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1. Acknowledgements

NHS England and NHS North West Commissioning Support Unit would like to express their thanks to the following for their support in implementing the Communication and Engagement Strategy and Operational Plan during the review of the North East Manchester Diabetic Retinopathy Eye Screening Service:

- Pennine Acute Hospitals NHS Trust
- NHS Oldham Clinical Commissioning Group
- NHS Bury Clinical Commissioning Group
- NHS Heywood, Middleton and Rochdale Clinical Commissioning Group
- Diabetic Retinopathy Screening Action Group
- Healthwatch Rochdale
- Healthwatch Oldham
- Healthwatch Bury
- NHS England Communications Hub (North)
- Bury Diabetic Retinopathy Network
- Greater Manchester Council for Voluntary Organisations
- Greater Manchester Voluntary and Community Sector Organisations
- ICE Creates

Extended thanks also go out to all the members of the public, patients and carers who took the time to take part in the formal engagement process and complete the on-line survey. It had been identified at the beginning of this project that this was a complex undertaking across the 3 localities in North East Manchester and involving 39,000 diabetic patients. Every effort was taken to ensure that the formal engagement process was supported by summary documentation that provided a clear/understandable, easy to navigate process to enable public comment.

During the formal engagement process (2nd August – 30th August 2015) this collaboration across the Pennine Acute footprint resulted in 1,311 patients, carers and key stakeholders visiting the dedicated website www.nemdesp.co.uk and 1,234 respondents completing the online survey.

Twitter analytics for the duration of the engagement timescale resulted in:

- 58 tweets
- 502 profile visits
- 10.8k impressions
- 51 retweets
- 25 link clicks
- Average 2 retweets per day
2. Executive Summary

Pennine Acute Hospital NHS Trust North East Manchester Diabetic Eye Screening Programme is commissioned by NHS England Lancashire and Greater Manchester 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.

Following the introduction of interim measures in February 2014, which resulted in the reduction of clinical sites for screening from 16/17 to 6, NHS England commissioners, in recognition of their statutory duties, agreed to undertake a communication and engagement exercise with patients, carers and key stakeholders. The communication and engagement methodology implemented followed the recognised process as detailed below:

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.

B. **Formal Engagement** - on the findings of the pre-engagement exercise and options agreement by commissioners. Formal sign-off sought from the Joint Overview and Scrutiny Committee.

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. Final submission to the Joint Overview and Scrutiny Committee.

At the launch of the formal engagement process, four half-day drop-in sessions across Heywood, Middleton & Rochdale, Bury and Oldham were held in addition to engagement across clinic sites during the engagement period.

The aim of these sessions was to raise local awareness of the proposed changes to North East Manchester’s Diabetic Eye Screening Programme and provide information about those changes so that local people and patients could make an informed choice as to where they would prefer local diabetic eye screening services to be provided in the future and share their views via a survey. The survey was available online via a dedicated website [www.nemdesp.co.uk](http://www.nemdesp.co.uk) as well as in hard copy format within the “North East Manchester Diabetic Eye Screening Programme Review’ brochure.
Local people, patients, those who accompanied them to eye screening appointments and other stakeholders were able to take the survey online (via iPads) or using the printed version at the four drop-in sessions, as well as the clinics during the engagement period.

The four drop-in sessions took place at Middleton, Oldham, Bury and Rochdale during August 2015. They each ran from 2pm up until 7pm to allow for those who were working to pop in after work. All venues were easily accessible and within walking distance of town centres and all had close public transport links. Refreshments were provided at all sessions and a broad range of stakeholders dropped in, including:

- Patients
- Carers
- Family members
- Staff
- Local councillors
- Representatives from NHS England
- Representatives from Pennine Acute Hospitals NHS Trust
- Private Ophthalmologists
- Representatives from Public Health England

Coverage on Twitter reached 10.8k impressions and a total of 1,234 responses were received via the online survey.

Further comments and feedback from the first three drop-in sessions can be found on Steller Story: [https://steller.co/s/4jUz2pp8XEa](https://steller.co/s/4jUz2pp8XEa)
The dedicated website www.nemdesp.co.uk was set up to provide information about the future provision of diabetic eye screening services in North East Manchester. This included information regarding the two alternative options for the future location of eye screening services, the online survey itself and a Twitter feed.

The website analytics from the period of the engagement campaign (2nd – 30th August 2015) were:

- 287 visitors across a total 589 visitors
- 52.5% new visitors and 47.5% returning visitors
- 1,311 page views

See Google analytics overleaf:
In addition to the website, a dedicated twitter account was set up, from which @NEMDESP was tweeted for the duration of the engagement campaign (2nd August – 30th August), promoting the drop-in sessions and signposting people to the survey and further information on the website: www.nemdesp.co.uk

Twitter analytics over these timescales were:

- 58 tweets
- 502 profile visits
- 10.8k impressions
- 51 retweets
- 25 link clicks
- Average 2 retweets per day.
Survey Response Levels

The survey received a total of 1,234 responses:

The increased levels of responses in latter days of the survey were as a direct result of increase engagement activity directly within the eye screening clinics. The response rates were being monitored on a day by day basis and mitigating actions were agreed in a final push to increase response rates.

Respondents were given two options to choose from:

Option A: to have 10 screening sites across the three localities, Oldham, Bury, Heywood, Middleton and Rochdale.

The additional sites to be considered were:

- Heywood
- Prestwich
- Failsworth
- Saddlesworth

Option B: to have 12 screening sites across the three localities, Oldham, Bury, Heywood, Middleton and Rochdale

- Heywood
- Prestwich
The preferred Option was B

The results showed that 50% of respondent had a preference for Option B, 12 screening sites. Some 22% of respondents chose Option A, 10 screening sites and a further 28% expressed no preference at all.

A qualitative analysis of the comments suggested that the rationale for respondents who chose Option A was ease of access and travel and a number specified clearly that ‘Prestwich’ was a preferred choice of screening venue. However, on further analysis of comments, those who responded Option B, also stated ease of access and travel accessibility motivated their response with further reference to ‘Prestwich’ being a preferred screening site. There did appear to be some confusion as respondents had not noted that ‘Prestwich’ was in both options.

There were a limited number of comments (3) from respondents who stated that ‘efficiency’ and ‘cost savings’ motivated their selection of a cheaper/ lesser option.
3. Formal Engagement Process

At the beginning of the Diabetic Eye Screening Programme review a Communications and Engagement (C&E) Sub-Group was established to support the design and deliver of the C&E Strategy and Action Plan.

The group met on a regular basis throughout the project and worked collaboratively to undertake the pre-engagement activity and the formal engagement process. Members of the group consisted of:

- Lead Commissioner (NHSE) : Audrey Howarth
- Strategic Engagement Lead (NWCSU) : Hilda Yarker
- Strategic Communications Lead (NHSE) : Amanda Stocks
- Head of Communications (PAT) : Andrew Lynn/Toby Jenkinson
- DESP Programme Manager (PAT) : Tanveer Kausser
- HealthWatch Managers
- Rochdale
  - Kate Jones
- Bury
  - Mafooz Bibi
- Oldham
  - Peter Denton
- Senior Equality and Diversity Lead (NWCSU) : Andy Wood
- Equality and Diversity Lead (PAT) : 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 C&E Lead : Alison Mitchell
- Oldham CCG C&E Lead : Mark Drury (email)
- HMR CCG C&E Lead : Phil Burton
- Rochdale MIND : Shahida Samreen

In June 2015 a pre-engagement exercise was undertaken to understand the views of patients and staff on the impact which they had felt since the introduction of the **interim** measures. Some 2,000 questionnaires were sent by post to a representative sample of diabetic patients with paper copies of the questionnaire and an enclosed pre-paid envelope. Respondents were also signposted to an online survey if they wished to respond to the survey directly on line. The exercise resulted in 777 responses with 70% of respondents saying that they were happy with the current clinic they were attending. The vast majority of the 30% of patients who were not happy cited distance/travel as being the main barrier to them attending a different venue for their annual screening.

When patients were asked if they were aware of the choice of screening venues available to them, 60% stated that they were aware they had a choice and 40% stated that they were unaware of the choice. When patients were asked if they would prefer an early evening or
weekend appointment, 40% said that they would like the option of an early evening appointment and 34% stated that a weekend choice would be preferable. The vast majority of respondents were aged between 50 and 79 years old with an equal distribution of male and female respondents.

The staff pre-engagement exercise was undertaken by Pennine Acute and involved all staff who delivers the diabetic screening service. When asked if they understood the rationale for introducing interim screening sites, 80% said they understood why with 20% stating they did not. When asked if staff found that patients were less happy with the change of venue, 60% of staff said that patients had raised concerns, mostly attributed to distance of travel and access to good public transport.

Copies of both survey reports are available on request.

The patient pre-engagement feedback from both patients and staff were collated and utilised to inform NHS England commissioner’s decision when agreeing the options for consideration during the formal engagement process. NHS England commissioners wrote and presented their business case options paper to a Joint Overview and Scrutiny Committee on 28th July 2015 with support from representatives from Pennine Acute Hospitals NHS Trust. Two options were being proposed for consideration by patients, key stakeholders and wider comment from members of the public and after much discussion the JOSC agreed for a 4 week formal engagement period to take place from 2nd – 30th August, 2015. JOSC requested that Rochdale be considered as an additional engagement event. As a result Rochdale Town Hall was booked for an engagement event on the 20th August.

The Communications and Engagement Action Plan was then implemented with input from all members of the C&E sub-group. The following engagement methods were agreed and actioned:

- Agree questions and establish an online survey.
- Establish a dedicated web address and signpost patients/key stakeholders etc.
- Establish a dedicated helpline number for patients who chose not to complete the survey online or who did not have access to the internet.
- Establish a twitter account to communicate engagement opportunity
- Establish and email address for patients to leave comments and for patients to request a paper copy of the survey with a pre-paid envelope.
- Staff within the screening clinics to directly engage with patients and encourage them to complete the survey online via an IPad at the clinics.
- Direct support from ICE Creates and NWCSU at screening clinics to capture views.
- Offer all documentation in other languages and formats via a dedicated number.

The aim of the engagement sessions was to raise local awareness of the proposed changes to North East Manchester’s Diabetic Eye Screening Programme and provide information about those changes so that local people and patients could make an informed choice as to
where they would prefer local diabetic eye screening services to be provided in the future and share their views via the survey.

The survey was available online via a dedicated website as well as in hard copy format within the “North East Manchester Diabetic Eye Screening Programme Review” brochure. Local people, patients, those who accompanied them to eye screening appointments and other stakeholders were able to take the survey online (via iPads) or using the printed version at the four drop-in sessions and clinic sites.

The four drop-in sessions took place at Middleton, Oldham, Bury and Rochdale during August 2015. They each ran from 2pm up until 7pm to allow for those who were working to pop in after work. All venues were easily accessible and within walking distance of town centres, with close public transport links. Refreshments were provided at all sessions and a broad range of stakeholders dropped in: patients, carers and family members, staff, councillors and representatives from NHS England, Pennine Acute Hospitals NHS Trust, private optometrists and Public Health England.

Coverage on Twitter reached 10.8k impressions, and we had a total of 1,234 responses to the survey.

Further comments and feedback from the first three drop-in sessions can be found on Steller Story: https://steller.co/s/4jUz2pp8XEaa
Attendance at Diabetic Eye-screening Clinics

NEDESP programme staff plus other engagement support staff spent time at the 6 screening locations engaging with patients and their carer’s. Time was spent explaining the process and rationale and then help was given (where needed) to fill in the questionnaire either on line or as a paper copy.

Media Coverage
A press release was sent out by Pennine Acute Hospitals NHS Trust, and the story was picked up by the local press.

Twitter
A dedicated twitter account @NEMDESP was set up, from which we tweeted for the duration of the engagement campaign (2\textsuperscript{nd} August – 30\textsuperscript{th} August), promoting the drop-in sessions and signposting people to the survey and further information on the website: 
www.nemdesp.co.uk . Twitter analytics over these timescales were:

- 58 tweets
- 502 profile visits
- 10.8k impressions
- 51 retweets
- 25 link clicks
- Average 2 retweets per day.
Website

A dedicated website [www.nemdesp.co.uk](http://www.nemdesp.co.uk) was established up to provide information about the future provision of diabetic eye screening services in North East Manchester. This included information regarding the two alternative options for the future location of eye screening services, the online survey itself and a Twitter feed.

The analytics from the period of the engagement campaign (2\textsuperscript{nd} – 30\textsuperscript{th} August 2015) were:

- 287 visitors across a total 589 visits
- 52.5% new visitors & 47.5% returning visitors
- 1,311 page views.

Stakeholder Activity Plan

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Action/Lead Officer</th>
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<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td>Web content publication date is 2\textsuperscript{nd} August 2015</td>
<td></td>
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<tr>
<td>The items to be uploaded are:</td>
<td></td>
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<tr>
<td>• Pennine Acute Website –</td>
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<tr>
<td>1. Future Service Delivery Options proposal.</td>
<td></td>
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<tr>
<td>2. Summary overview</td>
<td></td>
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<tr>
<td>3. Link to online survey</td>
<td></td>
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<tr>
<td>4. Details of helpline</td>
<td></td>
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<tr>
<td>PPGs / Health Forums/Patient Groups etc across each of the three CCG areas.</td>
<td>Communication information disseminated via the CCG Communications and Engagement Teams.</td>
</tr>
<tr>
<td>Diabetic Patients – Pennine Acute</td>
<td>NHS England</td>
</tr>
<tr>
<td>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.</td>
<td>Pennine Acute NWCSU</td>
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<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>4 Stakeholder events being held to launch the formal process. These will take place across the 3 CCG localities at time and venue below:</td>
<td>NHS England Pennine Acute NWCSU</td>
</tr>
<tr>
<td>4th August 2pm – 7pm Middleton Masonic Hall</td>
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<tr>
<td>5th August 2pm – 7pm Oldham Elizabeth Hall</td>
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<tr>
<td>6th August 2pm – 7pm Bury masonic Lodge</td>
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<tr>
<td>20th August 2pm-7pm Rochdale Town Hall</td>
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<tr>
<td>Available to stakeholders at the event: Future Service Delivery Options proposal. Summary overview Link to online survey Details of helpline</td>
<td></td>
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<tr>
<td>Young Diabetic Patients</td>
<td>NWCSU</td>
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<tr>
<td>Circulate information to the Young Diabetic Patients Network</td>
<td></td>
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<tr>
<td>Social Media</td>
<td>All members of the sub-group who have access to social media.</td>
</tr>
<tr>
<td>Daily twitter feed with links to online survey and relevant information.</td>
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<tr>
<td><strong>Encourage dissemination across other Social Media channels.</strong></td>
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<tr>
<td><strong>Diabetic Networks</strong></td>
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<tr>
<td>Disseminate relevant information across known Diabetic Networks in all 3 CCG localities</td>
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<tr>
<td>All members of the sub-group.</td>
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<tr>
<th><strong>Third Sector Organisations</strong></th>
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<tbody>
<tr>
<td>All information disseminated via VSNW and GMCVO network</td>
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<tr>
<td>NWCSU</td>
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<tr>
<td>All information disseminated via the Council for Voluntary Services</td>
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<td>NWCSU</td>
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<tr>
<td>Healthwatch – –</td>
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<tr>
<td>NWCSU</td>
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<tr>
<td>HW Managers</td>
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<tr>
<td>Disseminate information via their known networks</td>
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<tr>
<td>All members of the C&amp;E sub-group.</td>
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<thead>
<tr>
<th><strong>Clinical Engagement</strong></th>
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<tbody>
<tr>
<td>CCG Boards</td>
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<tr>
<td>NHS England Commissioner</td>
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<tr>
<td>GPs</td>
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<tr>
<td>Communication Bulletin via CCGs</td>
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<thead>
<tr>
<th><strong>Stakeholder Group</strong></th>
<th><strong>Action/Lead Officer</strong></th>
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<tr>
<td>Provider</td>
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<td>Pennine Acute</td>
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<tr>
<td>Clinical Quality/Governance Committees</td>
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<td>Pennine Acute</td>
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<tr>
<td>Health &amp; Wellbeing Boards</td>
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<tr>
<td>NHS England Commissioner</td>
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<tr>
<th><strong>Political Engagement</strong></th>
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<tbody>
<tr>
<td>Joint Overview &amp; Scrutiny Committee</td>
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<tr>
<td>NHS England Commissioner</td>
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<tr>
<td>MPs</td>
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<tr>
<td>At the discretion of NHS England and the CCGs</td>
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<tr>
<th><strong>Media Engagement</strong></th>
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<tbody>
<tr>
<td>Advertise via relevant media channels as determined by the media leads within the C&amp;E sub-group.</td>
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<tr>
<td>NHS England</td>
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</tbody>
</table>
Information Dissemination across Bury, Oldham, Heywood, Middleton and Rochdale (as submitted by C&E sub-group members).

- 117 GP Practices covering all 3 Clinical Commissioning Groups
- Rochdale Borough Council Communications team
- Link for Life Rochdale
- Healthwatch Rochdale
- Rochdale Law Centre
- Rochdale Mind
- Rochdale Borough User-Wide Forum
- Gateway Leisure
- Rochdale Cycling Club
- Spring Hill Hospice
- Lighthouse Project
- Rochdale Dawah Centre
- Rochdale CSS
- Rochdale Community Transport
- Rochdale Connections Trust
- The Junction Community Group
- Disability Network Rochdale
- The Spinal Foundation
- Petrus Rochdale
- Stepping Stone Projects
- Sanctuary Trust
- People Print Community Media
- Spiral Dance
- Pride Media Association
- KYP
- Rochdale Community Support Trust
- Rochdale Women’s Welfare Association
- BME Dementia Carers Support Group
- Castlemere Community Centre
- Alzheimer’s Society (North West)
- 7 x local mosques Patient Participation Groups
- Bury Third Sector Development Agency for onward sharing with 300 plus VCS organisations including ADAB (BME communities) and Big in Bury (mental health)
- Bury Customer Task Force (Bury Council)
- CCG Patient Cabinet members (x13)
- Bury Councillors via Bury Council Communications Team (x51)

Diabetic Retinopathy Action Group:
• All Heywood GP surgeries were informed by Group members of the Consultation period, apart from, Birtle View and York Street.
• Posted in detail on the Diabetic Retinopathy Action group page, including details of the four events during the month of August.
• Posted on the two group pages on Facebook, Remembering Heywood and Heywood Town, both of which have a huge following locally. We also posted reminders for the events on all three Group pages.
• Members of our Steering Group took copies for the survey to three or four Homes for the Elderly in Heywood, and also to the same amount of Warden controlled flats. The completed surveys from these locations.
• Placed a few copies of the survey in Tilly's Tea Rooms in Heywood Centre.
• The seven members of the steering Group also verbally made as many people as possible aware of the events and the online survey during the four week consultation period. We feel we gave it as much coverage as we possibly could, and have had quite a good response.
• Contact was mad with the local newspaper the Heywood Advertiser. Also we contacted Amy Westlake, reporter for Rochdale on line.

Healthwatch Bury distribution:

• Bury Third Sector Group – membership of 250
• Healthwatch Bury Membership – 65 which includes the following organisations
  • Citizens Advice Bureau
  • Bury Coalition for Independent Living
  • Rethink
  • Homestart Bury
  • Bury Hospice
  • Bury Council
  • BURY Involvement Group
  • Bury College
  • Age UK
  • Groundworks
  • Bury Blind society
  • Communic8te

Additional organisations

• Bury Gateway
• Christian Muslim Forum
• Creative Living
• Bury Housing Concern
• Bury Carers
• Civil Service Pension Alliance
• Bury Asian Women’s Group
The formal engagement process concluded on 30th August 2015 and resulted in 1234 respondents completing the survey. Analysis of the feedback can be found in the following section of this report.
4. Online Survey Feedback

Formal Engagement Analysis

Question one of the survey asked for the respondent’s postcode.

Question two asked respondents which of the options presented they preferred.

Option A – move to 10 sites for the eye screening service.
Option B - move to 12 sites for the eye screening service.
Some 50% of respondent chose Option B, 28% had no preference and 22% chose Option A. In looking at the reasons why option A was selected, of those that offered comments, the comments focussed on issues around the need for ease of travel and wanting ‘Prestwich’ as a choice of venue. However and confusingly ‘Prestwich’ is also a choice offered in Option B.

There were only 3 comments from those that selected Option A relating to ‘efficiency’ and ‘cost savings’.

There appears to have been an issue of clarity in the wording and presentation of the options proposal as respondents who selected Option A, citing the need for a service in Prestwich had clearly not picked up on the fact that Prestwich was also included in Option B. One could assume that they made the selection prior to reading Option B. If an adjustment was made for this then more people would have selected Option B, pushing it towards a high 60 to 70% agreement.
In spite of this confusion, there did seem to be a positive choice for option B - 12 sites.

When respondents were asked in Question 3 why they had chosen their preferred option there were a varied range of responses with many citing the reasons below:

- Accessibility by public transport
- Choice
- Nearer to home
- Free parking at some of the sites
- Cost saving as travel is reduced
- Independence and not having to rely on relatives to get to clinics
- Less stressful
- More supportive of those with mobility issues
- Patients more likely to not miss appointments when screening is so important

Question 4 asked respondents if the additional venues would improve the service, 82% of respondents felt that increasing the number of venues would improve the service whilst 6% said no and 12% said they were unsure if this would improve the service. The respondents who thought No did not leave a reason why they thought this. The 82% who said Yes, gave the same reasons as listed above.

Finally, when respondents were asked what other aspects might further improve the service 77% said no further improvement needed, but 23% stated that they did think further improvements were needed or that they had other concerns.

These were listed as:

- The service was not well organised.
- Communication was poor; the size of the print on letters is too small to read.
- No welcome on reception when patients arrive.
- Evening and weekend access would be most helpful.
- Service can be rushed on occasions.
- Car parking was always an issue.
- Why can’t this be done in the GP practice?
- Number of buses and connections not always on time.
- Vision board is too small?
- Improvement needed for wheelchair access.
- Staff ratio to patients needs improving, staff very rushed.
- Having to take time of work to attend.

Overall though the vast majority of patients (82%) rated the service as Excellent or Good with many commenting on how wonderful staff are who deliver the service.
Protected Characteristic profile of respondents

As a matter of course all protected characteristics are requested, this ensures that an assessment can be made on participation and that those affect by the issue can respond to the issue. This helps to spot any group that looks to be missing or excluded for the consultation process. Secondly; some protected characteristics are more relevant in certain situation; in relation to this exercise then the key protected characteristics are: sex, disability and ethnicity.

Gender

The responses based on gender were evenly distributed so no preference of option or any identified barriers were linked to male or female respondents.
### Ethnicity

The following table shows the ethnic group of respondents in the 2001 and 2011 censuses in Greater Manchester.

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<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>White: British</td>
<td>2,183,096</td>
<td>87.95%</td>
</tr>
<tr>
<td>White: Irish</td>
<td>42,646</td>
<td>1.72%</td>
</tr>
<tr>
<td>White: Gypsy or Irish Traveller [note 1]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White: Other</td>
<td>34,765</td>
<td>1.40%</td>
</tr>
<tr>
<td><strong>White: Total</strong></td>
<td><strong>2,260,507</strong></td>
<td><strong>91.06%</strong></td>
</tr>
<tr>
<td>Asian or Asian British: Indian</td>
<td>95,901</td>
<td>4.45%</td>
</tr>
<tr>
<td>Asian or Asian British: Pakistani</td>
<td>75,187</td>
<td>3.33%</td>
</tr>
<tr>
<td>Asian or Asian British: Bangladeshi</td>
<td>20,064</td>
<td>0.89%</td>
</tr>
<tr>
<td>Asian or Asian British: Chinese [note 2]</td>
<td>11,858</td>
<td>0.51%</td>
</tr>
<tr>
<td>Asian or Asian British: Other Asian</td>
<td>8,836</td>
<td>0.38%</td>
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<tr>
<td><strong>Asian or Asian British: Total</strong></td>
<td><strong>151,876</strong></td>
<td><strong>6.12%</strong></td>
</tr>
<tr>
<td>Black or Black British: Caribbean</td>
<td>16,233</td>
<td>0.69%</td>
</tr>
<tr>
<td>Black or Black British: African</td>
<td>10,255</td>
<td>0.42%</td>
</tr>
<tr>
<td>Black or Black British: Other Black</td>
<td>3,259</td>
<td>0.13%</td>
</tr>
<tr>
<td><strong>Black or Black British: Total</strong></td>
<td><strong>29,747</strong></td>
<td><strong>1.20%</strong></td>
</tr>
<tr>
<td>Mixed: White and Black Caribbean</td>
<td>13,164</td>
<td>0.53%</td>
</tr>
<tr>
<td>Mixed: White and Black African</td>
<td>4,860</td>
<td>0.20%</td>
</tr>
<tr>
<td>Mixed: White and Asian</td>
<td>8,547</td>
<td>0.33%</td>
</tr>
<tr>
<td>Mixed: Other Mixed</td>
<td>6,390</td>
<td>0.26%</td>
</tr>
<tr>
<td><strong>Mixed: Total</strong></td>
<td><strong>32,901</strong></td>
<td><strong>1.33%</strong></td>
</tr>
<tr>
<td>Other: Arab [note 3]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: Any other ethnic group</td>
<td>7,297</td>
<td>0.29%</td>
</tr>
<tr>
<td><strong>Other: Total</strong></td>
<td><strong>7,297</strong></td>
<td><strong>0.29%</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,482,328</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

This table represents the declared ethnicity of respondents, although slightly different categories were offered to respondents than those contained within the census. There is a correlation between demography and participants.
Comparison table:

<table>
<thead>
<tr>
<th>Broad category – see tables above for more detailed description</th>
<th>Census profile for Greater Manchester</th>
<th>Respondent profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>2.7%</td>
<td>0.7% (under reporting)</td>
</tr>
<tr>
<td>White or White British</td>
<td>83%</td>
<td>81%</td>
</tr>
</tbody>
</table>

In looking at the choices made by respondents based on ethnicity, all Asian and Asian British choose Option A, and comments left to support this requested that ‘Prestwich’ is their preferred choice. In looking at black & black British again all respondents choose Option A and again where comments were left, Prestwich was the main motivating factor. As Prestwich is listed in both options, their needs will be met.

**Disability**

Question 10 asks respondents to identify themselves as being ‘disabled or not’. 275 people have identified ‘yes’ – however there will be many people who have a limiting illness who will not consider themselves or want to class themselves as disabled. The following chart shows the ‘types’ of impairments and also the fact that more people (373) identify with the categories of ‘physical impairment,’ ‘mental impairment,’ ‘sensory impairment’, ‘long standing illness’ at question 11, than they do with the simple definition of ‘disability’ at
question 10. As such, any redesign of service must take into account how people describe their ability rather than the label applied.

In looking at the concerns raised by the different impairments, they all link to ‘ease of travel’ and ‘ease of access to the new venues’. Many feel (especially on the issue of Prestwich) that should a service not be present within this locality then this would seriously affect their ability to attend due to travel difficulties.
5. Legal Duties

NHS England commissioners are required to adhere to statutory legislation when undertaking engagement with the public; such legal duties are listed below:

Health & Social Care Act 2012

- duty to promote the NHS Constitution (13C and 14P)
- quality (sections 13E and 14R)
- inequality (sections 13G and 14T),
- promotion of patient choice (sections 13I and 14V)
- promotion of integration (sections 13K and 14Z1)
- public involvement (sections 13Q and 14Z2)
- innovation (sections 13K and 14X)
- research (sections 13L and 14Y)
- obtaining advice (sections 13J and 14W)
- the duty to have regard to joint strategic needs assessments and joint health and wellbeing strategies (section 116B of the Local Government and Public Involvement in Health Act 2007)
- Section 244 of the NHS Act 2006 duty to consult the relevant local authority in its health scrutiny capacity

Section (14Z2) outlines how this legal duty for involvement:

- in the planning of its commissioning arrangements,
- in developing and considering proposals for changes in the commissioning
- arrangements that would impact on the manner in which services are delivered or on the range of services available, and
- in decisions that affect how commissioning arrangements operate and which might have such impact.

Section (14v) Duty as to Patient Choice

Each NHS commissioner must in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

- **NHS Act 2006**

  Section.14T of the NHS Act 2006) (CCGs) the duty to have regard to the need to reduce inequalities

- **Public Sector Equality Duty 2010**
- **Planning and delivering service changes for patients, December 2013, NHS England**
- **Transforming Participation in Health and Care 2013, NHS England**
• Everyone Counts: Planning for Patients 2013/14, NHS England
• NHS Operating Framework for the NHS in England 2015/16
• Rules on service reconfiguration Indicative evidence requirements against the “Four Tests’
  - Test 1 – support from GP commissioners
  - Test 2 – strengthened public and patient engagement
  - Test 3 – clarity on the clinical evidence base
  - Test 4 – consistency with current and prospective patient choice

Independent Reconfigurations Panel Guidance

- Make sure the needs of patients and the quality of patient care are central to any proposals
- Assess the effect of the change and give early consideration to transport and access issues
- Proposals on other services in the area
- Provide independent validation of the responses to engagement and consultation.

Legal judgments confirm what should be obvious to everyone – consulting people on proposals are only of any value, if appropriate account is then taken of the views that emerge. This also means being seen to take account of views received. “It is clear from the views expressed to us that the process of public engagement and consultation did not entirely fulfil its purpose. Many members of the public felt that their comments had not been taken into account and there was a sense of unfairness...about some of the decisions taken.”

*Service Reconfiguration, Consultation and Judicial Review, David Mason, Peter Edwards, Gerard Hanratty and Belinda Dix 3rd Edition, Published by Capsticks Solicitors LLP, 2009* © Capsticks Solicitors LLP

Policy states that solutions need to be affordable, clinically safe and acceptable to users. As the guidance indicates that, ideally, decisions will give each of those factors equal weight, this is an indication as to how the Secretary of State will look at decisions that are referred to him by OSCs. This shows the need for the NHS to try to reach out to all users, given that opponents of proposals shout a lot louder than supporters.
By use of the following model:

In addition to this, the HM Government Code of Practice on Consultations (2008) states that consultations should last for **at least 12 weeks** with consideration given to longer timescales where feasible.

The Diabetic Eye Screening review did not require a formal 12 week process to be undertaken; the local JOSC approved a 4 week formal engagement process given the work which had already been undertaken in the pre-engagement exercise.

To ensure transparency of process, all documents should be clear about the process, which is being proposed, and the scope and the expected costs and benefits.

Reconfiguration of services is rarely a short cut. Indeed, it is frequently a lengthy process. Sustaining stakeholder engagement throughout the transition to formal engagement and subsequently to decision-making and beyond requires careful planning. The end of the formal engagement phase should not be seen as the end of the need to keep people informed. On the contrary, this may be the point at which people are most anxious to know what happens next.

Independent validation of process to validate responses is important (and CSU are independent as they are now a commissioned service provider, not influenced nor impacted by the outcome of a decision). The CSU role is to share the facts of the proposal and record the feedback with honesty and transparency throughout.

Equally, modification or refinement of proposals as result of process helps to show that local people’s opinions count. Moving too quickly from end of engagement to decision-making without adequate reflection time in between demonstrates the opposite.
In order to achieve the above objectives the NWCSU Engagement and Involvement strategists have a full and inclusive understanding of the statutory and legislative processes which are required to be undertaken in the delivery of major NHS health change projects or review of commissioning policies.

Equality Duty

As part of meeting the Public Sector Equality Duty this section of the report has drawn on data of people across protected characteristics who have taken part in the engagement exercise.

The full analysis and findings will be part of the full Equality Impact Assessment document. Furthermore particular groups representing the interests of protected characteristics have been informed of the engagement exercise will be informed of the agreed outcome.

6. Equality Impact Assessment

Equality Analysis Report

The Equality Act 2010 contains within it a statutory requirement known as ‘public sector equality duty’ (PSED). PSED requires that service provider examine ‘all functions’ and test these against three aims:

(a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Redesigning and changing how a service is provided is a service ‘function’ and therefore NHS commissioners must examine how the change and redesign meets the above aims. The purpose of this is to test whether any change would directly or indirectly discriminator or create untoward and unacceptable barriers preventing individuals from access the service and thus causing greater health inequality.

This section of the Stakeholder Engagement report will look at the equality analysis report and in addition will look at the circumstances for the change, what potential barriers could arise, and the results and analysis of the engagement exercise to check whether the consultees had identified particular worries or problems linked to potential discrimination. All of this will be assessed against PSED to inform NHS England decision makers, prior to making their final decision to change the service deliver model and determine whether or not PSED will be satisfied.
Service background Information and legitimate aim.

Since 2008 the diabetic eye screening programme 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, Bury, Oldham, Heywood, Middleton and Rochdale.

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 and 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 cameras – 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 North East Manchester Diabetic Eye Screening Programme (NEMDESP) 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.

Following a screening incident in February 2014, which involved the safe transfer of data, interim measures were introduced which resulted in the reduction of clinical sites for screening from 16/17 to 6.

Proposal:
It was therefore felt that the number screening sites should be reduced to 6 sites as an interim measure for quality and safety reasons. The chosen sites were jointly agreed between the commissioner and the provider of the service as they all had a secure N3 connection and provided an accessible service to the greatest number of patients. The
commissioner and provider were aware that some patients would be adversely affected by this change in the short term until such a time as a robust patient and staff engagement exercise could be undertaken.

**The change**

The move from 16/17 sites to a maximum of 6 is a ‘threshold’ shift and limited the accessible sites for patients to visit. This proposed change (which was always seen as an interim measure) may have resulted in the slowing down of patient activity, delaying appointments or further travel limiting a person’s ability to attend an appointment.

a) Impact – whilst there may have been more sites previously their poor quality and the resulting difficult with equipment did result in delays. Consideration has been given to the issue of patients not attending and it is now anticipated that a move to 10 sites (Option A) or 12 sites (Option B) will be more than enough to meet current and future demand of patient through-put. Therefore there will be no discriminative element in play

b) Geography and travel. The reduction of sites by default means that some locations will not be as accessible meaning some service users will have to travel further. Travelling further in and of itself is not discriminatory, but given the nature of some illness and disabilities linked to this service there may need to be mitigating actions around ensuring that public transport/ car parking / clear information and directions to new sites are given to patients who will have to travel further than previously. The formal engagement process is the process whereby patients/service users could voice their concern about proposed new locations, the analysis of the data shows that the changes didn’t present an unacceptable barrier to service users and no indirect discrimination was identified.

**Meeting PSED**

<p>| (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act; | the changes have not created any unintentional detriments for service users based on their protected characteristics satisfying section 19 (1) (2) (a,b,c,d) of the Equality Act 2010. The service is available for all who need at and there are no bars on attendance. The sites are fully accessible and staff are supportive of | Duty 149, 1 (a) is met. |</p>
<table>
<thead>
<tr>
<th>Service users and treat them in a respectful and dignified manner. This satisfies section 13 and 19 of the Equality Act 2010 and section 20 – duty to make reasonable adjustment – Equality Act 2010. The consultation process has ensured that service users have participated in the decision making and the data can be disaggregated by protected characteristic showing full inclusion and all groups present. Satisfying section 13 and 19 and section 149 (PSED) 3(b)</th>
<th>(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; The service is directly linked to a health need of trying to preserve eye sight and support those with diminishing visual faculty thus satisfying PSED criterion 3 (a) The continued offer of a number of sites across the different communities shows that different people will have maximum opportunity (with minimal disruption) to attend a clinic – this satisfies PSED 3 criterion (b) The consultation process was inclusive and allowed different people to express their views via a public forum. These views could be understood by protected characteristic and would allow voices of concern or descent to be heard. This satisfies PSED criterion 3(c)</th>
<th>Duty 149, 1 (b) is met</th>
</tr>
</thead>
<tbody>
<tr>
<td>(c) Foster good relations between persons who share a relevant protected characteristic and persons</td>
<td>The service provision is placed across various communities and can be seen to be available and</td>
<td>Duty 149, 1 (c) is met.</td>
</tr>
</tbody>
</table>
| who do not share it. | accessible to all of our communities. The consultation process showed that different protected characteristic took part of the process. As such it promotes understanding of the issue across of eye care and diabetes across different communities. As such it satisfies 149 PSED criterion 5(b).  
PSED criterion 5 (a) is not applicable with this project. |

**Section 149 Public Sector Equality Duty is met with the proposal of creating 10 (option A) or 12 (Option B) quality sites from which to offer eye care services. The programme of change can continue.**
7. Recommendations and Next Steps

NHS England commissioners need to assure themselves that they have fully adhered to their statutory duties in the undertaking of this exercise. When considering the NHS England four tests for any service reconfiguration:

Test 1 – support from GP commissioners – all 3 CCG’s within the North East Manchester locality were fully involved in all aspects of the process and were represented on the Communications and Engagement sub-group.

Test 2 – strengthened public and patient engagement – a full pre-engagement and formal engagement process was undertaken and demonstrated full adherence to NHS commissioner’s statutory duties, including the equality duty.

Test 3 – clarity on the clinical evidence base – given that this engagement exercise was specific to site location and access in terms of quality and assurance the clinical evidence base was less relevant. That said, there has been clinical input throughout the exercise from a Consultant in Public Health and the Clinical Lead within the Trust. In addition, clinicians within the 3 CCGs have also been aware of the exercise.

Test 4 – consistency with current and prospective patient choice – patient choice has been a ‘golden thread’ throughout the pre-engagement phase and the formal engagement phase with comments gathered from respondents of the prospect of an extended service to include evenings and weekends.

Survey and Equality Duty Recommendations

- Option B is the preferred option, moving to 12 sites across the following locations:
  - Oldham (3 sites)
  - Rochdale (2 sites)
  - Radcliffe
  - Bury
  - Heywood
  - Middleton
  - Prestwich
  - Failsworth
  - Saddleworth

- Extend service offer to include evening and weekend access.

- Improve communications with patients with regard to patient choice and appointment information.
• Consider staff to patient ratio.

• Monitor attendance rates to identify ‘drop off’ of service users from geographic areas previously served and if this becomes evident (people not attending due to shift in service geography) revisit the issue and look at support initiatives.

• Ensure that service users fully understand the change and when and where service will be open and operating from and that information covers – accessibility of bus routes/car parks and public spaces. The information provided must cover the needs of the service user’s ability (language/easy read/Braille etc as required).

Whilst a significant number of respondents cited access, transport and car parking as a key issue in attending clinics, these aspects of the process are areas which are difficult for commissioners to influence. There is a patient transport scheme in place to support some patients who meet the specified criteria, however, this does exclude some patients who experience difficulties and whose circumstance just miss fulfilling the criteria. Car parking at most NHS venues is a reoccurring challenge for some patients, however, car parking charges are now standard practice at most hospital sites and outside the influence of NHS commissioners. With regards to access, all of the venues chosen should be wheelchair accessible and the commissioners will look to the provider to assure them that this is the case.

**Next Steps**

There is a scheduled meeting of the NHS England Greater Manchester and Lancashire Senior Management Team (SMT) due to take place on Tuesday 29th September, 2015, during which a formal decision will be agreed and signed off. The findings of this report based on patient and user feedback will be considered carefully before a final decision is reached.

Following the decision of the SMT a formal presentation will be made to the JOSC (date to be confirmed) who are asked to approve the process and the outcome. See the table below for clarity on process:
<table>
<thead>
<tr>
<th>Activity</th>
<th>Action</th>
<th>Lead Officer</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collate all feedback and analyse findings.</td>
<td>Produce final engagement report for commissioner.</td>
<td>Hilda Yarker NWCSU</td>
<td>September 2015</td>
</tr>
<tr>
<td>Final outcome report</td>
<td>Commissioner to produce outcome of the service review and submit to NHSE SMT.</td>
<td>Audrey Howarth NHSE</td>
<td>September 2015</td>
</tr>
<tr>
<td>NHS England Senior Management Team</td>
<td>Submit report and findings for consideration. 29th September 2015.</td>
<td>Audrey Howarth</td>
<td>September 2015</td>
</tr>
<tr>
<td>Inform Joint OSC’s of final outcome of the process.</td>
<td>Submit final report and outcome of the review.</td>
<td>Graham Wardman/Jane Pilkington Audrey Howarth NHSE</td>
<td>Following agreement by NHSE SMT</td>
</tr>
<tr>
<td>Feedback to patients/public &amp; key stakeholders</td>
<td>Communicate the outcome of the formal engagement process and service review.</td>
<td>All members of the sub-group via engagement mechanisms used during the process.</td>
<td>October 2015 following approval by JOSC.</td>
</tr>
<tr>
<td>Implement new service.</td>
<td>Commissioner and Provider to implement new delivery model based upon final decision.</td>
<td>NHS England/ Pennine Acute Hospitals NHS Trust.</td>
<td>October 2015</td>
</tr>
</tbody>
</table>

Copies of all survey results and supporting documentation are available upon request to:

Hilda Yarker  
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NHS North West Commissioning Support Unit  
Hilda.yarker@nhs.net