

verve

Engagement evaluation report

North Central London Adult Elective
Orthopaedic Surgery Review

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Erratum

Please note this version has been amended following initial publication and circulation at the JCC meeting to correct an inaccurate reference on page 13. The original reference stated that the Equalities Matrix table could be found at **Appendix F table 7**. This has been corrected. The Equalities Matrix table is found at **Appendix C table 7**.

1. OVERVIEW

1.1 ABOUT THIS DOCUMENT

A review of adult elective orthopaedic surgery for the population of North Central London has been established by the Joint Commissioning Committee of North Central London (NCL) Clinical Commissioning Groups (CCGs).

This document contains the independent evaluation of an engagement exercise with residents, staff and local stakeholders carried out between August and October 2018.

The purpose of the engagement exercise was to:

- Share the draft [case for change](#)¹ and gather views to inform commissioners' decisions following the first stage of the review
- Make recommendations for future involvement of residents, stakeholders and front-line staff (should this be required).

Verve Communications was commissioned to conduct the evaluation. It was undertaken as a desk exercise based on raw response data and information about the engagement provided to us by the programme team. The purpose of this document is to provide:

- **Commentary on the process and its compliance with guidance and best practice**
- **Analysis of comments, feedback and views on the case for change received through the exercise.**

1.2 ABOUT THE ENGAGEMENT

Early engagement to support potential NHS service changes are an important opportunity to involve local people in key decisions about their healthcare and services, and to open a large-scale dialogue about priorities and options for the future.

Engagement fulfils several different purposes:

- Providing information
- Obtaining feedback on proposals and evaluating the priorities among different groups who may be impacted differently
- Demonstrating accountability, scrutiny and open, transparent planning
- Supporting a committee decision on specific proposals for change – which may be subject to future consultation.

1.3 ABOUT THE DATA ANALYSED

The programme used a range of communication channels with significant reach to local communities combined with targeted activity. This approach ensured notably high levels of local

¹ <http://www.northlondonpartners.org.uk/downloads/plans/Adult-elective-orthopaedic-review/Case%20for%20change/180817%20Adult%20Orthopaedic%20Elective%20Services%20Review%20-%20Case%20for%20Change%20v%201.8%20linked.pdf>

involvement and inclusion of groups likely to be disproportionately represented among elective orthopaedic surgery patients in north central London and those at risk of health inequalities.

Similarly, the views of clinicians and other professionals were gathered using a variety of methods to develop a rich picture of the views of provider staff, commissioners and institutions.

1.4 ENGAGEMENT SUMMARY

FACE TO FACE COMMUNICATION

Engagement Forum	Meetings/Events	Numbers
Patients and Public	13	181
Commissioners	7	54
Providers	10	287
Local Authority	6	22
Total	36	544

	Meetings/Events	Numbers
Workshops and plenary	5	63

WRITTEN COMMUNICATION

Channel	Organisational Channels
Written feedback	7
Website Feedback	78

PROACTICE PROMOTION

Reach	Organisational Channels (Electronic and print newsletters, mail outs, bulletins)	Social Media (Facebook, Twitter)
58,710	28,796*	29,914

Table A: The Scope of engagement - (Full details of channels used can be found at Appendix A)

The collection of notes and comments by the programme team was comprehensive and detailed. We were provided with a significant quantity and variety of free text comments as the raw data for analysis.

These came in a variety of forms, but were chiefly:

- Questionnaire responses
- Comments noted at meetings
- Formal responses from organisations or individuals (responding in an official capacity).

This report also takes as a starting point an Initial Equalities Analysis² conducted for the Adult Elective Orthopaedic Services Review to inform the engagement exercise. The analysis identified key groups sharing protected characteristics likely to be significantly impacted or groups at risk of health inequality enabling them to be prioritised.

Within this evaluation of the engagement activities we have aimed to:

- Reference all substantive points made
- Identify in broad terms themes and opinions including where the data suggests variations between the different groups identified (i.e. patients/public, providers, commissioners)
- Focus on issues relevant to groups 'scoped-in' within equalities analysis where possible.

1.5 COMMENTS ON THE DATA RECEIVED

The draft case for change was deliberately presented at an early stage of the process to enable participation by as many key stakeholders as possible and to test the rationale for change.

There is always a balance to be struck on the timing of engagement, and we have sought to take this into consideration in the analysis in the following ways:

- Respondents will not necessarily understand that the review is an iterative process and, even if the milestones are set out clearly, there may still be comments based on incomplete understanding of where, how and on what basis decisions will be made.
- Early engagement is likely to mean that there is not yet detailed, agreed answers for how the new model may be configured. For example, it is not yet clear whether imaging is proposed to be at the elective centre(s) or at base or local hospitals because the model has not been developed in enough depth at this stage.
- There may also be incomplete appreciation by respondents about the nature and extent of communications and engagement or equalities work and, for example, suggestions for dialogue which have already happened.

² North London Partners Equality Impact Assessment scoping v13 (Verve Communications, August 2018)

2. HEADLINE FINDINGS

Many people across all three groups (patients and the public, commissioners and providers) welcomed the proposed creation of elective orthopaedic centre(s), especially the **potential to improve patient experience and clinical outcomes** and the **opportunity for extensive consultation and engagement**.

Rationale for the review

Describing the drivers for the review – contributors recognised the pressures and issues the review is seeking to address and these resonated with their experience of services. However, questions were raised about whether the rationale for review could be articulated more clearly, with suggestions that more evidence should be presented about the current scale and impact of cancellations/delays, and particularly the need for a clearer local case to support the internationally suggested threshold of 5,000 cases per annum and minimum numbers of consultants per sub-specialism.

Opportunities to improve services in the new model of care

Patient experience - Vulnerable patients (e.g. those with learning disabilities, dementia, mental health issues) might find it difficult to travel to and find their way around an unfamiliar hospital, with unfamiliar staff. It was suggested that consideration could be given to having people available to assist them on arrival.

Continuity of care - There were several points raised around the subject of continuity of care. In the majority of cases these were in the form of questions about the location of pre-operative assessments and post-operative care/rehabilitation. These comments indicate that there is a need for the review to clearly explain where these activities will take place at the next stage of engagement.

Patients with complex needs - It was not clear where patients with complex needs (e.g. those with comorbidities) would have their surgery. This is a growing section of the population and it will be important for the review to produce clear and well justified recommendations.

Integration - Contributors stressed the importance of joined up working and integration between clinical, social care and rehabilitation services. The role of an integrated IT system was important if care is to be delivered across multiple locations.

Key dependencies or consequences that the new model of care will need to manage

Travel – always a key concern for public and patients, with the assumption that future proposals might mean more time and money spent on travelling to appointments, and potential impact on those with mobility impairments and economically deprived residents. There were repeated comments suggesting that an in-depth transport analysis should be considered so that the implications can be fully understood.

Across the system - A number of people referenced to the potential risk of unintended/indirect consequences for other parts of the local health economy. For example, loss of elective income might damage the viability of services at base hospitals, and that the separation of trauma and elective orthopaedic work might have a detrimental effect on staff training, skills, job satisfaction and retention/recruitment.

Patient choice - Some members of the public raised concerns about the potential restriction of patient choice through consolidating elective services into a small number of sites.

The model - More detail and reassurance was requested about the practicality of separating 'hot' and 'cold' work, based on the concern that staff might be pulled back to trauma work at times of high demand, winter pressures etc.

2.1 PUBLIC AND PATIENTS

Seen as benefits

- Common responses included reference to clinical rationale, proposal seen as "a good idea" which made sense with an ageing population and could achieve better outcomes
- Benefits for patients were seen as: consolidated expertise and the best equipment; ability to ring fence beds for elective procedures; relatively rare procedures could be concentrated in one centre, enabling clinicians to develop skills and experience; reduced waiting times; fewer infections; speedier recovery; and reduced cancellations
- Other advantages were seen to include cost saving/cost effectiveness, better staff retention and more scope for research and innovation.

Areas of concern

- Most commonly mentioned were concerns about transport/travel, particularly for patients with mobility impairments/disabilities - car parking was a specific concern
- How patients would navigate the system and the elective centre, especially for patients with learning disability, dementia and/or mental health problems
- Need more focus on the patient perspective (e.g. data from other areas about patient experience/satisfaction, and information about current levels of cancellations and delays should be cited)
- That the driver for the review might lead to a focus too strongly on saving money – there was a related concern that elective centres could lead to privatisation
- Some doubt that elective capacity could be effectively ring-fenced
- Staff might be reluctant to travel between sites, have less time to see patients and may confuse/complicate processes
- The impact on hospitals not selected as elective centres, particularly on trauma surgery and consequent distribution of services across north central London
- Some saw local hospitals as offering continuity of care – concern that an elective centre(s) may not be able to deal adequately with complex cases and maintain its own Intensive Care Unit or High Dependency Unit
- Assumption amongst those feeding back that physiotherapy/rehabilitation services would also be located at the elective centre, with consequent additional journeys required

- A perception from some respondents that recent investment in Chase Farm means it will automatically be selected as a specialist site, despite the perception of poor transport links
- A concern that patient choice could be reduced by having fewer sites carrying out elective orthopaedic surgery
- High-volume work within one specialism led some contributors to fear that staff could become bored with the “conveyor belt”.

Other points for further consideration

- Workforce issues/operational matters, e.g. recruitment and retention implications of narrower career/training opportunities if elective work is split from trauma work
- Social care/discharge, e.g. social care needs to be joined up with clinical care, and concern that a very large elective centre may struggle to cope with the volume of discharges across multiple boroughs
- The review: scope and timescale, e.g. explain the governance of the review, specify the decision date. Does the review cover surgery on hands and shoulders?
- Evidence-based medicine, e.g. is the review considering the Adherence to Evidence-based Medicine Consultation and looking at procedures of limited clinical effectiveness?
- Financial/investment, e.g. where will the funding come from to fit out the new designated centres?
- Surgery vs non-surgical intervention e.g. calls for more non-surgical options for patients, concern that new elective centre(s) might drive a more interventional approach.

2.2 COMMISSIONERS

The findings below are taken from seven meetings held with clinical commissioners. These meetings were more focused on the technical aspects of a potential new service model rather than a more deliberative approach used for other meetings.

Seen as benefits

- Positive reactions to the key concept of establishing elective orthopaedic centre(s)
- Awareness of similar reviews undertaken in other clinical areas (e.g. cancer or stroke services), with many benefits cited: reduced length of stay; reduction in unwarranted variation; procurement efficiency; and enhanced professional experience
- Acknowledgement that although patients would not necessarily welcome any potential additional travel, waiting times were seen as *the* paramount issue for patients and anything that impacts positively on this was welcomed.

Areas for further development

- Calls for the rationale for the review to be made clearer in the next iteration of the case for change specifically whether the key motivation was improved clinical outcomes or cost savings
- View that the next iteration of the case for change should be transparent about the potential downsides of a new service model and how they would be mitigated – particularly any potential implications for financial viability of other local hospitals e.g. interdependency between trauma and elective orthopaedic services

- Need to consider how the system can be designed to ensure that high standards of care are maintained across the whole patient experience, this should include social services involvement
- Workforce implications, such as whether clinicians might want to continue working on both trauma and elective and any implications for training, retention and how travelling time between sites would be managed
- Recognition that it may not prove easy to separate hot and cold capacity in practice
- Concern that the new model sets out clearly how patients with co-morbidities would be managed.

Other points for further consideration

- Ways of working – practical implications, e.g. there will need to be clear protocols across community services to ensure continuity of care, IT needs to be appropriate for moving records across different locations
- Engagement to achieve buy in from clinicians and public, e.g. needs to be representative of boroughs, needs to inform GPs so that they can talk to patients about it
- The need to work out and explain the patient pathway in the new system, e.g. how would it fit with the wider MSK pathway, patients need to understand what it will mean for them
- Further consideration of evidence/data to confirm the case for change, e.g. explain the statistical evidence supporting the proposals, GIRFT programme needs to be more prominent in communications
- Surgery vs. non-surgical intervention, e.g. calls for more non-surgical options for patients, concern that new elective centre(s) might drive a more interventionist approach.

2.3 PROVIDERS

Seen as benefits

- The vision was well-received, though there was recognition that “the devil will be in the detail”.
- A view that the public would accept extra travel if they were convinced about the delivery of better outcomes
- Benefits seen as: the opportunity to achieve more within current resources; economies of scale; improved efficiency through greater collaboration; better outcomes through standardisation and reduced variation; research; and training
- Could provide opportunities for staff to work across different sites and experience both trauma and elective work.

Areas for further development

- That surgeons working across multiple sites might find the experience frustrating, which could affect staff retention
- Standardisation might lead to a levelling down of outcomes, rather than levelling up
- The financial model was not yet adequately explained, specifically the potential for some (especially smaller) hospitals to lose out
- Whether resources would need to be shared e.g. pooled budgets across north central London

- Whether the proposed threshold of 5,000 cases per annum would be too high, and might rule out some locations
- Independent hospitals were concerned about implications of the review for the private sector
- Need to test further some of the evidence presented e.g. whether GIRFT data is sufficiently robust and how it will be taken into account
- Question about where High Dependency Unit services should be located
- View expressed that pre-operative assessment could be done at the site where surgery will take place, because of considerations around anaesthetic and perioperative care planning
- Some concern that any implications for spinal services were not adequately discussed in the proposal
- Concern about the impact of extra transport/travel for patients and families particularly challenging for deprived communities
- The process and proposals need to ensure a strong focus on patient experience and continuity of care.

Other points for further consideration

- Financial issues, e.g. will the necessary capital be available, how will the income of smaller hospitals be protected?
- Workforce issues, e.g. are surgeons supportive or anxious about this, have anaesthetists been consulted?
- Issues of scope and definition, e.g. where will day cases go, will it be a hub and spoke model?
- Spinal issues, e.g. is RNOH spinal work included in the review, have you liaised with the spinal networks?
- Local services/centralised services, e.g. where will rehabilitation take place, what will happen to imaging?
- Pathways and relationships within the local health and care economy, e.g. will there be unintended consequences, it needs good integration with social care/housing/rehab to get patients home
- Communication, e.g. need to make the case to the public, consolidation at Chase Farm could have been explained better
- Need to align with NCL work on discharge pathways for complex patients

2.4 PARTICIPATION IN ENFIELD

Special mention should be made of the response received as a result of work by Healthwatch Enfield, who produced their own questionnaire and materials summarising the draft case for change and ran a series of local events a number of which were attended by members of the programme team. This generated a significant number of comments.

Enfield residents were therefore able to participate through both the programme feedback routes and via Enfield Healthwatch. The raw data from the Enfield Healthwatch questionnaire was shared with the programme team so that it could be included within the integrated analysis framework and be reflected in the overall evaluation. Enfield Healthwatch have also produced their own local report on the feedback received.

3. MEETING BEST PRACTICE

3.1 POLICY AND GUIDANCE RELEVANT TO THE ENGAGEMENT EXERCISE

When major changes to NHS services are proposed, communications and engagement should be central at all stages of the process of developing proposals, considering options and making decisions.

3.1.1 NHS CHANGE LEGASLATIVE FRAMEWORK

- NHS Act 2006 (as amended by the Health and Social Care Act 2012) - s14Z2 (CCGs), s13Q (NHS E)
- Where substantial development or variation changes are proposed to NHS services, there is a separate requirement to consult the local authority under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the 2013 Regulations") made under s.244 NHS Act 2006. This is in addition to the duties on commissioners and providers for involvement and consultation set out above and it is a local authority which can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel.

3.1.2 EQUALITIES LEGASLATIVE FRAMEWORK

- Equality Act 2010 - s149 - Public Sector Equality Duty (PSED) and equality impacts.

3.1.3 CONSULTATION BEST PRACTICE

- The Consultation Institute (TCI) - The Consultation Charter – The 7 Best Practice Principles.

For commissioner-led processes there are statutory requirements and best practice guidance was published by NHS England in 2018 in *Planning, assuring and delivering service change for patients* (NHS England)³ which sets out responsibilities and the process, and separate guidance on equality and health inequalities legal duties was published in 2015⁴.

3.2 ABOUT THE ENGAGEMENT PROCESS

Programme leaders, the Review Group and programme team made clear and positive efforts to meet best practice, and in our view, the exercise meets the key criteria set out in guidance by NHS England.

We have provided a commentary on relevant elements of the engagement process against both NHS England best practice and the Consultation Charter standards (Appendix B)

³ <https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>

⁴ <https://www.england.nhs.uk/wp-content/uploads/2015/12/hlth-inqual-guid-comms-dec15.pdf>

3.2.1 NHS ENGLAND

In **Appendix B table 5**, we have referenced key points from NHS England guidance relevant to pre-consultation engagement and included observations on this exercise and appropriate recommendations for engagement in future phases.

3.2.2 THE CONSULTATION CHARTER

The Consultation Charter⁵ (The Consultation Institute) identifies seven principles. Although most commonly applied to consultation, these represent best practice at all stages of engagement.

In our view, this engagement fully met the principles of the consultation charter. They are set out in **Appendix B table 6**, alongside our comments relevant to this engagement.

3.3 REQUIREMENTS OF ENGAGEMENT TO SUPPORT THE PROGRAMME

If there is agreement to proceed, communications and engagement associated with later stages of the review will be required to meet the statutory requirements set out above. This will include:

- the development of a Pre-Consultation Business Case (PCBC)
- an options appraisal process
- a formal consultation.

In later stages, other checkpoints and/or guidance may also become relevant for communications and engagement. This includes: equalities impacts/Public Sector Equality Duty (PSED); the Government's four tests for reconfiguration, plus additional DH test on reduction of hospital beds Department of Health Gateway (programme readiness); and Governmental Code of Practice (should consultation be required).

3.4 APPROACH TO ANALYSIS

3.4.1 PRINCIPLES

The analysis and commentary set out in this document are our views based on a review of the data we received and the following approach:

- Scale and scope of engagement is compared with guidance and best practice (referenced where appropriate).
- The analysis is a qualitative exercise, and we have therefore avoided drawing "quantitative" conclusions. We note that participants and respondents are not necessarily a representative sample of wider populations (or professional groups).
- We have aimed to combine insights from a range of sources into a single framework for an integrated analysis to support decision-making.
- We have aimed to produce a comprehensive analysis of qualitative data (i.e. our purpose is to capture within the analysis all of the substantive points raised in order to provide the programme team with a rich but manageable checklist of views, issues and concerns)

⁵ The Consultation Institute <https://www.consultationinstitute.org/consultation-charter-7-best-practice-principles/>

- The views of providers, commissioners and public/patients are presented separately so that the reader can appreciate the perspective behind the opinion or question being expressed.

3.4.2 QUESTIONS

Questions were worded to reflect likely perspectives and experiences of different stakeholders.

Public and patients

1. What are your views on our ideas?
2. What are the advantages and disadvantages of consolidating onto fewer sites?
3. What are the top three considerations to take into account when thinking about how these services are delivered in the future?
4. If you have used these services (or know someone who has) please tell us whether the challenges set out in this draft case for change reflect those experiences?

Providers

1. Do the challenges set out in this draft case for change reflect your experiences of delivering adult elective orthopaedic services in north central London?
2. What are your views on our ideas?
3. What are the advantages and disadvantages of consolidating onto fewer sites?
4. From your perspective what operational considerations need to be taken into account in designing the new service model?
5. Are there some services that would be best placed locally rather than at a centre?
6. Are there key clinical dependencies that need to be taken into account?

Clinical Commissioners

1. Do the challenges set out in this draft case for change reflect your experience of elective orthopaedic services in north central London?
2. What are your views on our ideas?
3. What are the advantages and disadvantages of consolidating onto fewer sites?
4. From your perspective what operational considerations need to be taken into account in designing the new service model?
5. Are there some services that would be best placed locally rather than at a centre?
6. Are there key clinical dependencies that need to be taken into account?
7. What are your views on our proposed assessment criteria?

3.5 THE PUBLIC SECTOR EQUALITY DUTY (PSED)

The engagement exercise was informed by an initial Equalities Impact Assessment (EIA) which set out the responsibilities of commissioners under the Equality Act 2010 and assessed the likely impact on groups sharing protected characteristics or others at risk of health inequalities (deprivation, caring responsibility).

This identified groups with disproportionate need for elective orthopaedic surgery or differential need (for example, females and males may have different needs to access a service, but there is no evidence to suggest that either females or males have a disproportionate need).

It is summarised in Table B

Characteristic	Disproportionate need	Differential need
Age: Young people		
Age: Older people	✓	
Disability	✓	
Gender: Female	✓	
Gender: Male		
Gender reassignment	✓	
Marriage and civil partnership		
Pregnancy and maternity		
Race and ethnicity: White		✓
Race and ethnicity: Black		✓
Religion and belief		
Sexual orientation		
Deprivation	✓	
Carers		✓ ⁶

Table B: Summary of Scoped-In Groups (Protected characteristics in grey have not been scoped-in by the EIA)

Communication about the review and case for change and promotion of the engagement to the scoped-in groups was through a mix of thirteen different community channels (e.g. newsletters) provided by Healthwatch organisations and Clinical Commissioning Groups in each of the five boroughs in North Central London, plus a further four regular publications aimed at local patients produced by four of the providers.

In addition, direct approaches were made to organisations and networks with reach to all of the scoped-in groups. Invitations to participate in the engagement in format appropriate to each group were delivered. As a result, 26 organisations participated and there were nine meetings and events relevant to equalities communities.

All groups scoped in via the equalities impact assessment participated in the engagement exercise, with engagement methodology shaped in line with their preferences for participation (some preferred one-to-one conversations, some preferred to be part of a wider group conversation and others preferred to participate in an event established especially for their group e.g. those with learning disabilities).

Full details of equalities engagement can be found in the equalities matrix – Appendix C table 7

Equalities groups
<ul style="list-style-type: none"> • 26 organisations with reach to equalities communities (i.e. groups sharing 9 protected characteristics, caring responsibility, social deprivation) • 9 meetings and events relevant to equalities communities • 17 channels (5 boroughs via Healthwatch or CCG + 4 providers) to communities across NCL

⁶ NLP EIA scoping v13 ibid. p.26

4. RECOMMENDATIONS

FOR THE ADULT ELECTIVE ORTHOPAEDICS PROGRAMME

- Rec. 1.** Next stages of the review need to focus on the key concerns frequently mentioned by patients, public, clinicians and commissioners, exploring issues in-depth, identifying potential solutions and mitigations. In particular:
- Transport/travel - an in-depth transport analysis will need to be undertaken so that the implications can be understood.
 - Further examination of the impact of the proposed change in service model on the local health economy and any unintended consequences for other services and providers and how these may be mitigated.
- Rec. 2.** Issues relating to equalities and accessibility of services, particularly in relation to 'scoped-in' groups identified through the Equalities Impact Analysis, should be explored in more depth in the later stages of the review. This includes:
- The potential benefit of elective surgery centre(s) in developing real expertise relevant to rare conditions and/or small cohorts of patients. For example, increasing awareness and reducing the risk of treatment-related decreased bone density in the transgender population.
- Rec. 3.** The next stages of the review should articulate clearer and better-defined messages about the benefits of centralising elective orthopaedic services for patients and the public. Key areas of focus include:
- Clinical evidence on the improved outcomes which might be achieved
 - Explaining the whole care pathway, including rehabilitation, not only the surgical element; and
 - Assurances about how continuity of care and joined-up working will be delivered.
- Rec. 4.** Through governance and operational structures, recruit clinicians in a range of roles across north central London who are interested in representing and advocating for the programme in future phases with stakeholders, media and face-to-face with residents. This includes providing training, support and coordination.
- Rec. 5.** Consideration should be given to how any potential options appraisal and evaluation processes can be co-designed with patients, clinicians and other local stakeholders. This will include applying patient experience and patient outcome criteria during the evaluation process. Key themes identified as part of the engagement process should be taken into account when designing any options appraisal criteria (i.e. sustainability of the whole system, reducing health inequalities, improving health outcomes, accessibility, managing interdependencies and improving the quality of the environment and experience for patients).

- Rec. 6.** Further thought should be given to how patients and the public can have an effective role in governance and operating structures developed for the second stage of the programme.

FOR PROVIDERS AS THE REVIEW PROGRESSES

- Rec. 7.** There should be clear and defined messages for staff. Key areas include:
- Further examination of the working practicalities of separating elective care – for example the impact of pressure on clinicians through acute or trauma work during periods of high demand e.g. winter pressures.

FOR COMMUNICATIONS AND ENGAGEMENT LEADS IN THE SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

- Rec. 8.** Consider opportunities at a system level (North London Partners in Health and Care) to establish long-term forums for groups sharing protected characteristics and others at risk of health inequality, that can be drawn upon as part of engagement on health and care services, rather than needing to reach out for each individual change programme.

5. THANKS AND ACKNOWLEDGEMENTS

This independent evaluation was conducted by Verve Communications. We are grateful to the programme team for running a comprehensive engagement and providing a great deal of raw data through an exhaustive process which elicited rich feedback for analysis.

We would also like to place on record our thanks to those who provided and arranged and attended meetings, created material and published information, collected feedback, and represented the Partnership in face-to-face discussions with stakeholders and local people.

APPENDIX A – ENGAGEMENT CHANNELS AND RESPONSE

DATA RECEIVED

SCALE OF ENGAGEMENT AND RESPONSE RECEIVED

In Table1, below, we set out the scale of activity and – where possible – the level of participation.

Forum	Meetings/Events	Numbers
Patients and Public	13	181
Commissioners	7	54
Providers	10	287
Local Authority	6	22
Total	38	546

Table1: Levels of engagement

ENGAGEMENT RESPONSE

Design Workshops	Attendance Numbers
Design Workshop #1- Review Group - Multi disciplinary design workshop - Engagement Planning Meeting	35
Design Workshop #2 - Institute of Sport, Exercise and Health - Multi-disciplinary design workshop	28
Design Workshop #3 Whittington Health Education Centre - Multi disciplinary design workshop	27
Design Workshop#4 - Institute of Sport, Exercise and Health -Multi disciplinary design workshop	38
Plenary – Plenary Meeting Arlington	44
Patient Engagement planning	
Barnet Healthwatch – Engagement planning meeting	2
Public Voice Haringey – Engagement Planning meeting	1
Islington Healthwatch – Engagement Planning Meeting	1

Table 2: Design workshops

Clinical Engagement:	Attendance Numbers
Provider engagement events	
Royal Free Communications Team - Engagement Planning Meeting	2
UCLH Surgery and Cancer Board - MDT Clinical Board	13
UCLH Specialist Board - MDT Clinical Board	25
Royal Free Joint Audit Meeting -MDT Clinical Board	40
RNOH Clinical Meeting - MDT Meeting	150
BMI Meeting Cavell Hospital - Independent engagement	2
Aspen Health Care - Independent engagement	2
North Midd Orthopaedic Team - Provider Meeting	10
Whittington Health - Provider Meeting (18)	18
UCLH Orthopaedic Audit Meeting - Provider Meeting	25
Clinical Commissioners engagement events	
Haringey and Islington Governing Body in Common - Commissioning Forum	23
Camden Seminar Board - Seminar Board	10
North and East Herts CCG - CCG Meeting	3
Enfield Board Seminar - Seminar Board	12
Herts Valley's - CCG Meeting	4
North West London STP - Neighbouring CCGs	1
North East London CCG - Neighbouring CCGs	1

Table 3: Commissioner & Provider Engagement

Public Engagement:	Attendance Numbers
Public and Patient engagement events	
Camden CPEG – Patient engagement meeting	16
Islington Over 55s Group Clairmont Centre – Public event	23
Having A Say Group – Barnet Mencap- Learning Disability Group	10
Haringey Adult Social Care Joint Partnership Board – Patient Public engagement	16
Enfield CCG Voluntary Community Stakeholder Reference Group – CCG Stakeholder reference group – Patients/Public	11
Barnet Healthwatch – Patient and public event	11
Enfield CCG – Patient and public event	24
St Luke’s, Islington Group (with Healthwatch Islington) – patient group	9
Haringey CCG open event	26
Camden Healthwatch Group – community event	7
Camden Carers’ Group – meeting with carers in Camden	3
Enfield Healthwatch public event – patient public event	23
Gendered Intelligence – patient group	2
Local Authority engagement events	
Islington Lead Member - Local Authority Engagement	2
Enfield Lead Member - Local Authority Engagement	2
Haringey Lead Member - Local Authority Engagement	2
Barnet Lead Member - Local Authority Engagement	3
Camden Lead Member - Local Authority Engagement	3
Enfield Health and Wellbeing - Board Local Authority Engagement	10

Table 4: Public, Patient and Local Authority Engagement

APPENDIX B – BEST PRACTICE GUIDANCE

NHS ENGLAND GUIDELINES

From NHS England guidance on engagement	Ref.	Observations of this engagement exercise
Front-line clinicians involved, including playing a role in communicating the benefits of change	p.17	<ul style="list-style-type: none"> ○ Provider events attended by over 280 staff ○ Design workshops clinically-led ○ Clinical leaders developed and presented the draft case for change throughout engagement.
Patients and public engaged throughout development, planning and decision-making	p.17	<ul style="list-style-type: none"> ○ Engagement was conducted at early stage of development to gather views on the draft case for change and initial proposition for delivery models.
Early involvement with diverse communities, HealthWatch and the local voluntary sector	p.19	<ul style="list-style-type: none"> ○ Programme Equalities Impact Assessment clearly stated the 'scoped-in' groups most likely to be impacted ○ Efforts were made to engage all scoped-in groups.
Involvement should be part of an ongoing dialogue	p.19	<ul style="list-style-type: none"> ○ This exercise is part of a phased engagement with initial focus on the draft case for change ○ Evaluation report provides a headline 'checklist' of priority issues to be considered at later stages, specifically with patient representatives / Healthwatch, LA Scrutiny, social care and voluntary sector.
A communications and engagement plan should set out objectives and methods, and provide evidence at assurance checkpoints	p.19	<ul style="list-style-type: none"> ○ A Communications and Engagement Strategy was developed to support the engagement phase of the review and beyond.
Early and continued contact with local MPs and councillors	p.19	<ul style="list-style-type: none"> ○ Face-to-face meetings were held with lead members for health and care in all five north central London boroughs ○ A briefing was prepared for MPs across NCL, for distribution via CCG communication teams ○ One MP responded with some questions about the review and draft case for change.
Patient and public representatives should be involved in internal assurance processes and structures	p.19	<ul style="list-style-type: none"> ○ Two patient representatives (recruited by Healthwatch) sit on the Review Group ○ Structures for internal assurance in the next stage of the review are not yet developed – a recommendation is made in respect of this.
It is good practice for commissioners to involve stakeholders in the early	p.25	<ul style="list-style-type: none"> ○ At this early stage, a wide range of stakeholders were involved in discussions on the draft case for change including:

From NHS England guidance on engagement	Ref.	Observations of this engagement exercise
stages of building a case for change		<ul style="list-style-type: none"> • Healthwatch and patient representative groups • Equalities organisations and networks • Clinical commissioners • Front-line staff • Local politicians.
Service design and communications should be appropriate and accessible to meet the needs of diverse communities	p.14	<ul style="list-style-type: none"> ○ The engagement is designed to be accessible to 'scoped-in' groups likely to be disproportionately impacted, with active inclusion for relevant third sector and representative groups ○ Draft case for change was made available for download in large print ○ A public-facing leaflet to accompany the draft case for change was produced for distribution (5,000 run).

Table 5: Best practice in engagement

THE CONSULTATION CHARTER

Consultation Charter best practice principles	Comments
Integrity	<ul style="list-style-type: none"> • The engagement has been conducted at scale and independently evaluated
Visibility	<ul style="list-style-type: none"> • There has been a high-level of external communication, public meetings attended, and participation has been widely promoted
Accessibility	<ul style="list-style-type: none"> • Engagement has focused on accessibility, with issues relevant to scoped in groups specifically addressed and involvement by people sharing protected characteristics actively encouraged through a process providing different channels to respond and accessible buildings
Transparency	<ul style="list-style-type: none"> • At meetings and in the draft case for change programme milestones and the process are clearly set out
Disclosure	<ul style="list-style-type: none"> • Clear and detailed information has been widely publicised in the draft case for change, and a large number of individuals were engaged face-to-face to answer the questions posed
Fair Interpretation	<ul style="list-style-type: none"> • Specialist social research expertise was deployed in the analysis - The process of capturing and interpreting data from the various feedback sources was overseen by Graham Kelly. Graham has worked in social research for nearly 30 years and was previously Head of Social Research at a leading market research company. From 2010-2018 he was a member of the Standards Board of the Market Research Society, which sets and polices ethical and professional standards.
Publication	<ul style="list-style-type: none"> • This report will be made public

Table 6: Consultation Charter principles

APPENDIX C - EQUALITIES MATRIX

Organisation	Direct	Via CCG	via Providers	Via Healthwatch	Older people	Carers	Race	Physical disability People with learning disabilities	Older white women	Social deprivation	Gender reassignment	Invited to participate	Undertook wider promotion Programme attended open meeting	Participated in specific event
Age UK		X		X	X					X		X		
Barnet Seniors	X				X							X		
Hornsey & Tottenham Seniors	X				X	X						X		
Enfield Over 50s Forum	X			X	X	X			X			X	X	X
Carers First	X			X	X				X	X		X	X	
Camden Carers	X				X				X	X		X	X	X
Carers UK	X				X					X		X	X	X
African Health Forum					X	X				X		X		
Physical disability reference group				X			X					X		X
Mencap - Have Your Say group						X	X	X	X	X		X	X	X
Opening Doors London	X								X		X	X		
Wise thoughts	X										X	X		
Gendered Intelligence	X										X	X	X	X
Camden CPEG		X				X	X		X			X	X	X
UCLH carer network			X		X	X						X	X	
Adult Social Care Joint Partnership Board		X			X	X	X	X	X			X	X	X
Claremont Centre Drop In	X	X			X	X	X	X	X			X	X	X
Enfield CCG VCSRG		X			X	X	X		X			X	X	X
Barnet Healthwatch				X	X	X	X		X			X	X	X
St Luke's Centre drop-in		X			X	X		X	X			X	X	X
Enfield Patient Engagement Event		X			X	X			X			X	X	X
Haringey CCG public meeting		X			X	X	X	X	X			X		X
Camden Healthwatch				X	X	X			X			X	X	X
Enfield Healthwatch public meeting				X	X	X	X		X			X	X	X
Camden Citizens Panel		X			X	X	X	X	X	X	X	X	X	
Camden disability action	X	X			X			X				X	X	
Outbound communication														
Camden Voluntary Action E News		X			X	X	X	X	X	X	X	X		
Camden Healthwatch Social Media				X	X	X	X	X	X	X	X	X		

Table 7: Equalities Engagement Matrix