Improving Healthcare Together 2020 to 2030

Integrated Impact Assessment Steering Group

(IIASG) Independent Chair: Professor Andrew George

MEETING NOTES
Date: 1st June 2020
Time: 9:30 – 11:30
Location: Online meeting

In attendance:

Name	Initials	Role
Andrew George	AG	Independent Chair for IIA Steering Group
Mike Robinson	MR	Interim Consultant in Public Health, Merton Council; Deputy for Hannah Doody, Director of Community and Housing, Merton Council
Yasmin Broome	YB	Involvement Coordinator, Surrey Coalition of Disabled People
Susan Gibbin	PB	Lay member, South West London Governing Body
James Blythe	JB	Locality Executive Director (Merton & Wandsworth), South West London CCG
Russell Hills	RH	GP representative, Surrey Heartlands CCG Governing Body
Jonathan Perkins	JP	Lay members, Surrey Heartlands CCG Governing Body
Amanveer Nathan	AN	Patient and Public Engagement Manager (Merton), South West London CCG
Brian Niven	BN	Mott MacDonald
Sarah Reeves	SR	Mott MacDonald
Programme representatives		
Charlotte Keeble	CK	Senior Programme Manager, IHT Programme Team
Ioana Miron	IM	Project Manager, IHT Programme Team
Kester Holmes	KH	Opinion Research Services

No.	Agenda Item	Who
1.	**Welcome and introductions**	
	AG welcomed the members of the Steering Group and noted apologies from: • Imran Choudhury, Sutton Council • Pippa Barber, SW London CCG • Dorothy Watson, Sunnybank Trust • Iona Lidington, Kington Council • Laura Maclehose, Kington Council • Kate Scribbins, Healthwatch Surrey • Marta Ricardo Rocco, Volunteer Centre Sutton	

2.	**Notes of last meeting on 30th April 2020**	
	IIA Steering Group members approved the notes of the last meeting as an accurate record of the meeting pending correction to Dr Russell Hill's initials. With regards to the action log, the Chair noted: • All actions were completed; • A document outlining Mott MacDonald's response to the critical report was shared with members for review prior to the meeting; and • An update on next steps following the completion of the Integrated Impact Assessment will be provided at the meeting.	
3.	**Draft final IIA report**	
	The Chair noted: • Members of the Steering Group have had the opportunity to review and provide any feedback to the final IIA report during 20th May – 27th May and thanked those members who had provided comments. • The aim of this meeting is to review and agree any final amendments to the interim draft IIA report and to subsequently agree the final IIA report. • This is the last meeting of this group. **a. <u>Review of feedback from Steering Group members</u>** The Chair proposed to Steering Group members to review the feedback received in accordance to three categories: 1. Comments for further discussion – including a number of proposed replacements within the report 2. Comments that have been partially accepted 3. Comments that have been fully accepted **1. Comments for further discussion** Feedback included: • ***Recommendation to revise the impact magnitude assessment for health inequalities (section 1.4.1.3, pp. 8) from 'minor beneficial – larger impacts experienced through other factors' to 'minor adverse – which may be mitigated through other factors'*** BN proposed to not change the impact magnitude. This assessment was agreed by the Steering Group when the interim draft IIA report was approved by the Steering Group and therefore should remain. BN clarified that district service developments are a core part of the IHT programme, rather than mitigating factors. MR asked if a note explaining that no changes will be made at this stage. MR explained that although the impacts of the Covid-19 pandemic on service reconfigurations are yet unknown, there is evidence suggesting that people living in areas of health inequality may be affected. BN advised that district service model seeks to address health inequalities and	

	better integrated those services locally. The IIA report section on resilience also makes reference to addressing the surge in capacity when need arises. JB stated that in his view, the response to Covid-19 has not changed in factors in relation to the clinical case for change. JP confirmed that the clinical model is even more important post-Covid-19 pandemic and in terms of achieving the benefits. Feedback included: • ***Recommendation to change the impact magnitude assessment on longer journey time to acute services for patients (section 1.4.2.2, pp. 14), from 'marginal adverse' to 'significantly adverse'*** BN advised that this assessment was signed off by the IIA Steering Group and Travel and Access Working Group for the draft interim IIA report. As the updated travel analysis has not made any changes to the analysis, Mott MacDonald have proposed not to make any changes to the impact magnitude assessment. SG asked if there is a correlation between travel and pockets of high deprivation. BN explained that the travel impacts will be experienced differently for each option. The southern areas of Surrey Downs would experience the longest increase in journey times. Some deprived communities may experience longer journey times but not as extreme. Feedback included: • ***Suggestion to remove the newly added paragraph within the section on impact of journey times for visitors (section 1.4.2.3, pp. 16) as it can be perceived as contradictory with the rest of this analysis.*** BN clarified that the additional statement within this section provides an overview, whereas the next paragraph discusses the impacts on certain geographies across the study area. Feedback included: • **Request to update the impact rating in relation to other providers' funding and suggestion to change the impact rating to 'Low likelihood of significant adverse impact (which may be mitigated if sufficient additional funding is provided)' (section 1.4.2.5, pp. 19-20)** BN proposed for the wording around the impact magnitude to be updated to "Neutral given that funding will be available" considering that the funding has been agreed and each provider has confirmed acceptance of this. This change has also been made in section 5.12 (pp. 166).	

	MR advised that a more transparent wording is required considering that there have been instances in which the service cost has been greater than anticipated and which led to various pressures as a result. AG suggested to further refine the statement describing the impact magnitude clarifying that the impact on other providers would be neutral on the premises that funding is made available. This wording was accepted by Steering Group members **ACTION:** Mott MacDonald to revise the impact magnitude assessment for the impact on other providers to provide further clarity on the allocation of funding. • **Recommendation to reference within the report the write off by HMG of the £120.5m debt of Epsom and St Helier University Hospitals NHS Trust from 1 April 2020 to ensure the IIA captures accurately the challenges faced by the Trust.** **ACTION:** Mott MacDonald to include a footnote clarifying the write off by HMG of the £120.5m debt of Epsom and St Helier University Hospitals NHS Trust from 1 April 2020. Feedback included: • **Suggestion to include as potential mitigation that post-exposure prophylaxis (PEP) would need to be covered by both A&E and Urgent Treatment Centres (UTCs) (section 5.4.2, on the perceived impact of longer journey times on patient outcomes with reference to potential impacts on the LGBT+ communities, pp. 76)** BN explained this is would be too specific to include as a mitigation within the report and that therefore Mott MacDonald proposes no change. BN advised that PEP provision would need to be considered by the IHT programme in developing the UTC clinical specification. **2. Comments partially accepted** Feedback included: • **Most of the data collection and analysis within this report was completed before the Covid-19 pandemic. No updating of the judgments of impact likelihood, magnitude and duration have been done to take account of the "new normal", as at the time of publication this was still emerging.** BN explained that within section 5.9.4, on the resilience of services, an additional phrase was included to clarify that if any updates to the programme in light of emerging evidence from the Covid-19 pandemic are to be considered by the programme, the impacts identified within this impact assessment should be reviewed and reassessed. MR highlighted that although the IHT programme's scope won't change in light of	

	Covid-19, the wider context and environment in which the programme would be implemented has changed. For this reason, MR suggested including within the report a health warning explaining the above. JB advised that the CCGs are mindful of the potential changes within the wider context and will review the emerging evidence from Covid-19 in order to identify and assess any specific impacts. The CCGs will continue to review and consider any new/ available evidence as a part of their decision-making process. MR suggested that the report should encourage the programme to consider any potential updates in light to associated changes to the system as a whole in light of the emerging evidence post-Covid-19. **ACTION:** Mott MacDonald to clarify within the report that the programme should take account of changes within the NHS and wider context post-Covid-19. Feedback included: • **Suggestion to include in the report any uncertainty in the classification of impact ratings in terms of their likelihood, magnitude and duration.** BN explained that each of the thematic impact areas outlined in the report have been rated based on available evidence and data. A statement clarifying the assessment of impact ratings has been included in the report. Feedback included: • **Proposal to replace text in relation to the planned changes to district services (section 1.4.1.3, on impact on health inequalities, pp.8) to include reference to: '…provided that adequate investment is made in district services and these are aligned to wider improvements in the underlying determinants of health, the adverse impacts from longer journey times from deprived areas may be mitigated or reversed'.** BN explained that this phrase was updated to include reference to the investment in the district services and alignment to wider improvements in the underlying determinants of health. This phrase reads: 'On the assumption of investment in district services, and these are aligned to wider improvements in the underlying determinants of health, this should lead to improved health outcomes for those from deprived areas and help to reduce health inequalities.' Feedback included: • **Question on whether the detailed modelling undertaken by the programme was independently reviewed (in relation to section 1.4.1.5 on impacts on service delivery, pp. 9 - 10).** BN proposed for the existent statement around detailed modelling had been clarified by the Programme. BN advised that detailed modelling was undertaken by the programme to identify future capacity requirements. The modelling was reviewed by regulators through the regional and national assurance process.	

MR stated that the local government and/or external people have not been involved in the modelling to be able to validate this work.

CK advised that information around modelling was provided to stakeholders and is available in the public domain via the IHT website. The programme has, for example:

- Developed a stakeholder briefing which updated on the process and current thinking following the submission of the updated draft pre-consultation business case (which included information on the modelling undertaken) and which was cascaded to over 700 stakeholders.
- A paper on this was also taken to the Joint Health Overview and Scrutiny Committee (JHOSC) where a provider representative provided an update on the provider impact work this provided JHOSC members with the opportunity to scrutinise the modelling undertaken
- The modelling was developed and tested working with the Provider Impact Group

Feedback included:

- **Proposal to obtain data from GP practices to assess the relationship between deprivation and use of hospital services (pp. 100).**

BN proposed to include a footnote explaining that a proposal was made to examine the relationship between deprivation and use of hospital services by obtaining data from local GP practices and It was instead agreed that this analysis should be completed at LSOA level. BN advised that this analysis looks at individual LSOAs across the study area, which are directly linked to the indices of multiple deprivation, and the level of use of hospital services for each LSOA.

MR acknowledged the agreement to undertake additional deprivation analysis at the LSOA level and asked if GPs have been consulted on the proposals.

BN advised that during phase 2 IIA Mott MacDonald undertook a range of stakeholder engagement including, for example, interviews with Directors of Public Health, GP CCGs leads as well as GP representation at the IIA Steering Group and Travel and Access Working Group.

JB highlighted that during consultation GPs have been engaged through various events and senior meetings at GP practices (some of which have taken place in areas of health inequality), and via the CCGs Governing Bodies which are attended by Locality Leads.

CK added:

- Each Clinical Chair has also provided regular updates to their local GPs through their local networks throughout the duration of the programme.
- The Clinical Advisory Group, which played a key role in the development of the clinical model, includes in its membership various GPs.

The Chair asked Steering Group members if:

	• They agreed with the proposed approach and actions in response to the comments received on the draft final IIA report. • Members had any other comments on the draft final IIA report No further comments were provided by Steering Group members. The Chair confirmed that on this basis, the IIA could be updated with the proposed changes/approach as detailed above. **b. <u>Updated draft final rep</u>** The Chair proposed that: • The notes of the meeting and the updated final IIA report are be circulated to Steering Group members for information • The final IIA report will be signed off as Chair's action pending any final updates to the draft report as agreed with the Steering Group at the meeting. The Steering Group members agreed with the proposed approach for final approval of the IIA report. **c. <u>Publication of the final IIA report</u>** CK confirmed that: • The agreed final report will be shared with Programme Board and the CCGs' Governing Bodies prior to publication and used as part of their deliberation process. • The IHT report will be published on the IHT website and cascaded to key stakeholders in line with all other key documents.	
4.	**Next steps**	
	CK advised that next steps following the completion of the IIA include: • The IIA will assist the decision-makers by giving them better information on how they can promote and protect the well-being of the local communities they serve • The IIA is one of a number of pieces of evidence that the local CCGs will consider to inform their decision making process • The IHT programme will produce a decision-making business case, which will bring together all the information the CCGs need to consider prior to any decision making. • The CCGs will make their final decision at the Committees in Common meeting on the 3rd of July. MR asked when the papers for the CiC meeting on the 3rd of July will be published and whether the two CCGs' Governing Bodies will meet prior to the CiC. CK advised: • The CiC papers will be published on the IHT website 5 working days prior to the meeting. • The CCGs' Governing Bodies generally meet on a monthly basis as well as when required. The Governing Bodies have been updated on the IIA and any	

	other evidence to inform their decision making process. Governing Bodies and Programme Board members will be provided with a copy of the report at their next meeting in June.	
5.	**AOB and close**	
	No AOB was raised at this meeting. The Chair thanked the Steering Group for their considered input throughout the IIA and for their careful consideration and oversight of this programme of work which was carried out in a comprehensive and respectful manner. Members thanked the Chair for his independent chairing and for helping the group to work cohesively together.	