AGENDA FOR

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR PENNINE ACUTE NHS TRUST

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To: All Members of Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust

Councillors : Councillor Norman Briggs, Councillor Joan Davies, Councillor Mark Hackett, Councillor Derek Heffernan, Councillor Sarah Kerrison, Councillor Colin McClaren, Councillor Kathleen Nickson, Councillor Linda Robinson, Councillor Stella Smith, Councillor Ann Stott and Councillor Roy Walker

Dear Member/Colleague

Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust

You are invited to attend a meeting of the Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust which will be held as follows:-

Date:	Tuesday, 28 July 2015
Place:	Meeting Rooms A&B, Bury Town Hall, Knowsley Street, Bury BL9 0SW
Time:	1.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	**Sandwiches will be available from 12.30pm**

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of the Joint Committee are asked to consider whether they have an interest in any of the matters on the agenda and, if so, to formally declare that interest.

3 PUBLIC QUESTIONS

Members of the public present at the meeting are invited to ask questions on any matter relating to the work or performance of Pennine Acute NHS Trust. A period of up to 30 minutes is set aside for public questions.

4 NORTH EAST MANCHESTER DIABETIC EYE SCREENING REVIEW AND ENGAGEMENT PROCESS *(Pages 1 - 52)*

In attendance will be Jane Pilkington; Head of Public Health Commissioning (Greater Manchester); Dr Graham Wardman – Consultant in Screening and Immunisation; Audrey Howarth – Screening and Immunisation Manager; Ruth Molloy – Screening and Immunisation Coordinator.

Reports attached.

5 URGENT BUSINESS

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

Agenda Item 4

NHS England

North East Diabetic Eye Screening Programme Screening site review

Purpose:

To provide the OSC with information regarding North East Manchester's Diabetic Eye Screening Programme (NEDESP) review of screening sites; to share the engagement and communications work undertaken and planned with patients and the public; to seek comments and suggestions for improvement.

Summary:

Following a Serious Incident in the NE DESP (covering Bury, Oldham and Heywood Middleton and Rochdale) in February 2014, screening sites were reduced from 16-17 to 6 as an interim measure to ensure the safety of the screening programme. It was intended to perform a full review of the screening sites for the programme within 6 months of the 6 static sites. Work began on this review at the beginning of 2015 and a Communication and Engagement sub-group was established in April to support this process. This group includes several public/patient representatives, plus representation from Healthwatch. A Communication and Engagement plan has been produced by this group to ensure that a comprehensive and meaningful engagement exercise can take place to influence the outcomes of the review, alongside the other clinical, equality impact work being undertaken by the programme.

1) Background

NHS England Lancashire and Greater Manchester Area Team is responsible for commissioning the North East Diabetic Eye Screening Programme (NE DESP) covering Bury, Heywood Middleton and Rochdale (HMR) and Oldham (as from 1 April 2013). This is by providing screening, diagnosis and referral for treatment for patients with diabetes as part of the screening pathway to the eligible populations.

What is Diabetic Retinopathy?

- Diabetic retinopathy is a complication of diabetes and is one of the leading causes of blindness in the working population in the developed world. Diabetic retinopathy, if left untreated, can lead to sight loss which can have a devastating effect on individuals and their families. By promptly identifying and treating the disease, these effects can be reduced or avoided completely
- Diabetic retinopathy may not cause symptoms until it is quite advanced which is why screening is important
- All people with diabetes are at risk of getting diabetic retinopathy

The Diabetic Eye Screening programme

The aim of the National Diabetic Eye Screening Programme (DESP) is to reduce the risk of sight loss amongst people with diabetes by the prompt identification and effective treatment if necessary of sight threatening diabetic retinopathy, at the appropriate stage during the disease process. Since the introduction of the national screening programme, diabetic retinopathy is no longer the leading cause of blindness in the working population. The NEDESP uptake of screening is currently at 76.3% which is above the acceptable level.

- Individuals are identified by their GP and referred into the DESP.
- Annual screening appointments are offered to all people aged 12 and over with diabetes (type 1 and 2)

The Programme comprises of a number of elements:

• identifying and inviting all eligible people for screening at regular intervals (i.e. call/recall)

• taking digital images of service user's eyes

• grading the digital images of service user's eyes

• providing surveillance clinics with slit lamp bio-microscopy assessments

• providing surveillance clinics using virtual photographic clinics

• ensuring service users with referable eye disease are referred to appropriate Hospital Eye Services/Treatment Services

• undertaking internal Quality Assurance (QA)

• providing clinical oversight and governance for the Programme

2) Why are we undertaking an engagement process?

• Following a serious incident in the NE DESP programme which was the result of networking problems and the safe transfer of data, action needed to be taken to ensure that screening in the programme was safe, of the highest quality and adhering to the National Standards. It was critical that IT issues were addressed as soon as possible to maintain screening. The previous service provision of 16-17 mobile sites was reduced in the interim to 6 static community based sites with N3 wireless data transfer connection. This made the programme safe from an IT perspective. All of the static sites met the requirements of the Equality Act 2010

• Following the need to implement interim measures, it was the intention of Pennine Acute Hospital Trust to carry out a full review of the clinical sites and patient engagement is a key part of this.

NHS England has produced a number of documents [1] in relation to good practice around planning and delivering service changes. These documents state that:

"Patients, the public and staff should be engaged throughout the development of proposals from their very early initiation through to implementation. Engagement should seek to build and on-going dialogue with the public, where they have an opportunity to shape and contribute to proposals". (We should) 'engage with patients, carers and the public when redesigning or reconfiguring healthcare services, demonstrating how this has informed decisions.'

It is essential to ensure that equality is at the heart of engagement and that all participation activity reaches communities and groups who experience poor health outcomes [2]

3) Rationale for the selection of the 6 interim sites

The NE DESP had 6 cameras at the time of the serious incident, which is why 6 sites were selected based on the highest number of eligible patients. The rationale for the decisions at the time were based on; room availability, the venues available for the longest periods of time, the number of eligible patients being screened. Other screening site options were explored but were unavailable or not suitable.

4) Who is undertaking this process?

It is both a Commissioner and a Provider Role to undertake the engagement task.

- NHS England is considering changes that will have an impact on services that are being delivered to individuals. Therefore NHS England has an obligation to make arrangements to involve such individuals in the decision making process.

- Pennine Acute Hospital Trust is the provider, and as an NHS trust, has its own engagement obligations under s.242 of the 2006 Act. It is the intention for NHS England to undertake a joint engagement to avoid any duplication or confusion.

[1] (Planning and Delivering Service Changes for Patients, NHSE 2013)

'Transforming Participation in Health Care'

[2] (Transforming Participation in Health Care, NHS England, 2013)

Why Undertake the Review?

Following the UK National Screening Committee's decision to commission to deliver a population based systematic National Diabetic Eye Screening Programme. Pennine Acute Hospital Trust undertook to set up the NE DESP to deliver to the diabetic population of the three CCGs Heywood, Middleton and Rochdale, Oldham and Bury.

The NE DESP as part of the National Screening programme undertook to ensure consistency, testing, quality and standards. To follow strict protocols and criteria regarding training and testing and monitoring of all elements of the programme.

Since 2008 this has been delivered using a community based mobile service, operating by the movement of digital cameras from 16-17 clinic sites across the three LA Boroughs.

As part of the Quality and Assurance process for this screening service, regular visits are undertaken by the External Quality Assurance Team for Diabetic Eye Screening. Following the EQA visit in 2012, several recommendations set out in the EQA Action Plan, made reference to the quality and safety of the way the service was being delivered.

These particularly highlighted the unsafe nature of transfer of data by USB sticks and the concerns regarding the frequent movement/transportation of digital camera's – particularly around the camera life and quality of images being reduced when equipment is moved around.

The programme had experienced some camera failures, not because of the age of camera's but due to movement which resulted in settings being altered in transit, resulting in poor quality images.

Identification of availability of sites had to be negotiated annually, prime site occupancy for certain sites was affected by short term booking.

The quality and safety of the programme was being compromised by the lack of an N3 connection. The N3 network is designed to ensure confidentiality and a safe way to transfer digital photographs and other information by NHS users. This lack of connection resulted in the frequent occurrence of sync failures which caused the service considerable disruption. This prevented them from being able to focus on the quality aspects essential for the service to improve.

The operational model of camera transfer between sites had set up implications for both the digital cameras and staff; digital camera downtime was significant – up to one day lost in the transit, staff time was lost due to the necessity to use two staff for the transfer. This impacted on staff time, in addition to patients having to be re-arranged at short notice and re-appointed when delays in the process impacted on the delivery of the service.

5) What is the review including?

Clear criteria for assessing potential clinic sites:

- Suitability
- Acceptability for the population density
- A safe IT system
- Reduction in barriers to access screening to improve uptake and reduce DNA's
- Location
- Staffed reception

An Equality Impact Assessment

'The current review of Diabetic Eye Screening Programme will be conducted in line with our requirements under the Equality Act 2010. To ensure the Public Sector Equality Duty is considered throughout the process a Pre Equality Assessment has been undertaken that will examine the:- rational for change, perceived impact it will have of particular individuals across protected characteristics, identify and support the engagement and communications processes.

Once the engagement exercise has been undertaken and the evidence has been analysed a final Equality Assessment report will be completed. This report will aid the development of the review work plans including the specification development and will incorporate user views, highlight any equality related risks, make recommendations to mitigate any adverse impact and ensure decision makers and commissioners make a their decisions in light of the findings of the full EA report'.

Information to inform and support the commissioner, provider and the patient/public documents are outlined in the table in this document below and are attachments as part of this document.

Engagement

A Communications and Engagement subgroup was established (which comprises of representation from Healthwatch, CCG, DESP Provider, NHS England Commissioner, patient and public representatives, NWCSU), and associated plan (attached) is steering the engagement.

Pre engagement questionnaires have been designed and distributed via a number of routes including

Online survey

Provision has been ensured for those without access to the internet. Those without access to the internet have been provided with telephone support to complete the survey.

The survey has been publicised via various routes. 2000 patients have received a postal survey with a freepost envelope to return the survey. The 2000 patients are equally divided between Bury, Oldham and HMR.

Paper copies have been distributed via patient representatives.

Pre engagement questionnaires will be validated and analysed.

Staff survey

All staff within the NEDESP have received an anonymised questionnaire to gather their views.

A series of options along with all of the evidence, including the mapping exercises will be shared and displayed at 3 public events. The 3 events are being planned to be as accessible as possible. The events will be drop-in events and will take place in the 3 localities

4th August – Middleton Masonic Hall

5th August – Oldham Elizabeth Hall

6th August – Bury Masonic Lodge

They will take place between the hours of 2-7pm, in each of the localities and will be well publicised locally, including through local Asian radio.

In addition The NEDESP will:

- Include information in the appointment letters which will go out during the engagement period (approx. 1,000 per week).
- Support patients to complete the survey when attending clinic during the engagement period.

The full Engagement and Communication Plan is attached.

6) Next Steps

The results from the engagement process and full analysis of the data will inform the final decision which will be made by NHS England and Pennine Acute Trust by the end of September. Joint OSC and patients and stakeholders will then be advised of this decision.

OSC is asked to:

- Comment on this process
- Identify any areas for improvement
- Receive a report on the outcome of this process

Number	Attachment	Type	Status	Lead
1	Diabetes prevalence by CCG	Map jpg	Completed/attached	NHSE
2	Demographic map of diabetic population	Map jpg	Completed/attached	PHE KIT
3	Stakeholder engagement activity plan	PDF	Completed/ attached	CSU
4	Transport map of current venues	Map	Completed/attached	TfGM
5	Equality Impact Assessment pre-engagement	PDF	Completed/attached	CSU
6	Engagement and Communication Plan	PDF	Completed/attached	CSU
7	Case for Change Reconfiguration	PDF	Completed /attached	NHSE

Additional information to follow:

Additional Transport map with suggested sites identifying potential travel time

Analysis of patient and staff pre-engagement responses

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The Case for change: North East Manchester Diabetic Eye Screening Programme Screening Site Reconfiguration

Author: Audrey Howarth Screening and Immunisation Manager, Graham Wardman Screening and Immunisation Lead

Purpose of the paper is to:

- Present background information regarding the Diabetic Eye Screening Programme
- Provide an outline of why the interim screening site change was introduced
- Outlines Case for Change for screening site reconfiguration proposals, taking into account the distribution of the Diabetic Population, quality standards of the programme. In addition to the information gleaned from the pre-engagement process, including patient choices and taking into account of the clinical evidence base
- Summarises the next steps in the Engagement and Communication Process which strengthens public and patient engagement to develop the proposals

1. Background

NHS England Greater Manchester Area Team is responsible for commissioning the North East Diabetic Eye Screening Programme (NE DESP) covering Bury, Heywood Middleton and Rochdale (HMR) and Oldham as from 1 April 2013. This is delivered by the Pennine Acute Hospital Trust. The NE DESP is commissioned to provide screening, diagnosis and referral for treatment of patients with diabetes as part of the screening pathway to the eligible populations. It is commissioned in line with the National Diabetic Eye Screening Programme service specification.

2. What is Diabetic Eye Screening?

- The aim of the National Diabetic Eye Screening Programme (DESP) is to reduce the risk of sight loss amongst people with diabetes by the prompt identification and effective treatment if necessary, of sight threatening diabetic retinopathy, at the appropriate stage during the disease process.
- Diabetic retinopathy is a complication of diabetes and is one of the leading causes of blindness in the working population in the developed world. Diabetic retinopathy, if left untreated, can lead to sight loss which can have a devastating effect on individuals and their families. By promptly identifying and treating the disease, these effects can be reduced or avoided completely
- Diabetic retinopathy may not cause symptoms until it is quite advanced which is why screening is important
- All people with diabetes are at risk of getting diabetic retinopathy
- Diabetic patients are referred into the NE DESP by their GP Practice
- All people aged 12 and over with diabetes (type 1 and 2) are offered annual screening appointments.

3. The NE DESP comprises a number of elements:

- identifying and inviting all eligible people for screening at regular intervals (i.e. call/recall)
- taking digital images of service user's eyes
- grading the digital images of service user's eyes
- providing surveillance clinics with slit lamp bio-microscopy assessments
- providing surveillance clinics using virtual photographic clinics
- ensuring service users with referable eye disease are referred to appropriate Hospital Eye Services/Treatment Services
- undertaking internal Quality Assurance (QA)
- providing clinical oversight and governance for the Programme

4. Why are we undertaking an engagement process?

Following a serious incident in the NE DESP programme which was the result of networking problems and the safe transfer of data, action needed to be taken to ensure that screening in the programme was safe, of the highest quality and adhering to the National Standards. It was critical that IT issues and other quality assurance issues were addressed as soon as possible to maintain screening. The previous service provision of 16-17 mobile sites were reduced in the interim to 6 static community based sites with N3 connection. This made the programme safe from an IT perspective and provided vital stability and time to the Programme so that all other remaining quality and safety issues could be addressed. All of the static sites met the requirements of the Equality Act 2010.

It was the intention of Pennine Acute Hospital Trust/ NE DESP to undertake a review following the interim reconfiguration of the clinic sites. General Practice colleagues were contacted during the initial interim measures to explain the rationale for change and asked (where required) on the choice of site to invite their patients to.

The NE DESP had 6 cameras at the time of the incident which is why 6 sites were selected based on the highest number of eligible patients. The rationale for the decisions at the time were based on room availability, the venues used for the longest periods of time, the number of eligible patients being screened at each site to reduce the impact on the greatest number of patients, areas of deprivation. Other options were explored but were not feasible or possible in the timescales to manage the urgent quality and safety issues. This arrangement was benchmarked against service provision by other Programmes operating a similar model. Whilst the interim measures have had an impact for a number of patients, the engagement process concludes there are a significant number of the diabetic patients who will have seen no change to their screening venue offer from previous years. It is estimated that of the 38000 of the diabetic patients being screened approximately 8000 patients will see an impact due to the change in the availability of a more local screening site.

The current engagement process aims to formally engage with patients to review existing sites, look at options to begin offering more choice to patients based on patient feedback and needs both in terms of additional venues and hours of operation to support an increase in screening uptake. This will be achieved whilst maintaining the quality and safety of the service. Due to action taken by the NE DESP programme, IT systems and the service model for all aspects of the screening pathway are quality assured and in-line with evidence of best practice.

NHS England suggests that it is good practice, when planning and delivering service changes that "Patients, the public and staff should be engaged throughout the development of proposals from their very early initiation through to implementation. Engagement should seek to build and on-going dialogue with the public, where they have an opportunity to shape and contribute to proposals". (Planning and Delivering Service Changes for Patients, NHSE 2013)

In addition NHS England have produced a document called 'Transforming Participation in Health Care' which states that we should 'engage with patients, carers and the public when redesigning or reconfiguring healthcare services, demonstrating how this has informed decisions.' It is essential to ensure that equality is at the heart of engagement and that all participation activity reaches communities and groups who experience poor health outcomes. (Transforming Participation in Health Care, NHS England, 2013).

5. Who is undertaking this process?

It is both a Commissioner and a Provider Role to undertake the engagement task.

- **NHS England** are considering changes that will have an impact on services that are being delivered to individuals. Therefore NHS England has an obligation to make arrangements to involve such individuals in the decision making process.
- **Pennine Acute Hospital Trust is the provider, and as an NHS trust**, has its own patient and public involvement obligations under s.242 of the 2006 Act. It is the intention for **NHS England** to undertake a joint engagement exercise to avoid any duplication or confusion.

6. Why Undertake the Review?

- Following the UK National Screening Committee's decision to commission to deliver a population based systematic National Diabetic Eye Screening Programme. Pennine Acute Hospital Trust undertook to set up the NE DESP to deliver to the diabetic population of the three CCGs Heywood, Middleton and Rochdale, Oldham and Bury.
- The NE DESP as part of the National Screening programme undertook to ensure consistency, testing, quality and standards. To follow strict protocols and criteria regarding training and testing and monitoring of all elements of the programme.

- Since 2008 this has been delivered using a community based mobile service, operating by moving of digital cameras from 16-17 clinic sites across the three LA Boroughs.
- As part of the Quality and Assurance process for this screening service, regular visits are undertaken by the External Quality Assurance (EQA) Team for Diabetic Eye Screening following the EQA visit in 2012, several recommendations set out in the EQA Action Plan, made reference to the quality and safety of the way the service was being delivered.
  These particularly highlighted the unsafe nature of transfer of data by USB sticks and the concerns regarding the frequent movement/transportation of digital camera's – particularly around the camera life and quality of images being reduced when equipment is moved around.
- The programme had experienced some camera failures, not because of the age of the cameras but due to persistent movement from site to site.
- Preferred sites were often difficult to secure as venues favoured services which could guarantee longer term bookings. However patient numbers in certain locations couldn't support this and only short term bookings were appropriate.
- The quality and safety of the programme was being compromised by the lack of an N3 connection. (The N3 network is designed to ensure confidentiality and a safe way to transfer digital photographs and other information by NHS users). This resulted in the frequent occurrence of sync failures which caused the service considerable disruption. This prevented the NE DESP being able to focus on the quality aspects essential for the service to improve.
- The operational model of camera transfer between sites had set up implications for both the digital cameras and staff; digital camera downtime was significant – up to one day lost in the transit, staff time was lost due to the necessity to use two staff for the transfer. This impacted on staff time, in addition to patients having to be re-arranged at short notice and re-appointed when delays in the process impacted on the delivery of the service.

The aim of review is to be able to offer eligible patients an acceptable level of choice of venues and opening hours as evidenced through the patient engagement process and the transport and eligible patient mapping process, whilst maintaining a screening programme that is extremely safe and of the highest quality. This should help improve uptake, reduce DNA's and reduce health inequalities.

7. Population Coverage

NHS England and the NE DESP as the service providers are working together to optimise coverage and uptake across the catchment area. There are currently over 38000 diabetic patients known to the NE DESP across HMR, Oldham and Bury and as described above the changes made by the interim measures has meant a change in screening site for approximately 8000 diabetic patients.

8. What are the main considerations in delivering the screening offer across the three CCGs?

- On average there is an annual 5% increase in the diabetic population
- The programme when set up as part of the national DESP was set up as a community clinic based service, which has grown considerably since established in 2008. This now stands at more than 38,000 patients and has to be balanced with the increase in demand for services against access for communities to take part in the screening offer.
- The number of clinic sites that are fit for purpose. This includes clinic sites that have the facilities required by the NEDESP, are available to be booked and can be booked for short periods of time each year. It is imperative that an N3 connection is available to safeguard the safe transfer of images/data, to prevent a further Serious Incident.
- That the digital camera is not moved frequently to ensure that the maximum life is achieved from the camera, whilst minimising harm to the patients. That the camera is placed in the right location to reduce DNA rate and optimise take up rate of the offer of screening.

9. Criteria for proposed clinic sites:-

1. **Suitability**
   A digital camera should not be moved frequently. This will ensure that the working life is maximized and will minimise harm. The cameras are designed to be static and can be easily damaged during transfer. The clinic room needs to be able to accommodate a camera for a minimum of 3 months (this is to ensure the patient has time to rebook if the initial screening invite appointment is not suitable), with space for the patient and screener. The room needs to be fit for purpose e.g. meeting the minimum standards to enable digital photographs to be undertaken. The cost of room hire is affordable within the parameters of the services budget.

2. **Acceptability for the population**
   The clinic locality needs to be acceptable to the local population. This could include geographical area, lighting, feeling safe, reception for assistance and ability to book room/clinic and retain (for more than one year). The patient engagement process will help to inform this.

3. **Safe IT system**
   The quality assurance standards require programmes to ensure that information gathered from the digital photograph is transferred back to the programme office within a specific time frame by a safe method and to reduce any elements that are at risk to fail. The current advice is that this is undertaken by what is known as a N3 connection. Any proposed clinic site requires N3 connectivity or the ability to install N3 connectivity for the secure transfer of the retinal photographs back to the programme.

4. **Accessibility for all to improve uptake and reduce DNA's**
   The service needs to ensure good accessibility for all people with diabetes. It needs to be accessed by public transport links, NHS funded transport and voluntary assisted schemes; in addition to have sufficient parking and disabled spaces and needs to comply with the Disability Discrimination Act. There needs to be the option to offer appointments outside the normal working hours for the working population and the offer to be screened close to a work site. Improving patient choice to attend any screening site more appropriate for the patient may have a positive impact on screening uptake.

5. **Location**
   This is important to ensure equity of access across the three Clinical Commissioning Group's (CCG's) boundaries to ensure that no population group is adversely challenged. Easy access close to where patients live and work, with the opportunity to change an appointment where appropriate.

6. **Staffed reception**
   This is important to ensure that patients are greeted and supported during their visit. Reception staff are able to signpost patients when necessary.

10. Case for change next steps

I. NHS England and Pennine Acute Trust have established an engagement and communication sub- group**.** This has been convened by a partner agency called the North West Commissioning Support Unit (NWCSU), this sub-group includes representation from the provider, the commissioner, communication leads from three CCGs, patient representation from each of the three CCGs/LA areas.

II. The pre-engagement process agreed through this group, concluded on the 26th June 2015. This included obtaining feedback from a sample of patients from across the 3 CCG/LA areas on existing locations, access to transport and preference for additional opening hours. Additionally NE DESP staff feedback was sought on the impact of the interim changes. A good response was received from the patient pre-engagement survey both on-line and through the post. Surveys were sent to 2000 patients of which nearly 650 were returned in the post. Response to these surveys is attached.

III. Options which the group would like to discuss with patients as part of the formal engagement process now include:

IV. Options for the reconfiguration

a) Option to have 10 screening sites across the three CCGs to include existing 6 sites, with 4 additional sites based on initial patient and staff feedback, transport mapping and location of eligible diabetic population. Sites to be considered: 1 additional site in Heywood for the Heywood and Middleton diabetic population, 1 additional site in Prestwich for the Prestwich Diabetic population, 1 additional site in Failsworth for the Diabetic population of Failsworth and 1 additional site in the Saddleworth area for the Diabetic population of Saddleworth

b) Option to have up 12 screening sites across the three CCGs to include existing 6 sites the sites to be considered are 1 additional site in Heywood for the Heywood population and 1 site in Middleton for the Middleton diabetic population, 1 additional site in Prestwich for the Prestwich Diabetic population, 1 additional site in Failsworth for the Diabetic population of Failsworth and 1 additional site in the Saddleworth area for the Diabetic population of Saddleworth. 1 additional site in Oldham central as additional capacity for the central Oldham population**.**

V. Full engagement with patient, public and key stakeholders across three CCG boundaries over a 4-6 week period to engage on the increased service offer. Beginning 01.08.15. During this period 3 events will be held as well as a number of other channels and groups utilised to gain as high as possible feedback on the options. A shorter formal engagement process has been requested as we have already had considerable feedback on the need for change through the pre-engagement process and would like to ensure that an increased offer of locations to patients can be offered as soon possible.

VI. NWCSU will analyse the findings from the formal engagement process with a final service model decision to be made by NHS England and Pennine Acute Trust by the end of September 2015. This will be presented to the OSC complete with an equality impact assessment.

VII. Communication of the final decision to all stakeholders and screening site review plans to be progressed by the NE DESP

11. Patient and Public Engagement in respect of the NHS constitution

NHS England is committed to ensuring that patients are at the centre of every decision that NHS England makes. Putting patients first needs to be a shared principle in all that we do. NHS England, through the geographical teams will ensure that this is demonstrated in the way care is provided and monitored through our formal contracting process with providers.

We expect all providers to demonstrate real and effective patient participation, both in terms of an individual's treatment and care, and on a more collective level through patient groups/forums; particularly in areas such as service improvement and redesign. It is essential that all providers of public health s.7A services demonstrate the principles of transparency and participation and offer their patients the right information at the right time to support informed decision making about their treatment and care.

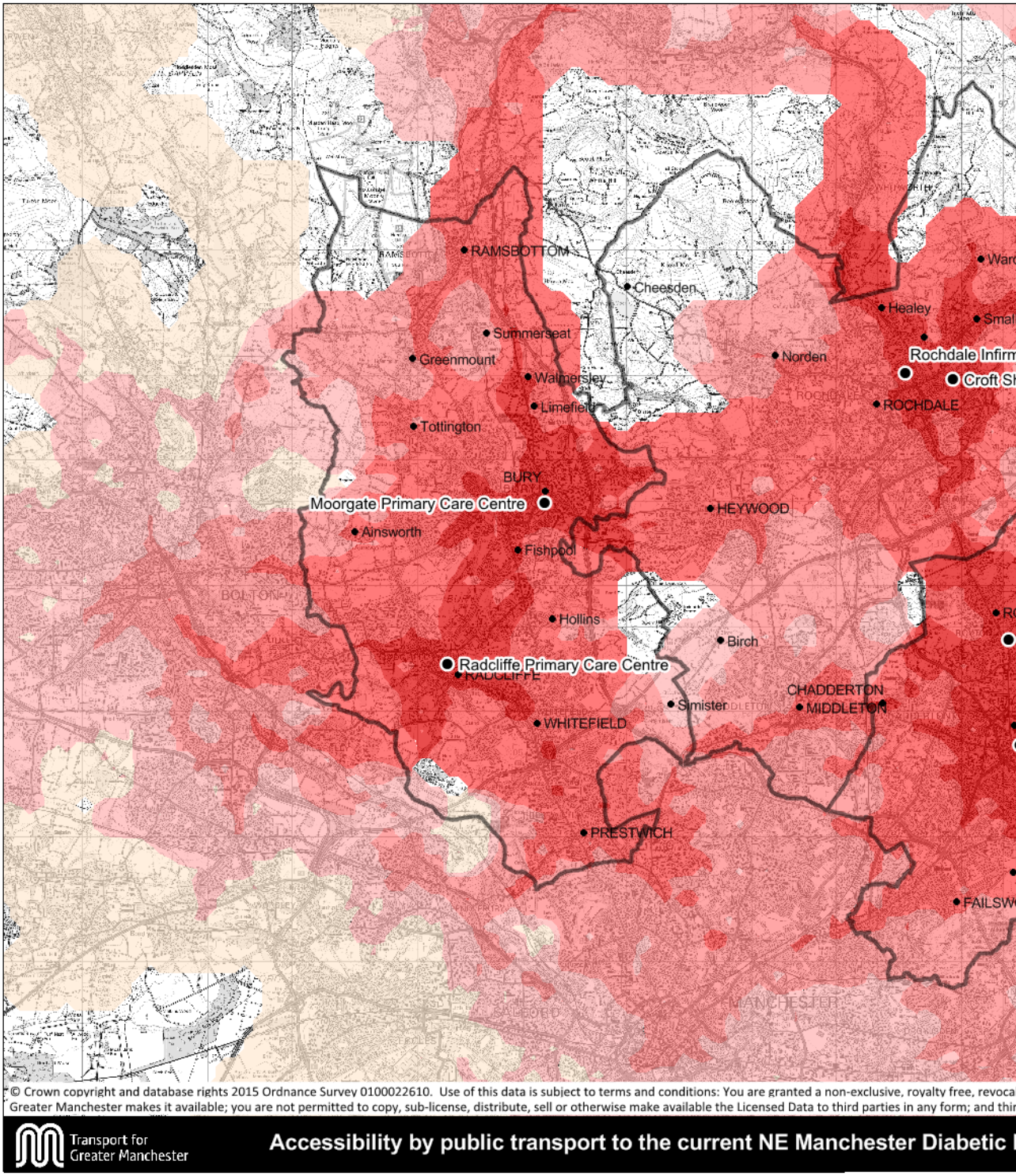
Appendix A
Patient Pathway – see below

http://healthguides.mapofmedicine.com/choices/map/diabetic_eye_screening1.html

Number	Attachment	Type	Status	Lead
1	Diabetes prevalence by CCG	Map jpg	Completed/attached	NHS England
2	Demographic map of diabetic population	Map jpg	Completed/attached	PHE KIT
3	Stakeholder engagement activity plan	PDF	Completed/ attached	CSU
4	Transport map of current venues	Map	Completed/attached	TfGM
5	Equality Impact Assessment pre-engagement	PDF	Completed/attached	CSU
6	Engagement and Communication Plan	PDF	Completed/attached	CSU
7	Case for Change Reconfiguration	PDF	Completed /attached	NHS England

Additional information to follow

- NHS England transport tool to**:** map suggested clinic site travel time for patient travel to access offer of screening.
- Analysis of patient and staff pre-engagement responses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Summerseat
Greenmount
Walmersley
Limefield
Tottington
Norden
Healey
ROCHDALE
BURY
Moorgate Primary Care Centre
HEYWOOD
Ainsworth
Fishpool
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Transport for Greater Manchester
Accessibility by public transport to the current NE Manchester Diabetic

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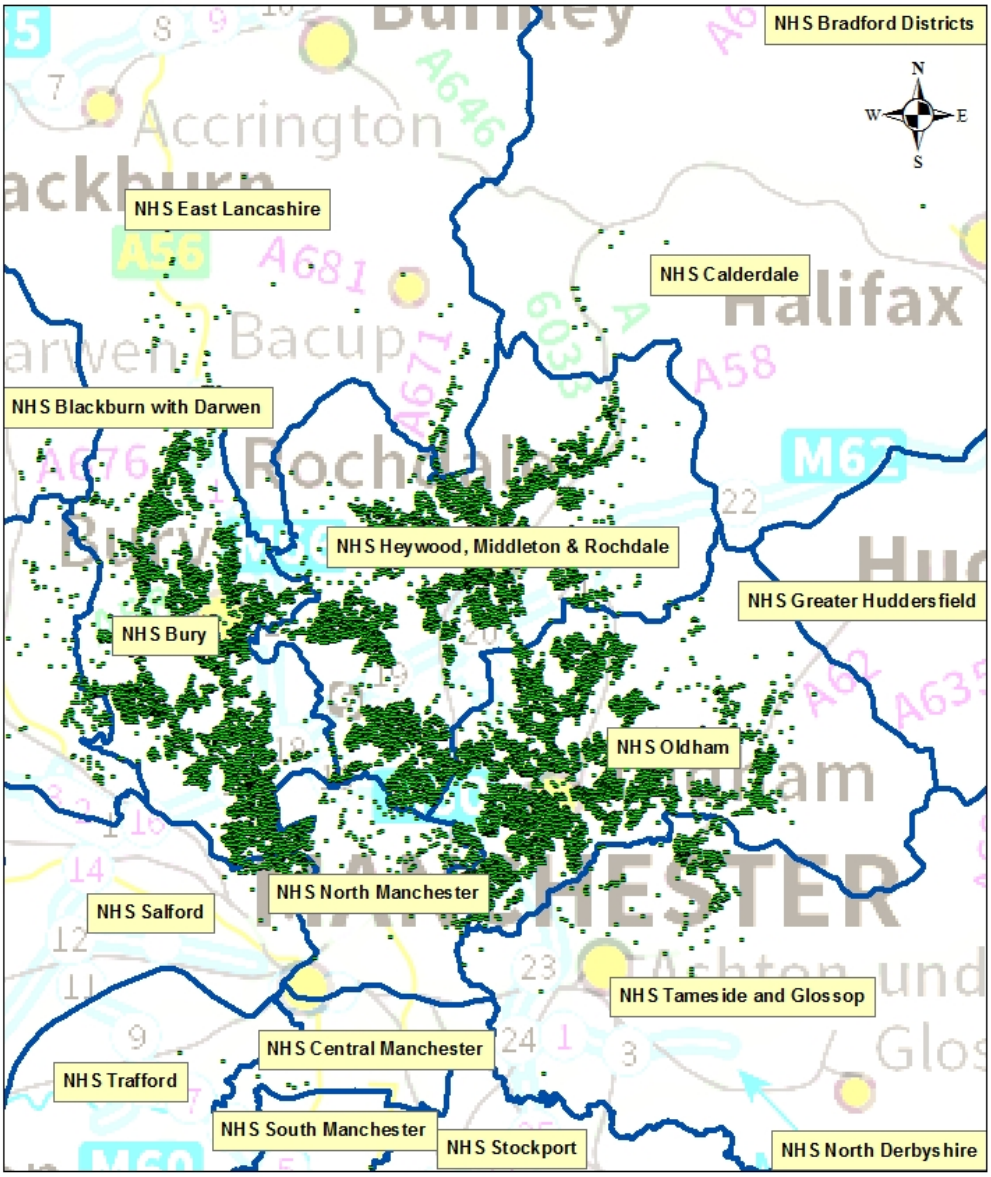

Map prepared by PHE Knowledge & Intelligence Team (North West)

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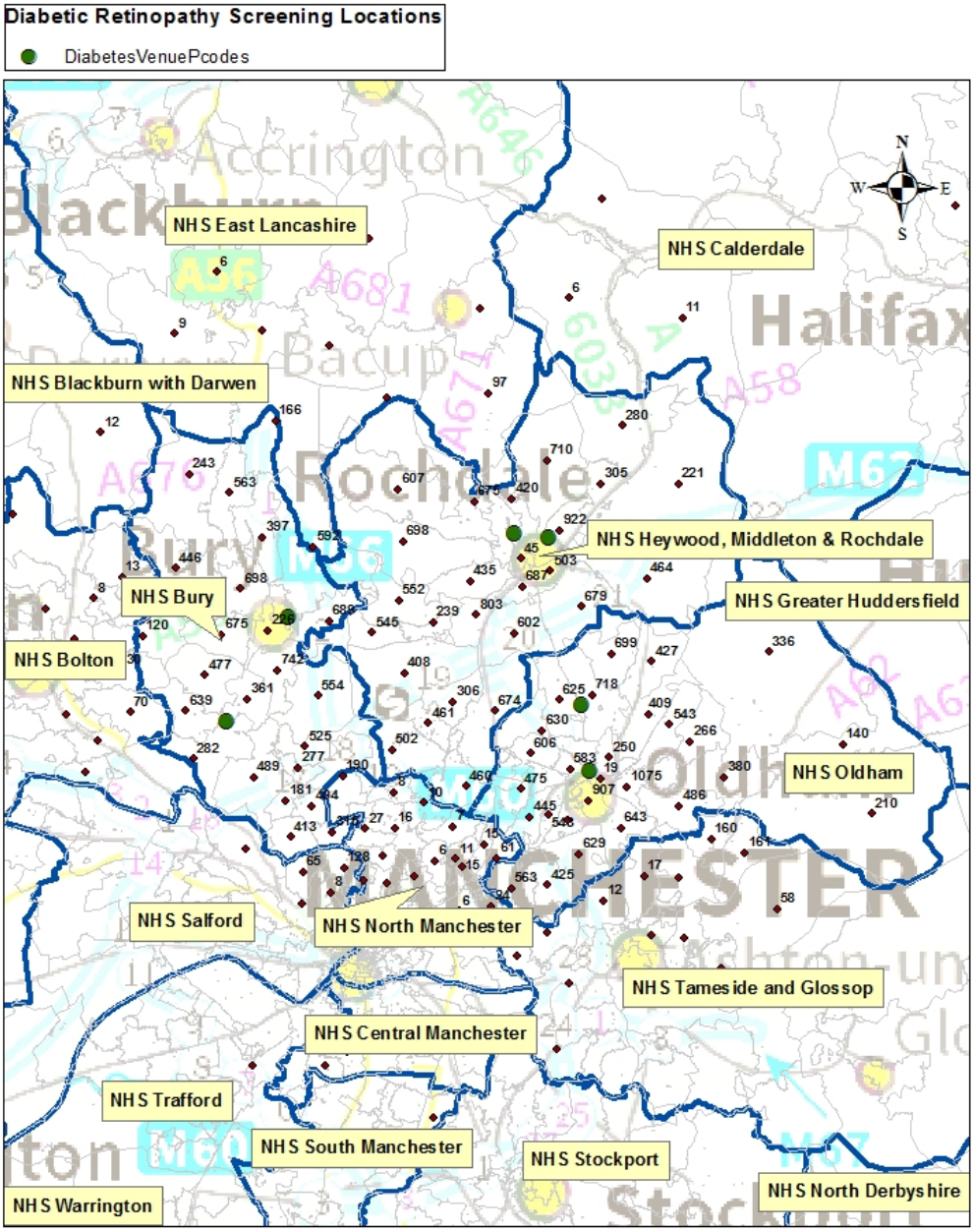

Map prepared by PHE Knowledge & Intelligence Team (North West)

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Equality Analysis Report: Pre-consultation

Date: 20/6/15 (pre assessment)
Date: 7/7/15 (pre assessment)
Date: 10/07/15 (pre assessment
Date : 21/07/15

Signature: Andy Woods

Signed Audrey Howarth on behalf of NHS England Commissioners

1. What is a Pre- Equality Analysis?

An equality analysis is the process by which decision makers assess the potential risk of discrimination to ensure that when taking decisions they do so in the full knowledge of section 149 - statutory Public Sector Equality Duty, the Equality Act 2010.

The primary function of this **pre-assessment** is to assist officers in understanding:

1) any equality implications of the proposed changes to explore these possibilities and minimise any disadvantage,

2) Identify engagement groups and to garner their views on the proposal and identify any undue impact on particular protected characteristics.

3) And to aid in developing a work plan that will incorporate user views, mitigating any adverse impact and to assist and aid their decision.

In order to meet equality legislation we have to consider the issues of:

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Scope of the Analysis

This analysis will examine the rational for the changes, the perceived impact it will have of particular individuals, identify engagement needs. A final review will be completed once all the engagement has been done and the evidence can be evaluated.

North East Diabetic Eye Screening Programme Screening Site Review Pre-engagement

Date: 10/07/15	Completed by: Andy Woods - CSU
Commissioned by: NHS England	

1. What is the overall purpose of the service/change in existing service?

The aim of the National Diabetic Eye Screening Programme (NDESP) is to reduce the risk of sight loss amongst people with diabetes by the prompt identification and effective treatment if necessary, of sight threatening diabetic retinopathy at the appropriate stage during the disease process.

NHS England Lancashire and Greater Manchester Area Team is responsible for commissioning the North East Manchester Diabetic Eye Screening Programme (NEM DESP) covering Bury, Heywood. Middleton and Rochdale (HMR) and Oldham (as from 1 April 2013). This is by providing screening, diagnosis and referral for treatment for patients with diabetes as part of the screening pathway to the eligible populations. Since 2008 Pennine Acute Hospital Trust which provides the North East Manchester Diabetic Eye Screening Programme offered the screening service from up to 16-17 different venues each year which were dependent on room availability. In some years this was lower due to lack of room availability.

Following a serious incident in the NE DESP programme which was the result of networking problems and the safe transfer of data, action

needed to be taken to ensure that screening in the programme was safe, of the highest quality and adhering to the National Standards. The quality and safety of the programme was compromised by the lack of an N3 connection and it was essential that this issue was addressed as soon as possible to maintain screening. The previous service provision of 16-17 mobile sites was reduced in the interim to 6 static community based sites with N3 connection. (The N3 network is designed to ensure confidentiality and a safe way to transfer digital photographs and other information by NHS users).The priority was to locate the cameras in sites that provided a safe N3 connection, to ensure the safe transfer of data and to reduce the frequent movement/transportation of digital camera's which was compromising the camera life and quality of images. The rationale for the decisions at the time, were based on room availability that facilitated the N3 connection, the ability to secure venues for long term use, access for the eligible diabetic population. All of the static sites met the requirements of the Equality Act 2010

The NE DESP had 6 cameras at the time of the incident which is why 6 sites were selected based on the highest number of eligible patients. The rationale for the decisions at the time were based on room availability, the venues used for the longest periods of time, the number of eligible patients being screened at each site to reduce the impact on the greatest number of patients, areas of deprivation . Other options were explored but were not feasible or possible in the timescales to manage the urgent quality and safety issues. This arrangement was benchmarked against service provision by other Programmes operating a similar model. Whilst the interim measures have had an impact for a number of patients whilst the engagement process concludes there are a number of the 38000 plus diabetic patients which will have seen no change to their screening venue offer from previous years. It is estimated that of the 38000 plus diabetic patients being screened approximately 8000 patients will be seeing a change in the availability of a more local screening site.

The intention was to review this service change after the initial change to 6 static sites with recognition of the requirement of an additional camera to ensure capacity for an expanding diabetic population.

NHS England and PAHT are engaging with patients to increase the offer of screening locations to up to 12 locations per year. This will be through a review of transport and population mapping as well as based on feedback from patients through this engagement process. The NEMDESP would also like to review the current hours of operation to include options to offer screening outside the core service hours for patients that find it difficult to access the service during the normal working day.

It is believed that the change will provide:

- improved patient safety and quality of service
- increase screening uptake
- allow the service to be networked to an N3 connection and be able to use equipment that is better equipped for the volume of images taken and reduce Information governance risks
- some stability of location for patients and staff members
- save time and costs in setting rota's and the risks associated with the transportation of the camera equipment to different sites throughout the course of the year

The service will look at hosting a few events each year linked to existing planned events to increase screening uptake.
The DESP will work in collaboration with the Screening and Immunisation Team as part of NHS England, in working with a population approach using the Health Inequality Strategy that has been produced to target and improve uptake to screening

2. What are the priorities and aims for this service?

To improve access to and uptake of screening to the entire eligible population whilst ensuring that screening is offered in venues suitable for screening, that have a secure N3 connection and meet the requirements of the Equality Act 2010. The service needs to plan locations that are convenient for the majority of patients as the eligible population continues to increase at a predicted 5% year on year.

To map transport options and promote the availability of these of these to the eligible population.

3. Who is expected to benefit from the service or proposed change

Service – will be able to run more effectively and efficiently and risks to service delivery reduced. Increased uptake of screening. Improved patient safety and quality.
Staff – stability of location for clinic staff along with a reduction in the administration process related to the frequent transportation of equipment
PAHT – The service will be much more cost effective and provide value for money whilst ensuring that patient needs are taken into consideration in the review of service provision.

Patients – Continuity of care in terms of staff and location as well as a location that is fit for purpose and more local to the patient. Additional hours outside core working hours to support an increase in attendance in the working populations as well as a choice to attend any one of the venues in operation if this is more convenient

4. Are there any related services, policies or guidelines that may be affected by this service or change in service?

No

5. Do different groups have different needs, experiences, issues and priorities in relation to this service or change in service? (If the answer is yes, please provide justification or legitimate aims in the space provided at Q9).

Yes – Some patients are happy for good central locations but others will want a venue that is very close to home. The service will be looking to offer all eligible patients a reasonably acceptable level of choice of locations and hours as evidenced through the patient engagement process. Service is being increased from current status however needs to cognisant of the historical quality and safety issues to ensure that these do not re-occur and that the service minimises the movement of any one camera.

6. Does the service affect one group less or more favourably than another, including possible discrimination against one group(s) over another? (If the answer is yes, please provide justification or legitimate aims in the space provided at Q9).

Yes this applies with regard to Age and Disability.

7.	**Is there public concern (including media, academic, voluntary or sector specific interest) in the policy area about actual, perceived or potential discrimination about a particular community?** (If the answer is yes, please provide justification or legitimate aims in the space provided at Q9). **Yes this is applicable in regard to age, disability and location.**

All protected characteristics need to be engaged on the proposal:

The final analysis will need to be cognisant of results of consultation and any other evidence presented but the initial equality issues that need attention look like:

Protected characteristic	Issue linked to travel and familiarisation	Comment /mitigation
age	Young and older patients may need to adjust to new arrangements All venues need to be strategically placed for ease of	Additional sites to be offered. Parents notified of changes/ proposals and options. Older patient notified of changes and offered 'pre –opening familiarisation visit' Fully engage with patients though surveys and planned events and engagement

	access in all geographic areas. Working age families and children	activities to ensure that views from patients from all age groups are sought. Additional hours of operation outside core hours to be considered as part of this review to support access for the working population.
disability	Severely disabled may be assisted by carers. Its vital that current users are part of the consultation process to identify their needs and worries about the change in service location Disability (e.g. diabetes) - limiting mobility/ amputees /blindness. Delays in appointments may	Additional sites to be offered which meet the requirements of the Equality Act 2010. Notify people with disabilities & carers in good time of the proposal seek their views through the engagement process. Patient transport is available for patients and sites to be considered that are on the approved list for patient transport. Work with local Voluntary organisations for guidance.

	have a detrimental effect.	
Gender reassignment	No impact	
Pregnancy & maternity	Change in routes/ bus/ parking	Notify in good time of changes – clearly indicating fresh routes and parking facilities
race	Spoken /written language	Language needs associated with patients are fully considered by the provider. Interpreters to be available at the planned patient engagement events. Ensure information is given to different communities, consider different language leaflets
Religion& belief	No impact	
Sex (M/F)	Male /female – other than the above categorises – no impact	
sexuality	No Impact	

1. Does this service go to the heart of enabling a protected characteristic to access health and wellbeing services?

Diabetic Eye Screening is a vital service for the monitoring, prevention and treatment of diabetic retinopathy to reduce blindness in the working age population

2. Who do you need to engage with?

All protected characteristics need to be engaged with and **particular efforts** must be made with ***service users and particular groups*** (such as diabetes sufferers and voluntary organisation that have an interest) to engage and understand their views of the proposal and to identify any concerns they may identify with the plans. Disability groups also need to be included in the design and layout of the new venues

Once engagement has taken place then the Equality Analysis will be reviewed and finally completed.

3. Is there evidence that the Public Sector Equality Duties will be met?

(a) Eliminate discrimination. –

Currently Commissioners and providers have provided assurances that the service is not being reduced and following the actions the Duty is currently being met

The development of the programme will need to be cognisant of threshold and criteria issues highlighted above as this has potential to indirectly discriminate against the protected characteristic of ***disability*** and ***older age***.

Commissioner and provider assurances to Threshold issues

- There will be no reduction in the financial envelope for this service.
- An additional camera 7 has been purchased to mitigate the increased demand/capacity issues on the service reducing potential risks to the offer of screening to diabetic patients in the three boroughs

  There will be no reduction in the hours of service provision – the service is currently looking to expand screening sites hours of operation (where possible/undertaking a pilot to evaluate demand) working population in earlier /Later appointment and weekend appointments

(b) Advance equality of opportunity

Pennine Acute Trust and the Commissioner will have to understand patients concerns and address them to show that there will be no negative impact on particular disabilities and that the service will in fact help to include and pull in to the service those that are disproportionally low/poor in using such services. Pennine Acute Trust needs to demonstrate how it will address health inequality of attendance in to this service with its new model.

Furthermore as previously referenced the collaborative work with Screening and Immunisation Team regarding their Health Inequalities Strategy , in addition the DESP has undertaken a CQUIN regarding Health Inequalities This was to undertake a stocktake of access and coverage for vulnerable and deprived groups.
The stocktake will, for each group, identify the group's current access to relevant services and compare the group's uptake and coverage to the local, regional and national average. The stocktake should attempt to identify factors which may result in poorer coverage. These factors could include cultural reasons, geographical distance, and lack of appropriate information.
This will be progressed by setting an Action Plan that will be worked through as a Service Development plan; action will be regularly monitored by the Programme Board.

(c) Foster good relations between different protected characteristics-

- Pennine Acute Trust and the Commissioner will have to demonstrate how it has engaged with service users and specialist interest groups – and listened to their views.

- As part of the plans, greater engagement with the community on the availability and benefits of the service will be part of its rolling programme of education.

4. Above have you identified key gaps in service or potential risks that need to be addressed or mitigated?

Yes –see action plan

ALL Activity below must take place before final decision is made to change the service.

issue	*Action*	*By whom*
Need engagement	Devise stakeholder analysis. Devise engagement process with clear proposal and steer from the Pre EA report	Pennine Acute Trust/ commissioner / CSU
Analysis results of engagement on completion of engagement	Identify from engagement any key concerns or worries connected to protected characteristics. Respond to key concerns/revise plans/ take	Pennine acute trust / Commissioner/ CSU Produce report make available to the public.

	mitigating actions	Feed report in to decision makers
Revise and produce final equality analysis report	Ensure final Equality Analysis report is completed and fed in to decision makers before final decision and any recommendations are fed in to the project specification. Check that it clearly shows how PSED is being met.	Pennine acute trust./ Commissioner Equality Analysis report to be published on line and made available to the public.

END of Pre-assessment.

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Public Health England

NHS England

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North West
Commissioning Support Unit

NHS England and Public Health England
North East Manchester
Diabetic Eye Screening Programme

STAKEHOLDER COMMUNICATIONS & ENGAGEMENT PLAN

Prepared by: Hilda Yarker, Strategic Consultant for Patient and Public Engagement, North West Commissioning Support Unit, on behalf of NHS England.

CONTENTS

1. Background Information

NHS Pennine Acute Hospital Trust's NE Diabetic Eye Screening Programme is commissioned by NHS England Lancashire and Greater Manchester Sub-Regional Team to deliver the National Diabetic Eye Screening service to the diabetic population of three CCGs, which are, Heywood, Middleton and Rochdale, Oldham and Bury. Since 2008 this has historically been delivered using a community based mobile service, utilising the movement of digital cameras from 16-17 clinic sites across the three LA Boroughs.

As part of the Quality and Assurance process for this screening service, regular visits are undertaken by the External Quality Assurance Team for Diabetic Eye Screening. Following the EQA visit in 2012 several recommendations were set out in the EQA Action Plan pertaining to quality and safety in reference to service delivery. Unfortunately due to a lack of dedicated programme management the delivery timescales have not been met and there is slippage in projected completion dates.

In November 2013, there was the intention to work through the outstanding recommendations of the EQA plan, particularly patients who had raised concerns about not being seen at the same site every year, fitness for purpose of the existing sites regarding accessibility and the service having to use sites based on availability. In addition, the lack of N3 connection was a key factor due to the frequent occurrence of sync failures which prevented the service being able to focus on the quality aspects essential for the service to improve. The recurrent problems with the frequent movement of the cameras resulted in patients appointments being cancelled on the day due to technical failures with the digital cameras.

In February 2014 following a serious incident in the programme, which was due to networking problems and the safe transfer of data, action needed to be taken to ensure that screening in the programme was safe, of the highest quality and adhering to the National Standards. It was critical that IT issues were addressed as soon as possible to maintain screening, previous service provision of 16-17 mobile sites were reduced as an **interim** measure to 6 static community based sites with N3 connections meeting the requirements of the Equality Act 2010.

The commissioners recognise that communication and engagements with patients who use this service was limited at the time of implementation of **interim** measure and are now seeking to rectify this by implementing the following three stages:

A. **Pre-Engagement -** with service users to inform the development of the business case for change and proposed options for a formal engagement process with patients/public and other key stakeholders, taking into account any patient insight/experience feedback which has been gathered by the

provider to date. This work to be undertaken in June 2015 and is dependent upon all parties playing an active role. Staff engagement, undertaken by Pennine Acute, will also need to take place during the pre-engagement phase.

B. **Formal Engagement** - on the commissioners proposed options is planned to commence following purdah in Mid-May 2015 and will last for 8 weeks (subject to OSC approval). Prior to formal engagement launch a presentation to the relevant Health Overview and Scrutiny Committees (3) needs to be scheduled to seek approval on commissioner's intentions and option plans and the communication and engagement plan. It is relevant at this stage to acknowledge that the three OSC's may decide on a different level of engagement and may call for a formal 12 week consultation process to be undertaken.

C. **Post-Engagement** – Audit and evidence of feedback from stakeholders produced for the commissioner to inform final decision. Commissioner will then seek to inform all participants of the outcome. A final Equality Impact Assessment to be produced. Projected timeframe for this is early August 2015, dependent upon the outcome of the engagement process.

2. Outline Project Plan with Timelines for Delivery

NHS England Diabetic Eye Screening Programme

Milestones	March	April	May	June	July	August	Sept
Develop Project Plan & Agree Key Milestones							
Form Communications & Engagement Sub-Group							
Develop & Agree TOR							
Organise & Plan Meeting Schedule							
Mapping Key Stakeholders & Creating Database							
Write & Agree Communications & Engagement Plan.							
Determine Communication Channels & Produce Relevant Materials							
Sent out 2,000 patient questionnaires as part of the pre-engagement process. Undertake staff engagement. Present findings to the commissioner to inform the Case for Change proposal.							
NHS England commissioner to present options paper to a Joint Health Overview & Scrutiny Committees for approval and sign off							
Launch full Engagement With Patient, Public & Key Stakeholders							
Produce Consultation Feedback Report For Commissioners With Full Analysis							

3. Delivery of Patient, Public and Stakeholder Engagement

An initial approach will be made to the three CCG Accountable Officers in Bury, Oldham, Heywood, Middleton and Rochdale (HMR) to be undertaken by the Lead Commissioner in April 2015, to determine collaborative arrangements during the process. A regular bulletin of progress will be shared with CCG Boards via email to the Accountable Officer (or other relevant member of staff as determined by each CCG). In terms of the engagement of key stakeholders, the stakeholder groups that are being targeted are: Patients, public and locality key stakeholders, HealthWatch organisations across the three CCG localities, Third Sector organisations, Health and Wellbeing Boards, OSC Committees and local MPs at the discretion of each local CCG. The pre-engagement work will begin immediately following purdah (May 9th) with a projected formal engagement stage beginning in early June 2015.

A formal Communications and Engagement Sub-Group will be formed in April and Chaired by the Strategic Engagement Lead, members to include the following:

➢ Lead Commissioner (GMAT)	Audrey Howarth
➢ Strategic Engagement Lead (NWCSU)	Hilda Yarker
➢ Strategic Communications Lead (NME)	Amanda Stocks
➢ Head of Communications (PAT)	Andrew Lynn/Toby Jenkinson
➢ Programme Manager (PAT)	Tanveer Kausser
➢ Directorate Manager (PAT)	Rachel Scott
➢ HealthWatch Managers	Kate Jones Mafooz Bibi Peter Denton
➢ Senior Equality and Diversity Lead	Andy Wood Naheed Nazir
➢ Operational Programme Support	Ruth Molloy/Simon Platt
➢ Project Officer Support	Helen Kavanagh
➢ Patient Representatives x 3	Janet Lees Marian Cornes Geoff Goldberg
➢ Bury CCG	Alison Mitchell
➢ Oldham CCG	Via Email
➢ HMR CCG	Phil Burton

Members of the Communications and Engagement Sub-Group have a significant role to play in ensuring all agreed actions are undertaken in a timely manner in order for the process to progress. All members are encouraged to send a representative to the meeting if they themselves are not available. All members are responsible for delivery of key actions they agree to undertake.

The table below highlights the responsible lead for each engagement activity. The Project Officer will be responsible for the distribution of all communications via the development of a robust database.

The Communications and Engagement Sub-Group will form part of the overall governance structure of the programme and will report directly into the NHS England Screening and Immunisation Executive Group within the Lancashire and Greater Manchester Sub-Regional Team.

The first meeting of the Communications and Engagement Sub-Group will be held at the Greater Manchester Sub-Regional Team offices at:

3 Piccadilly Place
4th Floor
Manchester
M1 3BN

A discussion will take place at the first meeting to determine the most convenient venue for all future meetings. Meeting schedule will be every two/three weeks, all members are encouraged to attend or send a deputy.

Equality Impact Assessment

An initial Equality Impact Assessment (EIA) has been undertaken by Pennine Acute Trust in advance of **interim** measures being implemented. A further EIA will need to be undertaken during the pre-engagement phase of the programme in order to inform the business case for change and the options presented at formal engagement.

Central Communications, Provider and Locality Lead Support

- Central communications will be provided by the Strategic Lead for Communications within the NHS England North & Midlands Hub to ensure timely responses to any potential reputational damage, respond to MPs correspondence and strategic sign-off on all direct media responses. The production of all generic communication material, including the development of a web-based platform for patient and public engagement responses during the formal engagement phase will be provided by NWCSU. This will include the production of an online survey for utilisation during the formal consultation period. All social media communications will be the responsibility of NWCSU.

- Locality Communication and Engagement leads will form an integral part of the pre-engagement and formal engagement process. Once approval is sought from each of the CCGs the C&E leads from Oldham, Bury and HMR will be invited directly to form part of the C&E sub-group. Their input will be fundamental to the successful delivery of the programme within the specified timeframe. Access to local information in respect of key stakeholders, third sector, patient groups/forums etc will form part of a developing database which will be utilised for all communication and engagement activity.

- Provider communications will also form an integral part of the pre-engagement and formal engagement process as well as undertake staff engagement to inform the preferred options for consideration. In addition provider communications will support the sub-group in providing a **helpline** during the formal engagement process to support patients who do not have online access to complete the survey

- HealthWatch and Patient Representatives on the C&E sub-group will form an integral part of the pre-engagement, formal engagement and post-engagement process. Their role is to ensure transparency of the process, provide representative input on behalf of patients and the public to the communications and engagement plan, and alert the C&E sub-group to wider opportunities for PPI engagement. Support the delivery of 3 local events to launch the formal process to enable as many individuals as possible to respond.

- Senior Equality and Diversity expertise on the C&E sub-group is intrinsic to the programme to ensure full compliance by the commissioner and provider to the Equality Act and to undertake a full EIA service during the process.

4. Leadership for Communications and Engagement

Pre-Engagement

Activity	Action	Lead Officer	Timeframe
C&E Sub-Group	Invite attendees, schedule meetings, write 'draft' plan for consideration and sign off, provide project officer support.	Hilda Yarker	March/early April
Key Stakeholders	Begin mapping of all key stakeholders, develop generic database for all communications activity.	C&E Sub-group supported by Project Officer. Support from CCG C&E Leads, Provider, HealthWatch and Patient Representatives.	Early May
Undertake pre-engagement via a structured questionnaire disseminated by Pennine Acute. Questionnaire to be sent to 2,000 diabetic patients. Members of the C&E sub-group to	An early engagement event has already taken place at the end of February, hosted by HW Rochdale and summary report provided to the commissioner by HW Rochdale.	Hilda Yarker/Audrey Howarth with support from HW and locality C&E Leads.	May

disseminate online survey details as widely as possible during the pre-engagement phase.			
Pre-Engagement Feedback from the survey.	Survey results produced and submitted to the commissioner to inform business case and options for future service delivery model.	Hilda Yarker	July
Staff Engagement	Pennine Acute undertake staff engagement and produce a report for commissioner to inform business case for change and options for future service delivery model.	Pennine Acute	July
Submit Plans to Joint Health Overview and Scrutiny Committees (	Prepare all documentation for consideration and approval from Joint OSCs. Ensure place on the agenda in advance of submission.	Audrey Howarth/Hilda Yarker	July

Formal Engagement

Activity	Action	Lead Officer	Timeframe
Following Joint OSC approval undertake an official launch of the formal engagement process holding 3 events across the 3 localities.	Invite all key stakeholders to 3 location events within the same week to launch the formal engagement process	Hilda Yarker/Audrey Howard/Tanveer Kausser	July/Aug
Ensure all communications mechanisms are functional and in place in time for the launch events	Communication leads to collaborate and embed/test agreed communication methodologies in time for launch events	Operational Communication Leads	July/Aug
Establish Freephone telephone helpline	Pennine Acute to establish a Freephone telephone helpline to gather patient/public feedback during the formal engagement period.	Andrew Lynn, Toby Jenkinson/Tanveer Kausser This needs further discussion with PAT as not enough resource to fund helpline for all 38k pts	June/July
Monitor responses.	Provide a weekly response report to monitor progress and determine if further communication is required to increase numbers.	Audrey Howarth/ Hilda Yarker/Tanveer Kausser/ Helen Kavanagh	August/Sept
Ensure wide communication to advertise the engagement opportunity.	To ensure a wide reach across the three localities utilise regular communications bulletins, social media and face to face opportunities to promote engagement.	Communication Leads, HealthWatch, 3rd Sector, Patient Representatives.	August/Sept
Strategic Communications	Prepare responses to media enquiries	Amanda Stocks/Andrew Lynn	August/Sept

Post-Engagement

Activity	Action	Lead Officer	Timeframe
Collate all feedback and analyse findings.	Produce final engagement report for commissioner.	Hilda Yarker	End of consultation (yet to be determined)
Final outcome report	Commissioner to produce outcome of the service review.	Audrey Howarth	TBC
Feedback to patients/public & key stakeholders	Communicate the outcome of the formal engagement process and service review	Pennine Acute	Following final outcome.
Inform Joint OSC's of final outcome of the process.	Submit final report and outcome of the review.	Audrey Howard	Following final outcome.
Implement new service.	Commissioner and Provider to implement new delivery model based upon final decision.	NHS England/ Pennine Acute	TBC
Equality Impact Assessment	NHS England commissioner to undertake an EIA	Andy Woods/Naheed Nazir	TBC

5. Range and Reach for Stakeholder Engagement

Target Audiences

The approach to communication and engagement aims to be comprehensive and robust. The aim of the sub-group is to work closely with key organisations that can easily communicate with a range of audiences within their networks as follows:-

- DESP Service users
- Third sector providers
- Voluntary Patient Groups
- Charities
- HealthWatch Organisations
- Council for Volunteer Service network
- Greater Manchester Clinical Senate
- Chairs and Chief Officers of Clinical Commissioning Governing Bodies
- CCG Directors of Commissioning
- GP's member practices of CCGs.
- Local Authority Health Joint Overview and Scrutiny Committees
- Local parish councillors and borough councillors
- Members of Parliament for constituent localities
- Directors of Public Health
- Health and Wellbeing Boards
- Relevant media

Engagement Channels

Stakeholder engagement will be carried out through a range of channels to promote and explain the purpose and progress of the review, including:

- Attendance at Joint Health Overview & Scrutiny panel
- Presentation to CCG Directors of Commissioning
- Presentation to LA Directors of Public Health
- Presentation to Clinical Senate
- 3 Locality Events to launch formal engagement phase
- Focus Group with Service Users
- Targeted communication to service users
- Service User Survey (Online)
- Staff Event
- Staff Survey (Online)
- Targeted letters and emails

- Newsletters information within Hospital Trust membership publications
- Internal staff briefings
- Web based consultation information and online survey
- Dedicated phone line (to be confirmed with Pennine Acute)?
- Targeted media communications.
- Audio version (to be discussed with the commissioner)?

The following key messages will be covered in all communications to all stakeholders and will form part of the outline business case for change and options proposal:

- The need for change
- Why is this a priority
- Who it would affect
- What are the benefits
- What this would mean to current service users
- How would be implemented
- What are the timescales
- What can you influence
- What are your views on this proposal

In order to be effective the communications and engagement plan may need to adapt over time to reach our target audiences in the most effective way. Progress against the key milestones will be monitored.

Local Patient and Public Meetings

It is recognised in planning the formal engagement launch events, the local knowledge of the CCG Communication and Engagement Leads, HealthWatch and 3rd sector colleagues will be intrinsic to the success of these planned events. In addition, the ability of the provider to ensure robust engagement with a significant patient cohort is also intrinsic to the success of the review.

Clinical Engagement

- <u>Board Level</u>
  CCG Chief Officers and Governing Body boards will be provided with regular updates on the progress of the review via an e-bulletin.

- GPs Practice Managers will also receive a copy of the e-bulletin for internal dissemination.
-

- Public Health/Health and Wellbeing Boards
  Health and Wellbeing Boards will also receive a copy of the e-bulletin to ensure they are regularly kept up to date with progress, (subject to being fully briefed by the project and having agreement from Directors of Public Health who sit on Health and Wellbeing Boards).

Political Engagement

Overview and Scrutiny/Health Select Panels will be sent the overview paper, full documentation summaries, and the link into the service review document in addition to a formal presentation to determine the length of the formal engagement process.

Informing local MPs will be at the discretion of the CCG, many of whom have meetings with MPs and this could be included for information as part of those discussions, to be advised by CCG Communications and Engagement Lead?

6. Leaving Feedback

Patient/Public and wider stakeholder respondents will be able to leave their feedback via either of the following ways:-

- Online – by visiting the Pennine Acute website and follow the link to an online survey and where they can read in more detail about the full service review.

- If people do not have access to the internet a freephone helpline number will be provided on all of the documentation. This service will be provided via Pennine Acute?

- For patients who have sensory impairment and if English is not their first language or they require the information in an alternative format, they will need to contact the freephone number for assistance.

7. Audit and Evidence of Stakeholder Engagement

Audit and evidence of engagement is an essential requirement in any engagement process. The CSU will hold this on behalf of the commissioner.

The audit trail requirements are established to support any potential challenge on who was included in the engagement and when, this will act as robust evidence to the process and is required to be available upon request.

Public Health England

NHS England

NHS

North West
Commissioning Support Unit

NHS England and Public Health England
North East Manchester
Diabetic Eye Screening Programme

STAKEHOLDER ENGAGEMENT ACTIVITY PLAN
August 2015

Prepared by: Hilda Yarker, Strategic Consultant for Patient and Public Engagement, North West Commissioning Support Unit, on behalf of NHS England.

Stakeholder Group	Action/Lead Officer
Patients and Public	
Web content publication date is **3rd August 2015** The items to be uploaded are: • Pennine Acute Website – 1. Future Service Delivery Options proposal. 2. Summary overview 3. Link to online survey 4. Details of helpline	Summary overview – AH Options Proposal – AH Online survey link - HY
PPGs / Health Forums/Patient Groups etc across each of the three CCG areas.	Communication information disseminated via the CCG Communications and Engagement Teams.
Diabetic Patients – Pennine Acute Pennine Acute to include additional information in all of the appointment letters which are sent during the formal engagement period (cira 1,000 per week). Letters will provide an overview, a link to the online survey and details of the helpline where patients can call and the internal team will complete the survey online on their behalf. Patients who attend for their retinopathy review during the formal engagement period will be provided with the opportunity to respond when attending clinic and whilst waiting for their appointment.	TK/HY/AH/RM/HK/
3 Stakeholder events being held to launch the formal process. These will take place across the 3 CCG localities at time and venue below: 4th August 2pm – 7pm Middleton Masonic Hall 5th August 2pm – 7pm Oldham Elizabeth Hall 6th August 2pm – 7pm Bury masonic Lodge Available to stakeholders at the event: Future Service Delivery Options proposal. Summary overview Link to online survey Details of helpline	AH/HY/RM/TK/HK

Young Diabetic Patients Circulate information to the Young Diabetic Patients Network	HY/HK
Social Media Daily twitter feed with links to online survey and relevant information. Encourage dissemination across other Social Media channels.	All members of the sub-group who have access to social media.
Diabetic Networks Disseminate relevant information across known Diabetic Networks in all 3 CCG localities	All members of the sub-group.
Third Sector Organisations	
All information disseminated via VSNW and GMCVO network	HY/HK
All information disseminated via the Council for Voluntary Services	HY/HK
Healthwatch - – Disseminate information via their known networks	HY/HK and HW Lead
Disability/ Carer Organisations Disseminate information via known networks	All members of the C&E sub-group.
Clinical Engagement	
CCG Boards	NHS England Commissioner
GPs	Communication Bulletin via CCGs
Stakeholder Group	**Action/Lead Officer**
Provider	TK/NN
Clinical Quality/Governance Committees	AL/TJ
Health & Wellbeing Boards	NHS England Commissioner
Political Engagement	
Joint Overview & Scrutiny Committee	NHS England Commissioner
MPs	At the discretion of NHS England and the CCGs
Media Engagement	
Advertise via relevant media channels as determined by the media leads within the C&E sub-group.	AS/TJ/AM/PB