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

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Improving Healthcare Together 2020 – 2030 – Integrated Impact Assessment (IIA) Draft interim IIA report – Summary of findings

1. Introduction

This summary report captures the findings of the Interim Integrated Impact Assessment as well as provides an overview of the process, assurance mechanisms, and next steps of this work.

2. About the IIA

In December 2018, the Improving Healthcare Together 2020 – 2030 commissioned specialist independent consultancy, Mott MacDonald, to undertake an Integrated Impact Assessment (IIA) to explore any potential health, equality, travel and access and sustainability impacts on the local population arising from the proposals for change at Epsom and St Helier University Hospitals Trust (ESTH).

The Programme has identified three potential solutions to meet the challenges faced by ESTH in delivering major acute services, in terms of clinical standards, estates and financial sustainability. These solutions are as follows[1]:

1. Locating **major acute services at Epsom Hospital**, and continuing to provide all district services at both Epsom and St Helier Hospitals.
2. Locating **major acute services at St Helier Hospital**, and continuing to provide all district hospital services at both Epsom and St Helier Hospitals.
3. Locating **major acute services at Sutton Hospital**, and continuing to provide all district services at both Epsom and St Helier Hospitals.

This IIA aims to provide helpful information to decision makers on any potential positive and negative impacts of the proposed service changes on the local populations and in particular those groups (sometimes referred to as protected characteristic groups) and communities who may be the most sensitive to changes. The IIA also includes potential solutions and enhancements where an impact is identified for the future delivery of health services.

This IIA also helps to ensure that the CCGs have properly and genuinely considered equality as part of their decision-making process. The purpose of the equality impact assessment (EqIA) of this IIA is to demonstrate that the decision-making process has been undertaken in a timely fashion and with full knowledge of the CCGs obligations under the Equality Act 2010. The EqIA (and by extension the IIA) therefore supports the CCGs compliance with the Public Sector Equality Duty (PSED).

Following best practice, the IIA is being undertaken in three distinct phases. It should be noted however that the IIA is designed to be an iterative process that can be revisited, and take on board any new information that may be relevant up until any formal public consultation has finished.

The first phase of the IIA has been completed and published on the Improving Healthcare Together website. This included the production of an initial equality scoping report (EqIA) and baseline travel assessment by Mott MacDonald, as well as a deprivation impact analysis (undertaken by The Nuffield Trust, PPL and COBIC). In addition to these assessments and as part of this phase, the

[1] Issues Paper, by Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups; Available at: https://improvinghealthcaretogether.org.uk/wp-content/uploads/2018/06/Improving-Healthcare-Together-2020-2030-Issues-Paper.pdf

Improving Healthcare Together programme has also undertaken a range of engagement activities with equalities groups.

This draft IIA interim report forms the second phase of this work and has been based on the evidence gathered during phase one of the IIA alongside further desk research, socio-demographic data collection and mapping, an exploration with health professionals and representatives of local community groups by way of in-depth interviews and focus groups, travel and access analysis, and air quality and carbon emissions analysis. The engagement undertaken for the full IIA was not intended to speak with representatives from the whole community or act as a formal consultation. Additional engagement has also been explored as part of second phase of the IIA with a number of seldom-heard groups and staff as part of our commitment for continued engagement to feed into the IIA process:

a) LGBT community
b) Carers
c) People with a learning disability
d) Gypsy, Roma and Traveller Community
e) Those from areas in the second quintile of deprivation in the south of Merton
f) Staff at the Epsom and St Helier University Hospitals NHS Trust

3. Governance and quality assurance

To enable effective input from the community, local authorities and technical experts across Merton, Surrey Downs and Sutton Clinical Commissioning Groups (CCGs), as well as to provide oversight of delivery of this programme of work, a governance structure was established at the beginning of phase 2. This included an IIA Steering Group and a Travel and Access Working Group. In addition, an Independent Chair for the IIA Steering Group, Professor Andrew George, was recruited to ensure that the IIA process was followed in accordance with the agreed scope of the work.

Both the IIA Steering Group and the Travel and Access Working Group (chaired by Dr Simon Williams, Clinical Director for Urgent Care & Integration at NHS Surrey Downs CCG) have agreed:

- The scope of the work and IIA process had been followed.
- The engagement plan based on local knowledge and intelligence on protected characteristic groups.
- The findings of the draft interim report, pending a number of suggested changes to it. The feedback received at both groups has been considered and where relevant included into the draft interim report, in accordance with agreement by the Independent Chair.

4. Summary of findings

The table below captures the key findings of the impacts associated with each option for change across the four IIA assessment areas: health, equality, travel and access, and sustainability. The impacts have been grouped by thematic area and by those impacts which are expected to bring about enhancements and those impacts which may have an adverse effect compared with the current situation.

The key findings captured in **Table 1** below should be considered in conjunction with Chapter 5 of the interim report, which outlines the potential impacts associated with the service change, highlights any protected characteristics groups which may be disproportionately impacted by each thematic area, and provides ratings of impacts according to magnitude, likelihood and duration.

The interim report further outlines potential ways to mitigate or reduce the effect of the potential negative impacts.

5. Next steps

This report will be further reviewed and refreshed in light of the findings from public consultation to ensure that fair coverage and consideration is given to:

- the full range of potential impacts likely to be experienced by the local community and specific community groups within this;
- any additional data sources which may support analysis of impacts; and
- any further mitigation actions which may help to alleviate the effects of the some of the impacts identified.

This will form Phase 3 of the integrated impact assessment work programme.

This work will conclude with the production of a final report for consideration by the IHT Programme Board and Committees in Common as they move into the Decision Making Business Case phase of their work.

Until the additional engagement of phase two is complete and the further analysis has been undertaken as part of phase three, this report remains interim and subject to further iterations as new evidence is identified and reviewed.

The draft IIA interim report can be accessed via the Improving Healthcare Together Programme website.

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Table 1: Summary of IIA interim report findings

Impact area	Key findings			Protected characteristics groups which may be disproportionally impacted
	Impacts expected to result in enhancements in service offering	Impacts expected to result in adverse effects for the local community	Impacts considered to be neutral	
Thematic areas where the impact is not expected to vary across the three options for change				
1. Patient outcome	• Improved outcomes for patients from a new clinical model. Those equality groups identified as having a disproportionate need for acute services expected to particularly benefit.	N/A	N/A	Potential **positively impacted** groups include: • Children and young people (under 16s and those aged 16-24) • Older people (65 years and over) • People with a disability • Gender reassignment • Pregnancy and maternity • Race and ethnicity • Sex • Sexual orientation • People living in deprived areas
2. Accessibility of district health services	• A positive impact is likely to result from clearer signposting, more integrated and responsive district services, and a greater choice in modes of contact.	N/A	N/A	Potential **positively impacted** groups include: • Children and young people (under 16s and those aged 16-24) • People with a disability • Race and ethnicity • People living in deprived areas

Impact area	Key findings			Protected characteristics groups which may be disproportionally impacted
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3. Patient experience	• Patient experience will be enhanced through consistent and integrated pathways, reduced variation and fragmentation of services.	• The clinical model will mean that the configuration and delivery of services for both major acute and district level hospital services will change at each site. Patients will therefore, be required to access services which may look and feel different and unfamiliar from the current site layout. Both local community representatives and those who attended focus groups have suggested that this may have an adverse impact on their initial experience of care under the new care pathways. This is likely to be a medium-term impact.	N/A	**Mixed impacts:** • Children and young people (under 16s and those aged 16-24) • Older people (65 years and over) • People with a disability • Gender reassignment • Pregnancy and maternity • Race and ethnicity • Sex • Sexual orientation • People living in deprived areas
4. Service delivery	• Positive impacts on service delivery are expected as a result of improved patient flow which enables resource to be utilised more effectively. • The proposed clinical model and detailed future modelling which underpins this, will ensure that the	• There may be a requirement to recruit a small number of additional staff. Without these additional staff, there is a risk that negative impacts may be experienced with regards to the quality and safety of patient care. Detailed modelling has, however, been undertaken by the Programme to ensure that sufficient capacity will be available.	• Neutral impact on the number of patient transfers between hospital sites and the resilience of major acute services.	Potential **positively impacted** groups: • Children and young people (under 16s and those aged 16-24) • Older people (65 years and over) • People with a disability • Gender reassignment • Pregnancy and maternity • Race and ethnicity

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Impact area	Key findings			Protected characteristics groups which may be disproportionally impacted
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	trust is able to deliver the clinical services required to meet the needs of its local population over the next ten years.			• Sex • Sexual orientation • People living in deprived areas
5. Workforce	• Positive impacts likely to be felt by staff as a result of sustainable rotas and working patterns, new job roles, training opportunities and through working as part of larger clinical teams.	• For some staff negative personal impacts may be felt in terms of adjusting to changes in relation to change in workplace and changes to the rota patterns, positions and teams within which they work.	N/A	N/A
6. Physical accessibility of services	• Accessibility of service has the potential to be improved through fit for purpose hospital facilities.	• The design of the site needs close consideration to ensure that accessibility isn't constrained from the result of a busier hospital site where services are consolidated onto a single site.	N/A	Potential **positively impacted** groups: • Older people (65 years and over) • People with a disability
Thematic areas where the impact *is* expected to vary across the three options for change				
7. Health inequalities	• Planned changes to district services as part of the clinical model may lead to improvements in health outcomes for those from deprived areas and bring about changes which help to reduce health inequalities.	Deprived communities may be disproportionately impacted by longer journey times. • Option 1: Epsom likely to result in the greatest proportion of people from deprived communities experiencing longer journey times.		Potential **positively impacted** groups: • People living in deprived areas • Race and ethnicity Potential **adversely impacted** groups:

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				• People living in deprived areas
8. Longer journey times for patients	• Across all the options, 99.7% of patients within the study area will still be able to access an acute service (this may not be at ESTH) within 30 minutes by either car or blue light ambulance; similar to the current situation. However:			Potential **adversely impacted** groups: • Option 1: People living in deprived areas for car and blue light ambulance • Option 2: Older people (65 years and older) for blue light ambulance
	N/A	• Option 1: Epsom Hospital - Merton and Sutton particularly likely to experience longer journey times by car and blue light ambulance. • Option 2: St Helier Hospital - Surrey Downs particularly likely to experience longer journey times by car and blue light ambulance. • Option 3: Sutton Hospital - All areas expected to see increases in journey times by car and blue light ambulance but small proportion in Sutton who may see journey time decreases.	N/A	
9. Longer journey times for visitors	N/A	Marginal journey time increases across the options: • Option 1: Epsom Hospital - Merton and Sutton particularly likely to experience longer journey times by car and public transport.	N/A	Potential **adversely impacted** groups: • Option 1: People living in deprived areas for car and public transport

Impact area	Key findings			Protected characteristics groups which may be disproportionally impacted
	Impacts expected to result in enhancements in service offering	Impacts expected to result in adverse effects for the local community	Impacts considered to be neutral	
		• Option 2: St Helier Hospital - Surrey Downs particularly likely to experience longer journey times by car and public transport. • Option 3: Sutton Hospital - All areas expected to see increases in journey times by car and public transport but small proportion in Sutton who may see journey time decreases.		• Option 3: People living in deprived areas for public transport
10. Transportation cost and accessibility of acute services	N/A	• While travel requirements for patients and visitors who are using district services are not expected to change, some may experience cost increases and more complex journeys to access acute services. • Option 1: Epsom Hospital - Sutton particularly likely to experience increased costs and complex journeys • Option 2: St Helier Hospital - Surrey Downs particularly likely to experience increased costs and complex journeys • Option 3: Sutton Hospital - Surrey Downs particularly likely	N/A	Potential **adversely impacted** groups: • Older people (65 year and over) • People with a disability • Pregnancy and maternity • Race and ethnicity • People living in deprived areas

Impact area	Key findings: Impacts expected to result in enhancements in service offering	Key findings: Impacts expected to result in adverse effects for the local community	Key findings: Impacts considered to be neutral	Protected characteristics groups which may be disproportionally impacted
		to experience increased costs and complex journeys		
11. Patient provision	N/A	• While many services relevant to 'informed choice' are already delivered from a single site, given their inter-dependencies with intensive care, the movement of the ED onto a single site will result in some services no longer being locally available to some patients. This may be perceived as limiting their choice. The district service developments may offset this somewhat by offering an expanded choice of alternative services.	N/A	All patients groups are expected to be equally impacted by a perceived reduction in choice.
12. Other providers	N/A	Neighbouring hospital providers will likely experience an increase in patients as a result of any change. Early modelling suggests that: • Option 1: Epsom predicted to result in the greatest increases in patient flows to other sites and may therefore have the most significant impact on providers.	• Potential for capacity of ambulance providers to be impacted through undertaking longer journeys but there may be fewer emergency transfers required.	N/A
13. Wider sustainability	N/A	All options are likely to result in some worsening of air quality in specific areas and an increase in	N/A	Potential **adversely impacted** groups: • Children (under 16 years)

Impact area	Key findings			Protected characteristics groups which may be disproportionally impacted
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		Greenhouse Gas (GHG) emissions although these impacts are expected to be low. • Option 1: Epsom Hospital - Air quality impact likely to have a greater impact than other options due to patients flow being increased to area of existing poor air quality. • Option 2: St Helier Hospital - GHG expected to the worst under this option due to a higher proportion of local residents having to travel further to access acute services. • Option 3: Sutton Hospital - Slight improvements in air quality expected due to the movement of patients away from areas of poor air quality.		• People living in deprived areas