Public Document Pack

AGENDA PAPERS MARKED "TO FOLLOW" FOR

JOINT HEALTH SCRUTINY COMMITTEE MEETING

Date: Monday, 14 January 2013

Time: 6.30 pm

Place: Committee Room 11, Manchester Town Hall, Albert Square, Manchester M60 2LA

	A G E N D A	**PART I**	**Pages**
5.	**NEW HEALTH DEAL FOR TRAFFORD - POST CONSULTATION**		1 - 60

To receive information for the Committee to consider in relation to the New Health Deal for Trafford consultation which concluded on 31 October 2012. The following items marked "To follow" are enclosed with this agenda:

- Item 5B – Strategic Programme Board Report to the Joint Health Scrutiny Committee
- Item 5H - Equality Analysis Report

THERESA GRANT and SIR HOWARD BERNSTEIN
Chief Executive Chief Executive

Contact

Helen Mitchell, Democratic Services Officer 0161 912 1229

Email: helen.mitchell@trafford.gov.uk

This supplementary agenda was issued on 3rd January 2013 by the Legal and Democratic Services Section, Trafford Council, Quay West, Trafford Wharf Road, Trafford Park, Manchester, M17 1HH.

Strategic Programme Board report to Joint Health Scrutiny Committee

14th January 2013

1. Introduction

Following a 14 week consultation process, the New Health Deal for Trafford public consultation closed on the 31st October 2012. Since this time the Trafford Strategic Programme Board (SPB) has been undertaking a decision making process which will culminate with a formal recommendation from the SPB being considered by the Board of NHS Greater Manchester on the 24th January 2012.

As part of this decision making process, a meeting of the Strategic Programme Board took place on the 19th December 2012 to review the evidence collated through the consultation process. The meeting was held in public. The chair and the vice chair of the Joint Health scrutiny committee were formally invited to attend this meeting as were members of the public reference group. This paper outlines the information presented, the discussion which took place and the proposals agreed within this meeting.

The Joint Health Scrutiny Committee is asked to consider the information outlined in this report, in conjunction with associated paperwork, and to provide comments which will be considered by the Strategic Programme Board, on the 15th January 2012, before final recommendations are made.

2. Information presented to the Strategic Programme Board (SPB)

On the 19th December 2012, the Strategic Programme Board was presented with a range of information, as outlined below in Table One (Agenda is attached at Appendix 1). Full reports/papers have been made available to the Joint Health Scrutiny Committee for consideration. The SPB also noted the information, presented to it on the 29th November 2012 at a meeting held in public, by Save Trafford General campaign group, staff side representatives including UNISON and the Royal College of Nurses and Trafford LINk (Appendix 2).

Table 1 – Information presented to Strategic Programme Board 19th December 2012

Reports/papers presented to Strategic Programme Board on 19th December 2012
• Report of National Clinical Advisory Team (May 2012) • Report of Integrated Care Redesign Board (November 2012) • Public Consultation documents x3 (July 2012) • Pre-consultation Business case (May 2012) • Consultation process report (December 2012) • Report of Public Reference Group (December 2012) • Report regarding compliance with the Equality Act (December 2012) • Analysis of public consultation responses (December 2012) • Report regarding transport Implications (December 2012) • Report by Transport for Communities (regarding transport solutions (December 2012) • Provider Assurance (December 2012)

Presentations received by Strategic Programme Board
• Presentation regarding clinical rationale and feedback from Integrated Care Redesign Board • Presentation regarding consultation process • Presentation from Public Reference Group • Presentation regarding compliance with the Equality Act • Presentation regarding analysis of public consultation responses • Presentation from North West Ambulance Service • Presentation regarding transport implications and potential solutions • Presentation regarding financial implications of New Health Deal proposals

3. Trafford Strategic Programme Board discussion

The Board received the information outlined above and a lengthy discussion relating to each item took place. Following this process, the voting members of the SPB were unanimously minded to make the following proposals:

- The Strategic Programme Board reaffirms it's support for the clinical rationale for the case for change relating to the New Health Deal proposals.
- The Strategic Programme Board accepts that 'do nothing' is not an option for Trafford General Hospital.
- The Strategic Programme Board wishes to make explicit reference to the Integrated Care Redesign Board view that a delay in decision making will have an adverse effect on the services currently provided at Trafford General Hospital (TGH).
- The Strategic Programme Board is satisfied that the consultation process has adhered to Section 149 of the Equality Act 2010 which promotes due regard to people who may be disadvantaged due to characteristics including age, race, disability, religion or belief.
- The Strategic Programme Board is satisfied that the consultation process has adhered to Section 242 of the NHS Act 2006 which relates to public involvement and consultation and includes a requirement by NHS bodies to ensure those who are affected by services changes are involved in consultation on the development and consideration of proposals for change.
- The Strategic Programme Board is satisfied that the consultation process has adhered to Section 244 of the NHS Act 2006 which relates to the functions of overview and scrutiny committees, as well as when NHS bodies must consult the committee and the information they must provide the committee.
- The Strategic Programme Board is satisfied that the consultation was conducted in a manner which was fair, objective, accessible and transparent.
- The Strategic Programme Board is satisfied that the consultation responses have been independently collated and analysed objectively and that the key themes/public concerns were identified.
- The Strategic Programme Board is content that the financial pressures outlined in the pre-consultation business case are reflective of the current financial situation in Trafford hospitals and that the clinical model outlined in the consultation process will largely resolve the £19m deficit.

The SPB also considered the information that had been presented to it against the Department of Health 4 tests for service reconfiguration. The details of the tests, and the assessments made, are presented below:

Test 1: Clinical Commissioner Support

The Chairs of Trafford Clinical Commissioning Group (CCG), Central Manchester Clinical Commissioning Group and South Manchester Clinical Commissioning Group were present for the whole meeting and constitute part of the voting committee. Each of the CCG chairs were asked to provide the response of their CCG, to the New Health Deal proposals, and these responses were received by the Board.

All Chairs agreed with the clinical case for change and voiced support for the New Health Deal proposals. The chairs of central and south Manchester CCGs highlighted the reassurance they had received, during the course of the meeting, in relation to the investment to be made in Integrated Care services in Trafford and the ability of local provider hospitals to cope with any changes in activity that might result following any changes that are made to Trafford General Hospital.

The Board was therefore minded to recommend that the requirements of Test 1 have been met.

Test 2: Strengthened Patient Engagement

The Board received a report on the consultation process and noted that over 1900 responses had been received to the public consultation. The Board also received a report from an independent consultant regarding compliance with the 2010 Equality Act and from the Public Reference Group who were tasked with independently assessing whether the consultation process was conducted in a manner which was fair, objective, accessible and transparent.

The Board also received the results of the independent analysis of the responses that had been made during the public consultation process and noted the petitions that have been presented, by the Save Trafford General Campaign group, to No.10 Downing Street. The Board also noted the presentations that had been made to the previous meeting on the Strategic Programme Board on the 29th November 2012 and noted the pre-consultation engagement that had taken place.

The Board was therefore minded to recommend that the requirements of Test 2 have been met.

Test 3: Clarity on Evidence Base

The Board were reminded of the clinical case for change and the clinical models made in the pre-consultation business case and the public consultation documents. The Board noted that the identification of the clinical case for change was undertaken by local clinicians and based on both national and local clinical guidance from bodies such as the Royal College of Surgeons and the Greater Manchester Critical Care Network. The Board noted that the proposed models of care were also developed by a range of local clinicians. The Board also noted the National Clinical Advisory Team report (May 2012) that supported both the clinical case for change and the proposed models of care.

The Board received feedback from the Trafford Integrated Care Redesign Board which had re-considered the case for change and proposed models in light of the feedback received during the consultation process. The Board noted the recommendations made by this group and also acknowledged the view of local clinicians that a delay in the decision making process would adversely affect the services provided at Trafford General Hospital.

The Board was therefore minded to recommend that the requirements of Test 3 have been met.

Test 4: Consistency with current and prospective Patient Choice

The Board received information relating to transport implications of the New Health Deal proposals and some potential solutions developed by a stakeholder group which included local residents, Transport for Greater Manchester and community transport providers.

The chair of Trafford Clinical Commissioning Group confirmed that the CCG was content that the proposals do not limit choice and will improve patient outcomes/experience.

A representative from Central Manchester University Hospital Foundation Trust (CMFT) provided the Board with information relating to the process of review, undertaken by the NHS Co-operation and Panel (CCP), of the acquisition of Trafford Healthcare Trust by CMFT. The Board heard that the CCP had no objections to the acquisition process and did not feel that this process limited patient choice.

The Board was therefore minded to recommend that the requirements of Test 4 have been met.

4. Responses made to themes identified within public consultation

The Board noted the results of the analysis of the public consultation responses and agreed that these responses represented a key component of the decision making process. However, the Board also agreed that the public responses needed to be considered against the feedback provided by clinical experts including local clinicians, CCG representatives, the National Clinical Advisory Team and national guidance.

A number of concerns were identified by the public within the consultation process and these were presented to the Board by the independent consultant who undertook the analysis of these responses. These concerns were discussed and the outcomes of these discussions fed into the overall decision making process.

The concerns raised by the Joint Health Scrutiny Committee during the consultation process, and the Board discussion that took place relating to these items, are summarised in Table 2.

Table 2 - Joint Health Scrutiny feedback

i. Joint Health Scrutiny Feedback: **The New Health Deal proposals should be considered as part of the Healthier Together process.**
Board Discussion: The Board heard that the Healthier Together process was in a relatively early stage of development and that no firm proposals within Healthier Together have yet been developed. The Board also heard that the clinical and financial situation in Trafford General Hospitals was such that senior NHS representatives felt it necessary to act, without delay, in order to ensure high quality services for patients. The Board was reassured that the two processes were being managed by the Greater Manchester service transformation team and that any necessary links between the two processes were being made. **The Board was therefore satisfied that it was correct to start the New Health Deal consultation in advance of definitive plans being made within the Healthier Together programme.**

ii. Joint Health Scrutiny Feedback: **Concern that the New Health Deal proposals only contained a single proposal.**
Board Discussion: The Board revisited the process undertaken to devise different options for the delivery of services within Trafford and the subsequent process of option appraisal which took place. The Board was reminded of the role of the National Clinical Advisory Team in this process and the firm view that was held, by local clinicians, that only distinct and viable models of care should be presented to the public in a consultation process. The Board reaffirmed it's view that it would be disingenuous to consult on models of care that could not be operationally implemented and that 'do nothing' was felt, by local clinicians, to represent neither a safe, or sustainable, option. **The Board accepted that more should have been done, in the consultation process, to explain to the local population the reasons for consulting on a single option, and agreed that this learning should be fed into future NHS consultations.**

iii. Joint Health Scrutiny Feedback: **Questions over the ability of UHSM, MRI, RMCH, SRFT and NWAS to cope with the proposed changes and the subsequent changes in activity those proposals may cause.**
Board Discussion: The Board heard that Central Manchester Foundation Trust, Salford Royal Foundation Trust and the North West Ambulance Service were content that they could manage predicted changes in activity resulting if an Urgent Care Centre was introduced at Trafford General Hospital (Model 2). The Board also heard that University Hospital of South Manchester was content that this change could be managed, within existing infrastructure, providing the plans of Trafford CCG to reduce urgent care activity via the further introduction of Integrated Care Services were realised. The Board was content, given the information provided by Trafford CCG regarding the planned investment and progress towards delivering improved delivery of integrated care, that this would be the case. **The Board felt that an appropriate assurance process should be put in place to 'double check' provider capacity before any proposed changes are implemented.** **In addition, the Board felt that it was important to ensure local provider organisations could also cope with any change from an Urgent Care model to a Minor Injuries Unit** (see iv below)**.**

iv. Joint Health Scrutiny Feedback: **Clarity regarding the change from model 2 (Urgent Care Centre at TGH) to model 3 (Minor Injuries**

Unit at TGH)
Board Discussion: The Board heard, from the analysis of public consultation responses, that there was a degree of confusion regarding the difference between an Urgent Care Centre and a Minor Injuries Unit. The Board accepted that, depending the outcome of the decision making process, more would need to be done to communicate to the public what future services would be available at Trafford General Hospital. **The Board agreed that a set of clinical criteria should be developed by local clinicians to outline when any change from an Urgent Care Centre, to a Minor Injuries Unit, could safely be made. These criteria will need to be endorsed by the Integrated Care Redesign Board and will incorporate the requirements of alternative providers including community and primary care services, before this transfer occurs.**

v. Joint Health Scrutiny Feedback: **Concern regarding the future provision of Integrated care services in Trafford**
Board Discussion: On the 29th November 2012 the Board received a presentation from Trafford CCG outlining the programme plans for the development of Integrated Care services. These plans included clear milestones and delivery plans for the further development of Integrated Care services and outlined the programme office and personnel that have been put in place to oversee this process. The Board were informed of the progress that has already been made against this plan. On the 19th December 2012, the Board received a presentation regarding the financial investment that Trafford CCG intends to make, over coming years, in Integrated Care services and noted the significant increase in investment this is planned over 13/14 and beyond. **The Board was assured that the programme and investment plans for the future provision of Integrated Care services in Trafford were robust.**

vi. Joint Health Scrutiny Feedback: **Concerns regarding Transport and Access**
Board Discussion: The Board heard, from the analysis of public consultation responses, the public concern about the transport and access implications of accessing alternative hospital sites, as a result of the New Health Deal proposals. The Board heard that local clinicians and the North West Ambulance Service did not believe that patient safety would be compromised as a result of slightly longer ambulance journeys which might result from the proposed changes. The Board also heard the outcome of data analysis that had been undertaken to attempt to quantify the number of people who might be affected, in terms of transport, by the New Health Deal proposals. The Board noted the large number of assumptions that had been made completing this piece of work and recognised that the figures provided were only indicative. The Board also heard the outcome of the work that had been undertaken with local stakeholders, including community representatives, to devise solutions to address some of the transport implications. **The Board accepted in full the recommendations made by the local stakeholders, including that investment should be made to subsidise the cost of a local link service in Trafford to ensure patients/visitors, particularly in Partington and Carrington, are able to more easily access this service in order to visit alternative hospital sites.**

The Board also accepted the suggestion that a 'health transport bureau' be set up for Trafford residents to provide guidance and support for those needing to access services at an alternative hospital site OR for patients from elsewhere needing to access Orthopaedic services on the Trafford hospital site.

vii. Joint Health Scrutiny Feedback:
Concern as to whether the Elective Orthopaedic Centre at TGH would be sustainable over the medium/ long term

Board Discussion:
The Board heard that patients across the country exercise their right to choose where they attend for planned surgical services and that, in many cases, patients choose to go to an alternative site than their local hospital. The Board also heard that many Manchester residents previously chose to attend the Greater Manchester Surgical Centre, situated on the Trafford General Hospital site, and accepted the view that there was no reason to assume this would be any different for an elective orthopaedic centre.

The Board were assured by comments from Manchester CCG that with the proviso of appropriate transport arrangements being available, they were supportive of the development of an Elective Orthopaedic Centre at Trafford General Hospital and felt the service would be of great benefit to the local population. The Board also heard that clinicians were content that elective orthopaedic services could be safely delivered in the absence of an on-site level 3 intensive care unit and were reassured with information provided that this model exists within a number of orthopaedic units/hospitals throughout the country including at Wrightington in Greater Manchester.

The Board therefore felt the Elective Orthopaedic Centre at TGH would be sustainable over the medium to long term.

viii. Joint Health Scrutiny Feedback:
How patient safety, for those who have day case surgery under New Health Deal proposals, can be protected

Board Discussion:
The Board heard that local clinicians, including local surgeons, were content that Day Case surgery could be safely provided at Trafford General Hospital in the absence of Level 3 Intensive Care services. The Board was reassured by a description of the arrangements that would be put in place to ensure patient safety and care for any patient whose clinical condition deteriorated unexpectedly. The Board was also reassured that the National Clinical Advisory Team had not voiced any concerns relating to the proposed clinical models.

The Board therefore felt that patient safety, for those who have day case surgery under New Health Deal proposals, can be protected.

5. Proposals made by Trafford Strategic Programme Board

The meeting on the 19th December 2012 concluded with the 5 voting members considering their formal proposal regarding the New Health Deal consultation. Having considered all the information provided, the voting members of the Strategic Programme Board were unanimously minded to move forward with the redesign proposals outlined in the public consultation documents with some recommendations. These recommendations are outlined in Table 3.

Table 3 – Trafford Strategic Programme Board recommendations

Recommendations	Rationale
The development of additional Integrated Care services for some parts of the Borough, specifically the introduction of a community matron service and a consultant community geriatrician, before changes take place to the Accident and Emergency service.	The Board recognised the need to ensure appropriate community services are in place for residents in Partington/Carrington in order to minimise the impact of changes to the Accident and Emergency service at Trafford General Hospital and to address current issues relating to health inequality.
The identification of appropriate pathways for those affected with Mental Health issues and who currently access services at Trafford General Accident and Emergency department at night and might be impacted by the potential changes. These pathways should be identified before any proposed changes take place to the Accident and Emergency service.	The Board recognised that those with mental health problems often represent a vulnerable group of patients. The Board also acknowledged that the consultation process had identified public concern regarding the services available to these patients if A&E services at Trafford General changed. The Board felt the arrangements for these patients needed to be clearly understood and communicated to patients/health professionals.
The investment in a subsidy for local Link services, to access alternative hospital sites, should be made before any changes to Trafford hospital services are implemented. The development of a health transport bureau should be in progress before any changes to Trafford hospital services are made.	The Board recognised the need to ensure appropriate transport services were in place to minimise the impact, on access, for patients who might be affected by the New Health Deal proposals. The Board felt that the development of a Health Transport Bureau and a subsidy in local link services provided the best solution for ensuring easy access was maintained.
The Integrated Care Redesign Board should be tasked to develop a set of clinical criteria which outline the circumstances under which a safe move from the proposed Urgent Care Centre (Model 2) to the proposed Minor Injuries Unit (Model 3) can be made.	The Board recognised the concern from local providers and the public regarding the move from an Urgent Care Centre to a Minor Injuries unit and the need to ensure appropriate community/primary care services are in place before this move is made.
Prior to any service changes, an assurance process should be established to further ensure alternative provider capacity is in place and services can be safely moved.	The Board recognised the need to ensure the implementation of service changes occurs in a way that ensures patient safety and promotes a positive patient experience.
The recommendations made by the Public Reference Group should be fully accepted and be made available to local and national NHS organisations planning consultation processes.	The Board recognised the important role that the public reference group played in monitoring the consultation process and felt their recommendations should be noted by others involved in any future consultation processes.

The draft minutes of the SPB meeting held on the 19th December are included in Appendix 3.

6. Conclusion

The Joint Health Scrutiny Committee is asked to consider the information outlined in this report, in conjunction with associated paperwork, and to provide comments which will be considered by the Strategic Programme Board, on the 15th January 2012, before final recommendations are made to NHS Greater Manchester.

7. Appendices

Appendix 1 – Agenda of SPB held on 19th December 2012.	2012_12_19_Agend a Trafford Strategic F
Appendix 2 – Minutes of the SPB held on the 29th November 2012	2013 01 03 TSB minutes 29th Nov FIN
Appendix 3– Draft minutes of the SPB held on the 19th December 2012.	2012 12 19 DRAFT TSPB minutes v 5.pdf

This page is intentionally left blank

Trafford Strategic Programme Board

Meeting to be held on 19th December 2012

Venue: Flixton House, Flixton Road, Flixton, M415GJ
9.30am - 17.00pm
AGENDA

Time	No.	Item	Lead
9.30am	1.	Welcome, Introductions and Apologies	Chair
9.40am	2.	Minutes of last meeting and matters arising Associated documents: ❖ Minutes of last meeting, 29th November	Chair
9.50am	3.	The clinical rationale • The clinical case for change • The proposed options • Feedback from ICRB • SPB Discussion/Response Associated documents: ❖ NCAT Report ❖ ICRB Report ❖ Public Consultation Documents (x3) ❖ Pre-consultation Business Case	Dr G Kissen & Mr R Pearson
10.30am		BREAK	
10.45am	4.	The consultation process • Report on consultation process • Equality Analysis • Public Reference Group Report • SPB Discussion/Response Associated documents: ❖ Engagement Report (including pre-engagement report as appendix) ❖ Equality Analysis Report ❖ PRG Report ❖ Pre-consultation business case Appendix J: Equality Analysis (see above) Links to: Section 242 & 244 NHS Act 2006 http://www.legislation.gov.uk/ukpga/2006/41/contents Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/contents	E Portsmouth I Blood H Bidwell

11.30am	5.	Public consultation responses • Analysis of responses • Responses from key stakeholders • Petitions • SPB Discussion/Response Associated documents: ❖ Final Report, analysis of public consultation	Dr J York Chair Chair
12.30pm	LUNCH		
1.15pm	6.	Summary from Workstreams • Emergency Transport • Non-Emergency Transport • Provider Capacity • Finance • SPB Discussion/Response Associated documents: ❖ Non-emergency transport reports: Report regarding transport implications & TfC Final report ❖ Provider Assurance Report	A Hickson S Travis J Williams T Barlow
2.15pm	7.	DH tests for service reconfiguration • Test 1: Clinical Commissioner Support • Test 2: Strengthened Patient Engagement • Test 3: Clarity on Clinical Evidence Base • Test 4: Consistency with current and prospective patient choice Associated documents: Description of 4 tests	CCG Chairs Board Discussion Board Discussion Board Discussion
3.00pm	BREAK		
3.15pm	8.	Summary of Board Responses & Agree proposals for New Health Deal for Trafford	Chair
4.30pm	9.	Any Other Business and Next Steps	Chair
4.45pm	10.	Close	

Time and Venue of next meeting: **15th January, 9.30am - 13.00pm , Flixton House, Flixton Road, Flixton, M415GJ**

Item 2

Minutes of the Trafford Strategic Programme Board
Held on Thursday 19 December 2012
Flixton House, Flixton Road, Urmston

DRAFT

Present:

John Schultz	(JS)	Chair, Trafford Strategic Programme Board
Terry Atherton	(TA)	Vice-Chair, NHS Greater Manchester
Darren Banks	(DB)	Director of Strategic Development, Central Manchester University Hospitals NHS Foundation Trust
Tim Barlow	(TB)	Director of Finance, Trafford Clinical Commissioning Group
Jonathan Berry	(JB)	Chair, Trafford Primary Health Ltd.
Deborah Brownlee	(DB)	Corporate Director for Children and Young Peoples Service, Trafford MBC
Mike Burrows	(MB)	Chief Executive, NHS Greater Manchester
Ann Day	(AD)	Chair, Trafford LINk
Mike Eeckelaers	(ME)	Chair, Central Manchester Clinical Commissioning Group
Stephen Gardner	(SG)	Director of Strategic Projects, Central Manchester University Hospitals NHS Foundation Trust
Nigel Guest	(NG)	Interim Chief Clinical Officer, Trafford Clinical Commissioning Group
Janet Hall	(JH)	Associate Director of Operations, Trafford NHS Provider Services
Anthony Hassall	(AH)	Director of Business Development, University Hospital of South Manchester NHS Foundation Trust
Claire Heneghan	(CH)	Divisional Director, Chief Nurse, Trafford NHS Provider Services
Andy Hickson	(AH)	Assistant Director of Commissioning, North West Ambulance Service
George Kissen	(GK)	Clinical Director, NHS Trafford
Gina Lawrence	(GL)	Director of Commissioning, Trafford Clinical Commissioning Group
David McNally	(DM)	Associate Director Delivery PMO & Service Reconfiguration, NHS North of England
Simon Musgrave	(SM)	Clinical Director, (Trafford Division), Central Manchester University Hospitals Foundation Trust
Bob Pearson	(RP)	Medical Director, Central Manchester University Hospitals Foundation Trust
Bill Tamkin	(BT)	Chair, South Manchester Clinical Commissioning Group
Jessica Williams	(JW)	Associate Director, NHS Greater Manchester
Leila Williams	(LW)	Director of Service Transformation, NHS Greater Manchester
Claire Yarwood	(CY)	Director of Finance, NHS Greater Manchester
Michael Young	(MY)	Executive Member, Adult Social Services and Wellbeing, Trafford Council

In attendance:

Jill Boardman	(JB)	Business Support Officer, NHS Greater Manchester (Minutes)
Alison Starkie	(AS)	Assistant Director, NHS Greater Manchester
Gemma Watts	(GW)	Project Manager, NHS Greater Manchester
Imogen Blood	(IB)	Imogen Blood and Associates
Erin Portsmouth	(EP)	Communications Lead, NHS Trafford
Stephen Travis	(ST)	Transport for Greater Manchester
Dr Janelle Yorke	(JY)	Independent Analyst

Action

1. Welcome and Apologies

Apologies for absence were received from:

Councillor Matthew Colledge, Leader of the Council, Trafford MBC
Kate Fallon, Chief Executive, Bridgewater Community Healthcare NHS Foundation Trust
Theresa Grant, Chief Executive, Trafford MBC
Gill Heaton, Director of Patient Services/Chief Nurse, Central Manchester University Hospitals NHS Foundation Trust
Karen James, Chief Executive, University Hospital of South Manchester NHS Foundation Trust.

John Schultz (JS) Chair, extended a warm welcome to members of the Board, members of the public and representatives of Trafford LINk and the Public Reference Group. He reiterated that the meeting is a meeting held in public and it is an opportunity for members of the public to witness the Board meeting but not take part in it. He outlined the business of the meeting and informed the members that aim of the meeting is to reach some preliminary conclusions on what the Board will be recommending to NHS Greater Manchester subject to the final views of the Joint Health Overview and Scrutiny Committee.

JS reiterated that any formal decisions made today would be made by the five voting members.

2. Minutes of the meeting held on 29 November 2012

The minutes of the previous meeting held on 29 November 2012 were approved as a correct and accurate record of the meeting subject to the following amendments:

Gina Lawrence, Janet Hall and Ian Williamson to be added to the list of members present at the meeting.

There were no matters arising from the minutes.

DRAFT

Action

Add Gina Lawrence, Janet Hall and Ian Williamson to the list of members present at the meeting on 29 November 2012. **Jill Boardman**

3. The Clinical Rationale

John Schultz (JS) acknowledged the input of the wide range of clinicians who have been involved in the process to date and reiterated that the clinical case for change and the proposed clinical model is contained within the consultation documents.

JS confirmed that members had received the documents below which form the written documentation to the clinical rationale:

- Integrated Care Redesign Board (ICRB) report
- National Clinical Assessment Team's (NCAT) report
- Consultation documents
- Pre-consultation business case

Dr George Kissen (GK) presented in summary form the background information to the clinical case for change and Mr Bob Pearson (BP) presented an overview of the proposed clinical model.

GK reported that the ICRB had considered the feedback from the public meetings, organisational responses and the preliminary analysis of the consultation and confirmed that the ICRB:

- Believed the clinical case for change outlined in the public consultation document was still valid.
- Supported the clinical model proposed in the public consultation and believed this offered the best viable opportunity to provide high quality services to the residents in Trafford
- Was not recommending any changes to the proposed model or any alternative models.

Key areas of response:

ICRB considered the public suggestion that staff could be rotated between hospital sites to allow all services to remain at Trafford General Hospital (TGH):
BP informed members that the Central Manchester Foundation Trust (CMFT) anticipate that a number of clinicians and allied healthcare professionals will work across both hospital sites, where appropriate, to maintain expertise on both sites. However, BP reiterated that, from a clinical perspective, focusing patients where there is sufficient critical mass to maintain expertise gives the best outcomes for patients and so in certain clinical areas rotation would not be possible.

Public concern regarding increased ambulance journey times:
GK informed members that the IRCB firmly believe that getting patients to the right hospital to receive the best possible treatment is the right thing to do and is already taking place with a number of critical conditions and there is no evidence

DRAFT

to support the idea that small increases in journey times would have an adverse effect on patient outcomes.

Public concerns regarding the safe provision of orthopaedic/day case surgery without an ICU:
BP reported that there will be facilities in place at TGH to care for patients who unexpectedly require level 3 support. BP described what level 3 intensive care support is and informed members there are a lot of hospitals who work with a high dependency model (HDU) to support level 2 patients, for example, Wrightington Hospital.

GK highlighted the following issues which the IRCB asked to be brought to the attention of the Board:

- Capacity in local secondary care providers and the North West Ambulance Service (NWAS) in order to manage the proposed changes
- Transport issues need to be addressed
- The model of level 2 HDU delivery at TGH should be described in more detail
- The pathway for mental health patients should be developed further before any service changes are made.
- A set of clinical criteria/parameters which outline the conditions for the safe move from model 2 to model 3 should be articulated and met before the proposed change to model 3 is made.

JS asked members if they had any questions regarding the presentation.

Terry Atherton (TA) commented there is public concern regarding the perceived increase in risk that patients will face as a result of increased ambulance journey times to receive care at an alternative location. He asked for a clinical view. GK responded that this had been discussed in detail at the ICRB meeting with NWAS in attendance. He informed members that certain critically ill patients were already being transferred to other centres and stated that there is no evidence that the distances relating to those in the Trafford health economy would have an adverse effect on patients. He reported that the view of ICRB is that there is no evidence to suggest an adverse effect and that these changes would have a positive effect on patients. A discussion ensued regarding the transport of patients between hospital sites.

Ann Day (AD) asked for clarification on the management of patients for the mental health 136 unit between midnight and 8.00 am when the proposed urgent care centre is to be closed. GK informed members that a wider discussion about the provision of the mental health 136 units across Greater Manchester has commenced with the mental health trust and other organisations. GK stated he is confident provision for these patients will be in place before implementation of the proposals.

Jessica Williams (JW) asked whether assurance be given that the general pathways for mental health patients would be in place before the implementation of the proposals as well as those with a Section 136. GK responded that the

DRAFT

mental health commissioning team are strengthening these pathways and they would be in place before any implementation of the proposals.

Jonathan Berry (JB) sought clarification on the provision of Day Case Surgery and Orthopaedics in the absence of a Level 3 ICU. BP responded that a level 2 HDU will be in place for patients who require that added level of support either post operatively or because they are acutely ill. He added that patients who may require level 3 support could be safely transferred to an alternative site and that any elective patient with a predicted high likelihood of complex need would be treated at Manchester Royal Infirmary (MRI). GK informed members work is taking place with NWAS on their paramedic pathfinder model to ensure patients are taken to the appropriate hospital and this pathfinder model is already operating in other parts of the North West. Discussions are ongoing regarding the setting of the threshold of activity to ensure patients access the appropriate hospital.

JW acknowledged the success of the elective orthopaedic centre will be dependent on patients travelling from outside Trafford to access this service. JW asked GK/BP whether they were confident that this movement of patients will take place? BP informed members that there has not been any opposition from patients or the public in Manchester to travelling to access the service.

Leila Williams asked for further clarification regarding the ICRB view that the rotation of staff between hospital sites to maintain all services at TGH, as suggested in some consultation responses, would not offer a practicable solution. BP commented that staff rotate already between MRI and TGH A&E departments; and the length of stay for staff in these jobs is a lot less than staff who are full-time on one site, therefore it is not an attractive proposition for long term recruitment. With regard to the critical care unit, these need to see a throughput of patients to maintain competence, and so staff rotation for certain grades of staff would not allow skills and competence to be maintained.

Deborah Brownlee stated that one of the consequences of the proposals is the closure of the paediatric observation and assessment unit at TGH and asked what steps are being taken to ensure that the needs of children accessing the urgent care unit would be met. BP explained the DoH guidelines/pathways regarding children attending A&E/urgent care unit departments.

The Chair asked the following formal questions:

Does the Board reaffirm its support for the clinical rationale for the case for change relating to the New Health Deal proposals?

The five voting members unanimously reaffirmed their support for the clinical rationale for the case for change relating to the New Health Deal proposals.

Does the Board accept that 'do nothing' is not an option for Trafford General Hospital?

DRAFT

The five voting members unanimously accepted that ‘do nothing’ is not an option for Trafford General Hospital.

How does the SPB wish to respond to the ICRB view that a delay in decision making will have an adverse effect on the services currently provided at TGH?

The Board favoured making explicit reference in its recommendations to NHS Greater Manchester that a delay in the decision making will have an adverse effect on the services currently provided at TGH.

How does the Board wish to respond to the issues outlined by the ICRB?

The Board agreed to respond to the issues outlined by the ICRB:
- Provider capacity
- Transport issues
- Mental Health pathways
- Clinical parameters from model 2-3

in its recommendations to NHS Greater Manchester.

4. The Consultation Process

John Schultz (JS) confirmed that members had received the following documents:
- Report on the Consultation Process
- Equality Analysis Report
- Public Reference Group report

and links to 2010 Equality Act and Section 242/244 NHS Act.

JS extended thanks to the Public Reference Group members and explained that representatives of the Group had attended all the public meetings in order to reach an independent view on the consultation process.

Erin Portsmouth, Communications Lead, Trafford Clinical Commissioning Group (CCG) presented the Report on the Consultation Process carried out for the new health deal for Trafford project, including a review and evaluation.

Imogen Blood, Imogen Blood & Associates, presented the Equality Analysis Report presentation which focussed on the process of the consultation and identified and assessed evidence to answer: was the consultation accessible to all? Was the engagement experience positive? Do those who responded reflect the diversity of the Borough?

Helen Bidwell, Independent Chair, Public Reference Group presented the Public Reference Group report which outlines the approach taken by the Public Reference Group in scrutinising the consultation process, outlined key themes and issues arising, and made recommendations for the future.

DRAFT

JS invited comments and questions from members of the Board.

David McNally (DMcN) made reference to the SHA's role in the consultation process and informed members that the SHA approved the proposals before they went out to public consultation. DMcN reported that part of this process considered the New Health Deal communications and engagement plans to ensure they met best practice and the relevant legislation. He commented that this had been an excellent piece of work.

JS reiterated that the Equality Analysis was an analysis of the consultation process and reminded members that there had been an equality analysis of the consultation proposals which was set out in Appendix J of the Pre Consultation Business Case. He informed members that the analysis in the pre consultation business case will be revisited when a final decision has been made on the consultation and should be taken forward as part of the implementation process.

JS brought members' attention to the recommendations made within the Public Reference Group and Equality Analysis reports, in both cases in the context of conclusions that were very supportive and favourable overall:

Equality Analysis recommendations:

- More publicity of the fact that this is part of a longer engagement process
- Need to demonstrate and feedback how response has shaped decision/ implementation

Public Reference Group recommendations:

- Some issues relate to timescales; a longer lead-in period will allow for adequate planning.
- Establish a public reference group as part of the pre-consultation phase; benefit earlier from independent scrutiny.
- Seek to use one delivery body to distribute materials, building in adequate timescales.
- Aim to receive the highest number of public responses via the least cost.
- Ensure health and social care staff, and others working to deliver public services are briefed and able to raise awareness/signpost to consultation documentation.
- Consider the submission of 'written' questions as part of a public meeting; avoid repetition, enabling fair distribution of question content and delivery of more considered responses.
- Ensure 'meeting rules' are made clear and understood.
- Where possible use one 'chair' to ensure continuity and provide an appropriate briefing.

Darren Banks (DB) reminded members of the processes the Board went through to come up with a single option to consult on, and comments made during the

DRAFT

consultation that the rationale for this had not been explained and communicated with sufficient clarity to the public.

Leila Williams (LW) commented that the rationale should be incorporated into the final report to NHS Greater Manchester Board, thereby proactively acting on one of the recommendations from the Public Reference Group.

Leila WIlliams

Ann Day (AD) commented that many members of the Public Reference Group had also previously been members of the reference group for the acquisition of Trafford Healthcare Trust. She stated that if the acquisition reference group had continued to meet during the pre engagement period of the consultation there would have been a better understanding of the pre consultation process and therefore the Public Reference Group should have formed earlier.

The Board accepted the recommendations made within the PRG and Equality Analysis reports and agreed to draw these to the attention of those in the NHS who undertake future public consultations.

DMcN informed the Board that policies regarding consultation are being drawn up nationally within the Policy Directorate of the NHS Commissioning Board and he agreed to feed the learning from this consultation into the national process.

David McNally

The Chair asked the following formal questions:

Is the Board satisfied that the consultation process has adhered to Section 149 of the Equality Act 2010 which promotes due regard to people who may be disadvantaged due to characteristics including age, race, disability, religion or belief?

The five voting members unanimously confirmed that they were satisfied that the consultation process had adhered to Section 149 of the Equality Act 2010 which promotes due regard to people who may be disadvantaged due to characteristics including age, race, disability, religion or belief?.

Is the Board satisfied that the consultation process has adhered to Section 242 of the NHS Act 2006 which relates to public involvement and consultation and includes a requirement by NHS bodies to ensure those who are affected by service changes are involved and consulted on the development and consideration of proposals for change?

The five voting members unanimously confirmed that they were satisfied the consultation process had adhered to Section 242 of the NHS Act 2006 relating to public involvement and consultation and included a requirement by NHS bodies to ensure those who were affected by service changes were involved and consulted on the development and consideration of proposals for change.

Is the Board satisfied the consultation process has adhered to Section 244 of the National Health Service Act 2006 which relate to the functions of overview and scrutiny committees, as well as when NHS bodies must

DRAFT

consult the committee and the information they must provide to the committee?

The five voting members unanimously confirmed that they were satisfied that the consultation process had adhered to Section 244 of the National Health Service Act 2006 which related to the functions of overview and scrutiny committees, as well as when NHS bodies must consult the committee and the information they must provide to the committee.

Is the Board satisfied that the consultation was conducted in a manner which was fair, objective, accessible and transparent?

The five voting members unanimously confirmed that they were satisfied that the consultation was conducted in a manner which was fair, objective, accessible and transparent.

5. Public Consultation Responses

John Schultz (JS) reminded members this item related to what came out of the process as distinct from the conduct of the process itself. He confirmed that Board members have received the Analysis of Responses report.

Dr Janelle Yorke, Independent Analysist, presented the A New Health Deal for Trafford Public Consultation which outlined the analysis of the responses to the consultation.

JS reminded members that the five voting members have received the full pack of stakeholder responses and that other members were given the opportunity to see these responses. He informed members that organisational responses include responses from Trafford CCG, Central Manchester CCG and South Manchester CCG, Joint Overview and Scrutiny Committee (between Manchester and Trafford), provider organisations, Trafford Primary Health, Trafford LINk, Save Trafford General, and staff organisations. He reminded members that at the last meeting on 29 November 2012 the Board received feedback from three key interest groups – Trafford LINk, Save Trafford General and Staffside organisations including RCN and UNISON.

JS reminded members that petitions had been received from the Save Trafford General campaign group as described within the consultation report. Erin Portsmouth (EP) outlined the size and content of the petitions, and reported that information is detailed on pages 47/48 of the consultation process report. EP reported that this information was sent to the Save Trafford General campaign group for response and that no response had been received. She reiterated that the information from the petitions had been made available to Dr Janelle Yorke.

JS commented on the public attachment to Trafford General Hospital as the symbolic birthplace of the NHS that had been highlighted in Dr Yorke's report.

GK responded that NHS Trafford recognise the importance of Trafford General

DRAFT

in this respect and the proposals being brought forward offer the best opportunity for Trafford General Hospital to have a viable and secure future. He reiterated that it is a very important part of the community and they want to see it continue to provide health services.
Stephen Gardener (SG) commented that CMFT wish to keep Trafford General Hospital as a local hospital serving the local community but at the same time serving a bigger role in Greater Manchester by putting in services such as the orthopaedic centre. A discussion ensued regarding securing the future of the symbolic birthplace of the NHS.

JS commented that there were a number of comments that the public have made about the current administration of outpatient services at T GH. DB responded that access to outpatients is monitored by organisations to deliver against national targets and outpatient clinics will continue to be delivered there.

SG outlined CMFT's proposals regarding delivering outpatient services at Altrincham and Stretford.

JS commented that the public had expressed some concerns regarding the capacity within primary and community services. GK responded this is being considered as part of the integrated care strategy and in particular the GP work stream are working to increase the capacity that GP practices have to care effectively for patients. GK reminded members that a presentation on integrated care had been given to the meeting on 29 November 2012. A discussion ensued.

JW asked for an update regarding the redevelopment of Altrincham General Hospital and how this fits in with Trafford General Hospital. SG responded informed members of the background to the proposals for Altrincham General Hospital. He informed members that the site does allow for expansion of capacity and CMFT Board have approved the proposal to expand the site and negotiations are ongoing with the developer. He added that discussions are taking place regarding the range of service to be provided at Altrincham General Hospital.

LW responded to the suggestion made by some in the consultation responses that the Trafford proposals should be part of the Healthier Together programme of work. She stated that Healthier Together is in its early stages and is a review of healthcare across Greater Manchester, with as yet no proposals, plans or decisions. Prior to the consultation commencing, NHS Greater Manchester were clear that the clinical advice received strongly indicated that changes need to be made at Trafford General Hospital as quickly as possible and could not wait for the proposed Healthier Together consultation next year. She then outlined the governance behind the work for the Healthier Together programme.

Mike Burrows (MB) commented that the clinical and financial position of services in Trafford are unique in Greater Manchester, but it is not inconsistent with the broader vision of Healthier Together which focuses on the quality and safety of services.

DRAFT

AD asked for an update on Stretford Memorial Hospital. SG responded that CMFT planned to maintain the existing services but on an alternative site in Old Trafford and a proposal is being looked at with partner organisations to deliver these services in a community setting at Shrewsbury Street.
Deborah Brownlee (DBr) confirmed that discussions are taking place with the local authority and Trafford Housing Trust regarding an extra care facility in the local area which would continue the existing services.

TA asked that a proper communication and engagement strategy be put in place to ensure robust communication to the public responding to the general and specific issues raised during the consultation. JS concurred with the request.

SG responded regarding the doubts cast expressed by some members of the public regarding the activity information and the analysis of data. He explained how activity is recorded on hospital sites, how the data is analysed, what the information is used for, assurance processes in place and external auditing of the information. A discussion ensued regarding the activity data.

The Chair asked the following formal questions:

Is the Board satisfied that the consultation responses have been independently collated and analysed objectively and that the key themes/public concerns have been identified?

The five voting members unanimously confirmed that they were satisfied that the consultation responses have been independently collated and analysed objectively and that the key themes/public concerns have been identified.

The Chair thanked the presenters.

It is noted that Gina Lawrence and Anthony Hassall left the meeting.

It is noted that Stephen Downes, Deputy Director of Finance at University Hospital of South Manchester NHS Foundation Trust, and Claire Yarwood, Director of Finance, NHS Greater Manchester, joined the meeting.

6. Summary from Work streams

John Schultz (JS) confirmed that members had received the following documents:

- Non-emergency Transport reports – report regard transport implications and TfC Final Report
- Provider Capacity Report

6.1 Transport

Andy Hickson, North West Ambulance Service (NWAS) gave a presentation entitled New Health Deal for Trafford – the NWAS perspective. This outlined

- NWAS involvement

DRAFT

- Work to date
- Implications
- The way forward

Alison Starkie, NHS Greater Manchester, and Stephen Travis, Transport for Communities, gave the Transport Analysis presentation which outlined the key issues raised throughout the pre consultation and consultation process regarding transport and car parking.

JS asked members if they had questions regarding the NWAS presentation or the presentation on non emergency transport.

Discussions took place regarding:

- The transport of very sick patients from Trafford General Hospital to MRI
- Ambulance turnaround times at hospital sites
- Transport solutions for patients from M31 postcodes
- Local link subsidy

GK commented that Trafford CCG were supportive of a local link subsidy and indicated that the Health Transport Bureau proposal would dovetail well with the transformed Trafford hospital appointments booking and management service, creating a patient co-ordination system incorporating transport. JS commented this is very important in view of the significance of transport issues in the consultation responses.

JS thanked Alison Starkie for her work on the programme, and wished her well with her imminent maternity leave.

6.2 Provider capacity

Jessica Williams informed members that responses have been received from all key stakeholder providers, these responses were broadly supportive and indicate that the A&E departments can cope with the move from the current position to Model 2, but there are various caveats around moving on to Model 3.

6.3 Finance

Tim Barlow (TB) gave a finance presentation which addressed the following areas of concern raised during the public consultation :

- How has the £19m deficit arisen?
- How is the £19m deficit currently being covered/financed?
- How will the proposals contained in the consultation document address the £19m deficit – managing provider risk?
- What financial plans does Trafford CCG have for investing in Integrated Care?

Discussions took place regarding:

- Ensuring a transport model is in place to allow access from patients out of Trafford area to support the financial model being proposed.
- Cash flow implications

The Chair asked the following formal question:

Is the Board content that the financial pressures outlined in the pre-consultation business case are reflective of the current financial situation in Trafford Hospitals and that the clinical model outlined in the consultation process will largely resolve the £19m deficit?

The five voting members unanimously confirmed that they are content that the financial pressures outlined in the pre-consultation business case are reflective of the current financial situation in Trafford Hospitals and that the clinical model outlined in the consultation process will largely resolve the £19m deficit.

7. DH Tests for Service Reconfiguration

John Schultz (JS) confirmed that Board members had received the excerpt from the presentation provided by David McNally and Claire Swithenbank regarding the Department of Health's four tests.

Test 1 – Clinical Commission Support

JS asked the CCG Chairs to respond on behalf of their organisation on the new health deal for Trafford proposals.

NG responded that the Trafford CCG Board fully supported the new health deal for Trafford proposals and they had been signed off by the CCG Board.

ME responded that Central Manchester CCG Board fully endorsed the proposals and is further reassured from today's meeting regarding:

- the investment in the integrated care system which is critical for the implementation of the proposed model;
- the capacity of the providers to incorporate the increased workload following implementation of the proposed model;
- the proposed transport solutions to allow patients to travel from Manchester to Trafford General Hospital.

ME confirmed he is satisfied that their original comments have been addressed.

BT responded that the South Manchester CCG is supportive of the proposals. BT commented that for integration to work, everyone must mean the same thing by integration so there is a consistent offer from primary care to all patients, and acute trusts then know what can be carried out in the community.

JS commented that support for the proposals had formally been received from CCG Boards but during the consultation process it had been suggested that a wider number of GPs were not supportive.

In response, NG informed members that Trafford GPs had had numerous opportunities to discuss the proposals, these proposals were endorsed by the GP Board and written support had been received from the Trafford Local Medical Committee. NG confirmed that there had been broad support across Trafford GPs for the proposals. JB reiterated Trafford Primary Health Ltd were in support of the proposals with the caveats previously mentioned.

The Chair asked the following formal question:

Is the Board satisfied that the proposal relating to the New Health Deal for Trafford has the support from GP commissioners and that the consultation has therefore met the requirements of Test 1 of the DoH Revision to the Operating Framework for the NHS in England 2010/11?

The five voting members unanimously confirmed that they were satisfied that the proposal relating to the New Health Deal for Trafford has the support from GP commissioners and the consultation had met the requirements of Test 1 of the DoH Revision to the Operating Framework for the NHS in England 2010/11.

JS confirmed that it is therefore the view of the Board that Test 1 had been met.

Test 2 – Strengthened Patient Engagement

JS acknowledged the contributions made under agenda item 4 regarding the consultation process, equality analysis and the view of the Public Reference Group. He invited Board members, Erin Portsmouth and Helen Bidwell to add any further comments – there were no further comments.

The Chair asked the following formal question:

Is the Board satisfied that an effective programme of patient engagement and consultation has been carried out in relation to the New Health Deal for Trafford and that the public, patients and staff have been involved in the planning, development, consultation and decision making in respect of this proposal and that the consultation has therefore met the requirements of Test 1 of the DoH Revision to the Operating Framework for the NHS in England 2010/11?

The five voting members unanimously confirmed that they were satisfied that an effective programme of patient engagement and consultation had been carried out in relation to the New Health Deal for Trafford and that the public, patients and staff had been involved in the planning, development, consultation and decision making in respect of this proposal and that the consultation had

DRAFT

therefore met the requirements of Test 2 of the DoH Revision to the Operating Framework for the NHS in England 2010/11.

JS confirmed that it is therefore the view of the Board that Test 2 had been met.

Test 3 – Clarity on Clinical Evidence Base

JS acknowledged the contributions made under item 3 – the clinical rationale. He invited George Kissen and Bob Pearson to add any further comments – there were no further comments.

The Chair asked the the following formal question:

Is the Board satisfied that clinicians have led in gathering the clinical evidence base for the New Health Deal proposal, considering current services and how they fit with the latest development in clinical practice, and current and future needs of patients and that the consultation has therefore met Test 3 of the DoH Revision to the Operating Framework for the NHS in England 2010/11?

The five voting members unanimously confirmed that they were satisfied that clinicians had led in gathering the clinical evidence base for the New Health Deal proposal, considered current services and how they fit with the latest development in clinical practice, and current and future needs of patients and that the consultation had therefore met Test 3 of the DoH Revision to the Operating Framework for the NHS in England 2010/11.

JS confirmed that it is therefore the view of the Board that Test 3 had been met.

Test 4 – Consistency with current and prospective patient choice

The Chair asked Nigel Guest on behalf of local commissioners: 'Are local commissioners content that proposals do not limit choice and will improve patient outcomes?' Nigel Guest confirmed that local commissioners are content that the proposals do not limit choice and will improve patient outcomes.

The Chair asked Stephen Gardner to remind the Board of the conclusions relating to choice of the Competition and Cooperation Panel when Trafford Healthcare Trust was acquired by CMFT. Stephen Gardner reminded the Board that the Competition and Cooperation Panel concluded that patient choice would not be reduced by the acquisition of Trafford Healthcare Trust by CMFT.

The Chair asked the following formal question:

Is the Board satisfied that local commissioners have considered how the proposed service reconfiguration affects choice of provider, setting and intervention? Specifically, that the service model offers patients the right treatment, in the right place, with appropriate access to transport, at the right time and that the consultation has therefore met the requirements of

DRAFT

Test 4 of the DoH Revision to the Operating Framework for the NHS in England 2010/11?

The five voting members unanimously confirmed that they were satisfied that local commissioners had considered how the proposed service reconfiguration affected choice of provider, setting and intervention. Specifically, that the service model offered patients the right treatment, in the right place, with appropriate access to transport, at the right time and that the consultation had therefore met the requirements of Test 4 of the DoH Revision to the Operating Framework for the NHS in England 2010/11.

JS confirmed that it is therefore the view of the Board that Test 4 had been met.

JS reiterated that it is the conclusion of the Board that Test 1 – Clinical Commission support, Test 2 – strengthened patient engagement, Test 3 – clarity on the clinical evidence base, and Test 4 – consistency with current and prospective patient choice have all been met.

8. Summary of Board Responses and Agreed Proposals for the New Health Deal for Trafford

JS asked members what the key issues are which need to be discussed to formulate recommendations and proposals.

TA responded there are issues of implementation and conditions which are applicable before implementation can commence:

1. Health Transport Bureau – should be a condition and should be set up to include patients who are residents of Trafford and Manchester.
2. Appropriate and robust mental health service (including the 136 unit) pathways and procedures in place before any proposals are implemented.
3. Improved integrated care system to be in place in Partington to address the needs to patients/residents in this area prior to the proposals being implemented.
4. It is essential to have assurance that there is appropriate provider capacity in place to safely manage any changes.

NG responded by outlining the commitment for the provision of an integrated care service to Partington patients by Trafford CCG. NG also committed to ensuring very clear pathways/provision are in place and are widely understood for mental health patients during the proposed hours of A&E closure.

LW commented that the main affected acute providers have stated within the consultation that they accept there is sufficient capacity for implementation of Model 2 and are making plans to accommodate this. However, LW wishes to see a robust assurance process in place should the proposals/recommendations be accepted by NHS Greater Manchester to ensure provider capacity is sufficient prior to any service implementation.

DRAFT

MB informed members that clarity is needed from the new system arrangements which will come into the NHS from 1 April 2013 and which will have responsibility for exercising the assurance processes.

He indicated a broad recommendation could be put in place, alongside the conditions, to ensure that there is an assurance process exercised by the NHS National Commissioning Board to oversee the discharge of these conditions after 1 April 2013.

LW stated that it is important that the Board give a commitment to support the cost of Dial a Ride and this should be in place before any changes take place.

JS asked if there were any other elements which need to be incorporated into the recommendations. JW commented that the recommendations from the Public Reference Group should be incorporated.

Discussions took place regarding the development of the integrated care system; and it was reiterated that the description of the criteria for moving from Model 2 to Model 3 would be the responsibility of the ICRB Board and would be aligned with the strategies of the CCG.

JS summarised the key pre-conditions which the Board believes need to be satisfied before implementation of the proposals. These are around the following themes:

1. Progress towards integrated care across Trafford Borough but specifically in and around Partington
2 Appropriate mental health pathways in place
3 Transport arrangements substantially in place – particularly the Healthy Transport Bureau available to Manchester residents accessing the specialist orthopaedic centre as well as Trafford residents; together with the subsidising of the Dial-A-Ride service
4 Provider capacity; provider assurance being given regarding capacity to move from status quo to model 2 and from model 2 to model 3
5. Local clinicians should be tasked to develop a set of clinical criteria which outline the circumstances under which a safe move from the proposed Urgent Care Centre (Model 2) to the proposed Minor Injuries Unit (Model 3) can be made. These will need to be endorsed by the Integrated Care Redesign Board.

JS asked if members were happy with the above summary. DB summarised the discussion: to implement Model 2, specific actions need to be completed around transport, Partington, mental health pathways, and the conditions which must be met around integrated care to move from the status quo to Model 2 and from Model 2 to Model 3.

The Chair asked the following formal questions:

Does the Board agree that the proposals should be subject to the above five pre-conditions and the recommendations in the Public Reference

DRAFT

Group and Equality Analysis reports (agenda item 4)?

The five voting members of the Board unanimously agreed that the proposals should be subject to the above five pre-conditions and the recommendations in the Public Reference Group and Equality Analysis reports (agenda item 4).
Taking into account the previous consideration of, and decisions on, the clinical rationale and subsequent recommendations from the ICRB, the consultation process, the consultation results, the reports from the work streams, and the consideration of the four tests, is the Board minded to move forward with the redesign proposals set out in the consultation process, but subject to the above conditions and recommendations and to considering the final views of the Joint Overview and Scrutiny Committee?

Before answering the question, JS reminded members that this is not, cannot be and must not be seen as a final decision of the Board Any decision made today will be put to the Joint Overview and Scrutiny Committee for comment.

The five voting members unanimously agreed that it was minded to recommend the redesign proposals set out in the consultation process, but subject to the above conditions and recommendations and to considering the final views of the Joint Overview and Scrutiny Committee.

The Board agreed to delegate to JW responsibility for the report to the Joint Overview and Scrutiny Committee due to meet on 14 January 2013. **Jessica Williams**

9. **Any Other Business**

There was no other business.

The next meeting of the Trafford Strategic Programme Board will take place on Tuesday 15 January 2013, 9.30 am, Flixton House, Flixton Road, Urmston.

DRAFT

ImogenBlood
& Associates

New Health Deal for Trafford: public consultation

Equality Analysis

Prepared by Imogen Blood

For NHS Greater Manchester

Friday 7th December 2012

Contents

Introduction ... 3
Scope, status and purpose ... 3
Aims ... 4
Methods ... 4
Structure of this report ... 4
Executive Summary ... 5
How accessible and inclusive was the consultation? ... 5
Did the response reflect the diversity of the borough? ... 6
Conclusions ... 6
Race, ethnicity and religion ... 7
Disability ... 11
Age ... 15
Younger people ... 15
Older people ... 16
Sexual orientation ... 18
Sex and gender ... 20
Socio-economic inequalities ... 22
Conclusions ... 25
References ... 27
Appendix: Detailed steps taken ... 29

Introduction

Scope, status and purpose

This Equality Analysis (EA) has been undertaken by Imogen Blood & Associates and was commissioned by NHS Greater Manchester. It focuses on the *process* of the consultation and builds on, but is separate from, the pre-consultation EA which focused on the likely impact of the *content* of the proposals on 'protected characteristic' groups in Trafford. In other words, this assessment is concerned with whether everyone can participate in the public consultation.

The '**protected characteristics**' (in relation to the Public Sector Equality Duty) are:

- age;
- disability;
- gender reassignment;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

Whilst there is no longer a specific duty to produce a document called an 'Equality Impact Assessment', the Equality Act 2010 places a responsibility on public bodies to demonstrate how they have engaged with different protected characteristic groups, especially when making a substantial decision such as this. The guidance on the S242 consultation duty contained within the Local Government and Public Involvement in Health Act 2007 also requires NHS bodies to be: "clear, accessible and transparent, open, inclusive, responsive, sustainable, proactive and focused on improvement" in their involvement activities. They must seek to involve 'hard to reach' groups as appropriate and document the methods used. We understand that the Public Reference Group's report tackles the broader legal requirements and principles, but expect that this EA will also contribute towards this.

"Local people who are enabled to play a full part in making decisions about their local services feel more involved in those services" (Stonewall 2011, p.4)

In conducting an EA, NHS Greater Manchester recognises that discrimination and disadvantage can emerge from how organisations operate, and seeks to identify changes and assess whether they lead to improvements. Institutional discrimination can occur where processes such as this public consultation are set up without recognition of the barriers which disadvantaged groups may experience and assumptions are made that they will be equally accessible to all. A systematic equality assessment is an evidence-based approach which identifies potential barriers and looks for any patterns of difference between groups, such as different response rates.

"Public authorities should ensure that their engagement methods take into account the needs of people with all the different protected characteristics, and enable them to participate fully." *Equality & Human Rights Commission (2011) p.12*

Aims

This EA aims to:

- Compile evidence of the steps that have been taken to ensure that the process is accessible to members of protected characteristic groups and to proactively capture diverse views;
- Assess the success of these in terms of people's access to, experience of and outcomes from the consultation process;
- Highlight any organisational learning regarding engagement and, where appropriate, make recommendations for next steps.

Methods

We have undertaken the following steps to inform this assessment:

- Reviewed relevant documents from the Trust, e.g. Pre-consultation EA, Communication & Engagement Strategy, Pre-consultation Engagement Report; Consultation documents, procedures, forms, flyers and web site; etc
- Attended two meetings with the Engagement and Communications Team;
- Observed two public meetings (Davyhulme, daytime; Partington, evening);
- Observed two group discussions facilitated by the Engagement Worker (one at Centre for Independent Living (Learning Disability) and one at Blue Sci (Mental Health));
- Attended a meeting of the Public Reference Group to gather their views for the EA;
- Phone discussions with SHA and Youth Cabinet; E-mail exchange with Campaign group;
- Review and secondary analysis of demographic breakdowns of responders;
- Internet-based search and review to gather supporting evidence

Structure of this report

This report consists of:

- An introductory section containing information about the scope, status, purpose and aims of the EA and the methods used to inform it;
- An executive summary which gives an overview of the approaches taken in the consultation and draws the headlines on the diversity of respondents from the main body of the report;
- A section on each of the following protected characteristics (each chapter presents evidence on the potential barriers and issues; steps taken by the Trust and evidence of their success):
    - Race, ethnicity & religion
    - Disability (including learning disability and mental health);
    - Age (including younger people and older people);
    - Sexual orientation;
    - Sex and gender (covering: sex, gender reassignment, pregnancy & maternity; marriage & civil partnership);
    - Socio-economic inequalities – although not required in law, Imogen Blood & Associates and NHS Greater Manchester agree that this is a significant and cross-cutting theme and have included it as good practice
- Conclusions
- References
- Appendix (giving more details of focus and facilitated groups, organisational responses, etc)

Executive Summary

How accessible and inclusive was the consultation?

The overall approach was to encourage and analyse formal individual or organisational responses to the consultation, ideally using the consultation response form. Public meetings were an opportunity to find out about the proposals through presentations and Q&A sessions, rather than a way of feeding views into the process. This approach has a number of advantages and disadvantages from an equalities perspective. The benefits include:

- Each individual response can be monitored by protected characteristic to gauge the representativeness of the response;
- Responses can be systematically analysed to identify any different themes from different groups, rather than trying to piece together notes from a range of sources;
- This approach does not assume that representatives, organisations, community leaders or token panel members can speak on behalf of disadvantaged groups;
- It does not depend on people being able to attend a meeting and being able to express their views in this setting; people can feed into the response anonymously and privately at a time and in a way that best suits them.

However, the dangers of this approach include:

- Disadvantaged members of some of the protected characteristic groups may be less likely to complete the form, since time, literacy, language, disillusionment, education and disability may act as barriers;
- There is a risk that people will attend meetings and believe they have contributed to the consultation by speaking but not follow up with their individual form;

The Trust seems to have been aware of these dangers and had from the outset, planned a number of steps to mitigate them which are summarised in the following table. Although these approaches should improve the accessibility of the consultation for everyone, the table also identifies protected characteristic groups which might particularly benefit, based on the evidence collated for this equality analysis.

Method/ adjustment	**Particular groups which may benefit**
Summary of proposals and response form sent out to each household (though there were delivery problems in some areas)	Older people with high support needs who do not leave the house much; Others who are more isolated within their communities; older and/or disadvantaged people who do not have internet access at home
Attractive and accessible web site containing video material, information about the consultation and online response form	Younger people, working people, carers/ parents, some disabled people (e.g. those with sensory impairments)
Alternative languages and formats advertised and provided on request	BME people, those with sensory and other types of disabilities
Twitter feed, Facebook page, mobile phone scan access to online survey	Younger people, LGB people, carers/ young parents
Outreach work to contact groups who may not otherwise be reached or may not understand the relevance to them	Disabled people, BME communities, younger people, LGB people, disadvantaged communities, older people, men and women

	(including trans men and women)
Developed and promoted a toolkit to help community groups consider the impact the proposals may have	People with learning disabilities, and those for whom language and literacy are barriers

Did the response reflect the diversity of the borough?

The demographic breakdown of those who did respond should not be the only criteria against which the accessibility and inclusiveness of the consultation response are assessed, especially given gaps in the monitoring data, and in data about the local population, and definitional issues. However, it does provide important evidence about the extent to which groups were able to access the consultation. It also helps us to check whether the responses received reflect the diversity of the borough. These were our key findings:

- All BME groups appeared to be under-represented, though the distance of the hospital from the largest BME communities may at least partly explain this. Pakistani responses were low (0.9%), given that this group makes up 2.4% of the population and 3% of A&E users, though the numbers are small and should therefore be treated with a degree of caution.
- Disabled people seem to have been fairly well represented in the response, for example, 8.6% reported a physical disability and 16% a long-term health condition. It is difficult to draw accurate comparisons to the population due to definitional issues and lack of data.
- People over 50 were well represented in the response compared to the local population. Despite being the biggest current users of A&E, the 18-34 year age group were significantly under-represented in the response though, given the challenges in engaging this age group, the Trust did reasonably well to encourage 54 people in their twenties to complete the response form.
- 67.6% of responders provided information about their sexual orientation, which is relatively high, given developing levels of understanding and confidence in this newer monitoring category. 27 people told us they were lesbian, gay or bisexual.
- The consultation seems to have been successful in engaging both men and women, with 39% of those supplying this information being men and 61% women.
- 11 people told us that their gender was different from that assigned at birth, which (assuming people understood the question and answered it accurately) matches the estimates of the proportion of transgender people in the population and is excellent.
- 3.2% of the working age people who responded told us they were 'unemployed: looking for work', which compares favourably with the 2011 estimated unemployment rate for the borough of 2.9%.

Conclusions

We conclude that the Trust has taken reasonable steps to identify and remove barriers to the consultation process for protected characteristic groups and has succeeded in attracting a diverse response. It has also demonstrated willingness to learn and adapt in response to constructive criticism and problems that have occurred. Giving clear feedback to the public regarding exactly whether and how their views have been incorporated into the decision-making (and re-iterating how views were sought and incorporated earlier on in the engagement process) is crucial now if the engagement and goodwill of these diverse groups is to be maintained.

Race, ethnicity and religion

What are the potential barriers to participation in the consultation?

The literature suggests typically lower response rates from BME people to postal surveys (e.g. Sheldon & Rasul 2006) and describes the traditional exclusion of BME groups from mainstream consultation (e.g. brap 2010).

There is enormous diversity within the black, minority ethnic and religious minorities in Trafford: and the differences between or within communities may be greater than those between BME and white British people in general. Factors which may make it difficult for some BME people to participate include:

- **Language**: some first generation migrants do not read, write or speak English fluently and this can be a barrier to participation (NWDA 2010), especially where the issues are complex and there is a lot of professional jargon.
- **Religious festivals/ worship** – may clash with timings for meetings
- **Gender issues**: in some ethnic/ religious groups, it is not culturally acceptable for women to mix with men, certainly men from outside of their community. This, combined with women's primary role as carer in many ethnic minority communities (NWDA 2010), can act as a further barrier in terms of time, ability to attend meetings, etc.
- **Fear of harassment or marginalisation** as a result of race or religion may affect the willingness of some BME people to attend mixed public meetings. In the national Citizenship Survey 2009-10 (CLG 2011), seven per cent of people felt that racial or religious harassment was a problem in their local area. Experience and fear of harassment were highest for black African and Pakistani people.
- **Disillusionment with or fear of a poor response from public services** can act as a barrier for some BME people. In the 2009-10 national survey (CLG 2011), members of ethnic minority groups (particularly those who were black African, black Caribbean or mixed race) were considerably more likely than white people to feel that they would be discriminated against in favour of other races by public services

What steps have been taken to promote equality for BME people and those from minority religions within the consultation?

Information stating that documents can be provided in other languages is given in 8 community languages on the full and summary consultation documents. Seven requests for documents in Urdu were received and met.

The Trust has taken a number of steps to engage with existing BME networks and representatives to raise the profile of the consultation and explain it as widely as possible. However, by accepting input from formal consultation responses only, the Trust has not expected leaders, workers and representatives of the BME communities in Trafford to speak for the residents in their communities (brap 2010).

Details of the specific steps taken during the public consultation are included in the appendix to this report. In summary, they include:

- Three facilitated group discussions with groups of BME people (another had been planned but was cancelled at short notice for reasons beyond the Trust's control);
- Two promotional events to raise awareness of the consultation to Muslims and African people;

- Two BME networks/ campaign groups were invited to sit on the Public Reference Group;
- Five meetings were held in the Old Trafford area where the highest proportion of the borough's ethnic minority residents live (three public meetings, one for the Old Trafford partnership, one at a local primary school);
- One church and one Muslim association contacted to consider options for engagement.

This work builds on steps taken as part of the longer term engagement process (described in more detail in *NHS Trafford (2012) A new health deal for Trafford Engagement report)*. As part of the pre-consultation work, the PCT held a focus group with ten Asian men and 14% of the 1107 residents interviewed as part of the telephone survey were from BME backgrounds. These discussions explored what mattered most to people in their encounters with health professionals and sought to gather 'burning issues' and 'bright ideas'.

How successful have these been?

The following table uses the most recent ethnicity estimates for the borough (mid-2009 resident population estimates by primary care organisation from the Office for National Statistics) and compares this with the ethnicity of the 1694 consultation responders who provided this information (11% of those responding did not). Since the numbers are quite small within the detailed ethnic categories, we also show the figures for the broad ethnic categories (White, Mixed, Asian, Black and Chinese/Other).

Ethnic category	% of total population	% of total response	% of total population	% of total response
White: British	82.6%	91.7%	88%	94.9%
White: Irish	2.1%	1.4%		
White: Other	3.3%	1.8%		
Mixed: White/ Black Caribbean	0.8%	0.3%	2.3%	1.1%
Mixed: White/ Black African	0.3%	0.3%		
Mixed: White/ Asian	0.6%	0.4%		
Mixed: Other Mixed	0.6%	0.1%		
Asian or Asian British/ Indian	2.1%	1.1%	5.5%	2.1%
Asian or Asian British/ Pakistani	2.4%	0.9%		
Asian or Asian British/ Bangladeshi	0.4%	0.1%		
Asian or Asian British/ Other Asian	0.6%			
Black or Black British/ Black Caribbean	1.3%	0.8%	2.5%	1.1%
Black or Black British/ Black African	1.0%	0.3%		
Black or Black British/ Other Black	0.2%	No category		
Chinese/ Other: Chinese	1.1%	0.3%	1.9%	0.8%
Chinese/ Other: Other	0.8%	0.5%		

Analysis of hospital statistics undertaken to inform the pre-consultation Equality Analysis showed that users of the A&E department roughly mirrored that of the local population in terms of their ethnicity. The largest groups of minority ethnic users were Pakistani people (making up around 3% of A&E users) and Indian people (making up around 2% of A&E users).

An organisational response was also provided by Chief CIC (working with BAME communities to tackle health inequalities).

Although there was no formal monitoring of people attending the public meetings, BME people seem to have been significantly under-represented at these meetings.

The following table compares the religion of Trafford's residents in the 2001 census (6.4% did not supply this information) with the religion of the 1326 (69.6% of) consultation responders who provided this information.

Religion	% of response	% of population (2001)
Christian	70.1%	81%
No religion	23.8%	12.8%
Muslim	1.1%	3.5%
Jewish	1.0%	1.2%
Hindu	0.6%	0.6%
Buddhist	0.2%	0.2%
Other	3.2%	0.2%
Sikh		0.5%

Muslims and Christians are under-represented in the sample (though, in the case of Christians, this may be at least partly accounted for by the significant numbers of people who gave specific branches of Christianity under the 'other' category rather than ticking the 'Christian' box). People saying they have no religion are over-represented in the response compared to the census group; other groups are represented proportionately.

Originally, two public meetings were scheduled for the Old Trafford area (which contains the largest Muslim community in the borough). Both of these were held in the St John's Centre which, despite being attached to the local church, is extremely well-used by the local Muslim population, particularly women. Unfortunately, due to problems finding availability in a suitable venue, both of these meetings were held on Fridays – one in the evening and one between 1 and 3pm. The Trust were aware of the clash with prayer time and arranged a further public meeting on a Monday from 10-12 at the Old Trafford Community Centre. A facilitated group discussion was planned with a group of Muslim young women on 25th October (organised through Trafford Connexions). Although the women had themselves suggested the date, this had to be cancelled at the last minute since they had forgotten that it was the night before Eid.

Discussion and analysis

- Each minority ethnic group is under-represented in the consultation responses compared to the estimated proportions of the Trafford population (by just under a half, though the numbers are small).
- Given that they formed the largest group of minority ethnic A&E users, Pakistani people are somewhat under-represented (forming 2.4% of the local population and 3% of A&E users but just 0.9% of the consultation responses), though the numbers are small and need therefore to be treated with a degree of caution.
- The ethnicity of 11% of those who responded is not known – some of this group are likely to be from BME backgrounds.
- The majority of Trafford's BME residents live in Clifford, with significant numbers of BME people also living in Stretford/ Gorse Hill. In the 2001 census, the non-white-British population of Clifton was 55% and of Stretford/ Gorse Hill 16% and it is likely that the minority communities in both of these areas has grown considerably in the last decade. For

Clifford residents, MRI is the nearest hospital and easier to reach by public transport than Trafford General, so we might expect to see less interest in the proposed changes from people living here.

- The proportion of BME people living in the areas surrounding the hospital is much lower: non-white-British people made up 8% of the population of Urmston; 5% of Davyhulme West; and 7% of Flixton in 2001. Cross-tabulation of ethnicity with postcode data suggests that 3.2% of respondents from these areas stated they were of non-white British ethnicity. This seems to fit with the overall finding that BME people are under-represented by about half (though it should be noted that the figures are low here and should be treated cautiously).
- When we compare the % of non-white British responses for different age groups, we find that there are some significant differences (in fitting with what we know about the younger age structure of most ethnic minority groups in the UK). 12% of the under 50s, compared to 5% of the over 50s (and the over 75s) were from non-white British backgrounds.
- Given the small numbers of BME people attending the public meetings, the approach of targeting individuals for a response through mail-outs and media promotion with some pro-active targeting of the BME community seems to have worked well.
- The BME people from M32 and M41 postcodes attending one of the focus groups said they had heard about the consultation through a range of different media, which is positive; but there was much lower awareness that Trafford General even has an A&E department. The themes from this meeting do not seem to differ significantly from those raised by other residents of a similar age living in similar areas and none of the points relate directly to ethnicity.

Disability

What are the potential barriers to participation in the consultation?

According to the Papworth Trust (2011), people with a disability or a long-term limiting illness are generally less likely than those without to feel that they can influence local decisions; yet disabled people make up around one third of the NHS users in Britain. Ensuring that the views of disabled people in Trafford can be heard within the New Health Deal consultation is therefore critical.

There is a huge range of disability – both in type and severity – and barriers will also be shaped by other circumstances: finances, availability of support, access to transport and IT and other equipment, as well as personal skills, preferences and personality.

Consultation with Deaf and disabled people to inform Trafford's JSNA found that:

"People wanted to be involved via a **variety of mechanisms**: focus groups, workshop days, postal questionnaires, use of the website, small forums, use of existing groups"

However, the following barriers to involvement were identified:

"Again **accessibility** was a key barrier including the **time of meetings**, the availability and cost of BSL **interpreters**, **transport** to meetings, over reliance on **computers** and **timescales** that do not take account of people's access requirements. There was also felt to be a **lack of support** for disabled people in taking part in panels, and consultations. There were also concerns about **staff awareness** around disability issues which results in accessibility problems and a lack of support". (p.46)

The Papworth Trust (2011) identified the following as being the most common **barriers to accessing buildings** among adults with impairments:

- moving around the building – for reasons related to stairs, doors or narrow corridors – 42%
- inadequate lifts or escalators - 23%
- parking problems - 22%
- approach areas: due to lack of ramps/handrails - 21%
- footpath design and surfaces - 15%
- difficulty with transport getting to the building - 14%
- lack of help or assistance - 14%

For people with learning disabilities and some severe mental health problems, **understanding complex proposals** sufficiently to be able to make and **communicate** informed views can be a challenge, especially where they involve **professional jargon** or abstract concepts.

For those with sensory impairments, there may be barriers around **accessing information**, **completing forms**, and participating fully in **public meetings**.

Concerns that events, websites, forms, etc will not be fully inclusive can put disabled people off trying to access them if there are not **clear messages about accessibility and values**.

More than 20% of disabled people have experienced **harassment** in public because of their disability (Papworth Trust 2011) and fears of harassment and crime can make some people reluctant to attend mixed public events, or to go out after dark to attend them.

60% of disabled people have **no car** available to their households, compared to 27% of the overall population (Papworth Trust 2011).

Only around half of households with a disabled member have **access to the internet**, compared to over two thirds of households with no disabled members (Papworth Trust 2011).

In the 2001 Census, around 12% of the adult population were providing unpaid care to an ill, frail or disabled family member, friend or partner. Although 42% of carers are men; women are more likely to give up work in order to provide care. Bangladeshi and Pakistani men and women are three times more likely to be carers than their white British counterparts. As a group, carers experience higher levels of poverty and ill-health and transport is a particular issue for many. The pre-consultation Equality Analysis recognised that carers are one of the groups most likely to be impacted by the proposed changes, so involving them in the consultation is vital.

9 in 10 carers find it difficult to leave their homes due to their caring role and many have to keep irregular hours so the internet plays a valuable role for many of them. Those that access the internet generally do so at home and most report very regular use. However, older carers and those who are financially disadvantaged are more likely to be digitally excluded (Crossroads/ The Princess Royal Trust for Carers 2011).

What steps have been taken to promote equality for disabled people within the consultation?

Accessibility of information

A video overview of the issues and proposals was produced and this could be watched/ listened to online. DVD copies of the film were used in group discussions, sent out to individuals on request and to groups as part of the toolkit.

An easy read summary of the key points was produced for focus group discussions with people with learning disabilities and used as an alternative format for some of the other group discussions.

Four requests for large print copies of the paperwork were met; one resident rang to request an audio format. The Trust offered to order a CD but, when told about the web site, the resident was happy to listen to multi-media content on the website and use the online response form with screen reader instead.

Accessibility of public meetings

People were asked about any communication or access requirements at the booking stage.

At public meetings, information was provided in a range of different formats – audio presentations and panel discussion; visual handouts and slides.

Members of the Public Reference Group assessed the accessibility and conduct of each of the meetings using a standard proforma. We present the key findings relevant to disability here:

- 15 out of 16 of the observers felt that the venue was accessible to all; the remaining venue did not have a disabled toilet
- All bar one of the venues was reported to have good public transport access; one was "some distance from bus stop"
- At a couple of the venues there were some issues with the availability of nearby free car parking
- The venues were felt to be spacious and appropriately laid out with plenty of comfortable seating
- There were a few complaints about signage in a couple of venues
- Observers confirmed that a working loop system was available at two of the venues but said that it was not at four of the meetings (in one there is a loop system which apparently works well usually but was not working that day); at the other meetings, observers were unsure/ left this blank
- At 12 out of the 14 observed meetings, the observer confirmed that they could see the presentations clearly and that none of the attendees said they could not; at a couple of

meetings the observer reported that it was difficult to see some of the slides from the back of the hall

- At 13 out of the 14 observed meetings, the observer confirmed that they could hear the presentations and discussions adequately, however there were some problems with sound during the panel sessions (members of the public being softly spoken, not being confident with the microphone, etc). There was evidence that event organisers and chair responded to this feedback and worked to improve this. They issued a 'Do's and Don'ts for the independent chair' which emphasised the need to use microphones, check whether the audience can hear, insist panel members stand up, etc. A couple of observers at the later meetings commented that the microphone usage had been much better.
- There were a few issues with presentations running over time, reducing time available for discussion/ people to complete feedback forms and/or consultation responses and meetings finishing later than scheduled, which may have a particular impact on disabled people/ carers.

Members of the public attending meetings were also asked to complete event feedback forms. 63 (16%) returned their forms. Most were very positive about the venue (61% were very satisfied; 23% were satisfied). Most people were also satisfied with the booking process/ pre-event arrangements. There were several comments about amplification problems and a couple of negative comments about accessibility/ signage. Responders gave more mixed responses to the questions about whether they found the *content* accessible (i.e. jargon-free and clear) and understood how to participate in the consultation.

Proactive steps to include the views of disabled people

Around twenty local disabled/ carer groups or organisations working with them were approached in the early stages of the consultation. They were told about the consultation (generally by phone) and ways in which they might involve their members and service users were discussed. All were offered a copy of the consultation toolkit and the opportunity for a member of the PCT engagement team to facilitate a group discussion. Documentation and toolkits were then sent to those organisations that had requested them. These organisations are listed in the appendix to this report.

As a result of these initial contacts and subsequent discussions, the following activities took place:

- Four group discussions were held (facilitated by a member of the PCT engagement team), two at Blu Sci centres in Old Trafford and Partington (for people with mental health needs); one at the Centre for Independent Living (with learning disabled people/ carers); and one with members of the Longsight and Moss Side Community Care Link (for South Asian carers and people with mental health conditions)
- The PCT had also planned to hold a stall at the Mencap roadshow at Trafford General Hospital (focusing on health issues for people with learning disabilities) but unfortunately the roadshow was cancelled.
- An article about the consultation was included in the Genie networks magazine for Deaf people and their families

It should also be noted that, during the pre-consultation engagement work, facilitated group discussions were held with a group of carers and a group of people with mental health problems.

How successful have these been?

In this section, we present the monitoring information from the consultation response forms. There are various problems with trying to find comparable statistics on the Trafford population: not only are there gaps in the evidence base but it is also difficult to agree a shared definition for disability

and people's self-labelling may vary. We have, however, presented some estimates to help make sense of these figures.

- 8.6% of responders said that they have a physical disability. Estimates from the Trafford JSNA (Trafford Council/PCT/CYPS 2010) suggest that between 10 and 13% of the working age population has a moderate or serious physical disability. A higher proportion of those completing hard copy responses reported a physical disability than those completing online responses (11.4% compared to 5.4%). This may be because disability is strongly related to age: 2.1% of 16-19 year olds are recorded as having a disability; 31% for those between the ages of 50-59 years; and 78% of people aged 85 or over (Papworth Trust 2011). Cross-tabulation of the age and disability data from the consultation show that 37% of those aged 50 and over and half of those aged 75 and over told us they had at least one disability and/or long term condition
- 2.5% of responders said they had a sensory (visual or hearing) disability. Around 3% of people are estimated to have sight loss in the UK (RNIB Key information and statistics) and around 1.3% are thought to be profoundly or severely deaf (Action on Hearing Loss 2011).
- 2.2% of responders said they had a mental health disability. The PANSI database (www.pansi.org) suggests an incidence of around 9.5% for 'common mental health disorders', though it is possible that many of those who suffer depression and/or anxiety will not label themselves as having a 'mental health disability'.
- 0.5% of responders said they had a learning disability. This is a slightly lower than the PANSI baseline estimate that 1.4% of the population aged 18-64 has a learning disability. However, a relatively high proportion of consultation respondents were from the older age groups (27% of respondents were over 70 years) and the proportion of people with a learning disability in these age groups is much lower, given differences in life expectancy. Allowing for this, the proportion of people with a learning disability seems to be about what we would expect.
- 16% of respondents reported having a long term health condition: nearly 1 in 5 of those completing a hard copy response ticked this box (again perhaps linked to age-related differences). The JSNA reports that around 24% of the total population has a disability and/or long term limiting illness. If we combine our 16% response with the 8.6% who told us they have a physical disability (bearing in mind there is likely to be some overlap between the two groups), this would suggest a representative sample of Trafford residents.

Additionally, organisational responses to the consultation were received from:

- Alzheimer's Society (Trafford)
- Disability Advisory Group (online)
- Transport for Sick Children

Age

Younger people

What are the potential barriers to participation and good practice principles?

- The Big Lottery Fund (2005) stresses the importance of using a **range of formats** to make consultation accessible to younger people. The NHS Federation (2011) argues that **technology and social media** are crucial to engaging with children and young people.
- "Children and young people need to be engaged **early** in the design of new health organisations and structures to ensure their views are included right from the start and regularly in the future" (NHS Confederation 2011).
- "Building the skills, knowledge, confidence and **capacity** of children and young people is crucial for their participation to make change happen. Access to information they can **understand** is also important for them to be able to make informed choices and decisions" (The National Youth Agency 2008).
- The National Youth Agency (2008) also recognises the importance of using **workers** who have the time and skills to work directly with young people.

What steps have been taken to promote equality for younger people within the consultation?

The Trust has developed long-term links with Trafford Youth Parliament. This project builds the capacity of young people to make an ongoing contribution to decision-making – a remit beyond the timescales and budget of the current consultation. Young people and the worker from this group were involved in the Public Reference Group, observing and rating the accessibility of public meetings. The Parliament also had two discussions regarding the proposals, one of which was attended by a local MP. Having an opportunity to meet with an elected member in this way is recommended in the National Youth Agency's *Hear by Right* standards. Issues were raised about the accessibility of the response form for young people; though the toolkit helped here and the youth participation worker explained that he had adapted this for the young people's discussion.

Three further, targeted focus groups were held to try and capture the views of young people outside of the parliament. These included one for under 18s, one for 19-30 year olds, and one for young parents in Davyhulme. Approximately 7 or 8 participants attended each of these focus groups.

The consultation used a range of online media, including an attractive web site with audio-visual material, an online questionnaire (which could be accessed via mobile phone bar code technology) and other means of e-mail feedback, and Twitter and Facebook.

Several groups were approached to promote the consultation amongst members and/or facilitate a discussion using the toolkit. These are listed in the appendix.

Older people

What are the potential barriers and good practice principles to participation?

- Older people are more likely than younger people to vote and to report a strong feeling of belonging to their neighbourhoods. However, in the Citizenship Survey (CLG 2010), only 30% of people 65-74 and 29% of people 75+ said they feel they can affect decisions in their local area, as opposed to 38% of working age adults in England.
- Basing consultation on formal meetings will only engage the type of people who are willing and able to attend meetings. Of the over 70s, less than half have a driving license and 38% have a mobility difficulty (Age UK 2012).
- Older people have higher rates of disability, including mobility issues, sensory impairment and cognitive impairments. Older disabled people are likely to experience similar barriers to younger disabled people, though they may be further disadvantaged by higher rates of poverty (14% of pensioners live below the poverty line, with incomes of less than £215 per week – Age UK 2012), lack of access to transport and ageist attitudes.
- Internet access: there has been a marked increase in the numbers of older people using the internet, however, only 37% of one-person pensioner households have internet access at home (compared to 79% of one-person working age households). Those older people who do use the internet tend to do so differently and less frequently than younger users, e.g. only 59% of users over 65 log on every day and only 8% of users over 55 have a social networking profile page (Berry 2011)

What steps have been taken to promote equality for older people within the consultation?

Hard copy distribution (with large print, audio versions and support available) and coverage in local free press should maximise the chances of engaging older people with high support needs who do not have internet access and spend most of their time at home.

Information about the consultation has been made available at libraries, GPs, post offices and community centres where older people are most likely to visit.

Four groups were approached to promote the consultation amongst members and/or facilitate a discussion using the toolkit. These are listed in the appendix.

Other proactive steps have included:

- Attending an older persons' coffee morning and a community group of older women in Sale to discuss the consultation and hand out response forms;
- Distributing consultation documents and toolkits at the Age UK AGM
- Sending flyers about the consultation/ toolkit to residential/ nursing homes near the hospital
- Trafford LINk facilitated group discussion with the Engage group in Partington (average age of 69 years old) and also visited an extra care housing scheme on the estate

How successful have these approaches been?

The following table shows the breakdown of consultation responses by age group and compares this with the resident population. As we might expect, there are significant differences between the age make-up of paper and online responders so we have included this detail here.

Age band	No. Trafford residents (in 1000s)	% of total population* (181,200)	Online responses	Paper responses	All responses
15-19	13.5	7.5%	0% (0)	0.6% (7)	0.5% (7)
20-29	25.6	14.1%	5.4% (14)	3.2% (40)	3.6% (54)
30-39	31.4	17.3%	20.0% (52)	9.4% (118)	11.2% (170)
40-49	36	19.9%	21.9% (57)	13.4% (169)	14.9% (226)
50-59	28	15.5%	23.5% (61)	17.7% (223)	18.7% (284)
60-69	22.6	12.5%	22.7% (59)	24.5% (309)	24.2% (368)
70-79	15.8	8.7%	5.4% (14)	20.5% (258)	17.9% (272)
80+	10.8	6.0%	1.2% (3)	10.9% (137)	9.2% (140)

*We have used the total for Trafford residents over 15 years (from 2011 census), since this is the target group for the consultation. We have calculated the number and proportion of residents using the 5 year age bands data from the census (ONS 2012).

Organisational/ group responses were provided by:

- Parents at Seymour Park primary school (Old Trafford residents)
- Youth Cabinet
- Transport for Sick Children
- Urmston Manor Rest Home – following 1-1 meeting with manager here
- Alzheimer's Society (Trafford)

Discussion and analysis

Those over 50 years are over-represented in the survey response: those under 50 years are under-represented. For example, the 15-29 age group makes up 21.6% of the population and 4.1% of the response. It is encouraging to note that a high proportion of responders in the older age groups also have a disability and/or long term health condition (37% of those over 50 and 50% of those over 75). We would expect the majority of these people to be regular users of health services and therefore those most likely to be affected by the proposed changes.

Trafford General Hospital statistics compiled for the pre-consultation Equality Analysis show that, whilst the oldest (over 75 years) age groups make up the largest proportion (38.4%) of current non-elective admissions, younger adults are the biggest group of A&E users, especially outside of core hours, when services will change if the proposals go ahead. 18-34 year olds make up 28% of outside core hours attendances and 24% of in-core hours attendances.

However, there are significant challenges in seeking to engage this age group as they:

- tend to move frequently,
- may be living with family (and not be the person in the household who completes the form)
- may be in private rented/ temporary accommodation,
- may be students who may feel they have less of a vested interest in the neighbourhood,
- are likely to be busy with work/ studies/ social life/ parenting; and
- are less likely than other age groups to be regularly involved in local groups/ networks

Given these barriers, the consultation has done well to gather responses from 54 individuals in the 20-29 year age group, even though the response is not proportionate.

Sexual orientation

> "Lesbian, Gay and Bisexual (LGB) people require the same services as the rest of the community, but they may access those services differently" (Stonewall, 2011, p.4)

What are the potential barriers to participation and good practice principles?

- LGB people are less likely to feel a strong sense of belonging to their neighbourhoods (three quarters of heterosexual people reported feeling this, compared to just over half of LGB people in the 2010 Citizenship Survey (CLG 2010)). LGB people may therefore be less likely to find out about or mobilise around neighbourhood issues.
- Some LGB people fear and/or have experienced marginalisation or exclusion from mainstream public services. For example, 1 in 14 lesbian and gay people expect to be treated worse than heterosexual people when accessing healthcare (Stonewall 2011). It is possible that these fears and feelings can extend to consultation.
- Around 40% of LGB people say they are worried about being the victim of a crime or being harassed because of their sexual orientation (Dick 2009). This fear can act as a barrier to people attending public meetings or 'outing' themselves in public and means that anonymity and confidentiality may be particularly important to these groups (Stonewall 2011).
- Perhaps for these reasons, opportunities to respond privately by questionnaire can be particularly welcomed by LGB people. Research with LGB people in Brighton found that 61% would like to see consultations being undertaken by questionnaire (Browne 2008). Stonewall (2011) recommends using a range of methods to engage LGB people, including internet surveys, Facebook, internet and social media. Pink News (2010) reports the findings of a US survey which suggests that LGB people are significantly more likely than heterosexual people to use Twitter, Facebook and read news, current affairs and political blogs.
- Stonewall (2011) also recommends using an independent facilitator at public meetings and monitoring and evaluating different approaches to build organisational learning about what works best in engaging LBG people.

What steps have been taken to promote equality for LGB people within the consultation?

The pre-consultation Equality Analysis recognised the need to ensure LGB people were included in the public consultation process to further understand the impact of proposed changes. The following steps were taken to ensure the views of LGB people were captured during the public consultation:

- A member of the engagement team met with a worker at the Manchester-based Lesbian and Gay Foundation to discuss the consultation and encourage organisational and individual responses to it.
- The consultation used electronic and internet-based communications methods and had a website (including videos and question and answers) so anyone who would rather not attend a public meeting could access the information they needed to inform their response and make their individual response privately and anonymously. Twitter, Facebook and mobile phone bar codes were also used.
- Sexual orientation was monitored on the individual consultation responses and reassurances about confidentiality and data protection given.

- An independent facilitator was appointed to chair public meetings and members of the public were encouraged to provide feedback on their experience of attending the meeting. People were not asked for equality monitoring information on these forms but there were no comments about people not being made welcome or included for any reason linked to their diversity.

How successful have they been?

32.4% of those responding to the consultation left the section on sexual orientation blank. The following table shows the numbers and percentages of the remaining 1288 people who provided this information:

	Online	Paper	Total (of those giving information)	Total (of all responses)
Gay	7 (2.4%)	7 (0.7%)	14 (1.1%)	66.2%
Lesbian	2 (0.7%)	3 (0.3%)	5 (0.4%)	0.7%
Bisexual	4 (1.4%)	4 (0.4%)	8 (0.6%)	0.3%
Heterosexual	284 (95.6%)	977 (98.6%)	1292 (97.9%)	0.4%
Not given				32.4%

Discussion and analysis

67.6% of total responses identified their sexual orientation on the form. This is relatively high given well-documented (e.g. Creegan & Keating 2010) issues with people not understanding the rationale or the categories, or not feeling safe enough to disclose. This suggests a developing degree of trust in the PCT's confidentiality procedures and their attitude to sexual orientation.

- If we assume that the 32.4% of respondents who did not give their personal information in this section share a similar breakdown to those who did, 2.1% of respondents would be from LGB people. However, it is quite possible that LBG people are over-represented in group of non-disclosures, given the perceived risks of 'outing' yourself, especially when asked for your postcode in the same section. The government and Stonewall currently use an estimate of 5-7% of the population being LGB.
- Given both the lack of accurate data about the numbers of LGB residents in Trafford and the significant gaps in the sexual orientation data on the consultation responses, it is difficult to draw firm conclusions about whether and to what extent LGB people were under-represented in the consultation. However, what we do know is that at least 27 LGB individuals *have* responded and told us their sexual orientation and that we have one organisational response from an LGB representative and campaign group.

Sex and gender

This section covers the following protected characteristics:

- Sex
- Gender reassignment
- Pregnancy and maternity

What are the potential issues here?

- There can be barriers for **men** in getting involved in community-based events, issues and networks – these can include time (especially in challenging economic times, men are more likely to prioritise work over other activities); awareness (men are less likely to be involved in community based groups and activities so may be less likely to find out about the consultation from these sources; and perceptions (norms of masculinity can put men off engaging). **Young men and BME men** are can be at particular risk of exclusion. See Johal et al (2012) for a more detailed discussion of all these issues.
- **Men and women have different patterns of involvement with health services**. For example, we know that, as a group, men are less likely to seek help for health-related problems and can experience later diagnosis and worse health outcomes as a result (Johal et al 2012); around 80% of the NHS workforce are female, though men tend to occupy more senior roles (NHS: The Information Centre);
- There are barriers to involvement for **women and men who are caring for children or others**. Although those with young children are more likely to be both at home and around and about in the local communities (at libraries, schools, community centres and parks), attending public meetings can be difficult and finding time to complete forms can be a problem; male carers do not always engage with local groups and networks. Carers (both of children and disabled people) are an important target group for this consultation, since, as a group, they may experience a significant impact from the proposed changes.
- Safety is a paramount consideration for many **trans people** who experience high levels of harassment and other transphobic crime (Community Connections 2012). Holding meetings in venues with nearby car parking/ public transport facilities and at different times of the day may encourage trans people to attend. Giving the option to access the information and complete the survey privately and anonymously on line or on paper should also encourage a greater response.

What steps have been taken to promote equality for these different groups within the consultation?

Focus groups were held with families and with Asian men as part of the pre-consultation engagement.

Promoting the consultation through a wide range of local media, delivering hard copies to homes and displaying materials in a range of community settings should increase the likelihood of both men and women hearing about it, regardless of whether they are working or caring or both.

Public meetings were held at different times of day; some in the evening so that people could attend after work (or carers could attend when other family members return from work).

Being able to access all the consultation information online, and having information available on Twitter and Facebook should make it easier for those caring and those working to engage with and respond to the consultation at a time and place that suits them and without needing child care, worrying about the provision of toilets, private space to breast feed, etc.

Gathering feedback via individual, private and anonymous questionnaires should also benefit those who are particularly worried about personal safety or are concerned that they will not be welcomed by other participants due to sexual orientation or gender assignment; or who have concerns about the cultural appropriateness of attending a mixed meeting.

One facilitated group discussion was held with Asian women (another was planned with Asian girls but did not go ahead); another group discussion was held with parents and other stakeholders at a primary school

- 2 bespoke focus groups were held at baby & toddler groups in Stretford and Davyhulme (each with 6-8 participants) and one with young parents in Davyhulme;
- Response forms were dropped off and staff informed of the consultation at a family centre and a toy library;
- FASNET (an umbrella organisation for community groups working with families), raised awareness of the consultation through their networks

How successful have they been?

- 11% of responders did not give their gender; of the remainder, 39% were men and 61% were women. Men were more likely to respond online than by hard copy: 44.5% of the online responses, compared to 37.7% of the hard copy responses were from men. According to the 2011 Census, men make up 49% of the population of Trafford. Given the potential issues identified above in engaging men, the consultation has been successful at engaging both men and women.
- 11 people (0.7% of the total) said that their gender was different from that which had been assigned at birth (10 of this group had responded by hard copy). Estimates of the proportion of trans people in the UK population vary between 0.5% and 0.8% (based on own calculations using data from Reed et al 2009) so, assuming people have understood the question and completed it correctly, this would suggest trans people have been proportionately represented in the consultation response.
- Individual responses were not monitored by pregnancy/ maternity, however, the issues from focus groups targeting parents of young children have been analysed and fed into the consultation alongside individual responses to ensure that the views of these groups have been included.

Socio-economic inequalities

The Institute for Public Policy Research (ippr) (Paxton & Dixon 2004) have questioned whether the UK is witnessing a widening 'citizenship gap' between the rich and the poor and caution that '… the forms of political engagement which are increasing (those that are more individualised) display a stronger pro-middle-class bias with a danger that this gap between the "two nations" will continue to widen in the future'.

We have already seen how socio-economic inequality cuts across the protected characteristics: with disabled people, carers, the oldest and youngest, and BME groups most at risk of poverty and social exclusion.

What are the potential barriers to participation in the consultation?

The **use of jargon** and large amounts of complex **information** can be a barrier for anyone but, can be particularly off-putting for people with lower literacy levels or those who have had fewer educational opportunities. Asking what things mean – especially in a public meeting – can be intimidating and many people do not have the confidence to do this.

The ippr study found that people's **sense of empowerment**, the feeling that they could influence decisions if they wanted to, is lower amongst the more deprived: 51% of the top social class felt they could influence decisions at a local level in 2003, compared to just 33% among the lowest social class.

Money and access to transport are likely to be barriers for those on low incomes: having to pay for a bus fare, a phone call, a postage stamp or for car parking in order to participate is likely to be at best off-putting, if not unaffordable. Disadvantaged groups are less likely to have access to the internet at home or via a mobile phone.

However, there may also be more opportunities to raise awareness in more deprived communities: word of mouth can be stronger; people are more likely to access local services – libraries, community centres, post offices – and to sit out with neighbours watching children playing in the street.

What steps have been taken to promote equality for more disadvantaged communities and individuals within the consultation?

No cost to return response form, either online or using Freepost reply slip.

Press coverage in free newspapers to raise profile of consultation.

Information in libraries, community centres, GP surgeries, etc.

Considerable engagement activity was focused on the different area-based partnerships, parish councils and residents' groups, some of which have a focus on tackling local poverty and engagement issues. Focused group discussions were held with the Partington, Old Trafford, Sale Moor and Lostock partnerships. A facilitated discussion had been held with residents at Broadheath during the pre-consultation engagement work, though attempts to engage through local housing associations were not successful during the public consultation. Additional flyers and leaflets were distributed around the Broadheath area and e-mails sent out to those on the partnership mailing list.

A bespoke focus group of 13 East Manchester residents was held (mostly to explore the impact of the proposed changes to orthopaedics) and the public meetings held in Manchester were focused on some of the more deprived/ diverse areas of the city (Cheetham Hill, Hulme and Wythenshawe).

The Trust sought to engage social housing tenants by contacting Trafford Tenants and Residents Federation to offer toolkits and other documents. Trafford LINk attended the Sale and Urmston

residents' panels run by Trafford Housing Trust; the engagement team contacted the Trust several times to organise activities in other parts of the borough but these were not successful.

G Force (working with disadvantaged families in South Trafford), Citizens Advice Trafford and the Voluntary Transport Group, all of which have contact with socially excluded residents, were contacted and offered toolkits and other information.

Trafford LINk did some street work, speaking to people using the shopping centres in Urmston, Partington and Stretford Mall and spoke to about 40 people in total at these sites.

Given the combination of public transport issues, geographical isolation and pockets of poverty and unemployment, Partington was a particular target for engagement activity. In addition to the public meeting on the estate, the following additional actions were taken:

- Discussions held at the Parish Council twice
- E-mails sent out to all Partington (agency) stakeholders at the outset
- Article in the Partington Transmitter
- Group discussion at the Partington Partnership
- Trafford LINk did some leafleting and outreach on the estate, speaking to over 20 individuals, visiting the shopping centre, health and wellbeing centre and extra care housing scheme
- A focus group was held with people using the Blue Sci service in Partington

How successful have these been?

The only available proxy measures to assess the consultation's success around socio-economic inclusion are the employment status and postcode of respondents.

The following table gives the breakdown of consultation responses by employment status:

	Online response	Hard copy response	Total response
Full-time employed	172 (58.7%)	317 (36.7%)	489 (42.3%)
Part-time employed	49 (16.7%)	180 (20.8%)	229 (19.8%)
Unemployed: looking for work	3 (1.0%)	26 (3.0%)	29 (2.5%)
Unemployed: not looking for work	69 (23.6%)	341 (39.5%)	410 (35.4%)

Since 'retired' was not given as a separate category, we must assume that retired people either ticked the 'unemployed: not looking for work' box or left this question blank.

Trafford Economic Bulletin (2011) estimated that there were 4263 unemployed people in the borough in June 2011. Using the working age population total from the census of the same year, this suggests an unemployment rate of 2.9%. Since a large number of people over retirement age responded to the consultation, these have been removed in order to compare the proportions. 904 people aged between 16 and 64 responded to the consultation; 3.2% of them told us they were 'unemployed: looking for work', which compares favourably with the estimated unemployment rate for the borough (2.9%).

88.7% of respondents supplied their postcode. A further 150 (8.9%) were residents from outside of Trafford. The breakdown by area (using postcode as the proxy) of the remaining 1539 respondents is presented in the following table, alongside the proportion of Trafford residents estimated to live in each of these areas (drawn from analysis conducted by Gill Fairclough at NHS Trafford).

Postcode area	No. of responses	% of responders identifying as Trafford residents	% of Trafford population
Old Trafford	69	4.5%	11%
Partington/ Carrington	116	7.5%	4%
Stretford	160	10.4%	10%
Sale	400	26.0%	24%
Urmston/ Flixton/ Davyhulme	574	37.3%	15%
Altrincham/ Timperley/ Bowdon	209	13.6%	36%
Other	11	0.7%	-

These figures suggest that Partington and Carrington residents were well-represented; and that, despite concerns about under-representation at the mid-point review, a good response from Stretford residents has been achieved. Old Trafford residents are under-represented, which, given the relatively high levels of deprivation (and high proportion of ethnic minority residents) could cause concern. However, it seems that the under-representation of Old Trafford and Altrincham, Timperley and Bowdon residents can be adequately explained by the geographical factors, i.e. distance from Trafford General and proximity to other hospitals. These factors clearly also explain the high response rate from Urmston, Flixton and Davyhulme residents.

Conclusions

We have reviewed evidence of the steps taken to remove potential barriers to participation and have analysed the demographic breakdown of those who responded to the public consultation. The Trust has, in our opinion, taken all reasonable actions, within the timescales and budget (which have been reasonable and proportionate), to engage groups who might otherwise not have been heard. Those who responded do broadly reflect the diversity of the borough, in particular those parts of the borough which are likely to be most affected by the proposed changes.

> "Thanks for coming back and for doing all that you could do to make the session accessible to LD [Learning Disabled] self-advocates. I think they have enjoyed being consulted, just as other groups have been, and I got the impression that they felt listened to throughout those couple of hours".
>
> *Worker at Trafford Centre for Independent Living following a facilitated group discussion*

The Public Reference Group was impressed by the Trust's willingness to hear their critical feedback and the speed with which they responded to concerns raised during the consultation period. They described practical improvements which had been made to public meetings as a result of their concerns, such as producing a glossary of acronyms and jargon for the chair and members of the public; circulating case studies which bring the changes to life; and tightening up microphone procedures.

Nevertheless, the meetings were relatively long and formal in their format and it is a fair criticism that there was a lot of complex information and jargon to digest. Attendance at some of the meetings was low; audiences often consisted mostly of observers, professionals and members of the campaign group with relatively few members of the local community. However, the meetings were intended to serve as just one of the ways in which people could find out about the proposals; they were not the means by which members of the public inputted their views. Our only concern here is that this perhaps needed to be spelled out more clearly at the outset and during these meetings, with more time dedicated at each meeting to making attendees aware of the fact that they needed to fill in the forms if they wanted their views to be incorporated.

There have been some unfortunate set-backs during the process, such as the failure of one of the delivery agents to get hard copies of the documents to a significant number of homes as contracted. The Trust decided it could not afford – both in terms of the time it would take and the additional costs – to order another print run and has instead delivered postcards and used local media to advertise the fact that people can ring in and request copies if they have not received them. Additional flyers, summaries and response forms have been distributed to community services and facilities in an attempt to boost awareness in the affected areas.

One of the main concerns of the Campaign group (and of a number of the members of the public attending meetings) has been whether and how residents' views can make a difference at this stage. The Trust has been clear about its decision not to offer apparent but disingenuous choices to the public at this stage and has taken legal advice on this point. It is clear from the extent of the pre-

consultation engagement exercise, which included an extensive public phone survey and a number of focus groups, that the public consultation is part of a longer term process in which diverse public views *have* been sought earlier on. However, it is important to publicise this fact and be very clear in feeding back to the public what difference their views have made to the decision-making if the goodwill of the diverse groups of people who have taken the time to complete response forms is to be maintained in the longer term.

> "Feel decision is already made".
>
> "I acknowledge that speakers are experts in their fields but that only small efforts were made to keep jargon to a minimum".
>
> *Comments from event feedback forms*

> "Someone needs to point out the services you are endeavouring to provide are what the public asked for i.e. care at home – not in hospital. Member of public felt "A&E action group" spoke language of their own – not understandable (They replied they have done research)".
>
> "Pleased to see at least a couple of new slides (particularly at the end advising people to complete the paperwork) and good idea to put "examples" on chairs for individuals to read".
>
> *Comments taken from Public Reference Group observation forms*

References

Action on Hearing Loss (2011) Facts and figures on hearing loss and tinnitus

Age UK (2012) Later Life in the United Kingdom, Age UK Factsheet, September 2012

Badham, B & Wade, W (2008) Hear by Right: standards framework for the participation of children and young people, National Youth Agency

Berry, R. (2011) Older people and the internet, ILC-UK June 2011

Big Lottery Fund (2005) Engaging young people in evaluation and consultation, Big Lottery Fund research issue 10

Brap (2010) Engaging people: Guide for improving the involvement of black and minority ethnic people in engagement activities

Browne, K & Lim. J (2008) Count me in Too: LGBT Lives in Brighton & Hove: General Health, Additional Findings Report, July 2008

Carers UK (2009) Facts about Carers, June 2009

Communities and Local Government (2011) Race, Religion and Equalities: A report on the 2009-10 Citizenship Survey

Community Connections (2012) Engaging Transgender People

Creegan, C & Keating, M (2010) Improving sexual orientation monitoring, Equality & Human Rights Commission

Crossroads Care/ The Princess Royal Trust for Carers (2011) How can the web support carers?

Dick, S (2009) Homophobic hate crimes and hate incidents, Equality and Human Rights Commission Research Summary 38

Equalities in Health/ NHS Greater Glasgow and Clyde (2010) Inequalities, Health and the Accident and Emergency response
http://www.equalitiesinhealth.org/documents/AEFinalReportwrefs23march2011.pdf

Equality and Human Rights Commission (2011) Engagement and the equality duty: A guide for public authorities, December 2011, Revised version

Johal, A.; Shelupanov, A. & Norman, W. (2012) Invisible men: engaging more men in social projects, Big Lottery Fund

The NHS Confederation (2011) Involving children and young people in health services

Northwest Regional Development Agency (2010) Unlocking the potential of the BME population

Office for Disability Issues (2010) A guide to delivering accessible events
http://odi.dwp.gov.uk/inclusive-communications/channels/events.php

ONS (Office for National Statistics) (2012) 2011 Census data for Trafford

Papworth Trust (2011) Disability in the United Kingdom 2011: Facts and figures

Paxton , W & Dixon, M (2004) The state of the nation: an audit of injustice in the UK, ippr

Pink News (2010) 'Lesbians and gay men more likely to read blogs and use online networks' http://www.pinknews.co.uk/2010/07/13/lesbians-and-gay-men-more-likely-to-read-blogs-and-use-online-networks/

Reed, B., Rhodes, S., Schofield, P. and Wylie, K (2009) Gender Variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution Gender Identity Research in Education Society

Sheldon, H & Rasul, F (2006) Increasing Response Rates amongst BME and other hard to reach groups – a review of literature relevant to the national acute patients' survey: Summary, The Picker Institute

Stonewall (2011) How to engage gay people in your work

Trafford Council/ PCT/ CYPS (2010) Trafford Joint Strategic Needs Assessment (2009-12)

Trafford Economic Bulletin (2011) 'Key Statistics for Trafford", Issue 01, August 2011

Appendix: Detailed steps taken

Race/ ethnicity/ religion

- St Francis Church was contacted directly and asked if they would like to receive a copy of the consultation toolkit and host a group discussion using it.
- The Black Health Agency and the Voice of BME Trafford were contacted, invited to join the Public Reference Group and sent information about the consultation at the outset.
- In early September, the team had a face-to-face meeting with a member of the Altrincham Muslim Association, who agreed to take flyers and promotional materials to the forthcoming Health Fair being held at the Islamic Cultural Centre in Hale.
- The team also attended the African lunch club in Old Trafford and told around 50 attendees about the consultation to encourage a response.
- A focus group of 7 Urmston/ Flixton/ Davyhulme BME residents was convened
- Contact had been made and a group discussion planned with young Muslim women in Old Trafford (through Trafford Connexions) but unfortunately this had to be cancelled (the young women and their worker suggested the date but had forgotten until the day before that it would clash with Eid preparations). There was also a plan to hold a group discussion with Pulling Together (a group of Asian women) but they said, in the end, that they would publicise the additional Old Trafford meeting instead.
- Trafford LINk spoke to several residents at the Seymour Grove medical practice (which has a high proportion of BME patients) as part of their promotional work around the consultation.
- The Chair of the Diverse Communities Board (intended to be a single point of access to community groups and groups within the community who are seldom heard) sits on the consultation's Public Reference Group.
- A facilitated group discussion was held with 7 members of the Longsight and Moss Side Community Care Link (presumably mostly South Asian carers/ people with mental health problems/ other care or disability issues?)
- ACE Women's Group (South Asian women): a facilitated group discussion was held here

Disabled people and carers

The following groups were contacted by phone and offered a copy of the consultation toolkit/ a visit from the engagement worker to facilitate a group discussion:

- Alzheimers Society (Trafford)
- Arthritis Care, Altrincham & District
- Blue SCI
- Cancer Aid & Listening Line (CALL)
- Disability Advisory Group
- Genie Networks (Deaf people)
- Henshaws Society for the Blind
- Trafford Centre for Independent Living
- Trafford Mental Health Advocacy Service
- The Stroke Association
- New Way Forward (mental health)
- Stockdales of Sale and Altrincham (learning disability)
- The Counselling and Family Centre
- Trafford Carers Centre – a facilitated group was set up but then cancelled (lack of interest)
- SENFSG (Dis children)
- Voluntary Transport Group
- Consultation documents and information were sent to the Diabetes Centre in Old Trafford
- A toolkit was sent to Stroke Support, Trafford

- 10 consultation forms were delivered to the Macmillan wellbeing centre in Urmston

Age: Older people

The following groups were contacted by phone and offered a copy of the consultation toolkit/ a visit from the engagement worker to facilitate a group discussion:

- Age UK Trafford
- Alzheimers Society (Trafford)
- Trafford Care & Repair
- Voluntary Transport Group

Other actions:

- Attended an older persons' coffee morning at Chapel Road, Sale to discuss consultation
- At a community group of mostly older women in Sale, 60 consultation documents were handed out to 45 people and a discussion and Q&A session was held
- 80 consultation documents and 30 toolkits were distributed at Age UK AGM (110 attended)
- Flyers about consultation/ toolkit were sent to the residential/ nursing homes near hospital
- Trafford LINk facilitated group discussion with 25 members of the Engage group in Partington (average age of 69 years old) and visited Elkin Court extra care housing scheme, speaking informally to staff, residents and relatives

Age: younger people

The following groups were contacted by phone and offered a copy of the consultation toolkit/ a visit from the engagement worker to facilitate a group discussion:

- SENFSG (Dis children)
- The Counselling and Family Centre

Other actions:

- 3 bespoke focus groups targeting younger people (1 x under 18s; 1 for 19-30 year olds; 1 for young parents in Davyhulme) were held – around 7 or 8 people attended each
- Trafford Youth Parliament held two discussions about the consultation (one attended by Kate Green MP), using a modified version of the toolkit
- FASNET – information about consultation and ways of getting involved sent out to community groups working with children, young people and families

Sex/ Gender

- ACE Women's Group: a facilitated group discussion was held here
- FASNET – see above
- SENFSG (Disabled children) – were offered a facilitated session but did not come back on this
- Extended services at Seymour Park Primary School – liaison to issue consultation toolkit – group discussion held using this
- 2 bespoke focus groups were held at baby & toddler groups in Stretford and Davyhulme with 6/8 participants and one with young parents;
- An engagement worker went to speak to staff at Delamere Toy Library about the consultation
- 10 consultation forms were delivered to the Big Life Family Centre in Old Trafford