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

16 October 2018

7.30 pm at the

Merton Civic Offices, London Road, Merton,SM4 5DX

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

Councillors: Councillor Zully Grant-Duff, Surrey County Council
Councillor Peter McCabe, Merton Council
Councillor Colin Stears, Sutton Council

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Niall Bolger
Chief Executive
Date: 5 October 2018

Enquiries to: cathy.hayward@sutton.gov.uk
Copies of reports are available in large print on request

A G E N D A

1. Election of Chair

2. Election of Vice Chair

3. Apologies for Absence

4. Declarations of Interest

5. Terms of Reference and Rules of Procedure for the standing and sub-committee 1 - 8

Indicative time: 2 minutes

6. Scrutiny issues : the approach of the Improving Healthcare Together sub-committee 9 - 12

An outline scope for the work of the Improving Healthcare Together 2020-2030 sub-committee.

Indicative time: 5 minutes

7. Improving Healthcare Together 2020 -2030 progress update 13 - 94

A briefing paper for the Improving Healthcare Together 2020 – 2030 JHOSC Sub-Committee which included updates on:

- Progress to date
- Provider impact
- Travel and access
- The engagement plan
- The Initial Equalities Analysis
- The Deprivation Impact Analysis
- The Integrated Impact Assessment

Indicative time: 1 hour

8. Q&A / discussion of progress update

Indicative time: 15 minutes

9. Dates for future meetings of sub-committee

Indicative time: 5 minutes

Establishment of a Joint Health Overview and Scrutiny Committee for South West London and Surrey County Council.

Background

Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, local authorities may establish a joint health overview and scrutiny committee to undertake health scrutiny functions on their behalf, and must establish a joint health overview and scrutiny committee to respond to consultation on proposals for substantial variation in health services affecting more than one local authority area.

Discussions between officers responsible for health scrutiny across South West London and Surrey County Council has concluded that the best way forward is the continuation of a Standing Joint Health Overview and Scrutiny Committee, with responsibility for responding to consultations on substantial service change affecting multiple boroughs across the area. This has proved to be a useful way to obviate the need to go through a separate decision-making process each time a consultation requiring the establishment of a Joint Health Overview and Scrutiny Committee is initiated, enabling local authorities to respond more rapidly and saving officer and member time. The draft terms of reference and rules of procedure are attached as Appendices 2 and 3. Points to note are:

- There will be two members of the Committee for each local authority represented, appointed in accordance with local procedures. Local authorities are also encouraged to nominate substitutes to attend when their primary representatives are unable to.
- The Committee will have the power to establish sub-committees, and much of the work in relation to specific consultation will be undertaken in these sub-committees. The members of a sub-committee may be members of the main committee, but constituent local authorities may also nominate another representative to serve on a specific sub-committee.
- Where a consultation affects some, but not all, of the constituent areas voting membership of the relevant sub-committee will be restricted to the authorities directly affected. Thus, for example, the sub-committee responding to consultation on the Mental Health Trust's estates strategy would not include Croydon as a voting member.
- There is no minimum frequency of meetings of the Committee, and when there are no current consultations there will be no need for the committee to meet.
- The life of the Committee will be for a maximum of four years. Constituent areas will nominate members annually, and there will be an annual election for the Chair and Vice-Chair of the Committee.

Appendix Two

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE SOUTH WEST LONDON AND SURREY.

TERMS OF REFERENCE

1.1 The South West London and Surrey Joint Health Overview and Scrutiny Committee is established by the Local Authorities of **London Borough of Croydon, London Borough of Merton, London Borough of Richmond upon Thames, Surrey County Council, London Borough of Sutton, London Borough of Wandsworth,** and the **Royal Borough of Kingston upon Thames (constituent areas)** in accordance with s.245 of the NHS Act 2006 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

1.2 It will be a standing Joint Overview and Scrutiny Committee or a sub-committee thereof which will undertake scrutiny activity in response to a particular reconfiguration proposal or strategic issue affecting some, or all of the constituent areas.

1.3 The length of time a specific matter / proposal will be scrutinised for will be determined by the Joint Committee or Sub Committee.

1.4 The purpose of the Standing Joint Committee is to act as a full committee or commission sub-committees to consider the following matters and carry out detailed scrutiny work as below:

(a) To engage with Providers and Commissioners on strategic sector wide *proposals* in respect of the *configuration* of health services affecting some or all of the area of Croydon, Merton, Richmond upon Thames, Surrey County Council, Sutton, Wandsworth, and the Royal Borough of Kingston upon Thames (constituent area).

(b) Scrutinise and respond to the consultation process (including stakeholder engagement) and final decision in respect of any reconfiguration proposals affecting some, or all of the constituent areas.

(c) Scrutinise in particular, the adequacy of any consultation process in respect of any reconfiguration proposals (including content or time allowed) and provide reasons for any view reached.

(d) Consider whether the proposal is in the best interests of the health service across the affected area.

(e) Consider as part of its scrutiny work, the potential impact of proposed options on residents of the reconfiguration area, whether proposals will deliver sustainable service change and the impact on any existing or potential health inequalities.

(f) Assess the degree to which any proposals scrutinised will deliver sustainable service improvement and deliver improved patient outcomes.

(g) Agree whether to use the joint powers of the local authorities to refer either the consultation or final decision in respect of any proposal for reconfiguration to the Secretary of State for Health.

(h) As appropriate, review the formal response of the NHS to the Committees consultation response."

1.5. The Joint Committee will consist of 2 Councillors nominated by each of the constituent areas and appointed in accordance with local procedure rules. Each Council can appoint named substitutes in line with their local practices.

1.6 Appointments to the Joint Committee will be made annually by each constituent area with in-year changes in membership confirmed by the relevant authority as soon as they know.

1. 7 A Chairman and Vice Chairman of the Joint Committee will be elected by the Committee at its first meeting for a period of one year and annually thereafter.

1.8 The life of the Joint Committee will be for a maximum of four years from its formation in May 2018.

1.9 For each specific piece of scrutiny work undertaken relating to consultations on reconfiguration or substantial variation proposals affecting all or some of the constituent areas, the Joint Committee will either choose to act as a full Committee or can agree to commission a sub-committee to undertake the detailed work and define its terms of reference and timescales. This will provide for flexibility and best use of resource by the Joint Committee.

1.10 In determining how a matter will be scrutinised, the Joint Committee can choose to retain decision making power or delegate it to a sub-committee.

1.11 The overall size of each sub-committee will be determined by the main Committee and must include a minimum of 1 representative per affected constituent area

1.12 Where a proposal for reconfiguration or substantial variation covers some but not all of the constituent areas, in establishing a sub-committee, formal membership will only include those affected constituent areas. Non affected constituent areas will be able to nominate members who can act as 'observers' but will be non-voting.

1.13 The Committee and any sub-Committees will form and hold public meetings, unless the public is excluded by resolution under section 100a (4) Local Government Act 1972 / 2000, in accordance with a timetable agreed upon by all constituent areas and subject to the statutory public meeting notice period.

Appendix Two

SOUTH WEST LONDON AND SURREY JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC)

RULES OF PROCEDURE

1. Membership of Committee and Sub-Committees

1.1 The London Boroughs of Croydon, Merton, Richmond upon Thames, Sutton, Wandsworth and the Royal Borough of Kingston upon Thames and Surrey County Council will each nominate, 2 members to the JHOSC, appointed in accordance with local procedure rules.

1.2 Appointments will reconfirmed annually by each relevant authority.

1.3 Individual authorities may change appointees in accordance with the rules for the original nomination.

1.4 Individual authorities will be strongly encouraged to nominate substitutes in accordance with local practice.

1.5 In commissioning Sub-Committees, membership will be confirmed by the JHOSC and can be drawn from the main Committee or to enable use of local expertise and skill, from non-Executive members of an affected constituent area.

1.6 The membership of a sub-committee will include at least one member from each affected constituent areas. An affected constituent area is a council area where the proposals will impact on residents. Non affected areas can appoint 'observer' members to sub-committees but they will be non-voting.

1.7 The JHOSC, may as appropriate review its membership to include authorities outside the South West London area whom are equally affected by a proposal for reconfiguration or substantial variation who can be appointed to serve as members of relevant sub-committees.

2. Chairman

2.1 The JHOSC will elect the Chairman and Vice Chairman at the first formal meeting. A vote will be taken (by show of hands) and the results will be collated by the supporting Officer.

2.2 The appointments of Chairman and Vice Chairman will be reconfirmed annually.

2.3 If the JHOSC wishes to, or is required to change the appointed Chairman or Vice Chairman, an agenda item should be requested supported by four of the seven constituent areas following which the appointments will be put to a vote.

2.4 Where a sub-committee is commissioned, at its first meeting a Chairman and Vice-Chairman will be appointed for the life of the sub-committee.

3. Substitutions

3.1 Named substitutes may attend Committee meetings and sub-committee meetings in lieu of nominated members. Continuity of attendance is strongly encouraged.

3.2 It will be the responsibility of individual committee members and their local authorities to arrange substitutions and to ensure the supporting officer is informed of any changes prior to the meeting.

3.3 Where a named substitute is attending the meeting, it will be the responsibility of the nominated member to brief them in advance of the meeting.

4. **Quorum**

4.1 The quorum of a meeting of the JHOSC will be the presence of one member from any five of the seven participating constituent areas.

4.2 The quorum of a meeting of a Sub Committee of the JHOSC will be three quarters of the total membership of the sub-committee to include a minimum of two members.

5. Voting

5.1 Members of the JHOSC and its sub Committees should endeavour to reach a consensus of views and produce a single final report, agreed by consensus and reflecting the views of all the local authority committees involved.

5.2 In the event that a vote is required, each member present will have one vote. In the event of there being an equality of votes the Chairman of the JHOSC or its sub-committee will have the casting vote.

6. JHOSC Role, Powers and Function

6.1 The JHOSC will have the same statutory scrutiny powers as an individual health overview and scrutiny committee that is:

- accessing information requested
- requiring members, officers or partners to attend and answer questions
- Referral to the Secretary of State for Health if the Committee is of the opinion that the consultation has been inadequate or the proposals are not 'in the interests' of the NHS

6.2 The JHOSC can choose to retain the powers of referral to the Secretary of State for Health for a particular scrutiny matter or delegate them to an established sub-committee.

7. Support

7.1 The lead governance and administrative support for the JHOSC will be provided by constituent areas on an annual rotating basis.

7.2 The lead scrutiny support for sub-committees will be provided by constituent areas on a per issue basis to be agreed by the sub-committee.

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7.3 Meetings of the JHOSC and its sub-committees will be rotated between participating areas.

7.4 The host constituent area for each meeting of the JHOSC will be responsible for arranging appropriate meeting rooms and ensuring that refreshments are available.

7.5 Each constituent area will identify a key point of contact for all arrangements and Statutory Scrutiny Officers will be kept abreast of arrangements for the JHOSC.

8. Meetings

8.1 Meetings of the JHOSC and its sub-committees will be held in public unless the public is excluded by resolution under section 100a (4) Local Government Act 1972 / 2000 and will take place at venues in one of the seven constituent areas.

8.2 Meetings will not last longer than 3 hours from commencement, unless agreed by majority vote at the meeting.

9. Agenda

9.1 The agenda will be drafted by the officers supporting the JHOSC or its sub-committees and agreed by the appropriate Chairman. The officer will send, by email, the agenda to all members of the JHOSC, the Statutory Scrutiny Officers and their support officers.

9.2 It will then be the responsibility of each borough to:

- publish official notice of the meeting
- put the agenda on public deposit
- make the agenda available on their Council website; and
- make copies of the agenda papers available locally to other Members and officers of that Authority and stakeholder groups as they feel appropriate.

10. Local Overview and Scrutiny Committees

10.1 The JHOSC or its sub-committees will invite participating constituent areas health overview and scrutiny committees and other partners to make known their views on the review being conducted.

10.2 The JHOSC or its sub-committees will consider those views in making its conclusions and comments on the proposals outlined or reviews.

10.3 Individual Overview and Scrutiny Committees will make representations to any NHS Body where a consensus at the JHOSC cannot be reached".

11. Representations

11.1 The JHOSC or its sub-committees will identify and invite witnesses to address the committee and may wish to undertake consultation with a range of stakeholders.

11.2 As far as practically possible the committee or sub-committee will consider any written representations from individual members of the public and interest groups that represent geographical areas in South West London and Surrey that are contained within one of the participating local authority areas.

11.3 The main Committee and any established sub-committees will consider up to 3 verbal representations per agenda item from individual members of the public and interest groups that represent geographical areas in South West London and Surrey that are contained within one of the participating local authority areas. Individuals must register to speak before 12pm on the day before the meeting takes place and will be given three minutes to make their representations to the committee.

11.4 The Chairman or any committee or sub-committee will have the discretion to accept more or late speakers where s/he feels it is appropriate.

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Report to:	South West London & Surrey JHSC sub-committee - Improving Healthcare Together 2020-2030	**Date:**	16 October 2018
Report title:	Scope and outline workplan for Improving Healthcare Together 2020-2030 sub-committee		
Report from:	Tom Alexander, Statutory Scrutiny Officer		
Ward/Areas affected:	Borough Wide		
Chair of Committee/Lead Member:	Councillor Colin Stears		
Author(s)/Contact Number(s):	David Olney, Commissioning & Business Insight Manager - 020 8770 5207		
Corporate Plan Priorities:	N/A		
Open/Exempt:	Open		
Signed:		**Date:**	28 September 2018

1. Summary

1.1 Attached is an outline scope for the work of the Improving Healthcare Together 2020-2030 sub-committee

2. Recommendations

The Sub Committee is recommended to:

2.1 Consider and comment on the scope.

3. Background

3.1 The Improving Healthcare Together 2020-2030 sub-committee was set up in June 2018 in order to scrutinise the work being undertaken by the 3 CCGs (NHS Surrey Downs, Sutton and Merton) responsible for the NHS plans to explore the ways we can address local health challenges, and make sure NHS services are sustainable and fit for the future.

4. Appendices and Background Documents

Appendix letter	Title
A	Scope and outline workplan for Improving Healthcare Together 2020-2030 sub-committee

Audit Trail		
Version	Final	Date: 28 September 2018

Background Documents
None.

Scope and outline workplan for Improving Healthcare Together 2020-2030 sub-committee

The committee is asked to consider the proposed approach to its work as set out below.

The sub -committee to consider Improving Healthcare Together 2020-2030 programme was established on 26 June 2018 as a sub-committee of the South west London and Surrey Joint Health Overview and Scrutiny Committee.

The Committee was established to carry out detailed scrutiny of the NHS Improving Healthcare Together 2020-2030 programme across both its early engagement phase and when it moves into a formal consultation phase, if that is the case, at some point in the future.

During the programme's engagement phase the sub-committee will undertake the following kind of work, this is not an exhaustive list of what the committee may choose to do.

- The sub-committee will prepare a workplan , using the Programme's timeline, to set out a timetable for its meetings and the relevant business content for those meetings;
- Hold public committee meetings to hear about and provide comment on the progress of the programme ;
- Receive and comment on reports on progress and actions from the programme director ;
- Participate in engagement activities to understand and contribute to the development of the programme.

If and when the programme moves into a formal public consultation the sub-committee will undertake its statutory responsibilities to consider whether the consultation is adequate and whether the proposals being put forward are in the interest of the local population.

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Joint Health Overview Scrutiny Sub-Committee

Improving Healthcare Together 2020 – 2030

Briefing Paper

October 16th 2018

1. Introduction

The following briefing paper has been prepared for the Improving Healthcare Together 2020 – 2030 JHOSC Sub-Committee. It includes updates on:

- Progress to date
- Provider impact
- Travel and access
- The engagement plan
- The Initial Equalities Analysis
- The Deprivation Impact Analysis
- The Integrated Impact Assessment

2. Progress

In June 2018 our Committees in Common, formed of the three CCGs, approved some key documents. These documents demonstrate the work we have done to date and include:

- An issues paper
- A case for change
- An emerging clinical model
- A potential solutions framework
- An engagement plan

The issues paper has been used to engage with our communities and includes 8 questions which we have asked local stakeholders to respond to. The issues paper is included in **Appendix 1**.

This paper identified specific issues with the long-term sustainability of healthcare in our combined geographies (i.e., the geographic areas covered by the three CCGs). Specifically, there are issues with clinical quality, estates and finance that create a need for us to consider how healthcare should change. To find potential solutions to our challenges, we have looked at:

- How our case for change can be addressed.
- How our clinical vision for care can be delivered.
- How our hospitals can be maintained into the future.

We are working towards developing a Pre-Consultation Business Case (PCBC), which will set out the evidence and process we have been through. The PCBC will need to include the analysis, processes and engagement we have undertaken to demonstrate a clear and logical process for identifying preferred potential solution(s) for change.

3. Provider Impact

A provider technical group has been established.

Since July, we have undertaken a process developed with NHSE/NHSI to understand impacts of potential changes to ESTH services on other local providers.

We have held 5 Technical Group meetings, with attendance from potentially affected providers (ESTH, Kingston, Croydon, St George's, Ashford St Peter's, Royal Surrey and SASH); and the ambulance services (LAS and SECAmb). Draft outputs have been shared with the group as the work has developed to facilitate discussion about approach and future outputs.

We have agreed an approach with this group to analyse patient flow:

- Using travel time as a core scenario
- Capturing other impacts and dynamics via a range of c. 10 sensitivities – to reflect drivers of patient flow other than travel time
- This has been applied to activity for each of the provisionally shortlisted options, to estimate the impact on providers

We have agreed that this impact analysis will also cover estates, workforce and income and expenditure.

During October, providers will estimate impacts in four areas:

- Capacity (beds, theatres, A&E, diagnostics)
- Estates and capital (new build / refurbishment, capital costs)
- Income and expenditure changes and,
- Workforce changes

A series of guidelines for consistency have been agreed across providers, including the basis of analysis and common assumptions.

The ambulance trusts have also agreed to estimate impact on them of any changes in similar areas. This analysis is planned to conclude by the end of October.

4. Travel and access

The Improving Healthcare Together programme commissioned Mott Macdonald to undertake a detailed travel time analysis to support this work and associated impact analysis. This is based on TRACC accessibility software, an industry standard approach, with data sourced from:

- Public transport timetable and,
- Network road speed data (derived from Traffic master GPS data)

This allows travel time between points in the geographies to be estimated. All geographical points within the three CCGs (+15km) were included. This analysis was completed for a weekday; as well

as a weekend day as a sensitivity. For each small geographical point in the area, a number of travel time metrics were produced including:

- Travel time by public transport, private care and blue-light ambulance response
- For morning peak, interpeak, afternoon peak and off-peak

These estimates were produced to and from all hospital sites in the area including:

- Epsom Hospital
- St Helier Hospital
- Sutton Hospital
- Croydon University Hospital
- East Surrey Hospital
- Kingston Hospital
- Royal Surrey County Hospital
- St George's Hospital (London)
- St Peter's Hospital (London)

A phase 1 analysis was undertaken to understand patients' access to services currently. A phase 2 is currently being undertaken to understand how patients' access and journey times could change, based on the services changes implied by each of the provisional short list of potential solutions.

5. Engagement plan

We are 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. We have followed their guidance and sought best practice advice from the Consultation Institute.

We are using a variety of different engagement activities to involve a wide number and range of stakeholders. Our early engagement plan commenced in June 2018. The participation, feedback and comments received from stakeholders so far are contributing to the development of our work and providing valuable thinking and challenges.

The briefing provides a summary of the engagement activity undertaken.

The Improving Healthcare Together video

The programme produced an animation video that explains the challenges the local NHS currently faces, how the programme is working together with stakeholders and the public to tackle them, and how local people can be involved.

The animation is subtitled, having been reviewed by the Surrey Disability Association to ensure it met disability guidelines, as recommended by the Stakeholder Reference Group. It is displayed on the homepage of the Improving Healthcare Together website and on the dedicated YouTube channel, whilst being regularly shared on social media platforms.

Discussion events

The programme has delivered 12 early engagement discussion events in total inviting members of the public to discuss and outline their thoughts and ideas to help address the local health challenges. The events were independently facilitated by Traverse.

Between 24th July and 2nd August 2018, the programme held 6 discussion events, 2 in each of the CCG areas it covers: Merton, Sutton and Surrey Downs.

The aim of these events was to engage with the wider public on a set of topics referred to in Improving Healthcare Together 2020 – 2030 Issues paper, including:

- The case for change
- The clinical model
- The evaluation criteria
- The potential solutions
- The process of developing a solution

The events were a mix of table discussions and questions and answers. These events saw 185 members of the public attend and share their thoughts.

Following on from the events in July - August, a second round of early engagement discussion events were held between 12th September and 25th September 2018, 2 each in the CCG areas the programme covers.

Some of the emerging issues identified by local people are captured below:

- Transport and accessibility to the site for patients
- Levels of deprivation in the area local to the site
- The desirability of the site and the local area to staff
- The health needs of the local population
- The impact on hospitals in neighbouring CCGs if patients chose to go elsewhere
- The cost of building and demolition
- The ability to maintain or increase the number of hospital beds

This round of discussion events were built upon the feedback and themes identified. The events were ran in a market place format with five stands on:

- Introduction to the programme
- The clinical model and workforce
- Deprivation and equalities
- Travel
- Evaluation criteria

Pop up/mobile engagement

The programme has delivered 6 engagement events in local community settings reaching out to communities targeting areas of high deprivation. The pop-up events have taken place between 8th – 15th September 2018.

The aim of the pop-up events is to:

- Engage local residents in areas of high footfall to hear a wider variety of voices
- Seek public feedback on the challenges we face and potential solutions
- Raise awareness of the September discussion events and other ways of giving us feedback

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As part of the engagement process members of the public were asked to complete a short survey aligned to the questions set out in the issues paper.

Focus groups with protected characteristic groups

The programme has commissioned Healthwatch Merton, Sutton and Surrey to conduct a series of focus groups with equality groups identified by the findings from initial Equalities Analysis (see point 7). Healthwatch developed its own plan to recruit to these groups using their own local expertise, relationships and knowledge. The information collected from the focus groups will feed into the options development and appraisal workshops as evidence to consider.

These focus groups will ensure we reach out to seldom-heard groups who are unlikely to access the other engagement activities planned.

The focus groups have commenced and will continue throughout October. Healthwatch will produce three independent reports collating the findings from this engagement.

Clinical model focus groups

Community members have been recruited to participate in six focus groups to obtain their feedback on the clinical model for the following service areas: maternity services, paediatric services, and emergency services as these are the areas most subject to potential change. This work will be independently undertaken by Traverse.

The objectives of these focus groups are to:

- Gather an overview of how participants feel they may be affected as either potential maternity, paediatric, or A&E patients depending on which potential solution is chosen from the clinical vision (major acute services at Epsom, St Helier or Sutton)
- Gather an overview of how participants, feel other types of maternity, paediatrics or A&E patients may be affected depending on which potential solution is chosen from the clinical vision (major acute services at Epsom, St Helier or Sutton)
- Find out how participants would like to be involved in the decision-making process

Each focus group will include:

- Engagement on the case for change and proposed solutions
- Capture specific concerns and identify how concerns could be addressed.

Stakeholder Reference Group

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

The SRG meets monthly and aims to create a platform for wider conversation, challenge and a feedback mechanism for the programme's proposed plans.

The membership of the SRG comprises a number of representatives from different communities of interest in the local area. Members include: patients or carers groups, third sector and community organisations as well as local Healthwatch branches and local authority contacts who indicated that

they wish to be involved in the programme. A number of organisations have been invited to get involved in this group.

The SRG is independently chaired by Sutton Healthwatch.

Members will be encouraged to bring the views of their communities to the table rather than their own personal views and they are the ones who decide the topics for discussion or review. They will also be encouraged to share the thinking of the SRG with their respective communities between formal SRG meetings.

6. Next steps

During the early engagement programme Improving Healthcare Together 2020-2030 has heard the views of hundreds of stakeholders and members of the public across Surrey Downs, Sutton and Merton. All information gathered from the engagement activities will be collated and analysed independently by The Campaign Company. The participation, feedback and comments received from stakeholders will be reviewed and fed into the future option evaluation process.

The Improving Healthcare Together programme has commissioned a number of additional studies to fully understand the potential impacts of any changes to the delivery of acute services that could be experienced by the local population in Merton, Sutton and Surrey Downs.

7. Initial Equalities Analysis

In June 2018, the Improving Healthcare Together programme commissioned Mott Macdonald to undertake an initial equalities analysis (EA). This work will support Merton, Sutton and Surrey Downs CCGs to understand which protected characteristic groups may be affected by any changes to the delivery of acute services.

The analysis considered each of the nine 'protected characteristic' groups as defined by the Equality Act 2010, as well as considering deprived communities and carers. The following groups have therefore been considered:

- Age - specifically children (those aged 16 and under), young people (those aged 16-24) and older people (those aged 65 and over)
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race and ethnicity (Black, Asian and Minority Ethnicity (BAME), White British, White other)
- Religion and belief
- Sex
- Sexual orientation
- Carers
- Deprivation

Whilst the purpose of the EA report is not to produce a set of firm conclusions, it has provided important information on those equality groups who may have a disproportionate and differential need/use for the acute services.

The Equalities Analysis report is included in **Appendix 2.**

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8. Deprivation Impact Analysis

The Nuffield Trust, PPL and COBIC were commissioned to undertake a deprivation impact analysis.

The scope of this work addressed the following questions:

a) What are the main health needs?
b) Do deprived communities have an increased need and usage for acute hospital services and do geographical factors influence this?
c) Which services are critical to retain?
d) How should any proposed clinical options be tested?
e) Are there any mitigations and balancing considerations?
f) Are there areas where further analysis be undertaken?

The key findings show:

- There is a wealth of evidence that deprived communities have worse health outcomes than non-deprived communities; however there is less evidence linking deprivation with the need/usage of the specific major acute areas being considered as part of the Programme;
- Within the combined geographies, deprivation is relatively limited when compared nationally at the average level, driven by pockets of deprivation;
- These pockets of deprivation are dispersed in several locations, in Sutton and Merton;
- The area of Sutton and Merton containing the pockets of deprivation is a fairly concentrated area. Given the current relative ease of access to major acute services within this area, and given the three current proposed locations for major acute services, any changes to locations of major acute services are likely to have relatively marginal impacts.
- The report understands these three proposed locations are the current proposed solutions, and that the Programme is open to other possible solutions for major acute service locations;
- Health inequality is an important factor, but that will not be solved or addressed specially by the decision about major acute service locations. Instead it will need be solved by wider partners.

The report will be published in October 2018.

9. Integrated Impact Assessment

The findings from the Equalities Analysis and Deprivation Impact Analysis are expected to inform the next phase of our work.

Mott Macdonald have been commissioned to undertake an Integrated Impact Assessment (IIA). The objectives of the IIA are to:

- Identify the **health impacts** for the population of Merton, Sutton and Surrey Downs as a result of any proposed changes to major acute services
- Identify **travel and access** impacts
- Identify which (if any) of the **protected characteristics groups** are more likely to be affected by any proposed changes. This work is critical in order to support the Clinical Commissioning Groups in meeting their obligations under the Equality Act 2010 and,

- Provide recommendations on ways in which positive impacts can be maximised and adverse effects can be mitigated or minimised.

This work will commence in November with the establishment of an Integrated Impact Assessment Steering Group.

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

Improving Healthcare Together 2020-2030

NHS Surrey Downs, Sutton and Merton CCGs

Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton clinical commissioning groups

Issues Paper

NHS Surrey Downs Clinical Commissioning Group

NHS Sutton Clinical Commissioning Group

NHS Merton Clinical Commissioning Group

Contents

Foreword

We, the clinical leaders for NHS Surrey Downs, Sutton and Merton clinical commissioning groups (CCGs), are a body of experienced local GPs who lead the organisations responsible for planning care for our patients and communities. We want to ensure the very best quality of care is available to our patients and communities, and that it is sustainable into the future from buildings which are fit for purpose.

To do this, we have come together to resolve the long-standing healthcare challenges with our ***Improving Healthcare Together 2020-2030*** programme. We believe there is a compelling set of reasons why change has to happen now and we want to share these with you.

We have been working with our clinical colleagues across local healthcare organisations to develop our view of how healthcare needs to be delivered in the 2020s and beyond. We need to plan for the future and we want to share this early thinking with you.

At the heart of our vision is wanting to keep you well, and for as much care to be delivered as close to your home as possible. We want to do this in a joined-up way with GPs and clinicians from hospitals, community and mental health organisations, working together alongside social care practitioners and the voluntary sector.

We also need to ensure that when you are seriously unwell or at risk of becoming seriously unwell, you have access to the highest quality care, available at any time of day or night and on any day of the week.

We are committed to keeping hospital services within the combined geographies of the three clinical commissioning groups and so we are not proposing any solutions which will result in hospital-based services being moved from our area.

We have looked at all the different ways we could deliver this vision and address our challenges and we have come to a provisional view that there are three ways we could do this. It is important to state that we have made no decisions on which solution is best.

What we are certain of is that if we do not resolve these issues now, we will not be able to maintain all the services we currently provide locally and which our population need.

In this document, and the information we have published on our website, we want to share how we have got to these three potential solutions. This is the start of our conversation with you about this, and we are looking forward to hearing your views. Following your feedback, we are aiming to have a public consultation in early 2019 when we have a view on our preferred solution. We want to involve you throughout this process and for everyone to have the opportunity to have their say.

We look forward to hearing from you.

Yours faithfully,

Dr Russell Hills
Clinical chair of
NHS Surrey Downs CCG

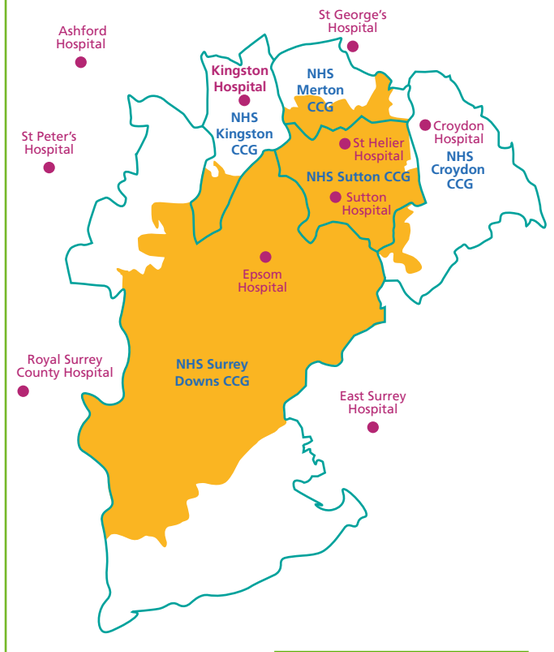
Dr Jeffrey Croucher
Clinical chair of
NHS Sutton CCG

Dr Andrew Murray
Clinical chair of
NHS Merton CCG

A compelling case for change

Combined geography of CCGs

Catchment area for Epsom and St Helier University Hospitals NHS Trust



Our three CCGs cover the catchment area of Surrey Downs, Sutton and Merton, known as the 'combined geographies', shown on this map. There are approximately 720,000 residents in our combined geographies and a number of healthcare providers are based here.

For some time, we and other neighbouring CCGs have been exploring ways to address long-term issues of sustainability particularly for acute hospital services. As many people will be aware, this has often focused on Epsom and St Helier University Hospitals NHS Trust so this map shows the catchment area it serves.

Last year, the Trust engaged with its patients and communities on what its next steps should be in providing care sustainably into the future and asked us, as commissioners, for our view. We reviewed the work of the Trust and we agree that we and they are facing three big challenges which mean a growing need for change. Collectively, we need to address these three main issues, which are:

Improving clinical quality
Our role as commissioners is to set clinical standards for care, assess objectively how these standards can best be met and then hold providers to account to deliver the standards. In line with national best practice, in 2017 we as commissioners defined clear clinical standards for six acute services. These standards set out expected senior staffing levels. Local providers of acute patient care were asked whether they believe they can meet these quality standards and all except Epsom and St Helier University Hospitals NHS Trust said they could. Therefore that Trust is a key focus of this discussion.

Based on the agreed standards, there is a shortage of consultants in emergency departments, acute medicine and intensive care. The Trust is not meeting the Royal College of Emergency Medicine guidance for consultant cover and this is something recently identified by the Care Quality Commission (CQC) the regulator of services, when it inspected acute services. Additionally, there is also a shortage of middle grade doctors and nursing staff.

The work which has been done across South West London and Surrey Downs to date indicates that there is not a need to look more broadly at changes to acute hospital services, other than those at the Trust.

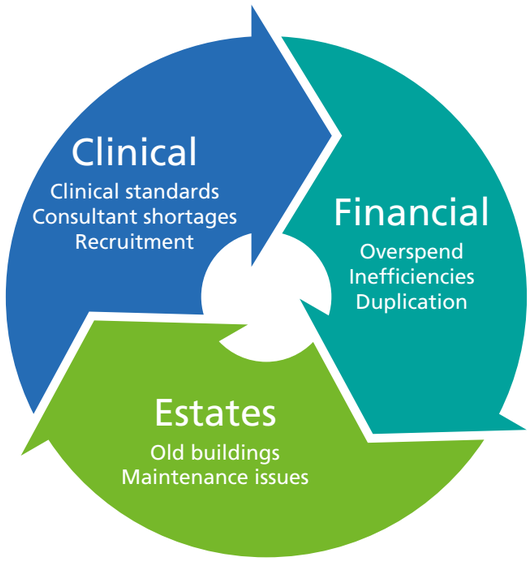
Providing healthcare from modern buildings
Many of the Trust's buildings were built before the NHS was founded and are rapidly ageing. They are not designed for modern healthcare, an issue repeatedly highlighted by the CQC, including in its latest report (May 2018). The Trust has a very significant and critical backlog of maintenance and the deterioration of the estate is affecting the day-to-day running of clinical services and patients' experience.

Achieving financial sustainability
The Trust has an underlying financial deficit which is getting worse each year. In 2013/14 it was around £7million and in 2017/18 it has increased to around £37m. This growing deficit is driven by unavoidable increases in costs for clinical workforce including temporary staff, increasing costs for estates maintenance and decreasing opportunities for changing the way we work. The financial position will continue to worsen unless changes are made.

Conclusion

These three challenges faced in our local healthcare system will not only affect the experience of our patients and the quality of patient care, but also have the potential to affect the outcomes for patients. Moreover, these challenges each impact each other, as shown in the diagram below. If we do not solve each of these problems we will not be able to provide high quality healthcare into the future.

Local NHS cycle of challenges



We would like you to consider the following question:

In addition to solving the challenges of clinical quality, financial deficit and poor quality buildings in our local NHS, are there any other challenges you think we may need to solve?

Our clinical vision for care: prevention, integration and acute services

As a group of local GPs, we have considered from a clinical perspective how to address the overall challenges our local healthcare system faces. We want to resolve these challenges and believe that the best way to do this is by looking at how to deliver care in the future. We are doing this with our partners from all health and social care providers in the area.

Looking at the long-term healthcare needs of our population, we have identified four key local aims for the future. These are:

- Improving the health of our populations
- Delivering care as close to patients' homes as possible
- Ensuring high standards of healthcare across all our providers
- Maintaining the provision of major acute services within our combined geographies

This will be achieved through:

- Greater prevention of disease
- Improved integration of care
- The delivery of enhanced standards in major acute services

This is consistent with the NHS's direction of travel set out in its 2014 *Five Year Forward View*.

Prevention of disease
We need to avoid people becoming ill wherever possible, either by preventing disease in the first place or preventing existing conditions deteriorating. We are developing a range of prevention initiatives.

Integration of care
Integration is key to ensuring continuity of care closer to patients' homes. Integrating care, which means 'joining up' health and care services so they work effectively together, requires a completely different approach and there are examples of where we are doing this. All three CCGs have plans to integrate services and provide care which is more proactive than reactive. The boxes that follow show some examples of this.

Enhanced standards for major acute services
Our emerging clinical model focuses on two types of services: district services and major acute. This builds on the work we have been doing on integrated care and all the services where we can provide high quality care for you.

Sutton Health and Care

Sutton Health and Care (SHC) delivers integrated health and social care services for patients with long-term, complex needs in two ways. Firstly, preventative and proactive care to support people staying well in the community. Secondly, reactive care, to avoid admissions and accelerate discharge for the frail, older population. It is a joint venture between the London Borough of Sutton, the hospital trust, the mental health provider and Sutton GP Services (a federation of GP practices in Sutton). SHC has ambitious plans to extend integrated services to cover all ages and patient groups which would benefit from organisations working closer together to deliver their care, as close to home as possible.

Sutton CCG also pioneered the 'red bag scheme'. This sees residents from nursing homes bring a specially packed red bag to hospital, which means patients arrive with a discharge plan already in place, as well as clothes to go home in, meaning quicker and easier discharge.

Epsom Health and Care

Epsom Health and Care @home has been established to provide extra support and care within a patient's home to support those who have two or more long-term conditions to live as independently as they can and to prevent them from needing a hospital admission.

It also sees patients over the age of 65 discharged earlier from hospital and, where possible, cared for at home rather than in hospital. This is a joint venture between acute services, GPs and Surrey County Council. The @home service has seen a reduction in patients needing to stay the night and excellent feedback from patients and carers.

Merton Health and Care Together

The Merton strategy for integrated community and primary care focuses on local teams working together to take action to prevent patients who are frail or have complex conditions from becoming unwell in the first place. It also sees a rapid response for vulnerable patients who become unwell, with measures in place to ensure patients are discharged from hospital at the right time.

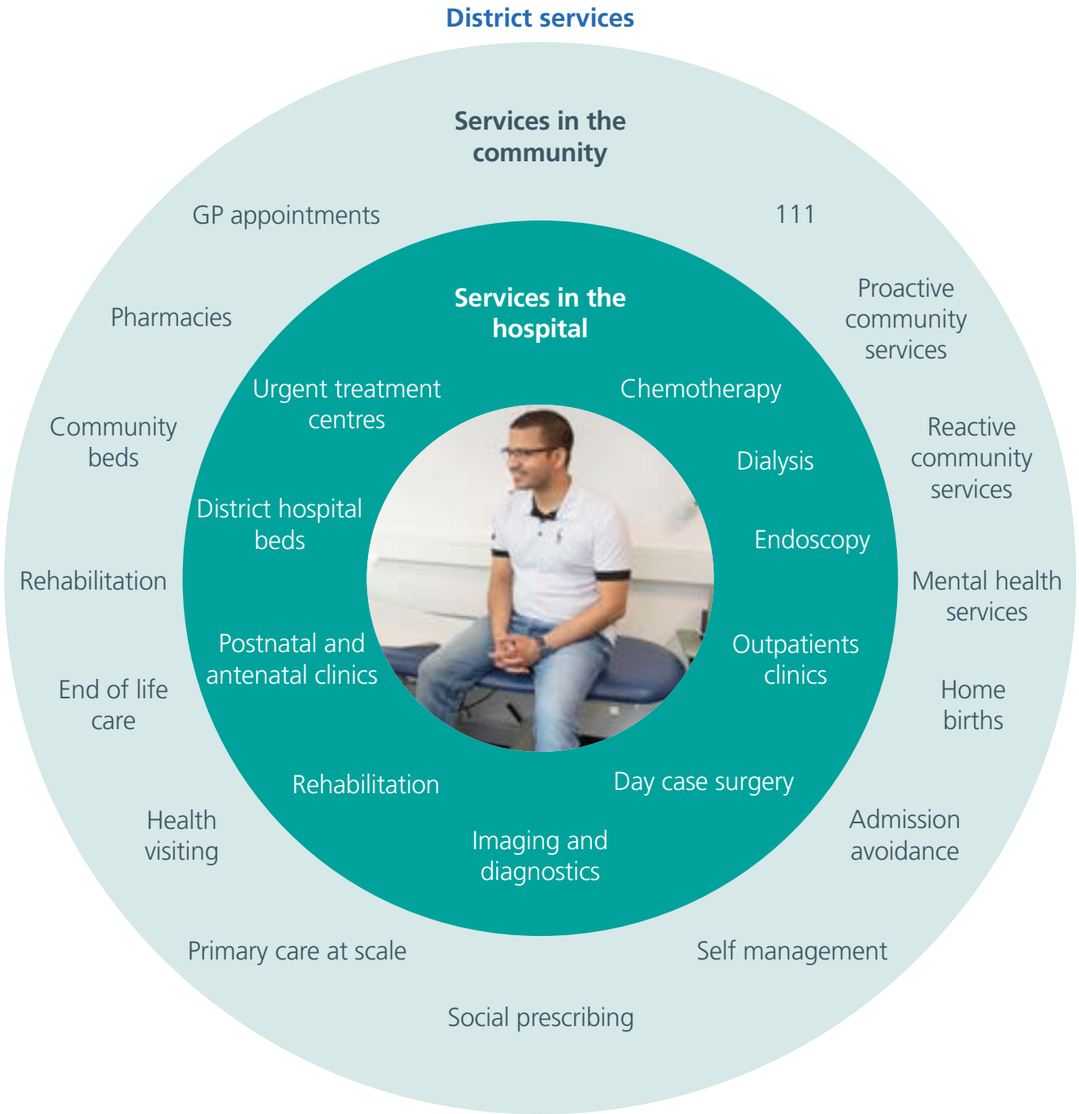
East Merton has seen GP practices work in teams to give patients better access to care, undertake 'social prescribing' and initiatives to look after the wellbeing of residents.

Merton has also been working closely with local A&E departments to help them determine which patients may have urgent rather than emergency care needs, and provide the right care.

Most health services in the local area will not change. The majority of services, including those for patients who do not need lifesaving, emergency, or unplanned care, will be unaffected by any potential changes.

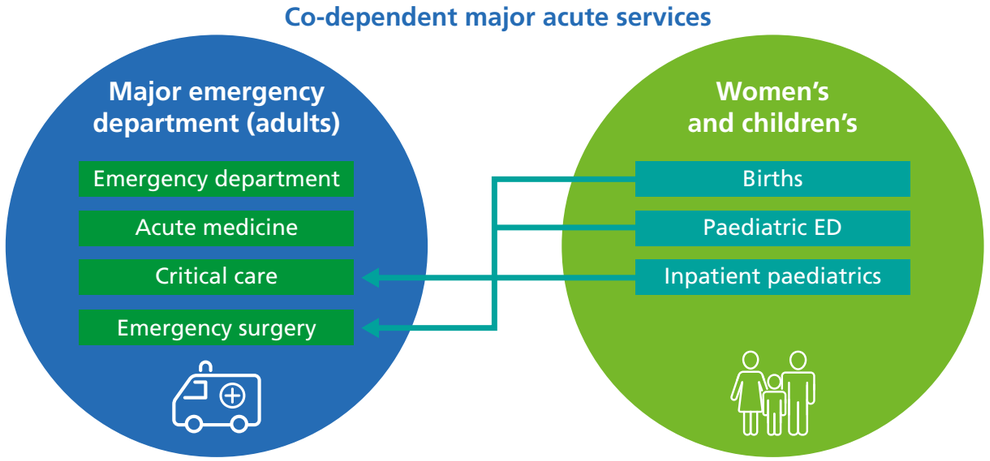
District services are services which are provided locally. These are services which patients are likely to require more frequently, and in each area there is a local strategy which is working to ensure they are co-ordinated and integrated with community, primary, social and voluntary care. Where there is not a case for change for these services, they would continue to develop in line with current plans.

District services include urgent treatment centres, outpatients, day case surgery, low-risk antenatal and postnatal care, imaging and diagnostics, and district beds. District services and how they relate to other services are shown in the diagram opposite:



Major acute services are often needed if you are very unwell. These major acute services include emergency departments, acute medicine, critical care, emergency surgery, obstetrician-led births and paediatrics. These services all depend on the use of intensive care services and specialist input for patients who are the highest risk and sickest. There are other 'co-dependencies' between services (meaning that they have to be located together) which are shown on the diagram on the following page.

We believe these six major acute services may need to change so that people who are very unwell, or at risk of becoming very unwell, get the right support straight away from senior specialist staff.



We have developed and approved a set of clinical standards for these six major acute services, which reflect the national move to deliver services 24/7 and the importance of patients being treated by the appropriate specialist in a timely manner. This will mean better survival rates and improved outcomes for our patients.

These clinical standards are accompanied by a required number of consultants for each of the six major acute services per site. This requirement is compared to the current position for the Trust in the table underneath which indicates a number of important gaps.

Service	Total consultant requirement (two sites)	Current consultant staffing	Gap (two sites)
Emergency department	24	14	10
Obstetrics	22	26	-
Emergency general surgery	10	10	-
Paediatrics	24	26	-
Acute medicine	24	11	13
Intensive care	9	7	2

The Trust has already moved its emergency surgery and critical care to St Helier Hospital, which has improved care for patients. Emergency fractured neck of femur (broken hip) services have been brought together at St Helier Hospital and now see significantly better outcomes for elderly patients than the national average. This means that less people die as a result of breaking their hip. These improvements have been possible because, by having a single team on one site, the Trust has been able to ensure that patients have access to the right specialist. This is why we think change may be needed – because we believe it will improve clinical standards and care for patients.

We would like you to consider the following question:

Do you think our vision, based on greater prevention of disease, improved integration of care and the delivery of enhanced standards in major acute services, is the right vision for this area?

Developing potential solutions

To find potential solutions to our challenges, we have looked at how our case for change can be addressed. We have explored how our clinical vision for care can be delivered and how our hospitals can be maintained into the future. We have focused on this process in two different ways:

Firstly, we have focused on major acute services only, as there is a need for significant changes in these services. District services, which comprise the majority of healthcare provided on our hospital sites, do not face the same issues and can continue to be developed through local strategies, which includes looking at delivering care in a more integrated way.

As highlighted in this section, we are also doing work as part of this programme to analyse the different needs of communities in our combined geographies, and in particular how relative levels of deprivation affect those needs and the ability to access services.

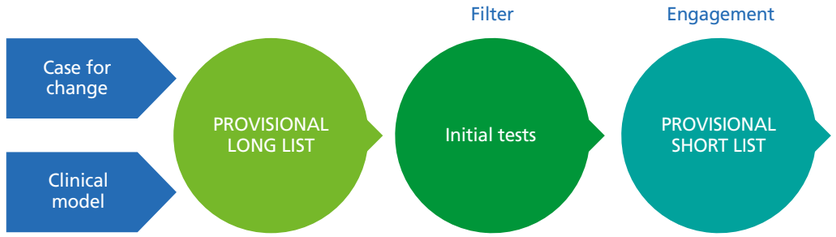
Secondly, we have focused only on changes within our combined geographies. Our focus has been on major acute services, and how the Trust could deliver care in line with the quality standards for major acute services. However, if these changes impact on other providers including other hospitals, this would be considered as part of a detailed analysis of ways services can be delivered.

Based on this, we have then made further considerations. We have looked at how potential solutions might develop into a long list of ideas for solving our health and care challenges. This is intended to capture a wide range of potential solutions so we can then consider whether they meet the needs of local people and address the problems we are facing.

We have then considered variations in the number of sites for major acute services, the workforce implications and whether workforce from outside the area could be used to supplement rotas, and which sites could be used to deliver major acute services.

All the combinations of these factors leads to 73 potential solutions. This forms our provisional long list of ideas for solving our challenges.

Our long list is refined by testing these potential solutions against three initial tests, which are in line with our case for change and include whether services are maintained in our combined geographies. This is shown in this diagram.



We have applied three initial tests to this long list to reach a provisional shorter list we can consider in detail. The most important of these tests is whether a solution fits in with our collective commitment to maintaining services within our combined geographies. Our other two tests are about whether we can deliver the solution based on the agreed quality standards and the quality of the estate.

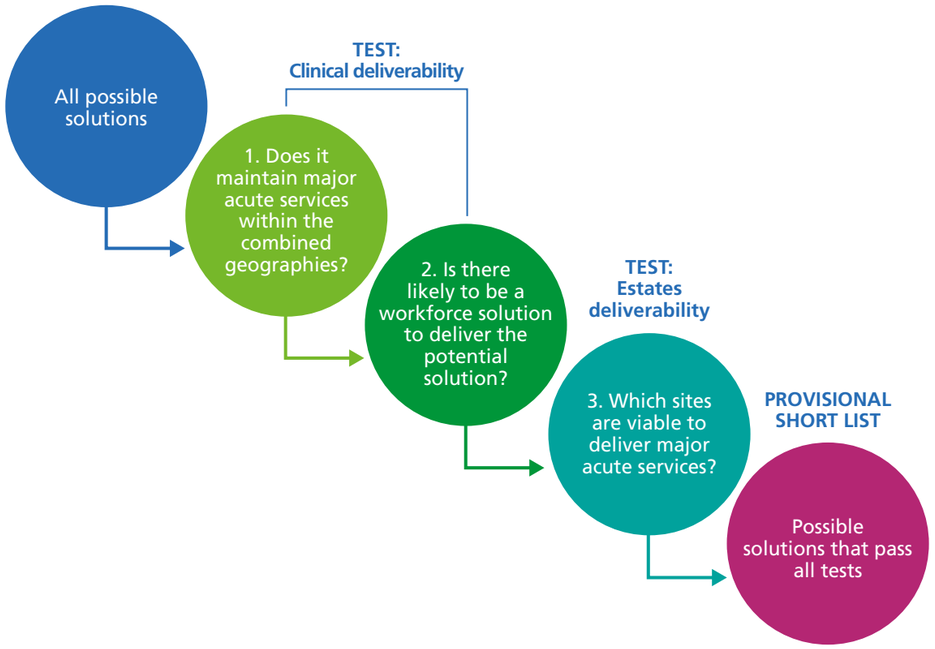
The initial tests we have applied are:

1. Does the potential solution **maintain major acute services within the combined geographies**? This is a key commitment for us and any potential solution must maintain all major acute services within our combined geographies.

2. Can the agreed **quality standards** for major acute services be met? This considers whether there is likely to be a **workforce solution**.

3. From which **sites** is it possible to deliver major acute services? This considers whether different sites are feasible for the delivery of major acute services.

Applying these tests, shown in this diagram, sequentially reduces the long list:



- After the first test, **any potential solution that does not offer all major acute services within the combined geographies is eliminated** (e.g. no major acute hospitals or only providing major adult emergency department services within the combined geographies). This provisionally results in 50 potential solutions.
- After the second test, workforce limitations and the six acute services which need to be located together mean that **any potential solution with more than one major acute site and any potential solution relying on external workforce is eliminated**. This provisionally results in four potential solutions – a single major acute site from one of four sites, including the possibility of a new site. Detail on this analysis is included in the technical annexe which we have published.
- After the third test, where we looked at other locations in our geographies, **only existing sites appear feasible**. This provisionally results in three potential solutions.

We will compare these solutions with the concept of continuing as we are.

There are therefore three potential solutions in our provisional short list.

This provisional short list includes:

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

This table shows the number of senior specialist doctors which are needed by a service when they are brought together in one place, compared with two.

Service	Current consultant staffing	Total requirement (two sites)	Total requirement (one site)	Gap
Emergency department	14	24	12-16	0
Obstetrics	26	22	12-16	0
Emergency general surgery	10	10*	10	0
Paediatrics	26	24	12-16	0
Acute medicine	11	24	12	1
Intensive care	7	9**	9	2

To build on the engagement work already done by the Trust with patients and our communities, further public engagement is taking place on our provisional short list of three potential solutions, which we have described in this document. Any views on this provisional short list will be taken into account in the next phase of work, which will be informed by the views gained through this engagement.

The case for change makes clear that we need to consider our plans for the future and explore the ways in which the issues we face can be addressed. We are clear that any potential solutions must address the three main issues of clinical quality, estates and financial sustainability, while supporting our broader plans for healthcare locally. Further work is required, and we will continue to explore:

- How the clinical model can change to address our challenge of clinical quality and ensure that care is integrated and standards for major acute services are met
- The potential solutions which deliver this clinical model to our populations while addressing our challenges of workforce, estates and financial sustainability

* Emergency general surgery is already only provided on one site
** Intensive care services for the sickest patients are already only provided on one site

We would like you to consider the following question:

Do you think we should consider any other initial tests – apart from those described in this document – as we develop the long list of ideas into a final short list?

Other important things to consider

As part of this work, there are a number of other important considerations for our patients and their families and carers. We will consider pieces of work as we progress further. These include:

- **Travel and access:** What kind of journey would patients have, and what kind of distance would they need to travel, in order to access care? What public and patient transport would be available or needed?

- **Impact on deprived communities:** We will consider how potential changes might affect communities within our local area which are affected by deprivation, such as poverty, poor education or housing, all of which can affect health and wellbeing.

- **An equality impact analysis:** This will consider the impact of any change on our communities, including people with protected characteristics.

- **Impact on other hospitals:** This will consider the impact of any change on nearby hospitals.

We have already started looking into these important elements of how care is accessed, using experts to analyse work which has already taken place.

We would like you to consider the following question:

Do you think there are other important things we should consider as we take this work forward?

Next steps

There is lots of work to be done on our challenges in healthcare, and a number of key issues which need to be considered. During this phase of engagement, we intend to listen to and talk with our communities through a number of engagement activities. This document is the start of the engagement process.

We also have a stakeholder reference group for local patient, community and other organisations which will be sharing thoughts and ideas. Additionally, we are undertaking a number of activities to make sure people know about this programme and can tell us their thoughts.

Potential timeline

During this engagement period, we will publish the equality impact and deprivation analyses. We will also be seeking stakeholder input to the issues set out in this document. In the future, we will also be seeking your views on any potential evaluation criteria we might use to evaluate any shortlisted solutions. However, we will as CCGs consider all feedback from stakeholders, patients, staff and the wider public before proceeding with any future review of potential solutions.

After that phase, the next phase of the programme will be to take all this information into account as we create a series of options for how we might change the way deliver care. We will continue to involve our local communities and other important stakeholders to ensure we receive feedback to inform our thinking.

If significant change is proposed, then we would draft a document which asks for the funding needed to undertake this work called a pre-consultation business case (PCBC) for approval by NHS England and, if approved, we would consider proceeding to consultation.

We would like you to consider the following questions:

Do you have any questions about the process we are proposing to follow or any suggestions for improving it?

Can you think of any other ways of tackling the challenges described in this document, within what the document describes as possible?

What are the best ways for involving our patients and community in developing ideas to address the challenges described in this document?

How to get involved

It is vital that this programme talks with local communities who may be affected by changes to services in the area. As lead clinicians working to improve healthcare into the future, we and our colleagues want to hear from local patients, their families and carers to establish their thoughts, feelings and ideas about local healthcare and how it can be improved.

We will be publishing details of upcoming engagement activities. We would also like to ask you some questions in response to this document. Most of these questions appear throughout this ***Issues Paper*** – we have collated them here for you to consider.

Please send us your answers to these questions, or any other thoughts, questions or comments, using the contact details on the back cover of this document.

1. In addition to solving the challenges of clinical quality, financial deficit and poor quality buildings in our local NHS, are there any other challenges you think we may need to solve?
2. Do you think our vision, based on greater prevention of disease, improved integration of care and the delivery of enhanced standards in major acute services, is the right vision for this area?
3. Do you think we should consider any other initial tests – apart from those described in this document – as we develop the long list of ideas into a final short list?
4. Do you think there are other important things we should consider as we take this work forward?
5. Do you have any questions about the process we are proposing to follow or any suggestions for improving it?
6. Can you think of any other ways of tackling the challenges described in this document, within what the document describes as possible?
7. What are the best ways for involving our patients and community in developing ideas to address the challenges described in this document?
8. Would you like to receive the regular electronic update newsletter we propose to publish? If so, please let us know. Our contact details are on the back page.

Improving Healthcare Together 2020-2030

NHS Surrey Downs, Sutton and Merton CCGs

Please send us your thoughts, questions or comments.

Online: www.improvinghealthcaretogether.org.uk

Email: hello@improvinghealthcaretogether.org.uk

Post: Freepost IMPROVING HEALTHCARE TOGETHER 2020-2030

There is no need to use a stamp. Please write this address on a single line without any other addressing details such as road, town, or postcode. The address must be written using upper and lower case, exactly as above.

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This document is available in large print, audio and other languages on request.

June 2018

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MOTT MACDONALD

Improving Healthcare Together 2020-2030

Initial equalities analysis of major acute services

August 2018

Equalities Analysis

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Improving Healthcare Together 2020-2030

Initial equalities analysis of major acute services

August 2018

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Information class: Standard

Contents

1 Background and methodology

Mott MacDonald has been commissioned by Surrey Downs, Sutton and Merton CCGs to undertake an initial equalities analysis (EA). This work will support local commissioners to understand which protected characteristic groups may be affected by any changes to the delivery of acute services. The following chapter will outline the context for this analysis and the approach undertaken by Mott MacDonald.

1.1 Improving Healthcare Together 2020-2030

The Improving Healthcare Together 2020-2030 programme, led by NHS Surrey Downs, Sutton and Merton Clinical Commissioning Groups (CCGs), is working to improve healthcare sustainably. It is working to address three main challenges in the combined geography of the three CCG areas. These are:

- Improving clinical quality
- Providing healthcare from modern buildings
- Achieving financial sustainability

The Improving Healthcare Together issues paper states that six major acute services[1] may need to change so that people who are very unwell, or at risk of becoming very unwell, get the right support straight away from senior specialist staff.

Three potential solutions have been put forward:

- Locating **major acute services at Epsom Hospital**, and continuing to provide all district services at both Epsom and St. Helier
- Locating **major acute services at St. Helier Hospital**, and continuing to provide all district hospital services at both Epson and St. Helier
- Locating **major acute services at Sutton Hospital**, and continuing to provide all district services at both Epsom and St. Helier [2]

1.2 Equality analysis and scope of this report

It is important that those involved in making decisions about future health service configuration understand the full range of potential impacts that any changes could have on the local population. It is particularly important that they understand the potential impact on groups and communities who will be the most sensitive to service changes.

Within this context, this initial EA will help local NHS commissioners to understand which groups, particularly protected characteristic groups, are likely to have a greater need for acute services and are therefore more likely to be impacted by any changes in provision. This report focuses on the following acute services:

- A&E
- Acute medicine
- Emergency general surgery

[1] A&E, acute medicine, emergency general surgery, intensive care, obstetrics, paediatrics

[2] Improving Healthcare Together 2020-2030: NHS Surrey Downs, Sutton and Merton Clinical Commissioning Groups Issues Paper accessed online at http://www.surreydownsccg.nhs.uk/media/271539/committee-in-common-papers-combined.pdf

- Obstetrics
- Paediatrics

Intensive care has not been explored in its own right as admission to this unit is via admissions through emergency or elective medical and surgical services and so disproportionate need for this service will be covered in the discussion of other acute services.

As this is an initial analysis, this report is a **high-level scoping** report. It outlines preliminary observations on which groups are considered to have a disproportionate or differential need for the hospital services under review.

1.3 Methodology

The report considers each of the nine 'protected characteristic' groups as defined by the Equality Act 2010, as well as considering deprived communities and carers[3]. The following groups have therefore been considered in this report:

- Age – specifically children (those aged 16 and under), young people (those aged 16-24) and older people (those aged 65 and over)
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race and ethnicity (Black, Asian and Minority Ethnicity (BAME), White British, White other)
- Religion and belief
- Sex
- Sexual orientation
- Carers
- Deprivation

For each group, a summary table is presented identifying whether, and for which acute services under consideration[4], they have a disproportionate or differential need.

Definition of terms

- **Disproportionate need** refers to a need for the service/treatment over and above the general population.
- **Disproportionate use** refers to the higher use of services/treatments over and above the general population
- **Differential need** refers to a group that has different types of need for the service during delivery.

[3] Although not identified as protected characteristics in equality legislation, it is accepted best practice to include those from deprived communities and carers.

[4] Please note that this study explores the following acute service provisions: A&E, acute medicine, paediatrics, emergency general surgery and obstetrics. Intensive care has not been explored in its own right as admission to this unit is via admissions through emergency or elective medical and surgical services and so disproportionate need for this service will be covered in the discussion of other acute services.

Please note: the disproportionate use of services/treatments and the disproportionate need of services/treatments can often be interdependent and it is not always possible to disaggregate one from the other.

The report considers each protected characteristic group through:

1. An **evidence review of available literature** which identifies protected characteristic groups who may have a disproportionate need for services. A range of documents have been reviewed including, academic papers, CCG reports and Joint Strategic Needs Assessments (JSNAs).
2. **Demographic analysis** which sets out the characteristics of the study area, and particularly the distribution of residents from different equality groups[5].
3. **Qualitative in-depth telephone interviews** with 18 individuals. These individuals described the ways in which services are 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 experiences of delivering services.
    - **6 representatives of key user groups** who discussed the potential impact of any changes to acute services for those they represent.

This information has been used to 'scope in' groups who may have a particular need for the acute services under review. This is not to say that other groups will not need these services, rather it is to suggest that there does not presently exist a body of strong clinical evidence indicating a disproportionate or differential need.

Methodological assumptions and limitations:

It is important to set out the following principles on which this initial EA is based:

- The purpose of the EA is to inform rather than decide. The objective is not to determine the decision, but to assist decision makers by providing better information.
- It is not the purpose of the EA to justify, defend, or challenge the rationale or principles behind potential changes to acute services within ESTH. The EA is being undertaken based on the assumption that any emerging changes to services will be designed by the local commissioners with the objective of realising benefits for all people requiring the services under review, thereby helping to improve outcomes for patients overall.
- The purpose of this initial EA report is not to produce a set of firm conclusions; rather it is to highlight equality groups and their need for acute service. Though doing this, the report should act as a means of outlining which groups may experience potential impacts and highlighting issues that need to be further investigated.
- This initial EA report is based on review and analysis of available secondary data such as publicly available reports, policies, and literature. The protected characteristics identified in this report as having a disproportionate need for the services under review are not considered to be an exhaustive or definitive list at this stage. Where other evidence emerges, particularly through further engagement with local equality and community

[5] We have undertaken a demographic analysis on the following; the population of children (under 16 years); the population of older people (65 and over); the population living with a long-term illness; the population of females (aged 16-44 years); the population from BAME background; indices of multiple deprivation; and the population by sex. This analysis has been based on available data and focused on those groups which are expected to experience a range of impacts across the majority of the acute service,

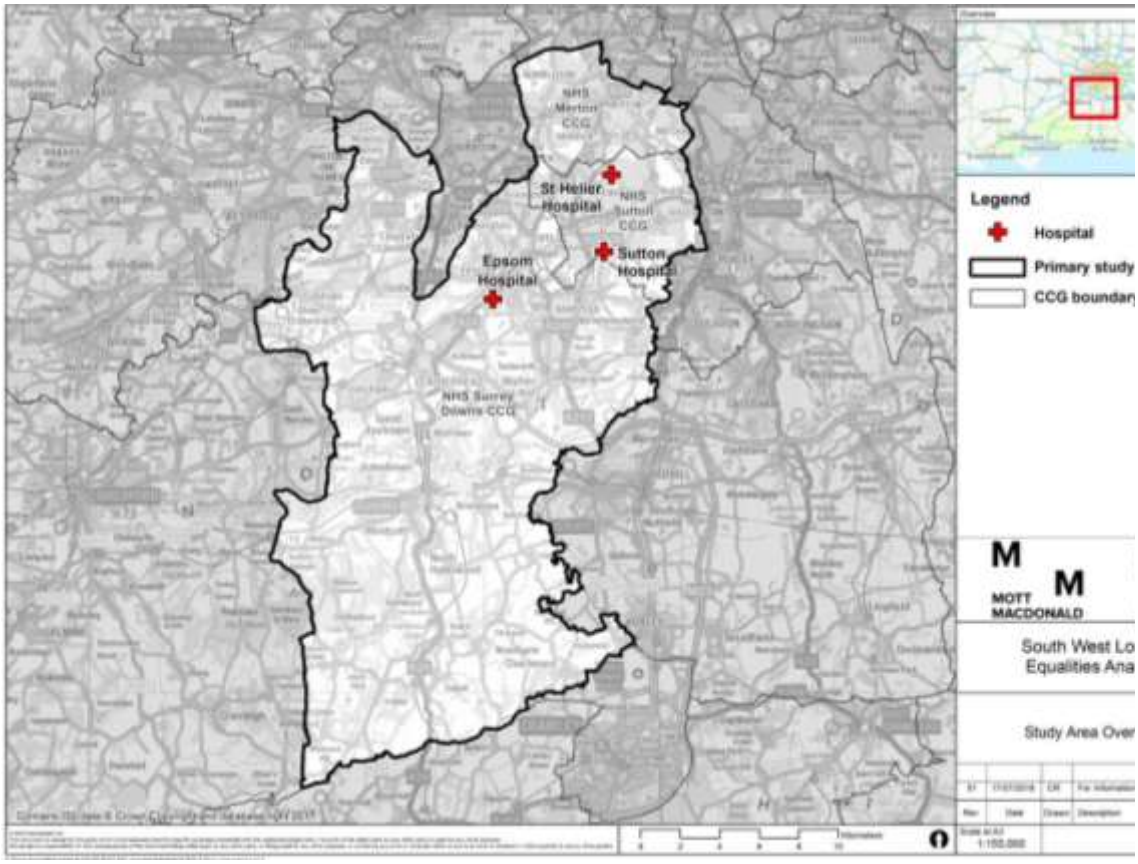
representatives, clinical professionals and other patient groups, these preliminary findings may need to be updated.

- Socio-demographic analysis has been undertaken for the study area to provide an insight into the geographical distribution and concentration of certain key populations. This profiling concentrates on the population groups that have been identified as being sensitive to the proposed changes and those with a 'disproportionate need' or 'differential need' for the services under review, based on the evidence examined to date.
- The latest available census data has been used to complete the demographic analysis. In most cases this means that the 2016 mid-year population estimates have been used, except for demographic information pertaining to the black Asian minority ethnic (BAME) population and limiting-long term illness (which is used as a proxy for disability). In these instances, the 2011 census data has been used.
- Quantification and distribution of impacts are not included. Detailed quantitative analysis of where and which patient groups would be affected by each reconfiguration option does not form part of this report.

1.4 The study area

The primary study area spans the three CCGs that have come together to undertake the Acute Sustainability Programme: Merton, Surrey Downs and Sutton CCGs. However, this report also considers a wider study area to recognise patient movement in and out of the CCGs, which is linked to the proximity of other hospitals to the Trust's main sites. As such, an additional 15km area has also been considered as part of this study. Detailed maps of just the primary study area are proved in Appendices. While hospital sites in the area have been mapped, existing providers of community care have not been. However, a full EA should look to consider the impact of any acute reconfiguration on community care.

Figure 1: Primary study area



Source: Mott MacDonald

The overall population and the density of population provide a baseline from which to break down the key socio-demographic trends in the study area.

1.4.1 Total population

The table below shows the total population of each of the three CCGs, as well as wider area comparators.

Table 1: Total population

Area	All usual residents
Merton CCG	205,029
Surrey Downs CCG	288,199
Sutton CCG	202,220
Primary study area	695,488
Wider study area	6,669,807

Source: LSOA population estimates 2016, ONS

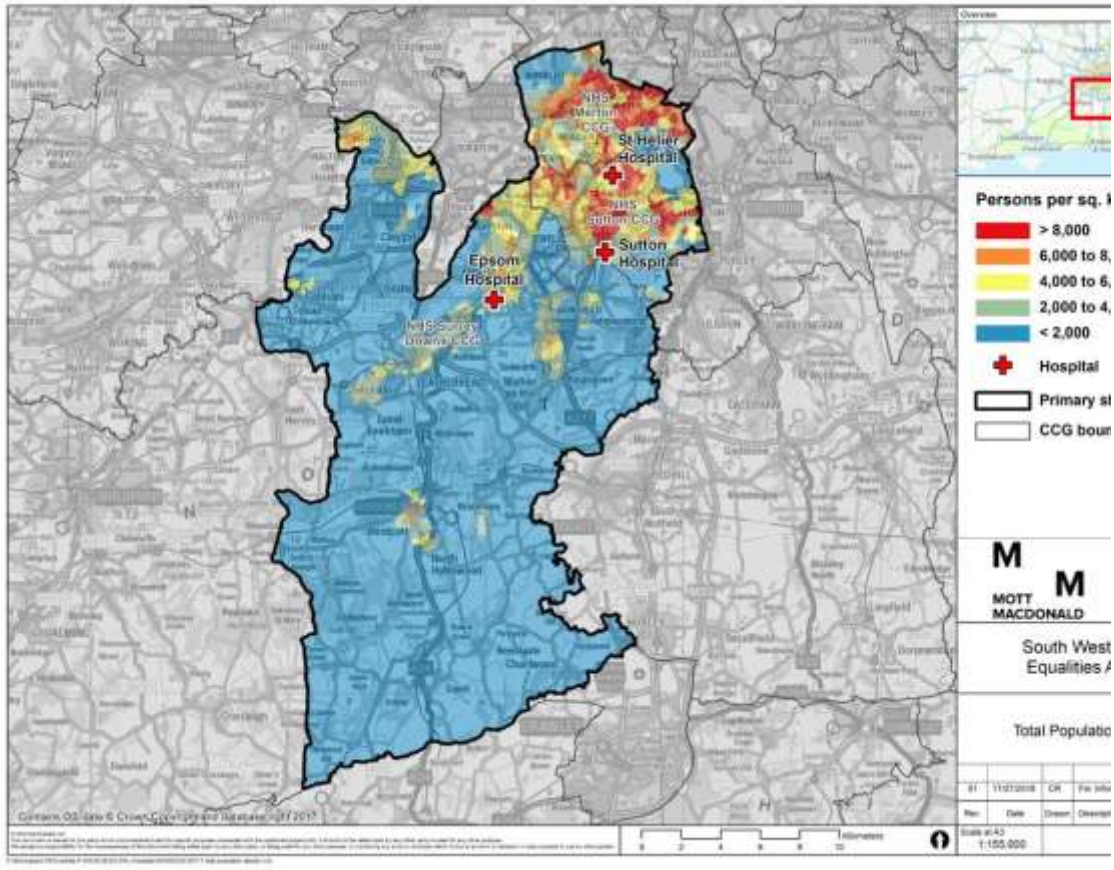
The table indicates that the largest numbers of people live in Surrey Downs CCG (with c.288,000 people), followed by Merton CCG (with c205,000 people) whilst the least populated CCG area is Sutton (with nearly 202,000 people). The total population of the study area is just under c.700,000. The wider study area is over 6 million.

It should also be noted that:

- Merton's population has been projected to increase by around 6.45% between 2014 and 2020. In particular Merton is projected to see a notable growth in those under the age of 16 years and those over 50 years. It is also projected to see a growth in people from a Black, Asian and Minority Ethnic (BAME) background (37% in 2014 to 40% in 2020).[6]
- Surrey Downs' population is estimated to grow by 9% between 2015 and 2025. In particular, Surrey Downs is predicted to see a growth in all ages over 55 while the proportion of people in the 20 to 29 age group set to decrease.[7]
- Sutton's population is forecast to increase by around 12.7% between 2014 and 2024. The population of children and young people aged 0 to 19 years is particularly expected to increase. The proportion of older people aged over 65 is also expected to increase.[8]

1.4.2 Population density

Figure 2: Population density



[6] Merton (2016) 'Merton Joint Strategic Needs Assessment'. Available at: https://www2.merton.gov.uk/health-social-care/publichealth/jsna/merton-place-people/mpp-people.htm#gla_population_projections_2013_round_trend_based

[7] Surrey (2015) Surrey Downs CCG Health Profile 2015. Available at: http://www.surreydownsccg.nhs.uk/media/144405/sdccg_health_profile_2015.pdf

[8] Sutton (2017) Sutton Joint Strategic Needs Assessment: Population fact Sheet'. Available at:

Source: Mott MacDonald

The map above illustrates the overall population density for the study area. It shows that the highest densities of people live predominantly in the north of the area, around Merton and Sutton. Areas located further from London show a lower population density, in part linked to large areas of parkland within the study area, particularly around Epsom. The difference in density between the areas is therefore largely linked to access to services in the Merton and Sutton area.

1.5 Structure of the report

The remainder of the report is structured as follows:

- **Chapter two** provides the scoping review of the equality impacts
- **Chapter three** provides a summary of findings

2 Initial equalities analysis

The following chapter outlines where there has been found to be a differential or disproportionate need across the acute services under review for each of the protected characteristic groups (plus deprivation and carers).

2.1 Age: Children (those aged 16 and under) and younger people (those aged 16-24)

Evidence of disproportionate need / use has been identified for accident and emergency (A&E), obstetrics, and paediatrics.

Table 2: Scoped in services – Children (those aged 16 and under) and younger people (those aged 16-24)

Service Area	Evidence of disproportionate need or disproportionate use	Evidence of differential need
A&E	✓	
Acute medicine		
Emergency general surgery		
Obstetrics	✓	
Paediatrics	✓	

Source: Mott MacDonald, 2018

2.1.1 Demographic profile of children (aged 16 and under)

The table below shows that within the primary study area (covering the three CCGs), the proportion of children aged under 16 (20%) is broadly in line with the national average (19%).

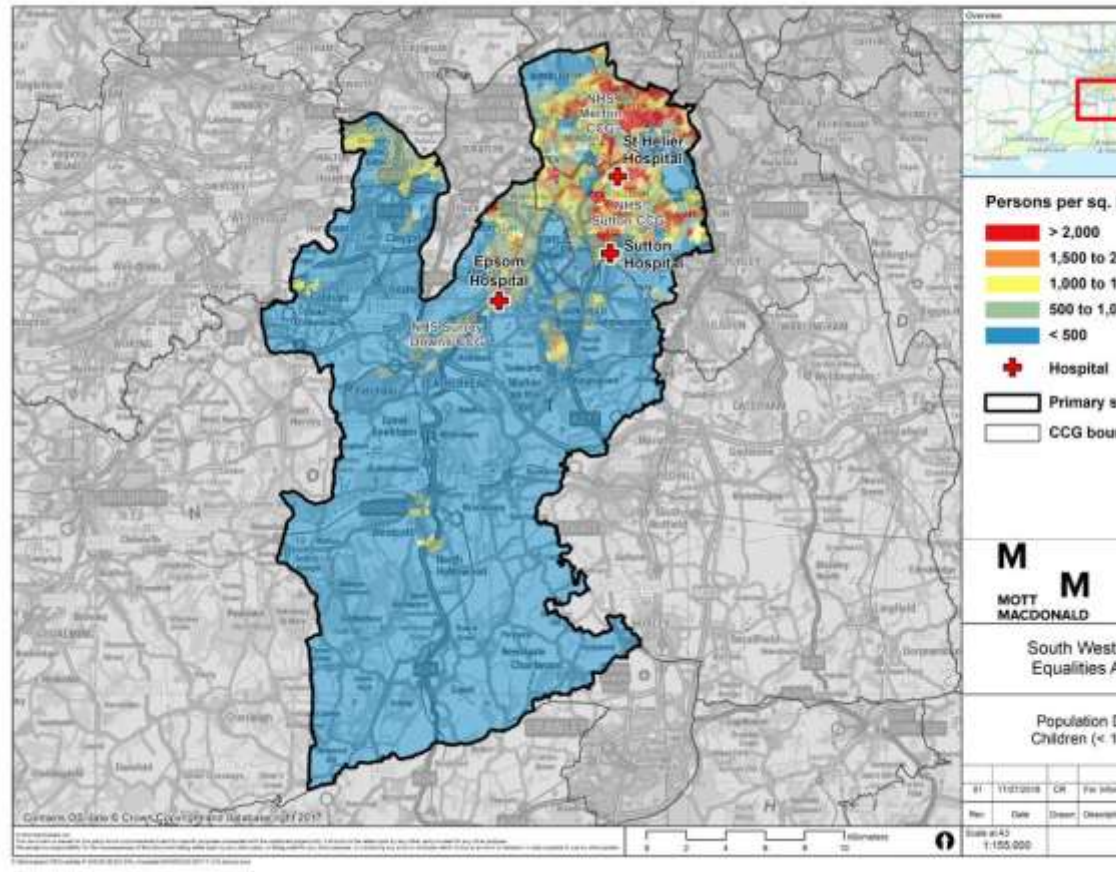
Table 2: Age – children (under 16)

Study area	Total population	Under 16	Under 16 %
Merton CCG	205,029	42,658	21%
Surrey Downs CCG	288,199	57,198	20%
Sutton CCG	202,220	42,143	21%
Study area	695,448	141,999	20%
England	55,268,067	10,529,100	19%

Source: LSOA population estimates 2016, ONS

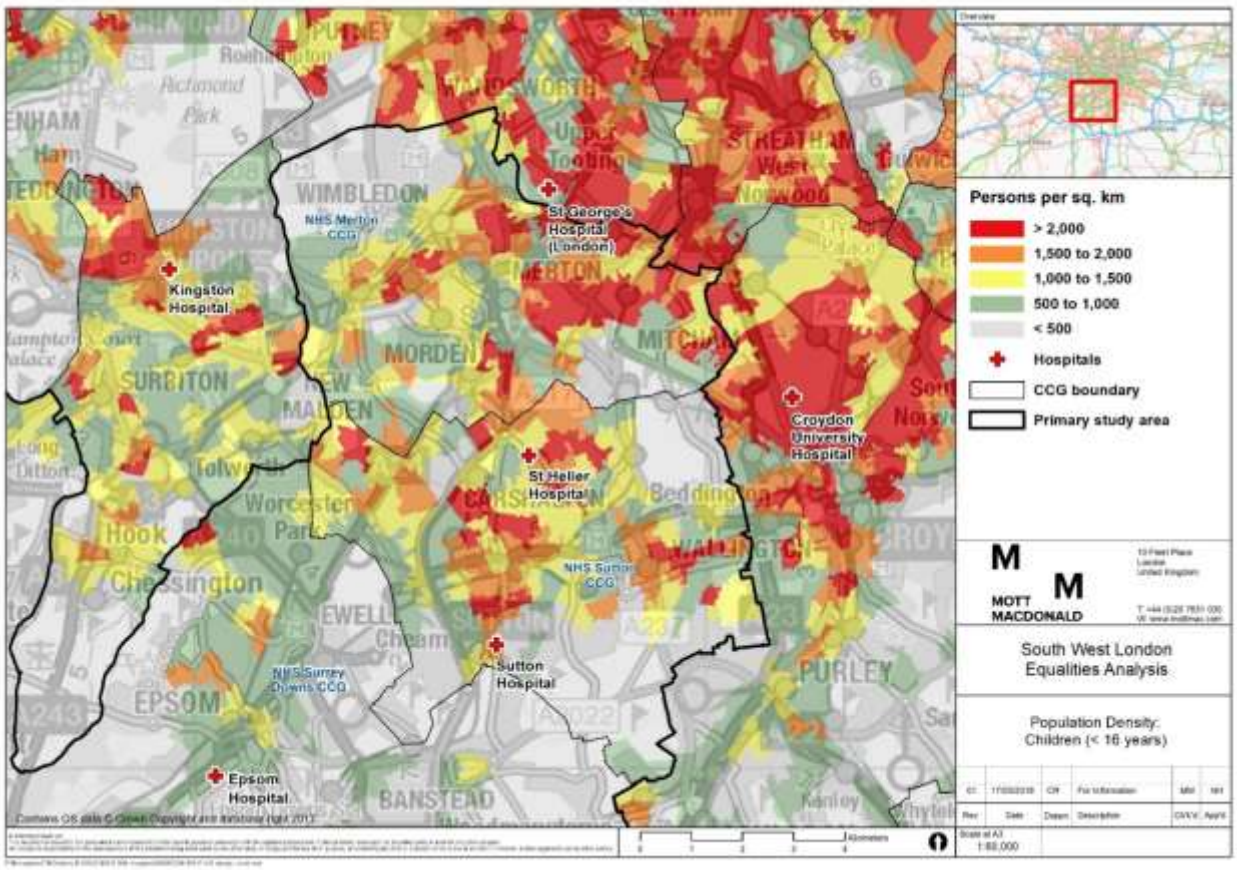
Figures 2 and 3 below shows that most concentrated density of those aged under 16 are located within Merton and Sutton CCGs with the highest densities around Merton and Carshalton. The majority of the study area has a low density of children under 16.

Figure 3: Population density of residents aged under 16 years



Source: Mott MacDonald

Figure 4: Population density of residents aged under 16 years – higher density areas



Source: LSOA population estimates 2016, ONS

2.1.2 Demographic profile of young people (16 to 24 years)

The table below shows that within the primary study area (covering the three CCGs), the proportion of young people aged between 16 to 24 (9%) is consistent across the three CCGs but is below the national average (11%).

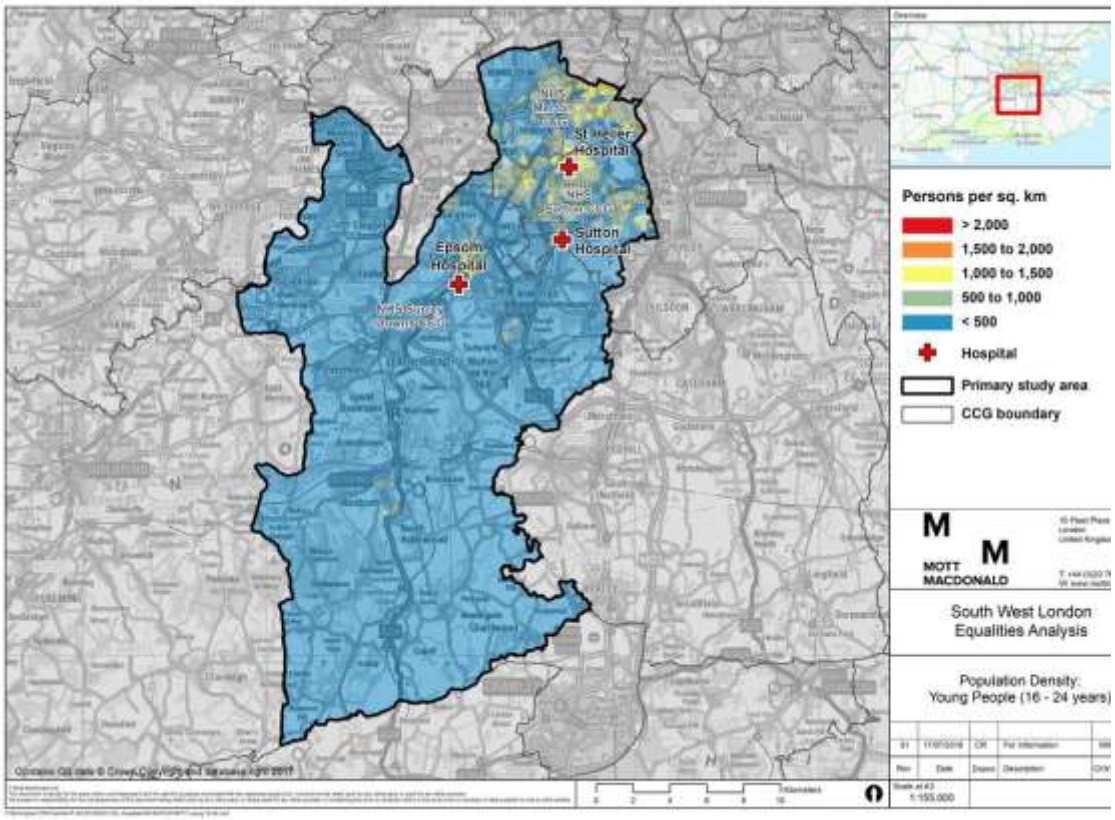
Table 4: Age – 16 to 24

Study area	Total population	16- 24	16-24 %
Merton CCG	205,029	18,153	9%
Surrey Downs CCG	288,199	25,789	9%
Sutton CCG	202,220	18,720	9%
Study area	695,448	62,662	9%
England	55,268,067	6,137,832	11%

Source: LSOA population estimates 2016, ONS

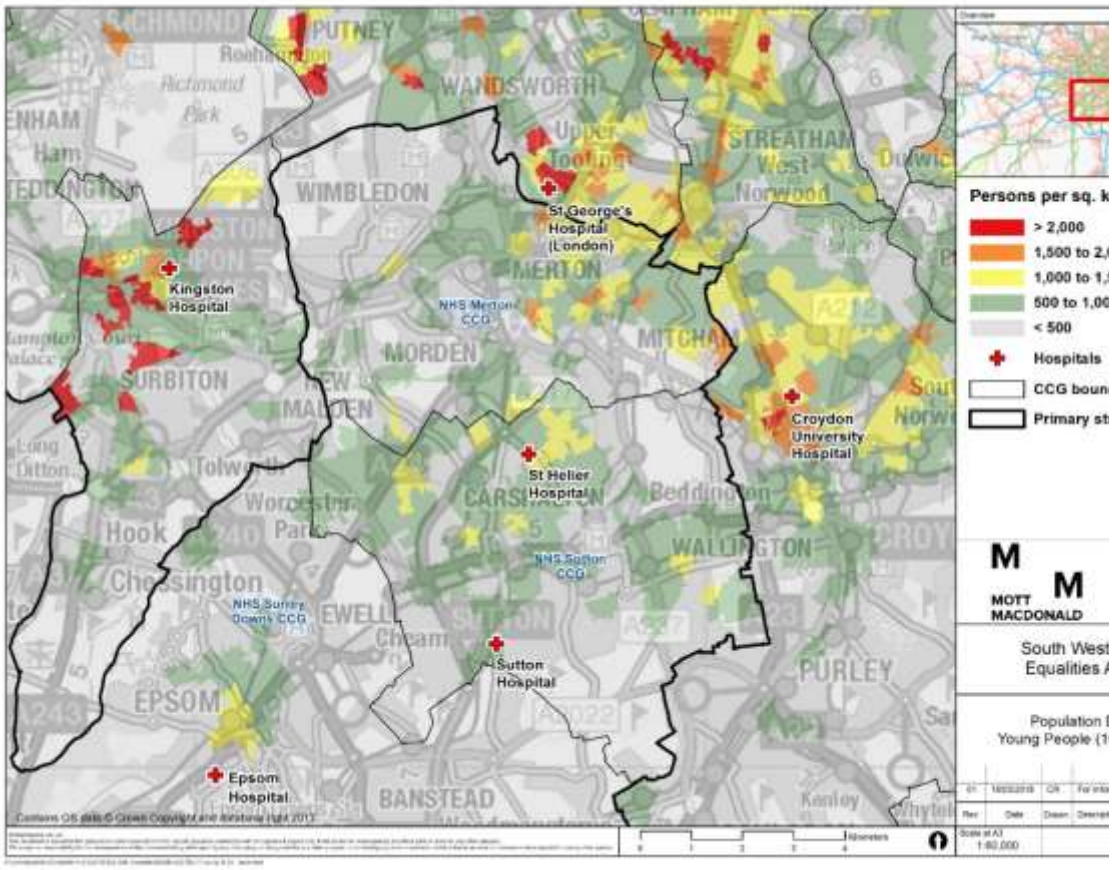
As with the population density for under 16s, figures 4 and 5 below show the largest concentrations of 16 to 24 year olds are in Merton and Sutton CCGs with the highest densities around Merton and Carshalton. The majority of the study area has a low density of young people.

Figure 4: Population density of residents aged 16 to 24 years



Source: Mott MacDonald

Figure 5: Population density of residents aged 16 to 24 years – higher density areas



Source: Mott MacDonald

2.1.3 A&E

There is a disproportionate use of A&E services by children (under 16) indicating that there may also be a disproportionate need for these services. Hospital accident and emergency activity data shows that children comprise of around 21% of attendances at A&E in England while this group represents 19% of the English population.[9] In addition, estimations of the proportion of emergency department attendances which are unnecessary and potentially avoidable vary from 15% to 40%. Within these estimates the largest subgroup is children presenting with symptoms of minor illness.[10]

Moreover, young children make up a disproportionate number of A&E attendances with approximately 10% of A&E attendees in England are aged four or younger. This is higher than the percentage of 0-4-year olds as a proportion of the whole population (8%).[11]

[9] NHS (2017) *'Hospital Accident and Emergency Activity, 2015-16'*. Available at: https://files.digital.nhs.uk/publicationimport/pub23xxx/pub23070/acci-emer-atte-eng-2015-16-rep.pdf

[10] Royal College of Paediatrics and Child Health (2015) '*Facing the Future: together for Child Health'*. Available at: https://www.rcpch.ac.uk/sites/default/files/Facing_the_Future_Together_for_Child_Health.pdf

[11] NHS (2017) *'Hospital Accident and Emergency Activity, 2015-16'*. Available at: https://files.digital.nhs.uk/publicationimport/pub23xxx/pub23070/acci-emer-atte-eng-2015-16-rep.pdf

2.1.4 Obstetrics

Research indicates that adolescent mothers (aged 10 to 19 years) face higher risks of eclampsia, puerperal endometritis, and systemic infections than women aged 20 to 24 years, and babies born to adolescent mothers face higher risks of low birthweight, preterm delivery, and severe neonatal conditions than those born to women aged 20 to 24 years.[12] As such, teenage mothers are more likely to have a disproportionate need for obstetrics.

Pregnant teenagers and young fathers are less likely than older people to access maternity care early in pregnancy (the average gestational booking is 16 weeks while NICE recommends that women be seen by 10 weeks[13]) and are less likely to keep appointments. Research has suggested that this may be attributable to a number of interlocking factors. For example, it has been suggested that young women may:

- not realise they are pregnant;
- take time to come to terms with the pregnancy;
- actively seek to conceal the pregnancy for as long as possible, because of fears about the reaction of her family or peers;
- prioritise other crisis issues such as housing and income over healthcare;
- have a chaotic lifestyle;
- lack a stable address;
- not be able to afford or find transport to a hospital or clinic, especially in rural areas.[14]

London has one of the highest rates of teenagers having unwanted pregnancies in the UK[15], although Surrey Downs has relatively low rates.[16] Whilst the number of teenage pregnancies is decreasing (in the last 18 years there has been a 60% reduction in the under-18 conception rate), in 2016 there were 18,076 conceptions to women aged 18 and under in the UK with just over half of these conceptions leading to an abortion (51%)[17]. There is also evidence that almost 40% of girls who give birth between the ages of 14 -16 years will give birth again aged 17-19.[18]

2.1.5 Paediatrics

As paediatrics is a medical speciality that manages conditions affecting babies, children and young people, by the nature of the service children aged 0-16 years will have a disproportionate need.

[12] Ganchimeg T, et al. (2014) '*Pregnancy and childbirth outcomes among adolescent mothers: a World Health Organization multicounty study*'. Available at: https://www.ncbi.nlm.nih.gov/pubmed/24641534

[13] NICE (updated 2017) '*Antenatal care for uncomplicated pregnancies: clinical guidance*'. Available at: https://www.nice.org.uk/guidance/cg62/chapter/appendix-d-antenatal-appointments-schedule-and-content

[14] Department for Children, Schools and Families, Department of Health, Royal College of Midwives (2008) '*Teenage parents: who cares? A guide to commissioning and delivering maternity services for young parents*. Available at: http://webarchive.nationalarchives.gov.uk/20130321053758/https://www.education.gov.uk/publications/eOrderingDownload/Teenage%20parents.pdf

[15] NHS England (2013) '*Transforming primary care in London*'. Available at: https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/Call-Action-ACCESSIBLE.pdf

[16] Surrey Downs (2015) '*Surrey Downs CCG Health Profile 2015*'. Available at: http://www.surreydownsccg.nhs.uk/media/144405/sdccg_health_profile_2015.pdf

[17] ONS (2016) '*Conceptions in England and Wales: 2016*'. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2016

[18] Department for Education (2013) *'Reducing risky behaviour through the provision of information: Research report'*. Available at: https://pdfs.semanticscholar.org/ea41/6669dc5b822b5ac3e42b6a18d9678d6ed14e.pdf

2.2 Age: Older people (those aged 65 and over)

Evidence of disproportionate need / use has been identified for A&E, acute medicine and emergency general surgery. Evidence of differential need has also been identified for A&E.

Table 5: Scoped in services – older people (those aged 65 and over)

Service Area	Evidence of disproportionate need or disproportionate use	Evidence of differential need
A&E	✓	✓
Acute medicine	✓	
Emergency general surgery	✓	
Obstetrics		
Paediatrics		

Source: Mott MacDonald, 2018

2.2.1 Demographic profile of older people (those aged 65 and over)

The table below shows that within the three CCGs covered by ESTH, the proportion of those aged 65 and over (16%) is slightly lower than the national average (18%). However, Surrey Downs CCG has a higher than average proportion of older people.

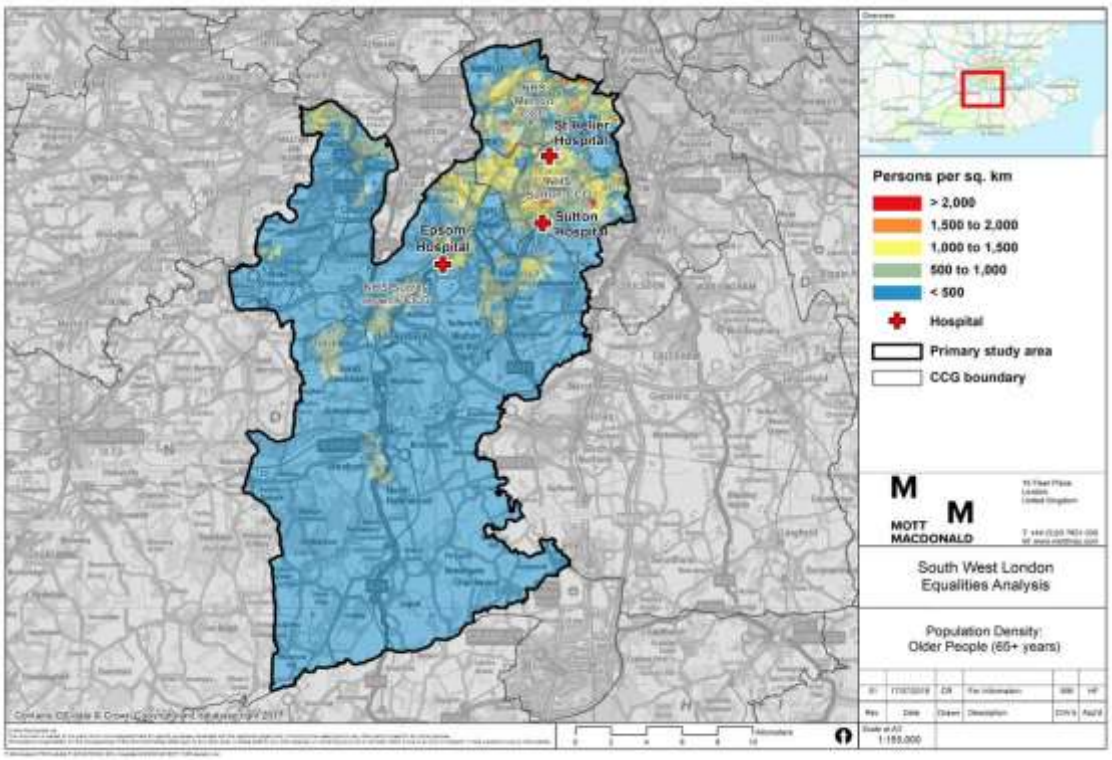
Table 6: Older people (those aged 65 and over)

Study area	Total population	Over 65	Over 65 %
Merton CCG	205,029	25,362	12%
Surrey Downs CCG	288,199	58,608	20%
Sutton CCG	202,220	30,607	15%
Study area	695,448	114,577	16%
England	55,268,067	9,882,841	18%

Source: LSOA population estimates 2016, ONS

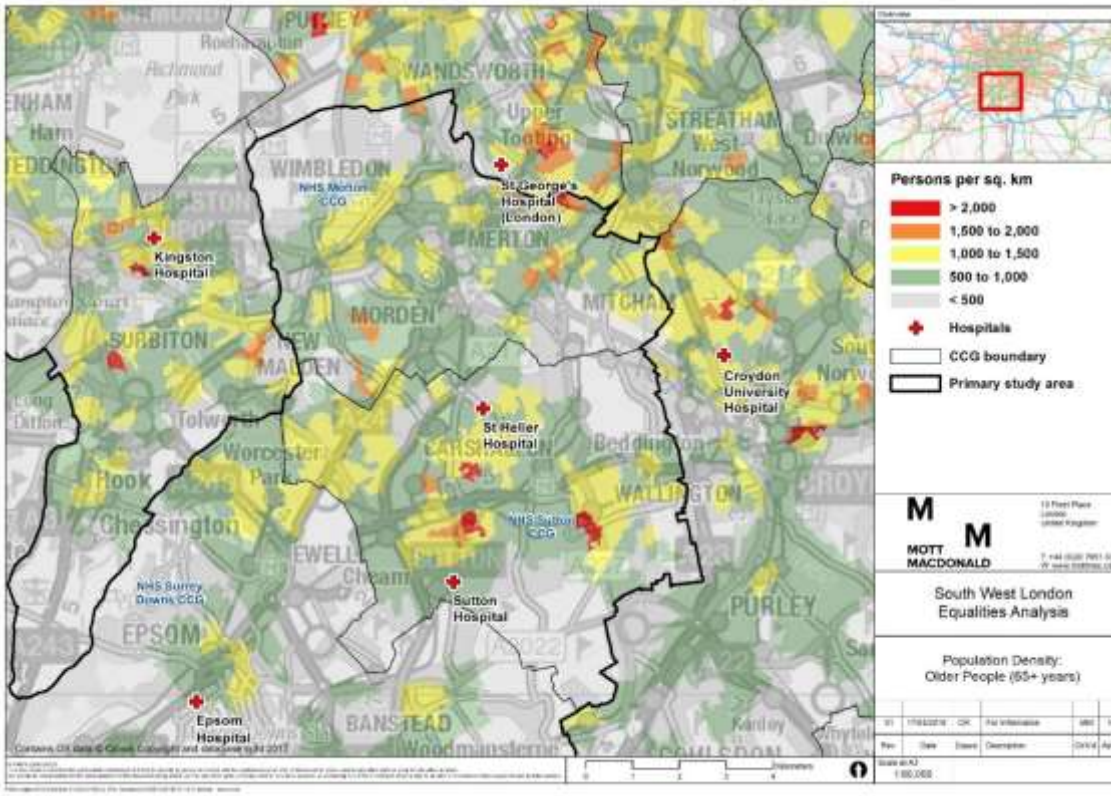
Figures 6 and 7 below indicates that the highest densities of those aged 65 and largely clustered around Sutton and Merton CCG. In particular, Sutton CCG has a number of very high-density areas (over 2,000 per sq. km) located around St Helier and Sutton Hospitals. Despite this, the majority of the primary study area has relatively low densities of people aged 65 and over.

Figure 6: Population aged 65 and over



Source: Mott MacDonald

Figure 7: Population aged 65 and over – higher density areas



Source: Mott MacDonald

2.2.2 A&E

There is a disproportionate use of A&E services by older people. Data on hospital accident and emergency activity has shown that 42% of all A&E attendances in England are from older people while this group represents 18% of the English population. Further, approximately 10% of A&E attendees in England are aged 80 or over, while this group represents 5% of the English population.[19]

The population of south west London is predicted to grow over the next 10 years with the greatest increase in older age groups.

In Merton CCG, the 65-84 age group is projected to increase by around 22% and the 85 years and older group is projected to increase by 16%. In Sutton CCG, the 65-84 age group is projected to increase by around 21% and the 85 years and older group is projected to increase by 20%. Finally, for Surrey Downs the 65-84 age group is projected to increase by around 18% and the 85 years and older group is projected to increase by 26%.[20] These increases are likely to place greater pressure on A&E services as well as the other scoped-in services in south west London for this group.

Older people may also experience a differential need for A&E services as they are more likely to have complex needs that take longer to resolve. The likelihood of A&E attendees having multiple long-term conditions increases dramatically with age and it was found that people aged 75 years and older spend an average of 213 minutes in A&E compared to 149 minutes for those aged under 75 years.[21] Stakeholders also reported that older patients may require longer time in services before discharge as they require an increased link with social care and after care arrangements.

2.2.3 Acute medicine

Acute medicine is concerned with the assessment, diagnosis and treatment of adult patients with urgent medical needs. While it is distinct from emergency medicine (A&E) patients who are admitted to hospital from emergency medicine will likely draw on acute medicine.

Ove the last few years there has been a steady increase in emergency admissions. Evidence suggested that this is in part linked to an aging population with older people making up more than half of growth in emergency admissions between 2013-14 and 2016-17. Some of this is down to demographic change; between 2013-14 and 2016-17, the number of people aged 65 and over grew by 6.2%. However, over the same period, emergency admissions for people aged 65 and over grew by 12%, almost twice the rate of population growth[22]. The need for acute medicine is closely tied with emergency admissions. This evidence suggests that older people disproportionately need and use acute medicine.

There is also evidence of a disproportionate need for acute medicine for example, the older a person is, the more likely they are to develop coronary heart disease (treated by acute medicine). The number of deaths caused by cardiovascular disease in 2017 was highest

[19] NHS (2017) *'Hospital Accident and Emergency Activity, 2015-16'.* Available at: https://files.digital.nhs.uk/publicationimport/pub23xxx/pub23070/acci-emer-atte-eng-2015-16-rep.pdf

[20] ONS (2016): '*Population projections by single year of age – clinical commissioning groups.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/clinicalcommissioninggroupsinenglandz2

[21] QualityWatch (2014): '*Focus on: A&E attendances. Why are patients waiting longer?*'. Available at: https://www.health.org.uk/sites/health/files/QualityWatch_FocusOnAEAttendances.pdf

[22] Department of Health and Social Care, NHS England (2018) '*Reducing emergency admissions'*. Available at: https://www.nao.org.uk/wp-content/uploads/2018/02/Reducing-emergency-admissions-Summary.pdf

amongst those aged between 75-84 years compared to other age groups.[23] Further, conditions such as pneumonia[24] or septicaemia[25] are common types of conditions presenting for admission to acute care. They can be developed at any age but are most likely to be in those with weaker immune systems such as older people.

2.2.4 Emergency general surgery

Older people have a disproportionate need for emergency general surgery. They are more likely to develop conditions that require emergency general surgery. The number of patients presenting as an emergency with a general surgical condition increases with age, these conditions include hip fractures, acute pancreatitis, ruptured abdominal aortic aneurysms or conditions that require emergency laparotomy.[26]

Stomach diseases can result in emergency gastrointestinal surgery and incidence increases sharply with age. Specifically, diverticular disease (related digestive conditions that affect the large intestine) is much more prevalent in older people; with evidence suggesting that by the time people reach 80 years old, they will have some diverticula.[27]

2.3 Disabled people

Evidence of disproportionate need/use has been identified for A&E, acute medicine, obstetrics and paediatrics.

Table 7: Scoped in services – people living with a disability

Service Area	Evidence of disproportionate need or disproportionate use	Evidence of differential need
A&E	✓	
Acute medicine	✓	
Emergency general surgery		
Obstetrics	✓	
Paediatrics	✓	

Source: Mott MacDonald, 2018

2.3.1 Demographic profile of people living with a disability

The table below shows that within the three CCGs covered by ESTH, the proportion of those with a disability (14%), while in line with London as a whole, is lower than the national average (18%).

A number of stakeholders suggested that the local area has both a high level than national average of people with a learning disability as well as those who have a mental health condition. It was generally felt that the high proportion of people with a learning disability was linked to the area historically having a number of institutions for people with a learning disability. There was less understanding amongst those interviewed as to why there is a high prevalence on mental health conditions in the area, particularly amongst younger people. National data, such as that

[23] British Heart Foundation (2017): '*Cardiovascular Disease statistics 2017*'. Available at: https://www.bhf.org.uk/research/heart-statistics/heart-statistics-publications/cardiovascular-disease-statistics-2017

[24] British Lung Foundation (2013) '*Pneumonia'*. Available at: http://www.blf.org.uk/Conditions/Detail/pneumonia

[25] NHS Choices (2014) '*Sepsis'*. Available at: https://www.nhs.uk/conditions/sepsis/

[26] K.F. Desserud, et al. (2015): '*Emergency general surgery in the geriatric patient''*. Available at: https://www.ncbi.nlm.nih.gov/pubmed/26620724

[27] NHS Choices (no date): 'Diverticular disease and diverticulitis'. Available at: https://www.nhs.uk/conditions/diverticular-disease-and-diverticulitis/

produced by the GP Patient Survey[28], does not indicate variation with the national average for those with a mental health condition or with a learning disability. However, local JSNA information suggests that there has been under recording of these conditions across the CCGs. In particular, Surrey Downs has indicated that Surrey has historically had large numbers of long stay hospitals and the placement of large numbers of people, from both inside and outside the county, into these hospitals during the last century, and their subsequent closure, has disproportionately increased the proportion of people with a learning disability in the general population when compared with other areas.[29]

Table 8: People living with an Limiting Long-Term Illness (LLTI).

Study area	Total population	LLTI	LLTI %
Merton CCG	199,693	25,232	13%
Surrey Downs CCG	280,125	38,097	14%
Sutton CCG	190,146	27,189	14%
Study area	669,964	90,518	14%
England	53,012,456	9,352,586	18%

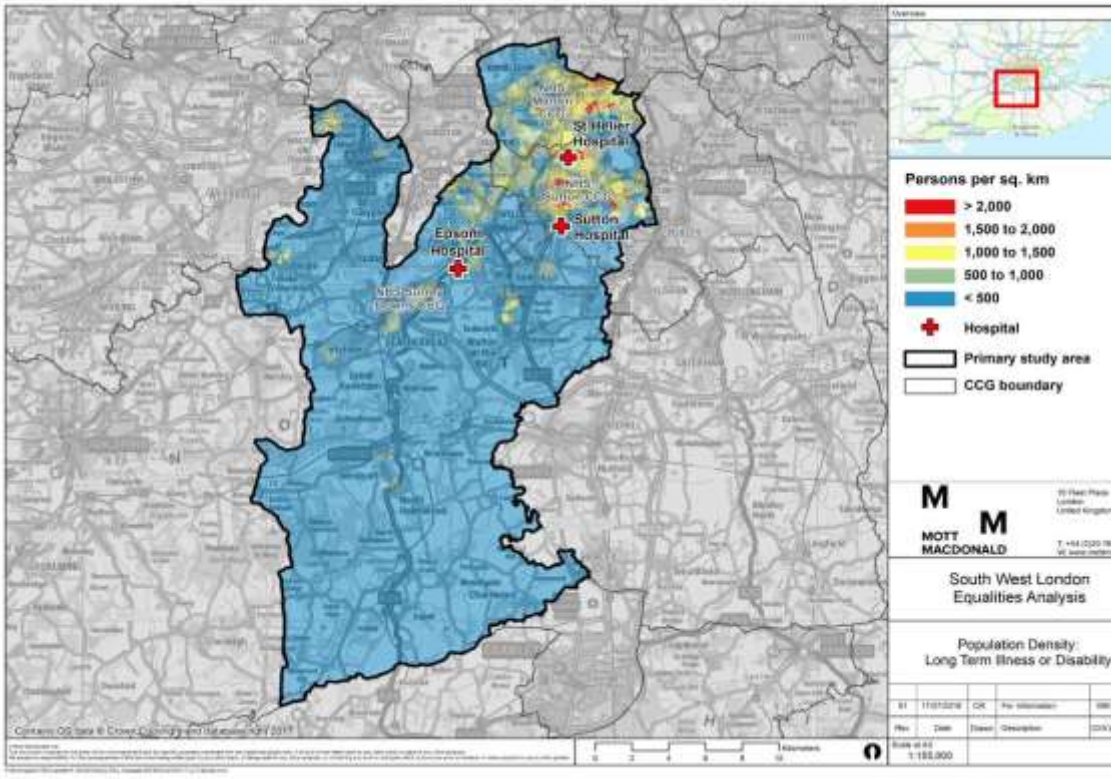
Source: Census 2011, ONS

Figures 8 and 9 below shows that the highest densities of people living with a disability are largely clustered around Sutton and Merton CCG. In both CCGs the density of people living with a disability tend to be highest in the areas located closest to a hospital (St George's, St Helier or Sutton).

[28] GP Patient Survey. Available at: https://www.gp-patient.co.uk/

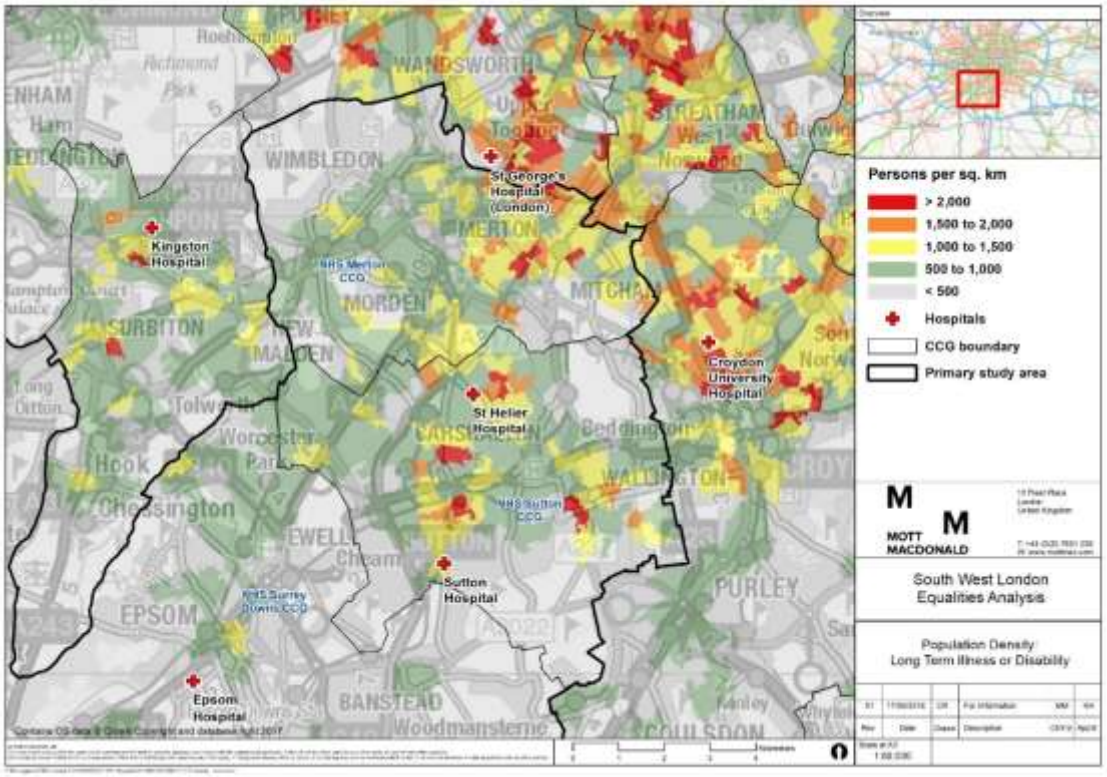
[29] Surrey Downs CCG (2015) '*Surrey Downs CCG Health Profile 2015*'. Available at: http://www.surreydownsccg.nhs.uk/media/144405/sdccg_health_profile_2015.pdf

Figure 8: People living with a LLTI



Source: Mott MacDonald

Figure 9: People living with an LLTI – higher density areas



Source: Census 2011, ONS

2.3.2 A&E

People living with some types of disability tend to have a disproportionate need for A&E services. People with Down's syndrome are a particular high-risk group, because they have a predisposition to lung abnormalities, a poor immune system and a tendency to breathe through their mouth.[30] Indeed many of the conditions identified as ambulatory care sensitive conditions (ACSCs), for example convulsions and epilepsy, and respiratory diseases, are more common among people with learning disabilities which can put this group at risk of requiring emergency care. [31]

People with other types of disability tend to disproportionately use A&E services. For example, users of mental health services are more than twice as likely to have attended A&E than non-users.[32] Research suggests that increased A&E service use among people with mental health problems is due to unmet health-related needs and an increased vulnerability to accidents and

[30] Royal College of Nursing (2013): '*Meeting the health needs of people with learning disabilities'*. Available at: http://www.complexneeds.org.uk/modules/Module-4.1-Working-with-other-professionals/All/downloads/m13p040b/meeting_health_needs_people_with_ld.pdf

[31] Royal College of Nursing (2011): '*Learning from the past – setting out the future: developing learning disability nursing in the UK'*. Available at: https://www.rcn.org.uk/professional-development/publications/pub-003871

[32] NHS Digital, (2013). '*Focus on Accident & Emergency'*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/focus-on/focus-on-accident-emergency-december-2013

self-harm.[33] Local stakeholders also reported higher usage of services by those with mental health conditions.

2.3.3 Acute medicine

Disabled people often have a disproportionate need for treatment as a result of, though not necessarily associated with, their disability. For example, respiratory disease is the main cause of death in people with learning disabilities and is much higher than the general population. People with a learning disability also have a higher risk of respiratory tract infections caused by aspiration or reflux if they have swallowing difficulties.[34]

Research undertaken by St George's hospital has shown that adults with intellectual disabilities are likely to disproportionately use acute medicine services, experiencing twice as many emergency hospital admissions overall compared to the general population. [35] The research found that of those with intellectual disabilities, 23% had an emergency admission compared to 12% of those in the control group. The overall annual rate for emergency hospitalisations in adults with intellectual disabilities was 182 per 1,000 adults, nearly three times higher than the comparable group when adjusted for comorbidities, smoking and deprivation.

Further, other long-term disabilities, for example Alzheimer's, can also result in higher levels of emergency admissions, and subsequently a disproportionate use and need for acute medicine. In particular, these patients are more likely to suffer from falls and other accidents. In 2012/13, 73% of hospital admissions for Alzheimer's suffers were emergency admissions.[36]

Finally, a 2013 study into the effect of mental health conditions on unplanned admissions found that patients with a mental health disorder were more likely than patients without a mental health disorder to have unplanned admissions (10.8% compared to 4.5%) or potentially preventable unplanned admissions (2.1% compared to 0.8%).[37] This links closely with views expressed by local stakeholders who reported disproportionate need and use of services by those with mental health problems, linked to issues around access and contacting services only when at a critical stage.

2.3.4 Obstetrics

Existing studies evidence that disabled women disproportionately use maternity services more than non-disabled women for example, physically disabled women disproportionately use ante and postnatal services. Those with sensory impairments are more likely to have met staff before labour. Women with mental health disabilities tend to disproportionately use services and with a greater need for communication and support. [38]

Women with long term conditions may have a disproportionate need for obstetric services as they are at a higher risk of developing complications during pregnancy. Women with type 1

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[33] Keene, J. and Rodriguez, J. (2006). '*Are mental health problems associated with use of Accident and Emergency and health-related harm?*'. Available at: https://academic.oup.com/eurpub/article/17/4/387/500754

[34] Royal College of Nursing (2011): '*Learning from the past – setting out the future: developing learning disability nursing in the United Kingdom*'. Available at: https://www.rcn.org.uk/professional-development/publications/pub-003871

[35] SGUoL (2017) '*Potentially preventable hospital admissions for patients with intellectual disabilities revealed'*. Available at: https://www.sgul.ac.uk/news/news-archive/potentially-preventable-hospital-admissions-for-patients-with-intellectual-disabilities-revealed

[36] Alzheimer's Society (2009): '*Counting the costs: Caring for people with dementia on hospital wards*'. Available at: https://www.ahsw.org.uk/userfiles/Arts%20&%20Dementia%20files/Counting_the_cost_report.pdf .

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

[38] Redshaw, M, et al., (2013) *'Women with disability: the experience of maternity care during pregnancy, labour and birth and the postnatal period*'. Available at: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-13-174

diabetes can develop problems with their eyes (diabetic retinopathy) and their kidneys (diabetic nephropathy) or find that existing problems get worse. Women with pre-existing type 1 or type 2 diabetes are also at higher risk of having babies who: do not developing normally/have congenital abnormalities; are stillborn or die soon after birth; have health problems shortly after birth, such as heart and breathing problems which require hospital care. Furthermore, drugs taken to treat the pre-existing condition might have to be altered during pregnancy which can cause complications for the mother.[39]

Babies born to women with some chronic illnesses, such as rheumatoid arthritis, and mental health conditions, such as schizophrenia are more likely to have a low birthweight in comparison to babies born to other women.[40]

Barriers in access to healthcare providers and facilities have been reported for many women with physical disabilities and mental health conditions, resulting in higher rates of abortion, miscarriage, caesarean section and low usage of contraception.

2.3.5 Paediatrics

Disabled children have a disproportionate need for paediatric services as they are likely to have poorer overall health and less access to adequate healthcare in comparison to children without a disability.[41] The needs of disabled children, young people, and their families are unique to them, they include issues to do with stamina, breathing, fatigue, social and behavioural impairments. These require multi-disciplinary response across paediatrics. There is also evidence to suggest that disabled children are likely to have multiple complex needs, for example, it is estimated that up to 40% of hearing impaired children have an additional disability or that 10% of patients with paediatric congenital heart disease have some form of learning disability.[42] [43]

2.4 Gender re-assignment

Evidence of disproportionate need/use has been identified for A&E.

Table 9: Scoped in services – gender re-assignment

Service Area	Evidence of disproportionate need or disproportionate use	Evidence of differential need
A&E	✓	
Acute medicine		
Emergency general surgery		
Obstetrics		
Paediatrics		

Source: Mott MacDonald, 2018

[39] NHS Choices (2015), *'Diabetes and pregnancy''*. Available at: https://www.nhs.uk/conditions/pregnancy-and-baby/diabetes-pregnant/

[40] Jomeen, J et al (2013) '*Assessing women's perinatal psychological health: exploring the experiences of health visitors'*. Available at: https://www.tandfonline.com/doi/abs/10.1080/02646838.2013.835038

[41] Contact a family (2015) '*Health services for disabled children and young professionals: Information for health professionals'*. Available at: https://contact.org.uk/media/625497/health_services_for_disabled_children_and_young_people.pdf

[42] Ndcs (2012) '*Deaf children with additional needs'*. Available at: https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwi4kLfxwo_bAhXJ2aQKHaFyAekQFggnMAA&url=http%3A%2F%2Fwww.ndcs.org.uk%2Fdocument.rm%3Fid%3D2613&usg=AOvVaw2yCT6Waeo_tNzugYC4ecx2

[43] NHS England (2016) *'Paediatric Congenital Heart Disease Specification'*. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/paed-spec-2016.pdf

2.4.1 Demographic profile – gender reassignment

Census information on the geographical distribution of the trans community is not available.

At present, there is no official estimate of the trans population. The Gender Identify Research and Identity Society (GIRES) in their Home Office funded study in 2009, estimated that the number of trans people in the UK to be between 300,000 - 500,000.[44] Most recent estimates are that in the UK, around 650,000 people, 1% of the population, are estimated to experience some degree of gender non-conformity (GIRES).[45]

In south west London, this equates to approximately 14,400 people.

2.4.2 A&E

There is evidence to suggest that transgender people have a disproportionate need for emergency care. The UK's largest survey of transgender people revealed that 34% of transgender people have attempted suicide.[46] The increased likelihood of attempting suicide could lead to a greater proportion of trans people presenting at A&E departments for emergency intervention.

There is also evidence to suggest that transgender people disproportionately use A&E departments. Research which grouped lesbian, gay, bisexual and transgender (LGB&T) people, found that they are also less likely to access some health services in favour of using A&E departments compared to the general public.[47]

2.5 Marriage and civil partnership

The evidence review does not indicate any disproportionate or differential need for this protected characteristic group.

[44] Reed, B., et al. (2009) '*Prevalence, incidence, growth and geographic distribution'*. Available at: http://worldaa1.miniserver.com/~gires/assets/Medpro-Assets/GenderVarianceUK-report.pdf

[45] ibid

[46] Nodin, N., et al (2015): '*LGB&T mental health, risk and resilience explored'*. Available at: http://www.queerfutures.co.uk/wp-content/uploads/2015/04/RARE_Research_Report_PACE_2015.pdf

[47] Hudson-Sharp, N. and Metcalf, H. (2016): '*Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence'*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/539682/160719_REPORT_LGBT_evidence_review_NIESR_FINALPDF.pdf

2.6 Pregnancy and maternity

Evidence of disproportionate need/use has been identified for acute medicine, obstetrics and paediatrics.

Table 10: Scoped in services – pregnancy and maternity

Service Area	Evidence of disproportionate need or disproportionate use	Evidence of differential need
A&E		
Acute medicine	✓	
Emergency general surgery		
Obstetrics	✓	
Paediatrics	✓	

Source: Mott MacDonald, 2018

2.6.1 Demographic profile – pregnancy and maternity

To analyse levels of pregnancy and maternity in the study areas data have been used on the number of women aged 16-44 within the population. The table below shows that within the study area, the number of women aged 16-44 (19%) is in line with the national average (19%). However, Surrey Down has a lower than the national average proportion of females aged 16-44 (16%) while Merton has slightly higher than average proportion (22%).

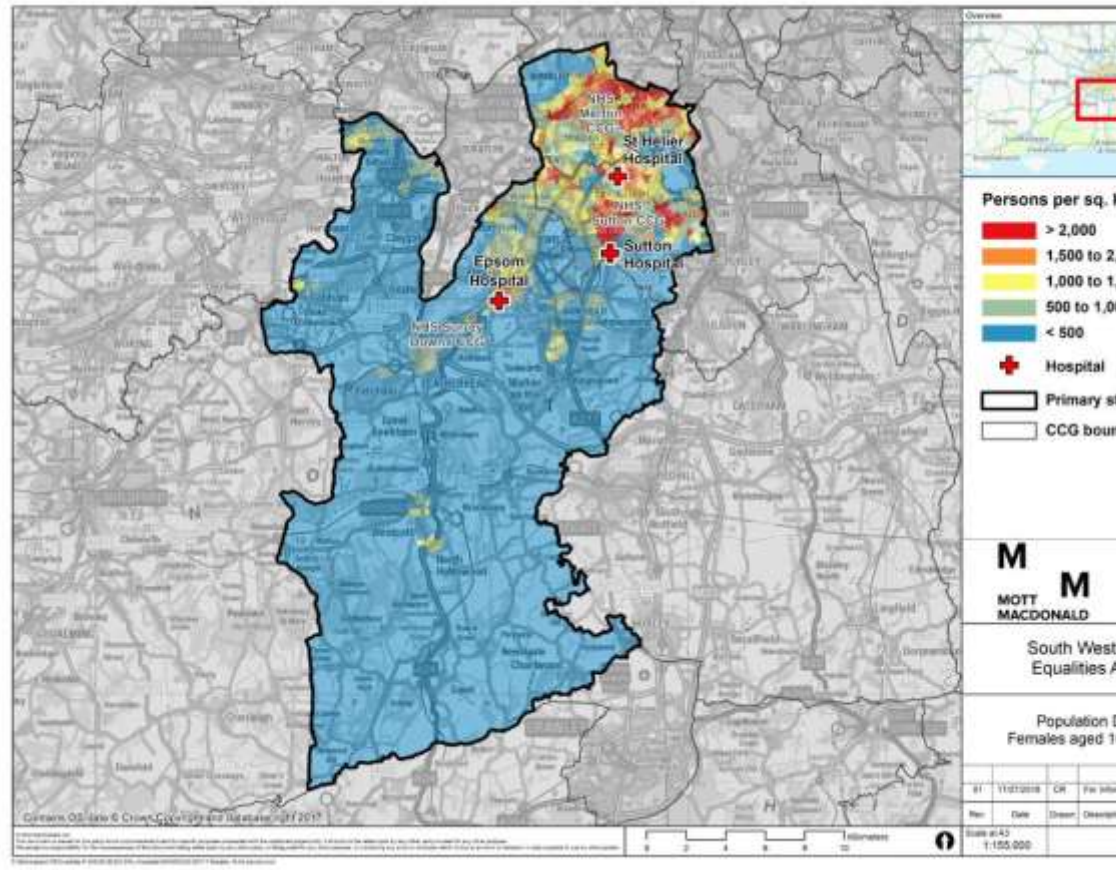
Table 11: Population of females aged 16-44

Study area	Total population	Females aged 16-44	Females aged 16-44 %
Merton CCG	205,029	45,013	22%
Surrey Downs CCG	288,199	46,372	16%
Sutton CCG	202,220	40,132	20%
Study area	695,448	131,517	19%
England	55,268,067	10,313,687	19%

Source: LSOA population estimates 2016, ONS

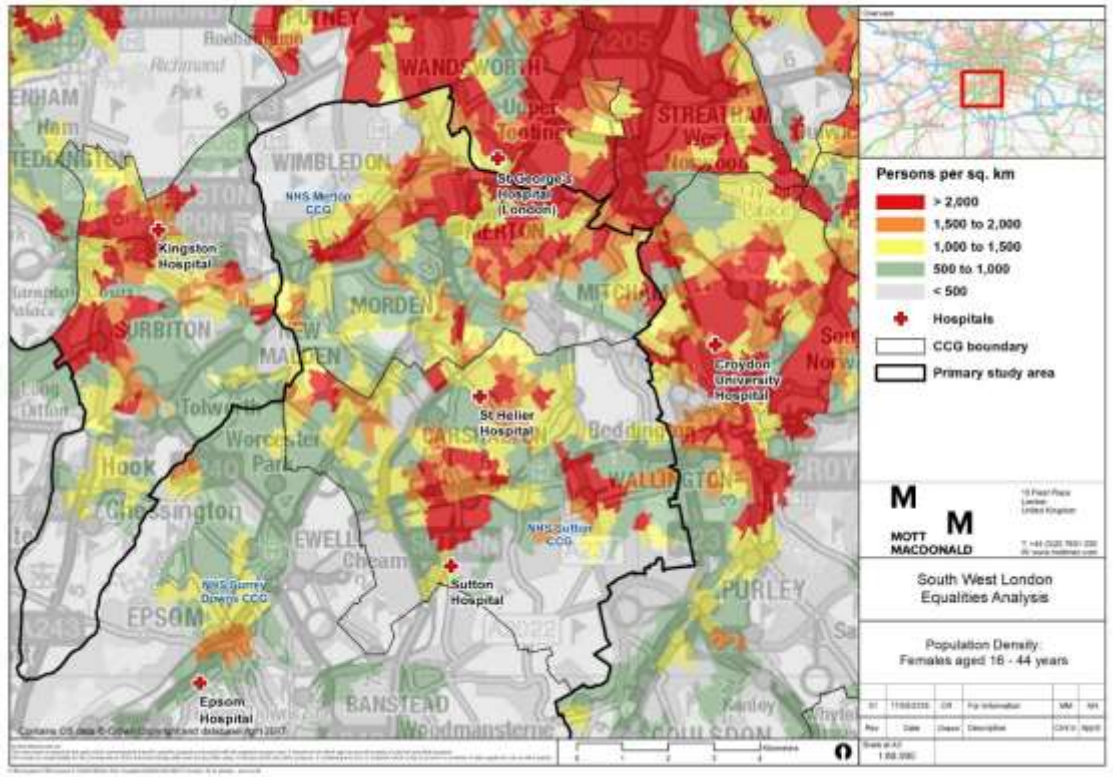
Figures 10 and 11 below shows that high densities of females aged 16-44 in both Sutton and Merton CCG with Sutton with the highest density clustered around Merton and nearest to St George's hospital.

Figure 10: Population of females aged 16-44



Source: Mott MacDonald

Figure 11: Population of females aged 16-44



Source: LSOA population estimates 2016, ONS

2.6.2 Acute medicine

Women who are in the early stages of pregnancy are likely to have a disproportionate need for acute medicine as they would be likely that they would be admitted to hospital as an emergency admission in the event of heart failure. Women who are in the early stages of pregnancy are more at risk of developing heart disease than women who are not pregnant. Heart disease is the biggest single cause of maternal deaths in the UK as there is a 50% increase in how much the heart has to do by the end of the first trimester, which needs to be sustained for six months.[48]

2.6.3 Obstetrics

By the very nature of these service areas, women who are pregnant, new mothers, or breastfeeding will experience disproportionate need for this type of care. In 2016 85% of births in England were in an obstetric unit.[49]

[48] British Heart Foundation (date unknown) 'Pregnancy and heart disease'. Available at: https://www.bhf.org.uk/heart-matters-magazine/medical/women/pregnancy-and-heart-disease '

[49] National Maternity Review (2016) '*Better Births: Improving outcomes of maternity services in England*'. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

2.6.4 Paediatrics

By the very nature of these service areas, women who are pregnant, new mothers, or breastfeeding will experience disproportionate need for paediatric services at post-partum. For example: monitoring of growth and developed of their new-born and anticipatory guidance.[50]

2.7 Race and ethnicity

Evidence of disproportionate need/use has been identified for A&E, acute medicine and obstetrics.

Table 12: Scoped in services – race and ethnicity

Service Area	Evidence of disproportionate need or disproportionate use	Evidence of differential need
A&E	✓ (BAME & White British White Other)	
Acute medicine	✓ (BAME)	
Emergency general surgery		
Obstetrics	✓ (BAME)	
Paediatrics	✓ (BAME)	

Source: Mott MacDonald, 2018

2.7.1 Demographic profile – race and ethnicity

The table below shows that within the study area, the proportion of those from BAME backgrounds is (30%) this is higher than the national average (20%). Within the three CCGs, over half of Merton CCG have a BAME background while Surrey Downs has below the national average (16%).

Table 13: Population of people from BAME backgrounds

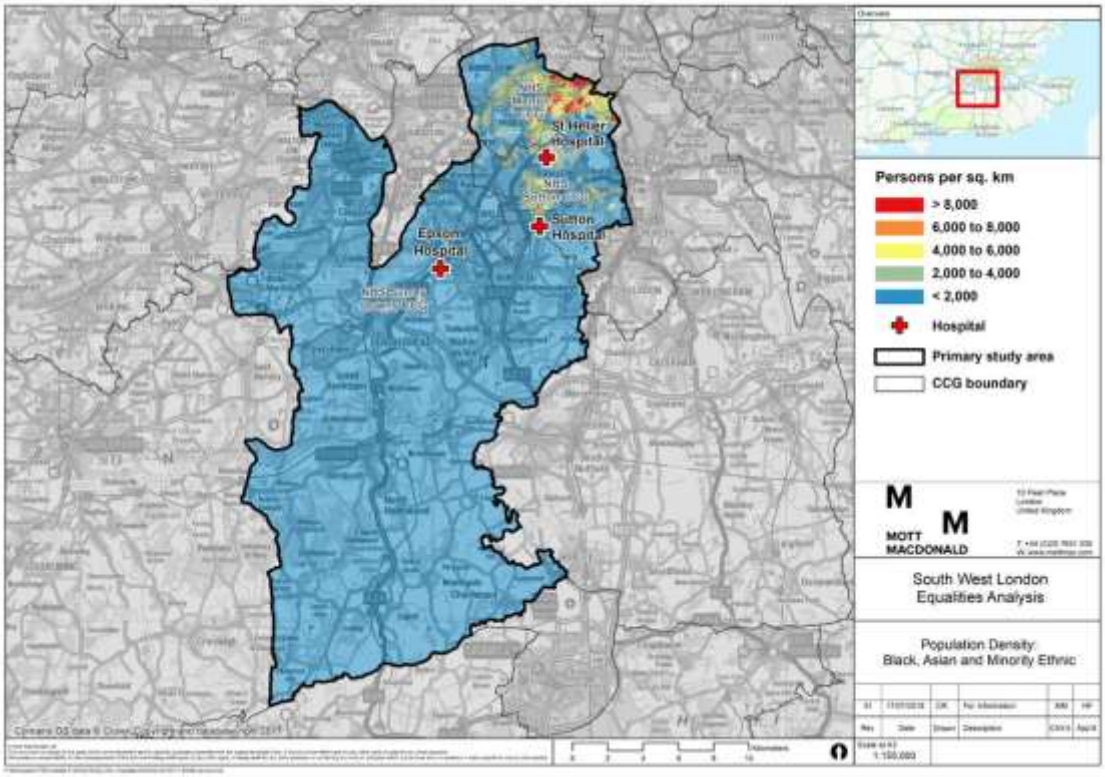
Study area	Total population	BAME	BAME %
Merton CCG	199,693	103,035	52%
Surrey Downs CCG	280,125	44,543	16%
Sutton CCG	190,146	55,292	29%
Study area	669,964	202,870	30%
England	53,012,456	10,733,220	20%

Source: Census 2011, ONS

Figures 12 and 13 below shows that the high density of people from BAME backgrounds is in Merton CCG with most the main hotspot being within Merton. Although overall, the study area has relatively low densities of people from BAME backgrounds.

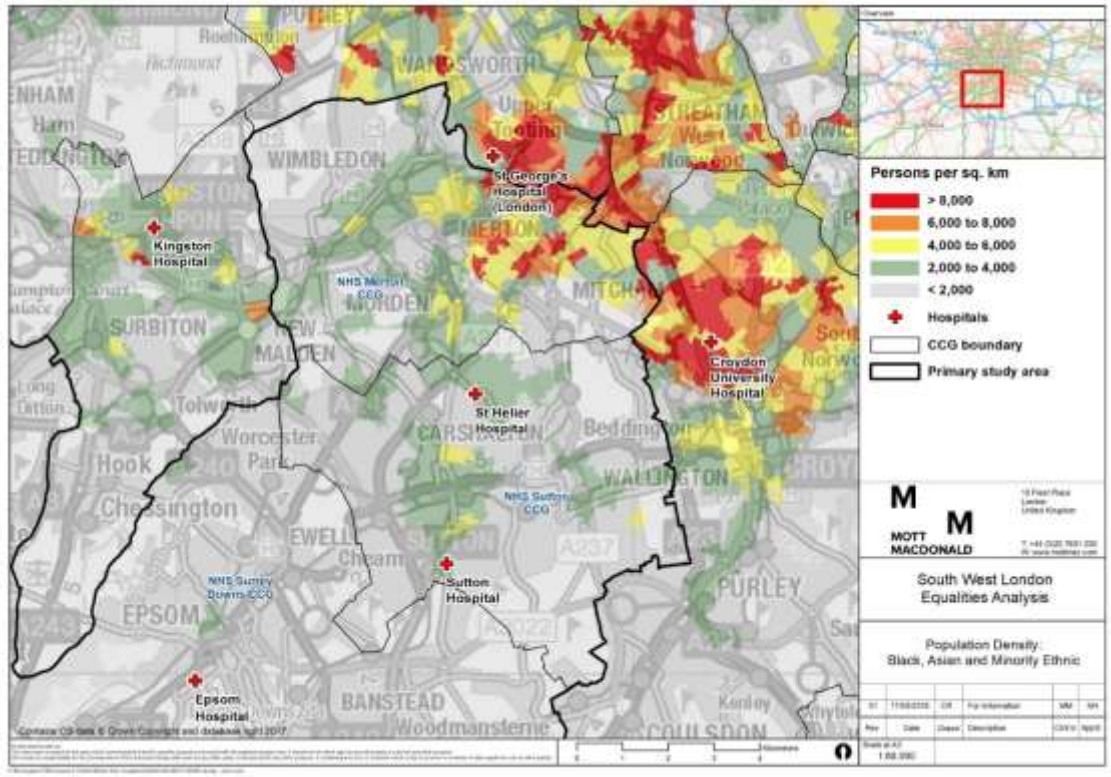
[50] Dossett, E., et al., (2015), '*Integrated Care for Women, Mothers, Children and Newborns: Approaches and Models for Mental Health, Pediatric and Prenatal Care settings*'. Available at: https://www.omicsonline.org/open-access/integrated-care-for-women-mothers-children-and-newborns-approaches-and-models-for-mental-health-pediatric-2167-0420.1000223.php?aid=36905

Figure 12: Population of people from BAME backgrounds



Source: Mott MacDonald

Figure 13: Population of people from BAME backgrounds – higher density areas



Source: Census 2011, ONS

2.7.2 A&E

2.7.2.1 BAME

Members of minority ethnic groups disproportionately use A&E, as they are more likely to present at A&E in comparison with those who are not part of a minority ethnic group. People from ethnic minority groups experience or perceive barriers in accessing primary care services.[51] This is corroborated by lower GP registration rates among this group.[52] This increased use of A&E has been shown within the study area. Local audits found that people from migrant communities were least likely to be registered with a GP and more likely to use A&E, even during normal working hours.[53]

Local stakeholders reported greater use of A&E by those people from ethnic minority groups, linking this to increased levels of deprivation within the local communities and reduced access to other health services due issues such as language barriers.

[51] Gibin, P. et al. (2011): '*Names-based classification of accident and emergency department users'.* Available at: https://pdfs.semanticscholar.org/7c53/2d61afaddf9c5140531528eadfdf8885fc8a.pdf

[52] ibid

[53] HSJ (2012) '*How to reduce A&E use by targeting diversity*'. Available at: https://www.hsj.co.uk/technology-and-innovation/how-to-reduce-aande-use-by-targeting-diversity/5052217.article

2.7.2.2 White British, White Other

Other White British, White Irish and Other White Groups have higher risk ratios for appendicitis.[54] In 2014-15, 97% of hospital admissions for appendicitis were emergency admissions[55], indicating a disproportionate need for this group.

2.7.3 Acute medicine

2.7.3.1 BAME

Evidence indicates that people from a BAME background have a disproportionate need for acute medicine. For example:

- People of South Asian background are three times more likely to require an emergency hospital admission for asthma, while people from an African Caribbean background are twice as likely to require emergency admission. [56] One reason attributed to south Asian men having a higher risk of respiratory disease is linked to a higher propensity to smoke compared to members of other minority ethnic backgrounds. [57]
- People of South Asian background also have the highest rate of coronary heart disease; people from an African Caribbean background have a higher risk of developing high blood pressure; and the prevalence of type-2 diabetes (which may cause complications to acute medical care) for both people of African Caribbean and South Asian ethnicity is much higher than in the rest of the population.[58]
- Gypsy Travellers, of which there is a high population in Surrey Downs, are more likely to experience high rates of undiagnosed hypertension; local research in Surrey Downs found that 52% had high blood pressure.[59]

Local stakeholders referenced that the local Sri Lankan and African communities tend to have an increased incidence of diabetes and heart disease – translating into an increase need for acute services.

2.7.4 Emergency general surgery

2.7.4.1 BAME

Local research with the Gypsy Roma and Traveller community in Surrey Downs identified high levels of smoking (48%) amongst the community.[60] This is associated with the need for

[54] Bhopal RS, et al (2014) '*Ethnic variations in five lower gastrointestinal diseases: Scottish Health and Ethnicity Linkage Study*'. Available at: http://bmjopen.bmj.com/content/4/10/e006120

[55] This percentage has been calculated using the statistics from HES Admitted Patient Care, England 2014-15. Of 44,653 recorded admissions, 43,120 were emergency admissions. For the data set please see: http://content.digital.nhs.uk/searchcatalogue?productid=19420&q=title%3a%22Hospital+Episode+Statistics%2c+Admitted+patient+care+-+England%22&sort=Relevance&size=10&page=1#top

[56] Department of Health (2011) '*An Outcomes Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England*'. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216139/dh_128428.pdf

[57] NHS Choices (2016) '*South Asian Health issues'*. Available at: https://www.nhs.uk/live-well/

[58] British Heart Foundation (date unknown) '*Your ethnicity and heart disease'*. Available at: https://www.bhf.org.uk/heart-health/preventing-heart-disease/your-ethnicity-and-heart-disease and British Lung Foundation (2013): '*Pneumonia*'. Available at: https://www.blf.org.uk/support-for-you/pneumoniav

[59] Surrey Downs CCG (2015): 'Surrey Downs CCG Health Profile 2015'. Available at: http://www.surreydownsccg.nhs.uk/media/144405/sdccg_health_profile_2015.pdf

[60] Surrey Downs CCG (2015): 'Surrey Downs CCG Health Profile 2015'. Available at: http://www.surreydownsccg.nhs.uk/media/144405/sdccg_health_profile_2015.pdf

emergency surgical services due to the development of cancers and other lung diseases associated with smoking.

2.7.5 Obstetrics

2.7.5.1 BAME

Those from a BAME background are likely to have a disproportionate need for obstetric services and use of obstetric services. The percentage of live births in England and Wales to mothers born outside the UK has increased every year since 1990 (when it was 11.6%) reaching 28% in 2016. It has been suggested that this trend in higher proportions of births to women born outside the UK, has in part been linked to better fertility levels among foreign-born women [61]. Other research suggests that certain sections of the UK's South Asian population – most notably Pakistani and Bangladeshi communities – are more likely to have large families, and therefore high fertility and birth rates are common.[62] Numerous population studies have revealed this trend and stakeholders also reported this in interviews.

Women from an ethnic minority have a disproportionate need for obstetric services, due to an increased risk of maternal death. The most recent data analysed by the Maternal, Newborn and Infant Clinical Outcome Review Programme found that women from a minority ethnic background continue to have an increased risk of maternal death compared to White women. [63] Evidence suggested that this is linked to health seeking behaviour and quality of care. This is often further linked to issues around accessing health services for reasons such as language barriers.[64] In Merton just under 60% of babies were born to mothers who were born outside[65] the UK and in Sutton 40% were born to mothers born outside of the UK[66]. For both CCGs[67] this is significantly higher in comparison to the rest of England.

2.7.6 Paediatrics

2.7.6.1 BAME

Those from a minority ethnic background have a disproportionate need for children's services and specialist care within paediatrics. Babies are twice as likely to die before the age of one if the mother was born in Pakistan or the Caribbean compared to mothers born in the UK. This indicates that babies of migrants from Pakistan or the Caribbean are likely to be high users of paediatric services.[68]

Research also suggests that babies from minority ethnic background are more likely to require care in a neonatal or specialist care baby unit as they are at higher risk of infant mortality and lower birth weights: in 2014-15, 9.5% of babies from an Asian background were recorded as

[61] ONS (2016) '*Births by parents' country of birth, England and Wales: 2016*'. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/parentscountryofbirthenglandandwales/2016

[62] Coleman, D. A and Dubuc S (2010): '*The fertility of ethnic minorities in the UK, 1960s-2006*'. Available at: https://www.jstor.org/stable/40646398?seq=1#page_scan_tab_contents

[63] Maternity, Newborn and Infant Clinical Outcome Review Programme (2017): *'Savings Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15.* Available at: https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202017%20-%20Web.pdf

[64] Anawo Ameh, C. and van den Broek, N. (2008) *'Clinical governance Increased risk of maternal death among ethnic minority women in the UK*.' Available at: https://obgyn.onlinelibrary.wiley.com/doi/pdf/10.1576/toag.10.3.177.27421

[65] Merton CCG (2015) Merton JSNA. Available at: https://www2.merton.gov.uk/health-social-care/publichealth/jsna.htm

[66] Sutton CCG (2017) Sutton JSNA. Available at: http://data.sutton.gov.uk/wp-content/uploads/2017/04/BIRTHS-Data-Sheet3.pdf

[67] Public data for Surrey Downs CCG on babies born to mothers born outside of the UK has not been found.

[68] Best Beginnings (date unknown): 'About health inequalities'. Available at: https://www.bestbeginnings.org.uk/health-inequalities

having a low birth weight (under 2.5kg). Compared to 8.4% for Black babies and 6.2% for those from a White background.[69]

The incidence of patients from black and minority ethnic (BME) communities with paediatric congenital heart disease is greater than the general population.[70]

2.8 Religion and belief

The evidence review does not indicate any disproportionate or differential need for this protected characteristic group.

2.9 Sex

Evidence of disproportionate need/use has been identified for acute medicine (males) and obstetrics (females). Evidence of differential need has been identified for A&E and emergency general surgery.

Table 14: Scoped in services – sex

Service Area	Evidence of disproportionate need or disproportionate use	Evidence of differential need
A&E		✓
Acute medicine	✓ (male)	
Emergency general surgery		✓
Obstetrics	✓ (female)	
Paediatrics		

Source: Mott MacDonald, 2018

2.9.1 Demographic profile – sex

The table below shows that the number of men and women living within the primary study area is the same as the national average (49% and 51% respectively).

Table 15: Sex

Study area	Total population	Males	Males %	Females	Females %
Merton CCG	205,029	100,780	49%	104,249	51%
Surrey Downs CCG	288,199	140,050	49%	148,149	51%
Sutton CCG	202,220	98,593	49%	103,627	51%
Study area	695,448	339,423	49%	356,025	51%
England	55,268,067	22,300,920	49%	27,967,147	51%

Source: LSOA population estimates 2016, ONS

[69] NHS Digital (2015) '*NHS Maternity Statistics – England, 2014-15*'. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2014-15 '

[70] NHS England (2016) *'Paediatric Congenital Heart Disease Specification'*. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/paed-spec-2016.pdf

2.9.2 A&E

Men and women have differential needs for A&E services as they are likely to suffer from different conditions which require access to these services. Gender differences in A&E attendance also vary by age group[71]:

- Boys aged 0-14, are more likely to attend A&E
- Women aged 15-34, are more likely to attend A&E overall - although there are specific incidents and cases where men are more likely to present at A&E.
- Men aged 35 upwards, are more likely to attend A&E overall

As well as differences by age men and women suffer from different health issues which are more likely to bring them into contact with A&E. For example:

- Men are six times more likely to have an abdominal aortic aneurysm than women.
- Men are also at higher risk of certain injuries than women. For example, men are more likely to be involved in road traffic accidents (RTAs) than women (RTAs make up 1.2%[72] of total attendances at A&E).[73] Research conducted by Brake, a road safety charity, found that men are more likely to hold a range of attitudes that are linked with dangerous or risk-taking behaviours[74], and therefore more likely to be involved in RTAs than women.
- In comparison to men, women are four times more likely to suffer from hip fractures which is one of the likely risk factors of osteoporosis.[75]

2.9.3 Acute medicine

A disproportionate need for acute medicine is found for men. Evidence suggests that men consult with their GP less than women and prolonged avoidance increases the risk that illness will require acute treatment.[76] Further, research shows that, compared to women, men are:

- 28% more likely to be hospitalised for congestive heart failure;
- 32% more likely to be hospitalised for long-term complications of diabetes;
- 24% more likely to be hospitalised for pneumonia.[77]

2.9.4 Emergency general surgery

Men and women have differential needs for emergency general surgery:

[71] House of commons (2017) 'Accident and Emergency Statistics: Demand, Performance and Pressure'. Available at: http://researchbriefings.files.parliament.uk/documents/SN06964/SN06964.pdf and NHS Digital (2017) 'Hospital Accident and Emergency Activity'. Available at: http://webarchive.nationalarchives.gov.uk/20180328130852tf_/http://content.digital.nhs.uk/catalogue/PUB23070/acci-emer-atte-eng-2015-16-rep.pdf/

[72] House of commons (2017) 'Accident and Emergency Statistics: Demand, Performance and Pressure'. Available at: http://researchbriefings.files.parliament.uk/documents/SN06964/SN06964.pdf.

[73] NHS Digital (2017) 'Hospital Accident and Emergency Activity'. Available at: http://webarchive.nationalarchives.gov.uk/20180328130852tf_/http://content.digital.nhs.uk/catalogue/PUB23070/acci-emer-atte-eng-2015-16-rep.pdf/

[74] Brake (date unknown): 'Driver gender'. Available at: http://www.brake.org.uk/facts-resources/1593-driver-gender

[75] Arthritis Research UK (date unknown) '*Who gets it?*'. Available at: https://www.arthritisresearchuk.org/arthritis-information/conditions/arthritis/who-gets-it.aspx

[76] Wang Y., et al (2013) '*Do men consult less than women? An analysis of routinely collected UK general practice data'*. Available at: http://bmjopen.bmj.com/content/3/8/e003320

[77] Jenna L. Davis (2016) '*The "Superman Syndrome": Why Men Are Reluctant to Pursue Preventive Care'*. Available at: http://www.primaryissues.org/2011/06/mens-health/

- Men are at higher risk of certain injuries than women (for example, men are more likely to be involved in RTAs than women[78]). Injuries such as these are more likely to lead to a referral on to treatment in emergency general surgery.[79]
- Duodenal ulcers are twice as common in men than in women. Men are also more likely to develop alcohol-related pancreatitis.[80]
- Gallstone related diseases account for around a third of emergency general surgery admissions and referrals.[81]Women are more likely to develop gallstones, particularly if they have had children, are taking the combined pill or are undergoing high-dose oestrogen therapy.[82]

2.9.5 Obstetrics

By the very nature of these service areas, women will experience disproportionate need for this type of care. In 2016 85% of births in England were in an obstetric unit. [83]

2.10 Sexual orientation

Evidence of disproportionate need/use has been identified for A&E.

Table 16: Scoped in services – sexual orientation

Service Area	Evidence of disproportionate need or disproportionate use	Evidence of differential need
A&E	✓	
Acute medicine		
Emergency general surgery		
Obstetrics		
Paediatrics		

Source: Mott MacDonald, 2018

2.10.1 Demographic profile – sexual orientation

Census information on the geographical distribution of people on the basis of their sexual orientation is not available.

2.10.2 A&E

There is evidence to suggest that lesbian, gay and bisexual (LGB) people have a disproportionate need for emergency care. Self-harm and thoughts of suicide are more common among people who are lesbian, gay and bisexual compared to those who are heterosexual.[84] The increased likelihood of attempting suicide could lead to a greater proportion of LGB presenting at A&E departments for emergency intervention.

[78] For more detail please see section 2.10.1 Accident and emergency

[79] Brake (date unknown): 'Driver gender'. Available at: http://www.brake.org.uk/facts-resources/1593-driver-gender

[80] Report of the Royal College of Surgeons of England/Department of Health Working Group (2011) '*The Higher Risk General Surgical Patient: Towards Improved Care for a Forgotten Group*'. Available at: https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/the-higher-risk-general-surgical-patient/

[81] Augis (2015) '*Pathway for the Management of Acute Gallstone Diseases'*. Available at: http://www.augis.org/wp-content/uploads/2014/05/Acute-Gallstones-Pathway-Final-Sept-2015.pdf

[82] NHS Choices (2015) '*Gallstones'*. Available at: https://www.nhs.uk/conditions/gallstones/symptoms/

[83] National Maternity Review (2016) '*Better births – improving outcomes of maternity services in England'*. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[84]The National LGB&T Partnership (2015) '*The Adult Social Care Outcomes Framework: lesbian, gay, Bisexual and Trans Companion Document'*. Available at: https://nationallgbtpartnershipdotorg.files.wordpress.com/2015/08/ascof-companion-piece.pdf

There is also evidence to suggest that LGB disproportionately use A&E departments. LGBT people were less likely to access some key health services (76 per cent used GP surgeries, compared with 90 per cent of the general population), but were more likely to have used accident and emergency services and minor injuries clinics (18 per cent and 12 per cent respectively) in comparison to the general population.[85]

2.11 Carers

The latest figures available state that:

- In Surrey Downs it is estimated that there are around 28,000 carers[86]
- In Sutton it is estimated that there are around 18,298 carers [87]
- In Merton there is thought to be approximately 17,000 carers[88]

It is commonly accepted that documenting the number of carers is difficult as many carers are unidentifiable. Therefore it is highly likely that the true number of carers is likely to much higher.

The evidence review does not indicate any disproportionate or differential clinical need for this group.However, carers are important within the study area and there are increased risks associated with being a carer such as the risk of back injuries, higher blood pressure and increased risk of stroke.[89] It was suggested by stakeholders that carers will be disproportionately impacted by changes to services when considering the likely travel impact some may experience from local acute services moving. Stakeholders stated that carers would struggle with the additional cost and difficulty in arrange travel to a different site which could impact on physical, emotional and mental wellbeing. This should be considered in the context that carers have been known to prioritise the care of those they care for, meaning that are less likely to access services such as primary care for their own needs. Challenges in finding someone to replace their caring responsibilities whilst they receive care may also reduce access to services. It is also suggested that carers may also be more likely to experience mental health conditions due to the anxiety and stress carers commonly suffer.

2.12 Deprivation

Evidence of disproportionate need has been identified for all services.

Table 17: Scoped in services – deprivation

Service Area	Evidence of disproportionate need or disproportionate use	Evidence of differential need
A&E	✓	
Acute medicine	✓	
Emergency general surgery	✓	
Obstetrics	✓	
Paediatrics	✓	

Source: Mott MacDonald, 2018

[85] Hudson-Sharp, N. and Metcalf, H. (2016). '*Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence'*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/539682/160719_REPORT_LGBT_evidence_review_NIESR_FINALPDF.pdf

[86] Surrey-I (2018) *'Joint strategic Needs Assessment'*. Available at: https://www.surreyi.gov.uk/health-profiles/surrey-downs/

[87] Sutton (2016) '*Sutton JSNA'*. Available at: http://data.sutton.gov.uk/wp-content/uploads/2017/04/CARERS-Fact-Sheet5.pdf

[88] Merton (2018) '*The Merton Story – health and wellbeing in Merton in 2018'*. Available at: https://www2.merton.gov.uk/Merton%20Story%20FINAL_June_2018.pdf

[89] Surrey Downs CCG (2015): 'Surrey Downs CCG Health Profile'

2.12.1 Demographic profile – deprivation

The table below shows that the proportion of people residing in the most deprived quintile in the study area (3%) is below the national average (20%).

The least deprived quintile in the study area (45%) exceeds the nation average (19%) in all three CCGs, with Surrey Downs (65%)having the largest population who sit within the least deprived quintile.

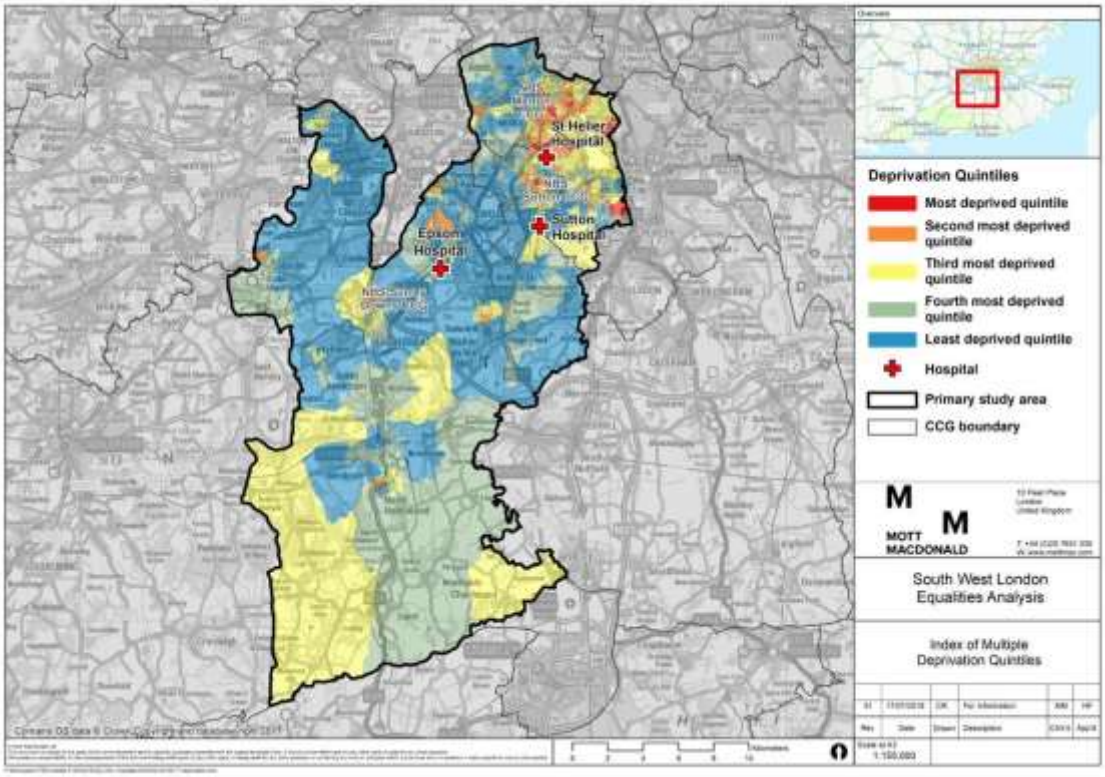
Table 18: Deprivation quintiles

CCG	Most deprived quintile	Second most deprived quintile	Third most deprived quintile	Fourth most deprived quintile	Least deprived quintile
Merton CCG	6,436 (3%)	43,937 (21%)	46,478 (23%)	46,876 (23%)	61,302 (30%)
Surrey Downs CCG	0 (0%)	12,889 (4%)	33,638 (12%)	53,100 (18%)	188,572 (65%)
Sutton CCG	11,113 (5%)	30,125 (15%)	45,082 (22%)	54,721 (27%)	61,179 (30%)
Study area	17,549 (3%)	86,951 (13%)	125,198 (18%)	154,697 (22%)	311,053 (45%)
England	11,239,243 (20%)	11,382,030 (21%)	11,090,316 (20%)	10,895,919 (20%)	10,660,559 (19%)

Source: IMD 2015

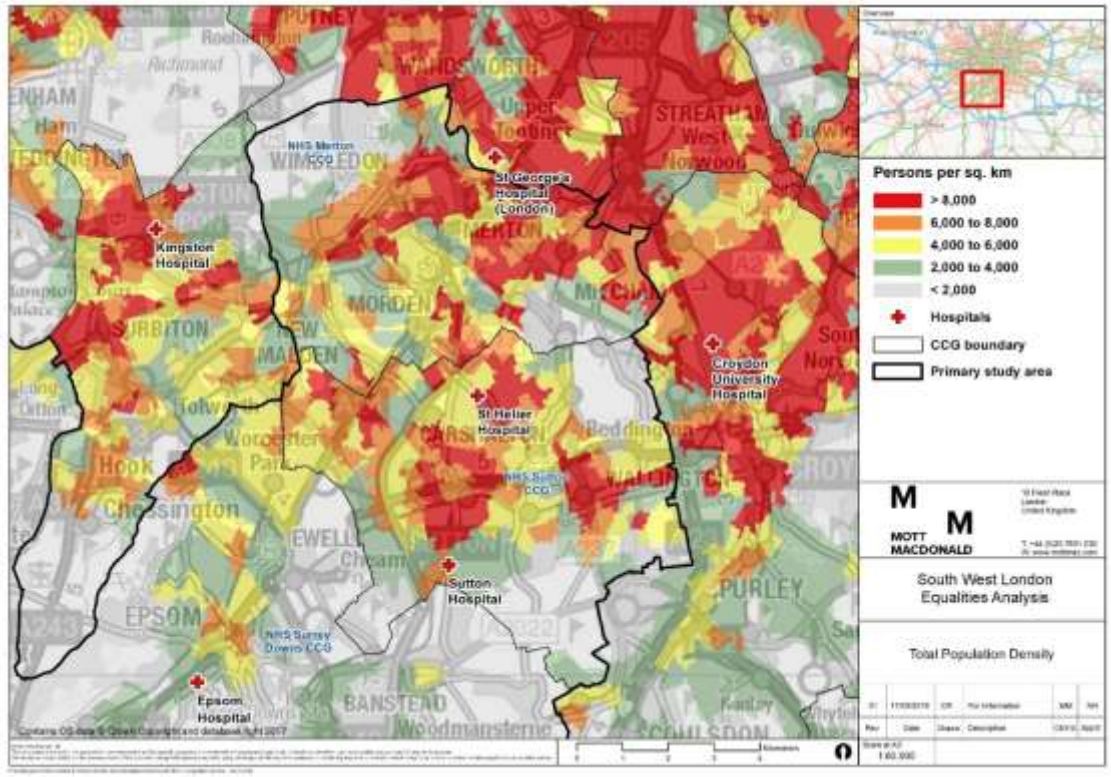
Figures 14 below shows distribution of the deprivation quintiles across the study area. The most deprived areas tend to be grouped in clusters in Merton and Sutton CCGs. Merton, Mitcham, Wallington and Carshalton see the highest density of those from the most deprived quintile.

Figure 14: Overall deprivation quantiles for the study areas



Source: Mott MacDonald

Figure 15: Overall deprivation quantiles for the study area – higher density areas



Source: IMD 2015

2.12.2 A&E

Between 2008 and 2013, those living in the 10% most deprived Lower layer Super Output Areas (LSOA) of England made twice the number of attendances in A&E (in both minor and major departments) compared to those living in the10% least deprived LSOAs.[90] The disproportionate use of A&E services by those from deprived communities has been explained by differences in need, the varying quality of alternative care in deprived areas and barriers to access.[91]

In addition, in 2015/16 A&E attendance rates were highest in the most deprived quintile. Children and young people from the most deprived areas experienced 58 per cent more A&E attendances than those in the least deprived areas (514.6 per 1,000 compared to 325.6 per 1,000).[92]

Local stakeholders reported greater use of A&E by those people living in in the deprived areas of the study area, relating this to lifestyle factors and delayed access to primary healthcare.

[90] NHS Digital (2013): 'Focus on Accident & Emergency'. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/focus-on/focus-on-accident-emergency-december-2013

[91] McCormick, B., Hill, P. and Poteliakhoff, E. (2012): 'Are hospital services used differently in deprived areas? Evidence to identify commissioning challenges'. Available at: https://www.chseo.org.uk/downloads/wp2-hospitalservices-deprivedareas.pdf

[92] Nuffield Trust (2017) 'Admissions of inequality: emergency hospital use for children and young people'. Available at: https://www.nuffieldtrust.org.uk/files/2017-12/nt-admissions-of-inequality-web.pdf

2.12.3 Acute medicine

It has been found that those living in the most socio-economically deprived quintile are more likely than those in the least deprived quintile to:

- have unplanned (8.2% v.4.1%) admission to hospital;
- or potentially preventable unplanned (1.7%v. 0.6%) admissions to hospital.[93]

Working age adults from a deprived background are at greater risk of poorer health, low mental wellbeing, and respiratory problems, including asthma and breathlessness.[94] This may lead to the need to present at and disproportionately need acute services. Local stakeholders reported greater need for acute care for people living in in the deprived areas of the study area, relating this to lifestyle factors.

2.12.4 Emergency general surgery

Lifestyle factors such as smoking and obesity are identified as being particularly important in contributing to the need for emergency surgical services, and have well established links to deprivation.[95] These factors all lead to the development of conditions that require the need to use emergency general surgery for example diverticular disease, many cancers, vascular diseases, and many oesophageal and gastrointestinal conditions.[96]

2.12.5 Obstetrics

There is evidence of a correlation between maternal obesity and socioeconomic deprivation. A large body of evidence links maternal obesity to adverse pregnancy outcomes, these include perinatal mortality (foetal deaths after 24 weeks of gestation and death before seven completed days), maternal death, cardiac disease, miscarriage or premature births, preeclampsia, gestational diabetes, and infections among other conditions. [97] [98] Maternal obesity is therefore likely to lead to a disproportionate need for obstetrics.

Further, the rate of maternal mortality has been found to be higher for those living in the most deprived areas.[99]

2.12.6 Paediatrics

A variety of reasons cause children from poorer backgrounds to disproportionately need paediatric services. There is evidence to suggest that poverty and low income is a factor in driving poor health in children.[100] Children from deprived communities are more likely to have poor nutrition and live in poor quality housing. They are therefore more likely to suffer from poorer general health. Alongside this, there is evidence of disproportionate need in children from deprived communities for treatment for conditions such as speech problems, Attention

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

[94] NatCen (2013) 'People living in bad housing – numbers and health impacts'. Available at: https://england.shelter.org.uk/__data/assets/pdf_file/0010/726166/People_living_in_bad_housing.pdf

[95] NHS Wales (date unknown) 'Emergency General Surgery Review: Review of the Evidence for the Case for Change'. Available at: http://www.wales.nhs.uk/sitesplus/documents/861/egss_case_10111.pdf

[96] ibid

[97] NHS England (2016): *'Saving Babies; Lives: A care bundle for reducing stillbirth'* Available at: https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf

[98] Heslehurst N et al (2010): '*A nationally representative study of maternal obesity in England'*. Available at: https://www.ncbi.nlm.nih.gov/pubmed/20029373

[99] MBRRACE–UK (2017) '*Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15'*. Available at: https://www.npeu.ox.ac.uk/mbrrace-uk/reports

[100] Wickham, S. et al. (2016) 'Poverty and child health in the UK: using evidence for action'

Deficit Hyperactivity Disorder (ADHD), diabetes, asthma, sleep apnoea and cardiovascular diseases.[101]

There is also a strong correlation between teenage pregnancy and social deprivation. The rate of teenage pregnancy in girls under the age of 18 is almost five times higher in the most deprived areas compared to the least deprived.[102] Babies of teenage mothers are at increased risk of some poor outcomes compared with babies of older mothers:

- 45% risk of infant death
- 30% less likely to breastfeed
- 30% higher risk of stillbirth
  - 20% higher risk of premature birth if a first baby
  - 90% higher risk of premature birth if a second baby
- 15% higher risk of low birthweight[103]

[101] The Children's Society (2013): ' *A good childhood for every child? Child poverty in the UK'*. Available at: https://www.childrenssociety.org.uk/sites/default/files/tcs/2013_child_poverty_briefing_1.pdf

[102] Glinianaia, S. V., et all (2013) *'No improvement in socioeconomic inequalities in birthweight and preterm birth over dour decades: a population-base cohort study*'. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3651338/

[103] Royal College of Nursing, Public Heath England and Department of Health (2015) '*Getting maternity services right for pregnant teenagers and young fathers'*. Available at: https://www.rcm.org.uk/sites/default/files/Getting%20maternity%20services%20right%20for%20pregnant%20teenagers%20and%20young%20fathers%20pdf.pdf

3 Summary and next steps

3.1 Scoped in equality groups according to service area

There is evidence to suggest that the protected characteristic groups scoped in in chapter two have a disproportionate and differential need/use for the services under review (as shown below in Table 19. It is important to note that the report is not suggesting that other groups will not need the services which are under review, rather it is to suggest that there does not presently exist a body of evidence indicating a disproportionate or differential need/use.

Table 19: Scoped in equality groups according to services area

	A&E	Acute medicine	Emergency general surgery	Obstetrics	Paediatrics
Age – Children (those aged 16 and under) and younger people (those aged 16-24)	✓			✓	✓
Age – Older people (65 and over)	✓	✓	✓		
People with a disability	✓	✓		✓	✓
Gender re-assignment	✓				
Marriage and civil partnership					
Pregnancy and maternity		✓		✓	✓
Race and ethnicity	✓	✓		✓	✓
Religion and belief					
Sex	✓	✓	✓	✓	✓
Sexual orientation	✓				
Carers					
Deprivation	✓	✓	✓	✓	✓

Across all acute services disproportionate or differential needs/use were identified for protected characteristic groups. The only protected characteristic groups where there is currently no evidence to suggest a disproportionate/differential need or use are: marriage and civil partnership, religion and belief, and carers. While a disproportionate/differential need or use for acute service was not found for carers, the stakeholder interviews did highlight that carers will likely be impacted by changes to acute services as a result of changes to travel time and complexity when using acute services.

Although almost all protected characteristic groups were found to have a disproportionate or differential need/use for A&E services, generally, need for/use of acute services and the drivers for these varied between protected characteristic groups. However, within protected characteristics and across the different acute services some commonalities were found. In particular:

- Patients from deprived communities were found to have a higher than average need for/use of all acute services under review. There is a strong link between poverty and social inequality with poor physical and mental health. Certain lifestyle factors such smoking,

obesity and excess alcohol consumption, along with poor living and working conditions and limited access to healthy food, can all result in increased interaction with acute services.

- Patients from minority ethnic communities have a higher than average need for/use of all the services under review, apart from emergency general surgery. A key driver for need can often be tied with a higher deprivation prevalence amongst this group. However, there are also some health conditions which are also likely to be more salient amongst ethnic minority groups which can result in increased interaction with acute services. Further, stakeholder interviews suggested that this group tend to experience access issues with health services, particularly primary care, for reasons such as language barriers and cultural norms. Stakeholders indicated that this can result in a high use of acute services, such as A&E, as they are more likely to access services at a critical stage.
- Similar to ethnic minority communities, patients who have a disability also have a higher than average need/use for all the services under review, apart from emergency general surgery. Often disabled people require treatment as a result of, though not necessarily associated with, their disability (e.g. respiratory disease is the main cause of death in people with learning disabilities). As such, their disability can result in an increase use of acute services, particularly in cases what patients have multiple complex needs.
- When looking at differences by sex, need for acute services varies for males and females:
  - Females tend to have a high need for obstetrics, paediatrics, and emergency general surgery which tends to be linked to childbirth.
  - Males tend to have a high need for acute services such as A&E, acute medicine and emergency general surgery which tends to be driven by lifestyle factors, such as higher propensity than women to be involved in accidents and poor use of healthcare services. However, males are more likely to experience specific health issues which would bring them into contact which acute services such as congestive heart failure, long-term complication linked with diabetes and pneumonia.
- Finally, evidence suggests that older people tend to have a higher need for/use of emergency acute services such as: A&E, acute medicine and emergency general surgery. Generally, linked to age, this group experience a range of health concerns which would bring them into contact with acute services and which tend to be exacerbated by a high proportion of old people living longer with complex co-morbidities.

The demographic analysis found a number of geographical areas which have high densities of scoped in protected characteristic groups. In addition to this, it also looked at proportional representation of groups to understand where groups are particularly prevalent in a certain area (compared with the overall population composition in that area). The following table outlines the key findings:

Table 20: demographic analysis

Scoped in groups	Geographical areas in the primary study area a high proportion or density of these population groups, compared to the overall population
Age – Children (those aged 16 and under) and younger people (those aged 16-24)	**Density trends:** The most concentrated density of those aged under 16 and those aged 16-24 are located within Merton and Sutton CCGs with the highest densities around Merton and Carshalton. **Population trends**: Across all three CCGs the proportion of children aged under 16 (20%) and people aged between 16 to 24 (9%) is broadly in line with the national average (19% and 11% respectively).
Age – Older people (65 and over)	**Density trends:** The highest densities of those aged 65 and largely clustered around Sutton and Merton CCG. In particular, Sutton CCG has a number of very high-density areas (over 2,000 per sq. km) located around St Helier and Sutton Hospitals **Population trends:** Across all three CCGS the overall proportion of those aged 65 and over (16%) is slightly lower than the national average (18%). However, Surrey Downs CCG has a high than average proportion of older of people (20%).
People with a disability	**Density trends:** The highest densities of people living with a disability are largely clustered around Sutton and Merton CCG. In both CCGs the density of people living with a disability tend to be highest in the areas located closest to a hospital (St George's, St Helier or Sutton). **Population trends:** The proportion of those with a disability (14%) cross the three CCGs, is lower than the national average (18%).
Gender re-assignment	No data available
Pregnancy and maternity	**Density trends:** The densities of females aged 16-44 in both Sutton and Merton CCG with Sutton with the highest density clustered around Merton and nearest to St George's hospital **Population trends:** The proportion of women aged 16-44 (19%) is in line with the national average (19%). However, Surrey Down has a lower than the national average proportion of females aged 16-44 (16%) while Merton has slightly higher than average proportion (22%).
Race and ethnicity	**Density trends:** The highest density of BAME communities are concentrated in the north of the study area. **Population trends:** The proportion of those from BAME backgrounds is (30%) this is higher than the national average (20%). The proportion of BAME groups living within the three CCGs is very varied, over half of the population in Merton CCG is from a BAME background while Surrey Downs has below the national average (16%).
Sex	In line with national averages
Sexual orientation	No data available
Deprivation	**Density trends:** The most deprived areas tend to be grouped in clusters in Merton and Sutton CCGs. Merton, Mitcham, Wallington and Carshalton see the highest density of those from the most deprived quintile. **Population trends:** Sutton has the highest percentage

Source: Mott MacDonald

3.2 Next steps

The findings of this research will be linked with a travel analysis being undertaken by Mott Macdonald.

The focus of this research highlights the key needs of protected characteristics within the study area. However, interviews with stakeholders invited discussion around the potential impact of any changes for those with a high need for acute services, as well as potential mitigations. When discussing the consolidation of acute services onto one site, the stakeholders highlighted the following:

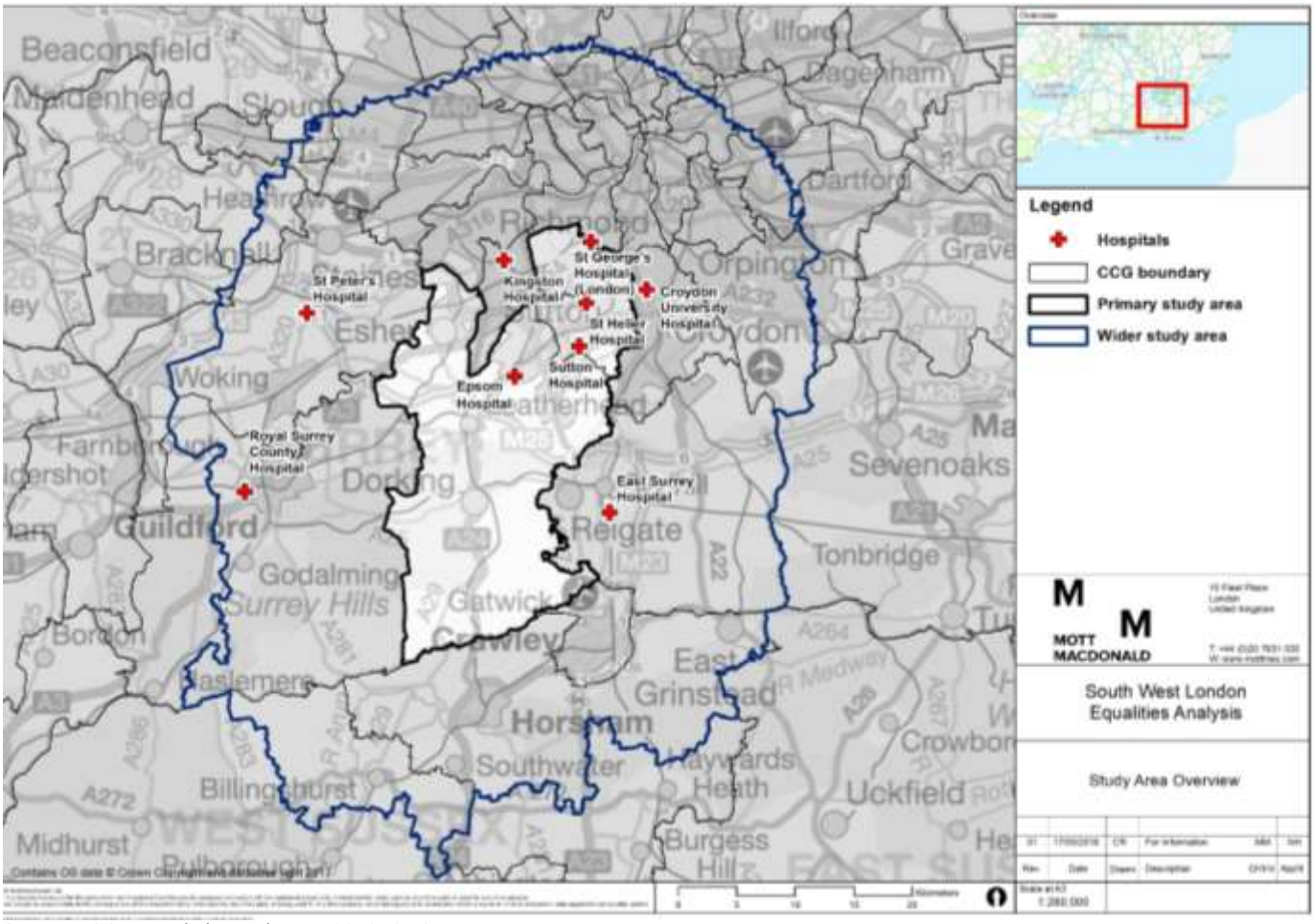
- It was felt that the movement to one site will likely have positive benefits for all patients as it will mean that they have access to better facilities and more specialised staff. It is expected that there will be better staffing levels and communication between teams. As such, it was felt that safety and the quality of care for patients will improve.
- It was also felt that the consolidation of services would be an opportunity to design a system which is fit for purpose for patients. A number of stakeholders felt that when moving services attention should be given to how the service interacts with local community services. It was mentioned that the movement of acute services onto one site would risk losing some of the ties to patients' local communities providers. It was felt therefore, that work needs to be done to build strong communication channels and improve technology to support new information sharing.
- As well as links to community providers, concern was expressed across the majority of stakeholders around the difficulty of travelling to the site. It was felt that wherever the site is located (Epsom, St Helier or Sutton) some patient groups would struggle to travel there. It was suggested by stakeholders that difficulties linked to travelling to the site were most likely to negatively impact vulnerable groups. In particular, it was often suggested that older people, those with a mental health condition, those with a learning disability, those with a physical disability and those from deprived communities may experience difficulty with traveling, especially when using public transport.
- To mitigate difficulties with travelling, a number of stakeholders suggested that it would be important for the commissioners to work with local transport providers to discuss improving access to the chosen site across the three CCGs. Consideration would also need to be given to parking costs to make travelling there more appealing.
- Stakeholders further suggested that it would be important to undertake a strong public awareness campaign to ensure that patients are clear around how to access and use acute services. It was felt that the Trust would need to be very clear with patients around the quality and safety benefits of consolidating service to prevent inappropriate use of other services and to prevent patients going to other sites.

The findings above outline initial thoughts around the potential impact of any change in the provision of acute services. It is recommended that the local CCGs takes these findings further through undertaking a full Equality Impact Assessment. This assessment would involve further stakeholder engagement (particularly with community groups), a full appraisal of the potential positive and negative impacts which could result from any changes to acute services. It would also explore potential mitigation actions which could be taken, as well as reviewing where enhancements can be made to ensure realisation of positive impacts.

Appendices

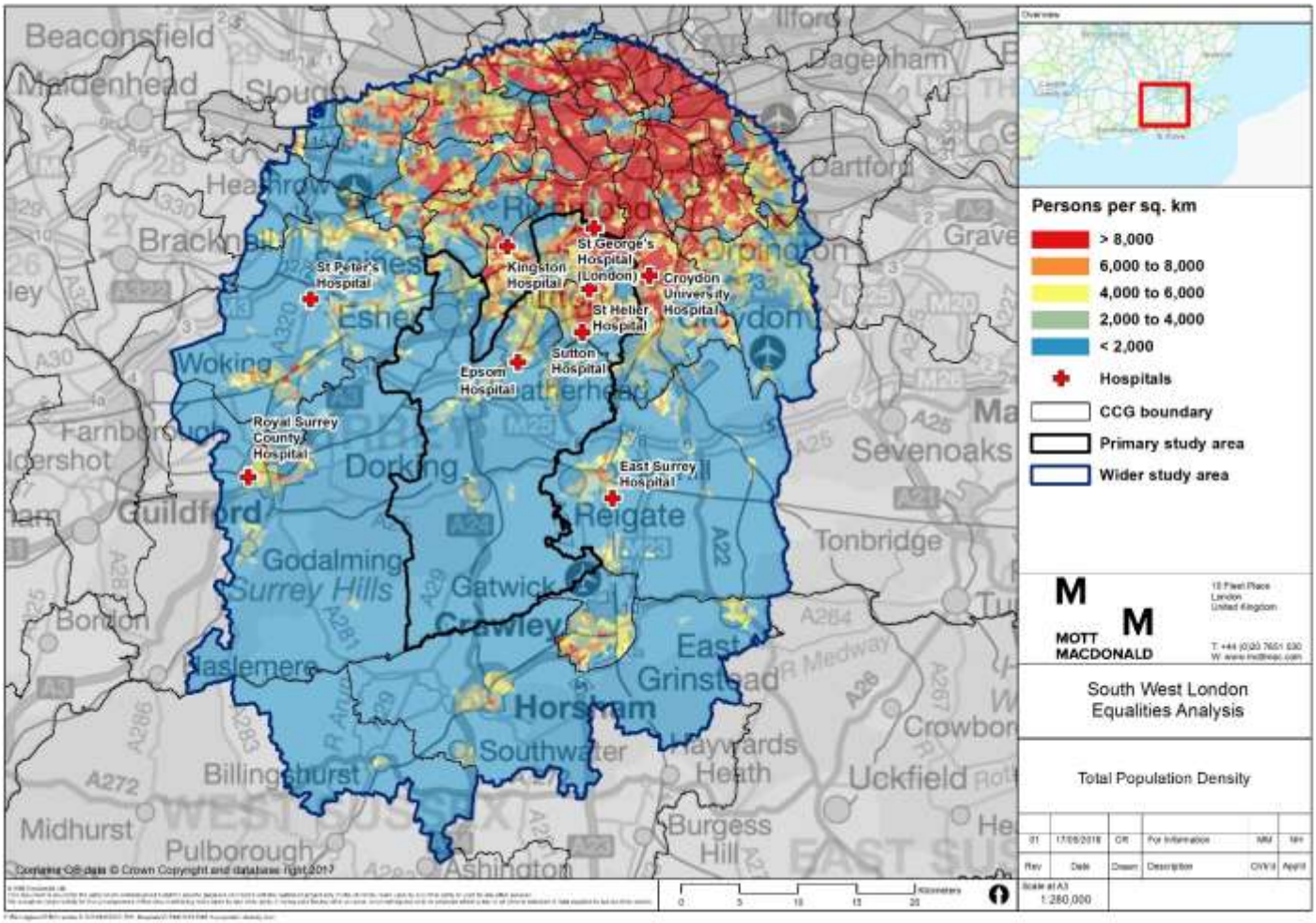
A. Primary and wider study area maps

Figure 2: Primary and wider study area



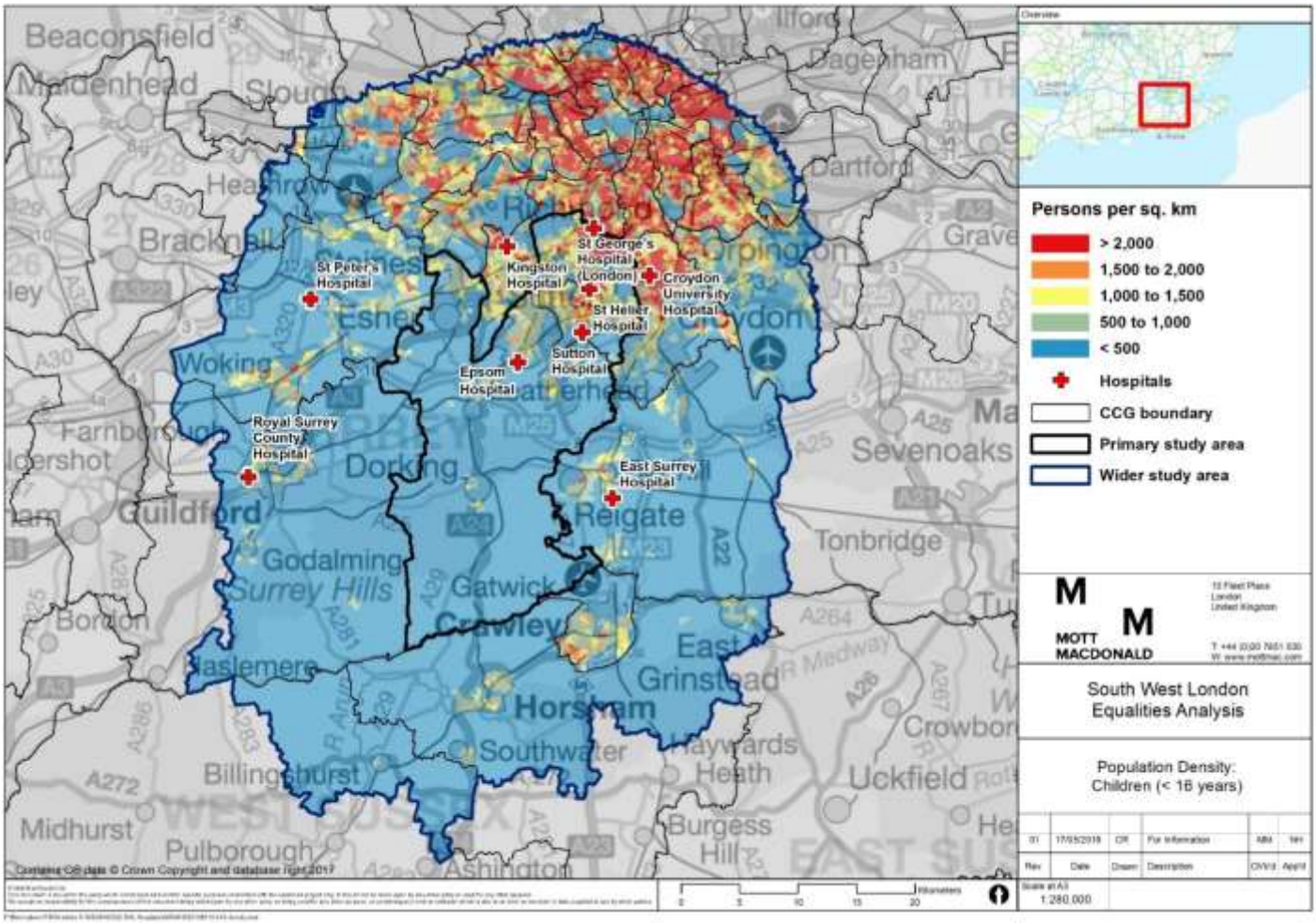
Source: LSOA population estimates 2016, ONS

Figure 3: Population density



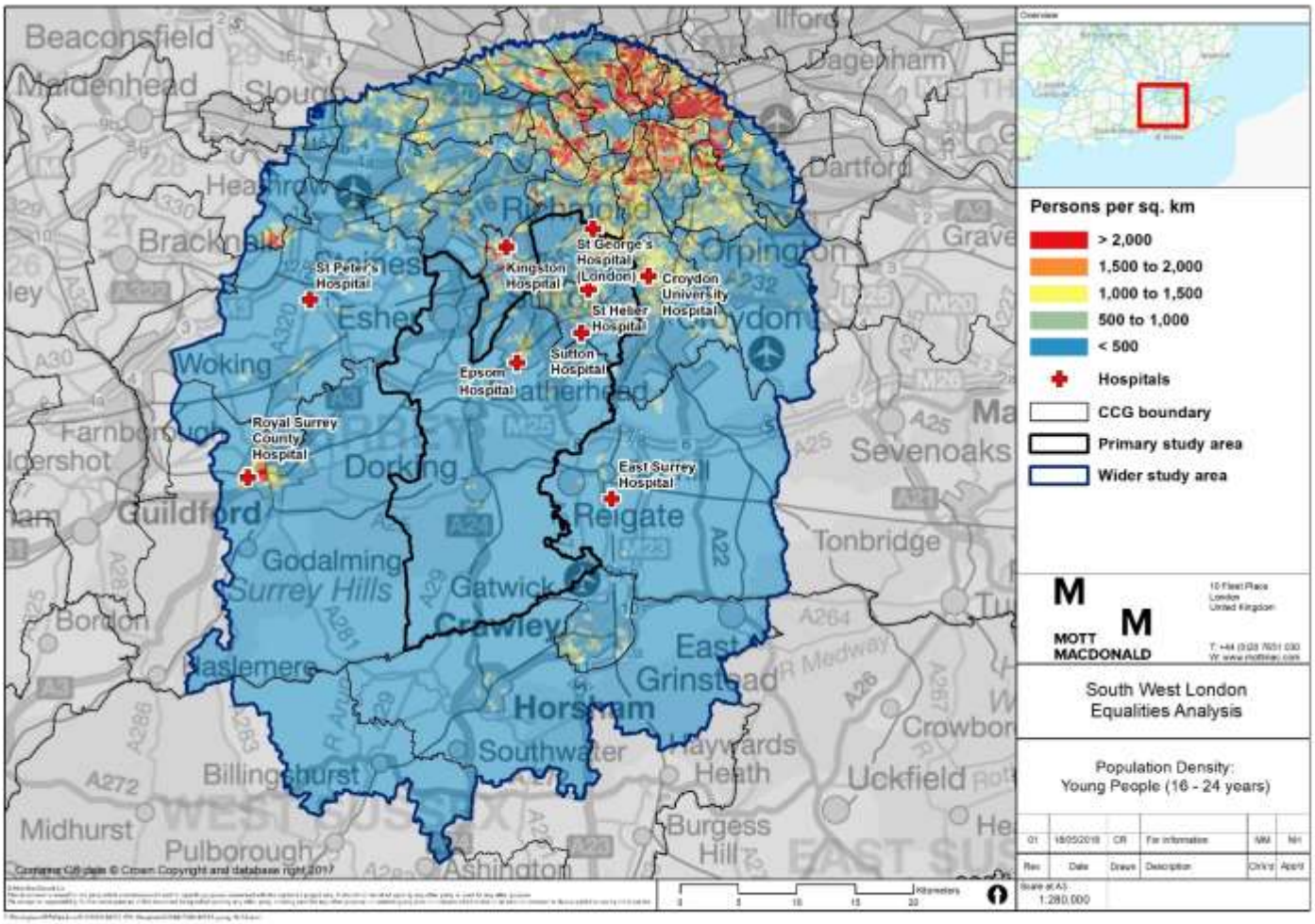
Source: LSOA population estimates 2016, ONS

Figure 4: Population density of residents aged under 16 years



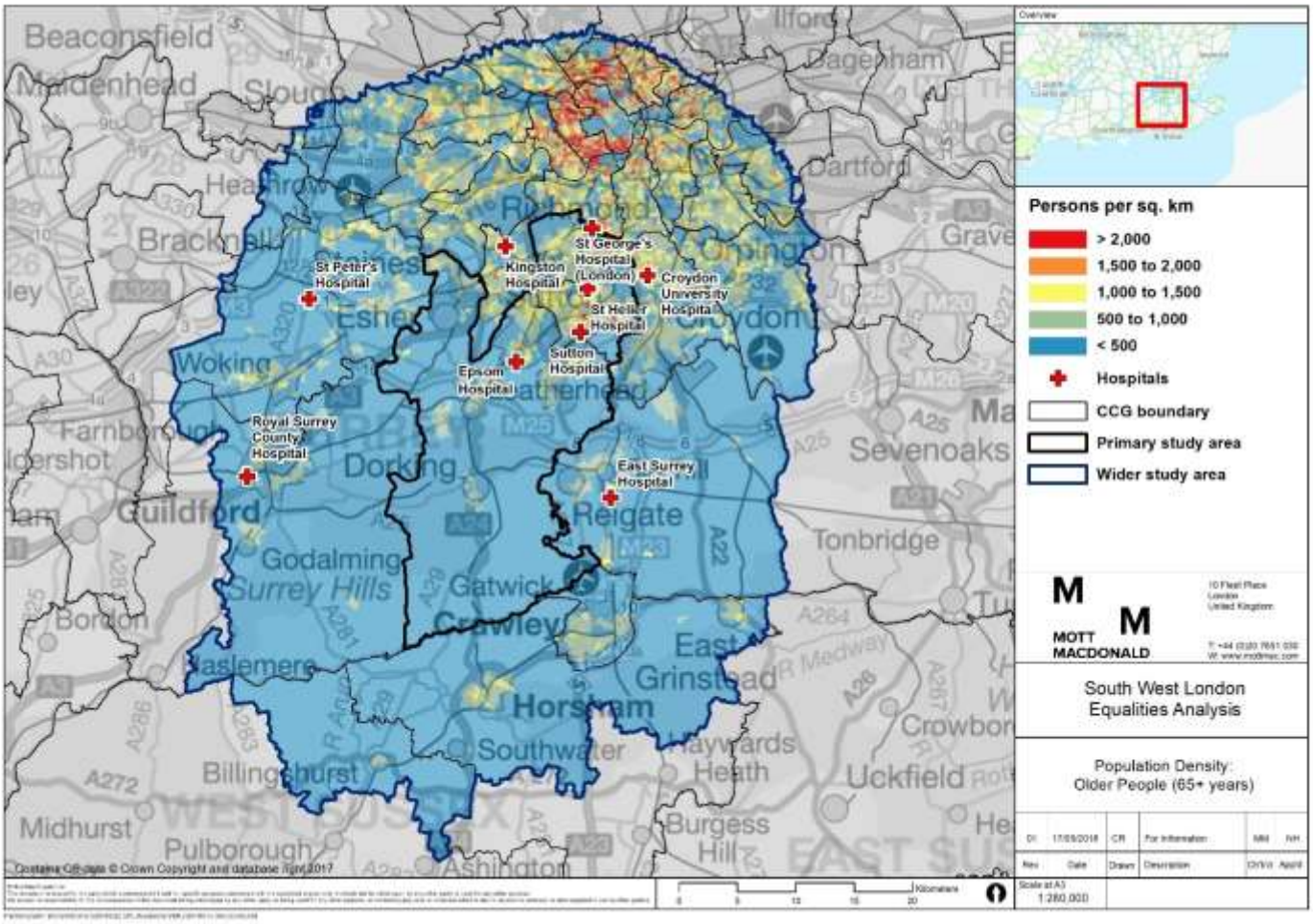
Source: LSOA population estimates 2016, ONS

Figure 5: Population density of residents aged 16 to 24 years



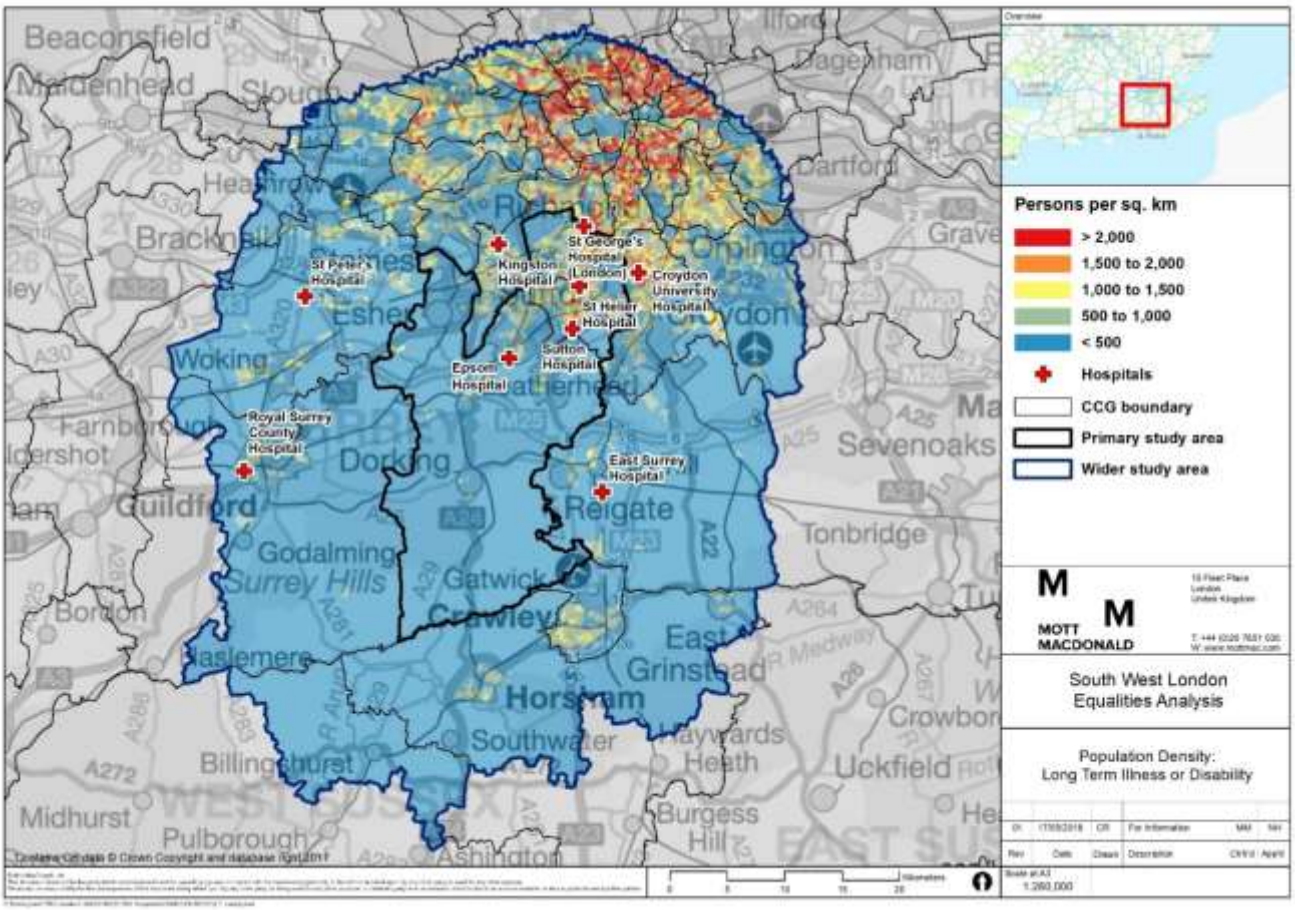
Source: LSOA population estimates 2016, ONS

Figure 7: Population aged 65 and over



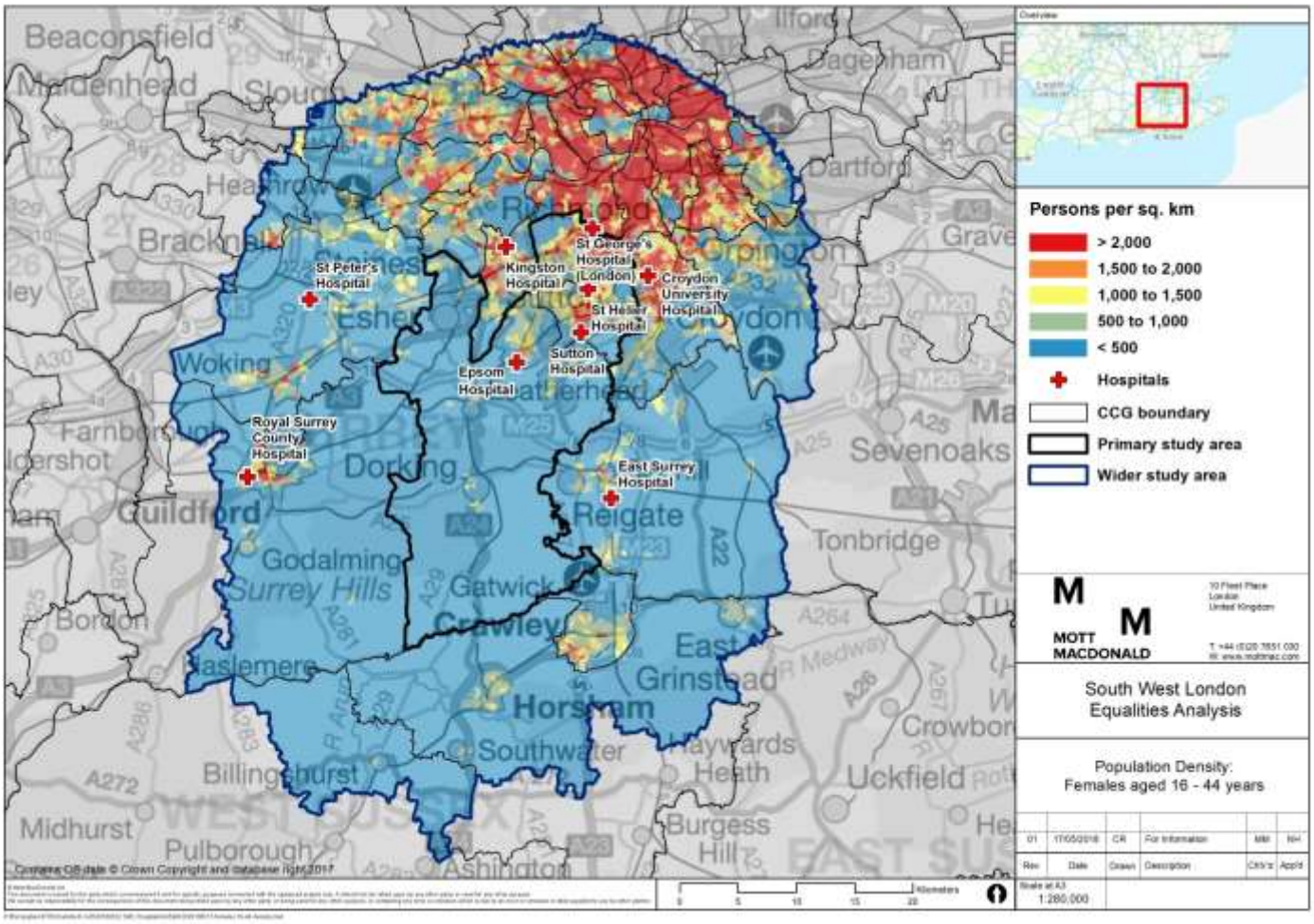
Source: LSOA population estimates 2016, ONS

Figure 9: People living with an LLTI



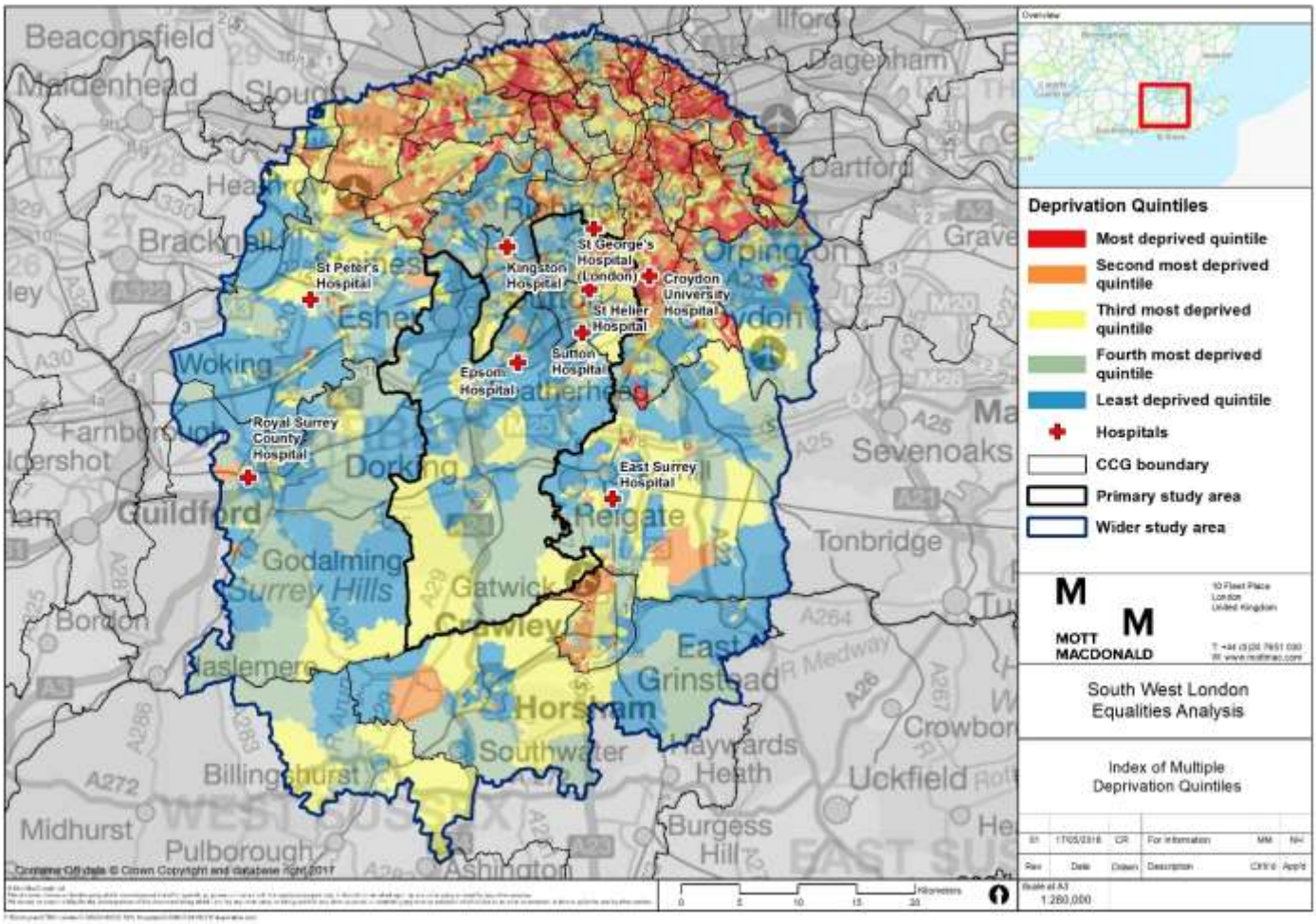
Source: Census 2011, ONS

Figure 11: Population of females aged 16-44



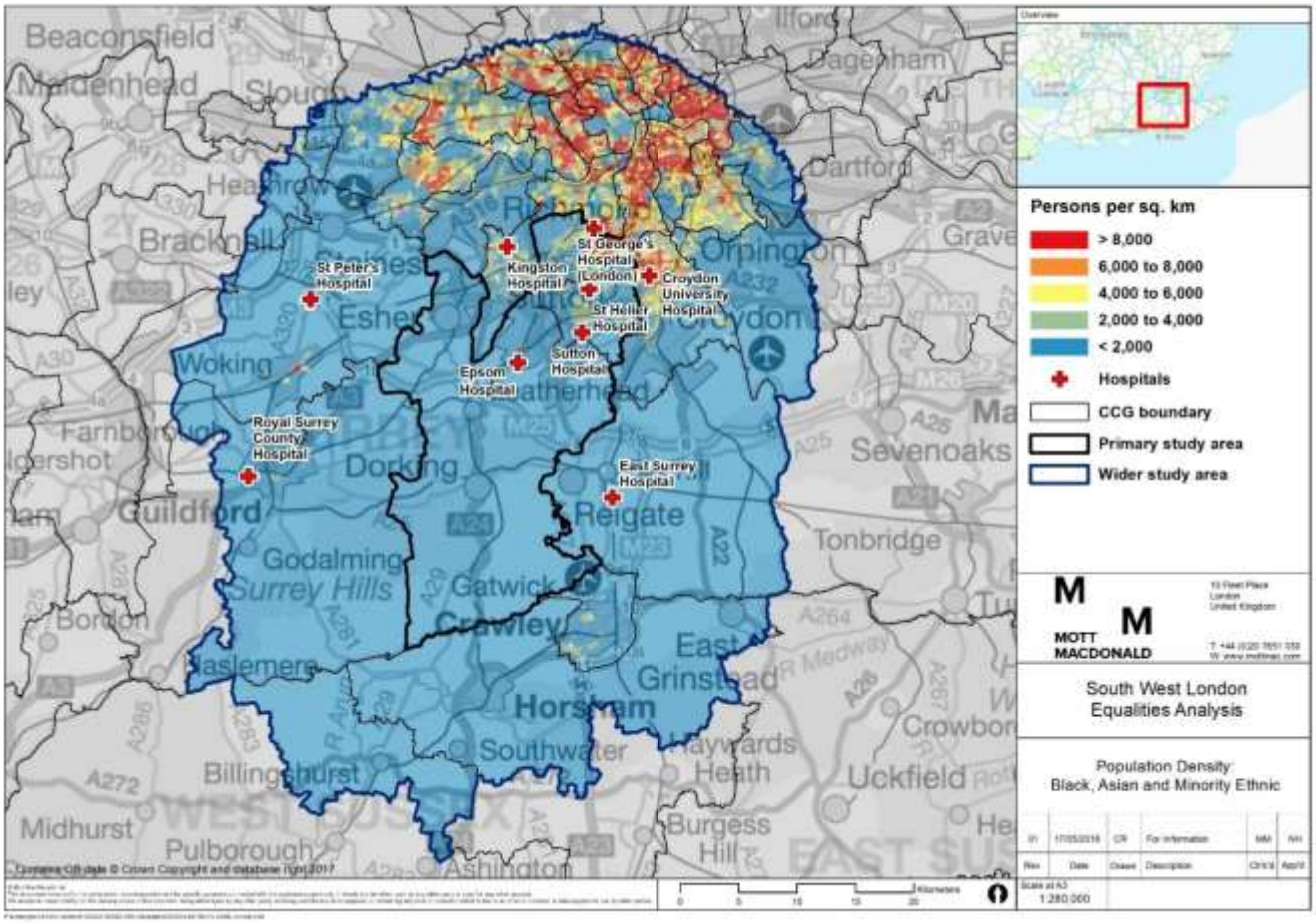
Source: LSOA population estimates 2016, ONS

Figure 15: Overall deprivation quantiles for the study area



Source: IMD 2015

Figure 13: Population of people from BAME backgrounds



Source: Census 2011, ONS