance reports.
- **Clinical evidence** used to develop proposed service changes.
- Information on trends in **population health and health inequalities** in the CCG areas, for example, using Joint Strategic Needs Assessments (JSNA) and public health reports from the local authorities.
- **Medical and clinical publications** revealing trends for the population most 'at risk' of requiring the services under review.
- **Literature on equality groups' needs** for and access to services under review, in terms of susceptibility to medical conditions and quality of care.

Demographic mapping: Maps communities around existing services and provides a way to measure the potential scope/coverage of negative or positive impacts subsequently identified. Data sources include **Census 2011** (and mid-year estimates), **Indices of Multiple Deprivation** (IMD), and **local CCG or local authority sources** where relevant. Profiling is based on data at the lowest available and robust geographic level. For many datasets this is Lower Super Output Areas (LSOAs). The socio-demographic evidence will be presented in GIS maps and tables.

Stakeholder engagement: Supports and adds to the evidence collated above. Allows stakeholders to give their views on potential impacts.

- One-to-one telephone interviews with clinicians, directors of public health (DPH), equalities leads, IHT project leads. IHT programme engagement undertaken with protected characteristic groups (published on website here).
- One-to-one telephone interviews with community groups
- 12 focus groups (4 per CCG area) comprised of people representing particular protected characteristics.
- 4 additional groups have been identified to engage with and this engagement is ongoing.

Health impact assessment

Health impact assessment – data sources

Desk research: Has used the following sources to assess the health impact:

- Existing reports on **activity and access**, for example, patient activity datasets and performance reports.
- **Clinical evidence** used to develop proposed service changes.
- Information on **trends in population health and health inequalities** in the CCG areas, for example, using Joint Strategic Needs Assessments (JSNA), the deprivation impact analysis and public health reports.
- **Medical and clinical publications** revealing trends for the population most 'at risk' of requiring the services under review.
- **Provider impact analysis**

Stakeholder engagement:

Supports and adds to the evidence collated above. Allows stakeholders to give their views on potential impacts

- One-to-one telephone interviews with clinicians, equalities leads, IHT project leads and Directors of Public Health.
- IHT programme engagement undertaken with protected characteristic groups (published on website here)
- One-to-one telephone interviews with community groups
- 12 focus groups (4 per CCG area) comprised of people representing particular protected characteristics.

Travel impact assessment

Travel impact assessment – data sources

Quantitative modelling of travel impacts

Travel impact analysis has been undertaken for four time periods (AM peak, PM peak, inter-peak and off-peak) for three modes of transport (blue light ambulance, car and public transport). The assessment is modelled using TRACC software which is the industry leading accessibility modelling software package.

Has looked at overall impacts on travel time and specific impacts on travel times for a range of equality groups within the study area.

Qualitative assessment of travel impacts

Qualitative assessment has been undertaken using:

- Information gathered from stakeholder engagement activities and discussions with the Travel and Access Working Group
- Review of literature on travel and access impacts in healthcare.
- Mitigation action also informed by Solutions Workshop

Sustainability impact assessment

Sustainability impact assessment – data sources

Carbon emissions

Changes in carbon emissions from transport has been calculated using carbon emissions factors based on the results of the travel analysis.

A lack of available evidence has meant that it has not been possible to quantify the carbon emissions from building energy use and carbon emissions from procurement.

Air quality

To understand air quality impacts, the following approach has been taken:

- Review of publicly available air quality information around each of the existing provider sites and the proposed future locations included in the three potential options.
- For each of the existing locations and the proposed future service locations we have assess the types of receptors nearby to determine how sensitive each of the areas are in terms of air quality.
- Provided a qualitative assessment of potential increases/decreases in emissions based on the potential for changes in road traffic emissions for each of the potential scenarios.
- For each of the potential scenarios rank them based on the risk of causing a deterioration in air quality.

Governance

Integrated Impact Assessment Steering Group

Established to:

- Review and agree the IIA scope
- Provide expert advice and information and local intelligence to support the engagement plan with protected characteristic and equalities groups across the combined geography
- Agree the membership for the Travel and Access Working Group and to receive updates on the progress of the working group
- Review the interim impact assessment report
- Review the final impact assessment report (post consultation)

Travel and Access Working Group

Has met on a fortnightly basis throughout the IIA analysis and was set up to provide advice to the Programme around the travel and access analysis.

Specifically, it has been tasked with:

- Reviewing and signing off the methodology for the travel impact assessment
- Review and agree relevant data analysis
- Agree to the travel impact assessment and identified anticipated travel impacts
- Provide input to potential travel mitigations
- Provide the communication link between the travel impact assessment and the organisations represented at the group and where appropriate ensure these organisations are fully briefed on all aspects of the IIA

Findings from the engagement

Approach for focus groups

- Participants were recruited by a market research agency using various methods including on street recruitment and phone recruitment. This was to ensure that new voices were heard.
- All groups were facilitated by experienced members of Mott MacDonald staff.
- Participants were paid an incentive to cover expenses.
- The majority of groups were scheduled in the evenings to accommodate working patterns but reflecting comments from the IIA steering group, two groups (deprivation and older people) were moved to afternoon sessions.
- All interviews were structured by a pre-approved discussion guide. The first draft was provided to the IIASG and notes from the meeting were taken on board.
- All focus group materials were agreed with the IHT team prior to use and the Consultation Institute reviewed and offered best practice advice on these materials.
- Focus groups started in late February and finished in early March.
- All twelve groups have been completed.
- Please refer to the engagement plan for full details of the approach and rationale for each group.

Focus groups

- **12 focus groups** across the 3 CCG areas.
- **Group selection intelligence led** – composition and location of the groups was selected according the evidence **available on the demographics of local areas** and the need for services. High density areas of these groups was therefore the focus areas for recruitment.
- Recruitment specified 8-12 participants at the groups – those which recruited less have 8 are being discussed with the chair

CCG	Group number	Date of group	Location of group by ward	Composition	Number who attended
Merton	1	25.02.2019	Colliers Wood	Females aged 18-44, from a BAME background	8
Merton	2	25.02.2019	Colliers Wood	People from a BAME background	9
Merton	3	07.03.2019	Pollards Hill	People from deprived communities	6
Merton	4	07.03.2019	Pollards Hill	People with a limiting long-term Illness (LLTI) including disability	8
Sutton	5	14.03.2019	Wandle Valley	Those aged 65 years old or older	10
Sutton	6	12.03.2019	Sutton Central	People from a BAME background	9
Sutton	7	14.03.2019	Wandle Valley	People from deprived communities	12
Sutton	8	12.03.2019	Sutton Central	Females aged 18-44	10
Surrey Downs	9	04.03.2019	Ewell	Those aged 65 years old or older	7
Surrey Downs	10	04.03.2019	Ewell	Parents	9
Surrey Downs	11	27.02.2019	Town	Those aged 18-24 years old	11
Surrey Downs	12	27.02.2018	Town	People with a limiting long-term illness including disability	9

Note on interpretation of the findings

- Please note that the findings presented in these slides are early findings from the groups, with more detailed analysis currently ongoing. As such, the findings outlined here may be subject to change and adaptation as new themes emerge.
- Verbatim comments from the groups has been included within this presentation. These comments have been selected to provide insight into a particular issue or topic, but should not be taken to define the views of all participants.
- The findings represent the views of participants and although views may not always be factually accurate they represent the truth to the participant.

Positive impacts identified and supported

Potential to bring about health and service improvements	*'All in one place you know you will get better care…reduced waiting times and means you can treated at that time.'* Parents
Potential to save money	*'Should save money – if everything is on one site'* Females aged 18-44, from a BAME background
Potential to result in improved buildings which allow for a safer service	'*I have to say Epsom is really old, you can pick up anything …A new building, everything would be built in, it would be bespoke to what's needed.'* People with an LLTI or disability

Negative impacts identified and supported

TRAVEL RELATED IMPACTS

Longer travel time when accessing acute services

‘*So people will have to travel further in ambulances – so people who are seriously ill might take them longer to get there – could be very bad.’*
People from a BAME background

‘*Price of travelling bus, train, and public transport – even for where I live to Sutton there is no direct route – long and expensive journey ’*
People from deprived communities

Accessibility of acute services if consolidated

Negative impacts identified and supported

HEALTH AND SERVICE RELATED IMPACTS

Potential to increase waiting times for acute services

'Merging of specialist time will lead to an increase of waiting times – as you would have twice as many people going to A&E with the same level of capacity.'
Older people

Will confusion not put burden on GP surgeries?'
People from a BAME background

Potential for further pressure to be put on the services

Potential to lose other health services to allow for acute services on one site

'If you look at A&E on the evening and weekend its packed, so if you are thinking a bigger area is need to allow a bigger maximum. What will hospitals lose to make access to one site. If you look at Epsom they don't have the carpark to fit more people. To make room for the acute services what is going to be lost in terms of other services.'
Young people

'*People might think its too far for people to go, so could make health worse and could increase emergencies*'
People from a BAME background

Potential to negatively impact on health outcomes

Equality and discrimination

Groups the options that are perceived as potentially discriminating against and those who may need to be given priority when deciding on the location

- Gender reassignment/sexual orientation
- BAME
- Deprivation
- Older people
- Disabled people

'Location of the service has a massive impact - in terms of gender reassignment/sexual orientation/race - Epsom is far less of a diverse location.'
Females aged 18-44 from a BAME background

'When you are ill I don't think people realise how much the illness can affect you mentally – you don't need the extra stress'
People with an LLTI or disability

'Deprived people wont be able to afford to travel to hospital – may put them off going to hospital. As the St Helier area is poorer then Epsom it may be more significantly impacted '
People from a BAME background

'Disability/carers/mental health should be the priority, the more vulnerable people needs to be supported, they need to prioritised.'
Females aged 18-44, from a BAME background

Next steps

Any further questions?