Equality Impact Analysis template

Title of document/service being assessed	Development of a north west London Elective Orthopaedic Centre at Central Middlesex Hospital
Date initial screening completed	December 2021
Date of full equality impact assessment commencement	January 2022
Date of full equality impact assessment completion	May 2022 (subject to approval)

1. What are the intended outcomes of this work? Include outline of objectives and function aims

The north west London integrated care system, through a collaboration of its four acute provider trusts, is building on the concept of fast-track surgical hubs to develop a more strategic, larger-scale approach to improving our provision of "high volume, low complexity" surgery across the sector, beginning with orthopaedic surgery.

The driver is to improve quality as well as to significantly expand access and shorten waiting times over the next few years. We have been exploring how we might best establish an elective orthopaedic centre for north west London alongside maximising our planned surgery capacity overall. We think the best existing location is likely to be the Central Middlesex Hospital – it is amongst our best quality estate, it is one of only two sites that do not provide inpatient urgent and emergency care services at all and there is good potential to expand and remodel existing facilities.

The patient benefits include:

- faster and equitable access for patients awaiting orthopaedic surgery across North West London.
- six day a week access to high quality care designed on best practice (GIRFT & NICE) principles the consistent application in a dedicated surgical centre, reducing the risk of cancellation of patients.
- strengthening and consolidating interfaces with MSK pathways pre and post operatively for patients.
- dedicated specialist pre and post operative patient care on site supported with digital care and networked teams.

The development of a NWL EOC will enable multidisciplinary teams across the NW London ICS deliver orthopaedic surgical care that:

- meets best practice standards and care as set out by GIRFT and NICE
- achieves top quartile, and ultimately top decile productivity in relation to theatre throughput and length of stay using Model Hospital data
- separates elective orthopaedics from trauma services, in line with the NHS Long Term Plan, Royal College of Surgeons' requirements and National Clinical Advisory Team reviews.
- delivers care in a purpose-designed environment separate from the pressures of emergency care.
- supports surgical skills training, new role development while offering new and flexible models of working
- continually improves and innovates patient care and modern surgical practice.

2. Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

A number of service delivery models have been explored. The preferred model is that the following elective orthopaedic patients will be treated at the centre:

- Patients referred for inpatient surgery following outpatient investigation under Imperial College Healthcare Trust, Chelsea and Westminster Hospital Trust and The Hillingdon Hospitals Trust (known collectively as the partner trusts), excluding those with complex anaesthetic needs or a need for joint revision surgery
- Patients referred for inpatient and day case surgery following outpatient investigation under London North West University Healthcare Trust (known as the host trust)

Patients requiring spinal surgery and children will not be treated at the centre.

The following approximate numbers of patients will be treated in the centre.

Admission Type	Annual Activity
Inpatient	4,500
Day case	1,500

Patients will be referred into the centre at the point of addition to the waiting list and will receive their pre-operative assessment and surgery under the care of the centre. Apart from this, they will undertake their pre- and post-operative outpatient care at their local trust (or the trust at which they chose to be referred from primary care).

The centre will employ c.330 WTE staff, from the following staff types:

Staff Type	WTE
Nursing	230
Medical	38
Allied Health Professions	35
Admin/Management	29

Of these, approximately 200 WTE are posts currently employed at partner trusts. The employment model has not been determined and is under discussion amongst the partners.

Key partners include:

- Primary care, who refer patients to acute trusts for orthopaedic care, and who provide continuity of care
- Community organisations, in particular those which support discharge
- Local authorities, which will provide support and scrutiny on behalf of their residents

3. What evidence have you considered?

List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them in the Evidence based decision making section on the last page of this template

Where local north west London data are available, analysis is provided in this document. Where this is not available, reference is made to analysis provided in the equality impact assessment for orthopaedics across London ("Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics" – Health Innovation Network South London and Imperial College Health Partners, Dec 2021). Reference is made throughout the document to specific resources.

Main data sources used were:

- Hospital Episode Statistics (HES) (https://digital.nhs.uk)
- Dr Foster (https://drfoster.com)
- Model Hospital (https://model.nhs.uk)
- GLA Housing Led Population Projections (https://data.london.gov.uk/dataset)
- Office for National Statistics (https://www.ons.gove.uk)
- Google Maps (https://maps.google.com/maps)
- Trust theatre systems

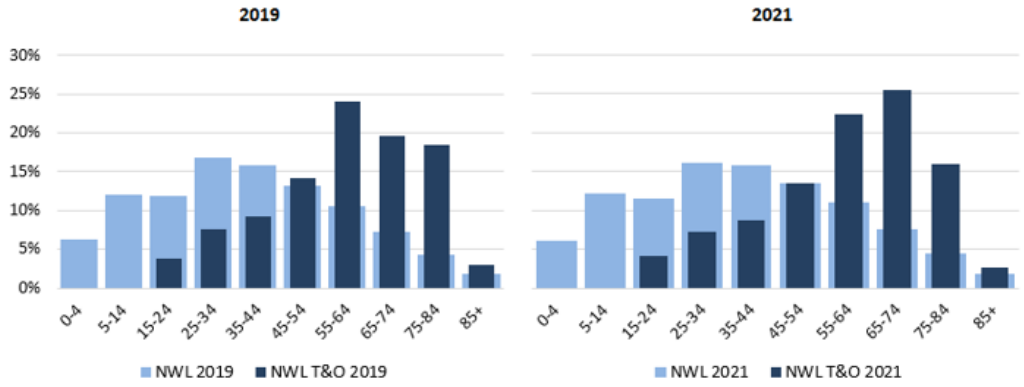
4. Age Consider and detail age related evidence. This can include safeguarding, consent and welfare issue

The following NWL analysis confirms, as would be expected, that the NWL elective orthopaedic population is older than the general population. The older population are more likely to require inpatient than day case surgery, the primary admission type for the elective orthopaedic centre.

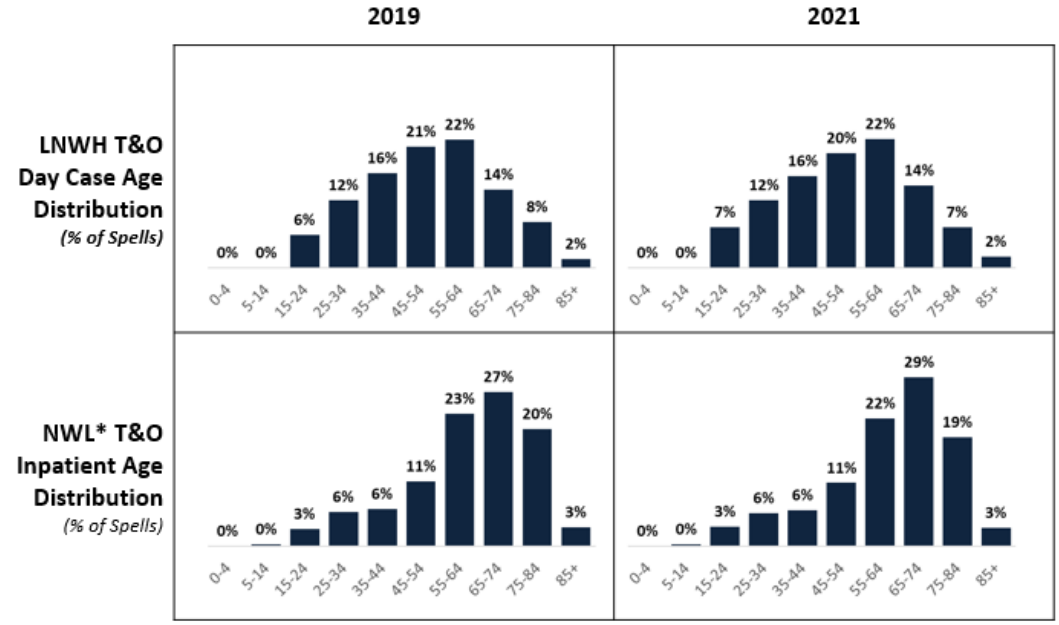
Travel and accessibility for older people, those with disabilities and individuals on low incomes could be a barrier to orthopaedic surgery. Section 13 shows that 90% of the elective orthopaedic centre's target population lives in the boroughs of NWL and shows the expected travel times to NWL trust sites by public transport and car. Central Middlesex Hospital, the most likely location for the elective orthopaedic centre, has the shortest average travel time.

NWL T&O Demographics (LNWH DC & Sector IP)

Y-Axis: % of Spells per Calendar Year/% of NWL Population



Source: HES Data (Dr Foster); GLA Housing Led Projections 2020



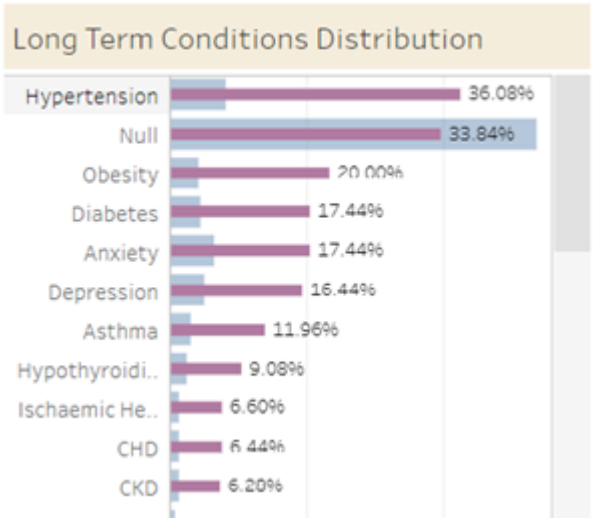
*Source: HES Data (Dr Foster); * NWL T&O includes IP activity of LNWH, ICHT, THHT & CWFT*

5. Disability. Consider and detail disability related evidence. This can include attitudinal, physical and social barriers as well as mental health/ learning disabilities.

Research from the London EIA (ref. “Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics” – Health Innovation Network South London and Imperial College Health Partners, Dec 2021)) identifies:

- Hearing impairment - Mask wearing creates a substantial barrier to healthcare services for individuals communicating through lip-reading, British sign language or relying on facial expressions. Additionally, for these patients with hearing impairments going to new and unfamiliar locations could present additional communication barriers.
- For people with learning disabilities making reasonable adjustments within healthcare provision is a requirement of the Equality Act 2010 (e.g., Easy-read information, avoiding medical jargon or longer appointment times). However often these are not put in place which can be a barrier to accessing healthcare settings. Research by Mencap found that hospital visiting policies during COVID restricted any family members / carers from accompanying patients with learning disabilities (LD) to provide support and assist with communication. 1 in 4 learning disability nurses they surveyed said that during the pandemic they had seen examples where carers, family members or supporters had not been allowed in hospital to accompany patients with LD. Although guidance issued on 8 April 2020 stated that someone with a learning disability or autism could have someone present if the patient has cause for distress3.
- People with autism have difficulty accessing and using online or telephone services to make appointments coupled with the fact that individuals with autism may have poor organisational skills prevent access to healthcare services. Individuals with autism have sensory sensitivities that affect how they access healthcare services. They may choose to avoid healthcare facilities or have adverse reactions in clinical settings because of their condition.
- People living with severe mental illness (SMI) experience some of the worst inequalities, with a reduced life expectancy with 2 in 3 deaths due to preventable physical illnesses such as cardiovascular disease. Diabetes is 1.9 times more prevalent compared to those without SMI. Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

Analysis of the current NWL wating list shows that hypertension, obesity and diabetes are the most frequently recorded long term conditions:



Long term conditions that are well-managed would not necessarily result in exclusion from the centre. However, those requiring additional time and medical intervention to stabilise their long term condition (in particular if it was a recent diagnosis) prior to surgery may not meet the criteria and would require surgery at their local Trust. They could, therefore, have differential waits for their procedure but would have equal clinical outcomes.

6. Gender reassignment (including transgender) Consider and detail evidence on transgender people. This can include issues such as privacy of data and harassment.

A national report published in 2016 (ref. Trans healthcare: What can we learn from people's experiences? Healthwatch, March 2020) found that trans people encounter issues when using the NHS due to the negative attitudes and lack of knowledge or understanding from some healthcare professionals. It is a criminal offence under the Gender Recognition Act 2004, to tell people about a person's previous gender without permission from the individual except when made to a health professional for medical purposes. Although Healthwatch found that trans people's experiences highlighted that often health professionals did not use their preferred or correct name, gender or pronouns in written and verbal communication. This can be highly distressing and deter trans people from using health services for fear of discrimination and prejudice.

Mitigation – Improving knowledge and cultural competency. The GMC provides a short 'top tips' video https://www.gmc-uk.org/ethical-guidance/ethical-hub/trans-healthcare

For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

7. Marriage and civil partnership. Consider and detail evidence on marriage and civil partnership. This can include working arrangements, part-time working, caring responsibilities.

For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

8. Pregnancy and maternity Consider and detail evidence on pregnancy and maternity. This can include working arrangements, part-time working, caring responsibilities.

A significant proportion of patients within the orthopaedic HVLC pathways are 50 years or over (and therefore highly unlikely to be pregnant), therefore we have assumed that this protected characteristic will impact a relatively small cohort.

Additionally, there are increased risks for pregnant women to undergo elective surgery, therefore it is unlikely there will be a high volume of patients who are pregnant will undergo elective orthopaedic surgery.

The majority of nursing staff, the largest staff group in the elective orthopaedic centre, are female. The centre will develop HR policies and procedures that recognise the needs of the workforce including considering staff's caring responsibilities.

9. Race Consider and detail race related evidence. This can include information on difference ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers.

In England, people from ethnic minority backgrounds face a range of inequalities compared to white groups in their health, as well as in their access to, experience of and outcomes from using health services. People from ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than their White counterparts. Ethnic minority groups are disproportionately affected by socio-economic deprivation, a key determinant of health status. This is driven by a wider social context in which structural racism and discrimination can reinforce inequalities among ethnic groups, e.g., housing, employment, which evidence shows in turn can have a negative impact on the physical and mental health of people from ethnic minority groups.

The COVID-19 pandemic has underlined the structural disadvantage experienced by people from ethnic minority backgrounds who have been at greater risk of contracting and dying from COVID-19. The death rate has been higher among ethnic minority populations, and early data from intensive care units found a disproportionate number of patients with COVID-19 were from ethnic minority background. Even when accounting for age and geography, there have been more deaths per capita in all ethnic minority groups (other than white Irish) than among white British people. A fear amongst ethnic minority patients of acquiring Covid 19 whilst being treated within an

hospital environment could impact upon the number agreeing to their surgical procedure.

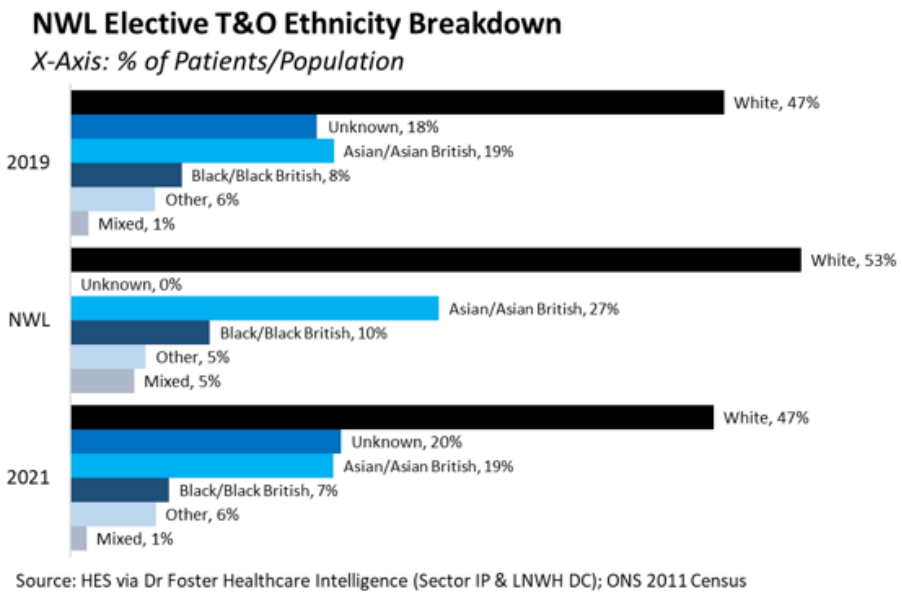
There are assumptions and stereotypes within healthcare provision that create racial bias. Research shows that healthcare professionals may have strong stereotypical views, lack cultural awareness and ability which can create barriers and generated resentment. In the US, they found healthcare professionals appear to have implicit bias in terms of positive attitudes towards white patients and negatives towards patients of colour.

Difference in literacy levels is another challenge, firstly although people may be able to speak English they might not be able to read it, thereby affecting the ability to understand written health related materials. Fewer than one third of Bangladeshi and Pakistani women and fewer than two thirds of older Bangladeshi and Pakistani men can read. Furthermore, even if letters and patient information leaflets are translated, people may not be able to read their own language. The study 'Access to health care for ethnic minority populations (Szczepura, 2005) found that over half of older Bangladeshi and Pakistani women cannot read their own language and about 20% of older men. Health literacy and understanding written information could have a negative impact upon certain ethnic minority groups including appropriate referrals for surgery, prioritisation, and outcomes if there is a lack of understanding of the surgical procedure and aftercare.

References:

- The health of people from ethnic minority groups in England, The King's Fund, Raleigh and Holmes 2021. The complexities of race and health, Danso and Danso, 2021.
- Will COVID-19 be a watershed moment for health inequalities? Institute of Health Equity and Health Foundation 2020
- Access to health care for ethnic minority populations, Szczepura, 2005; Implicit Racial / Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review, 2015

As shown below, 47% of NWL's known ethnicity is non-white. The non-white proportion is slightly greater in the elective orthopaedic cohort.



Source: HES Data (Dr Foster)

NWL ethnicity date (a/w). The centre will develop HR policies and procedures that recognise the needs of the workforce including considering staff diversity.

10. Religion or belief Consider and detail evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.

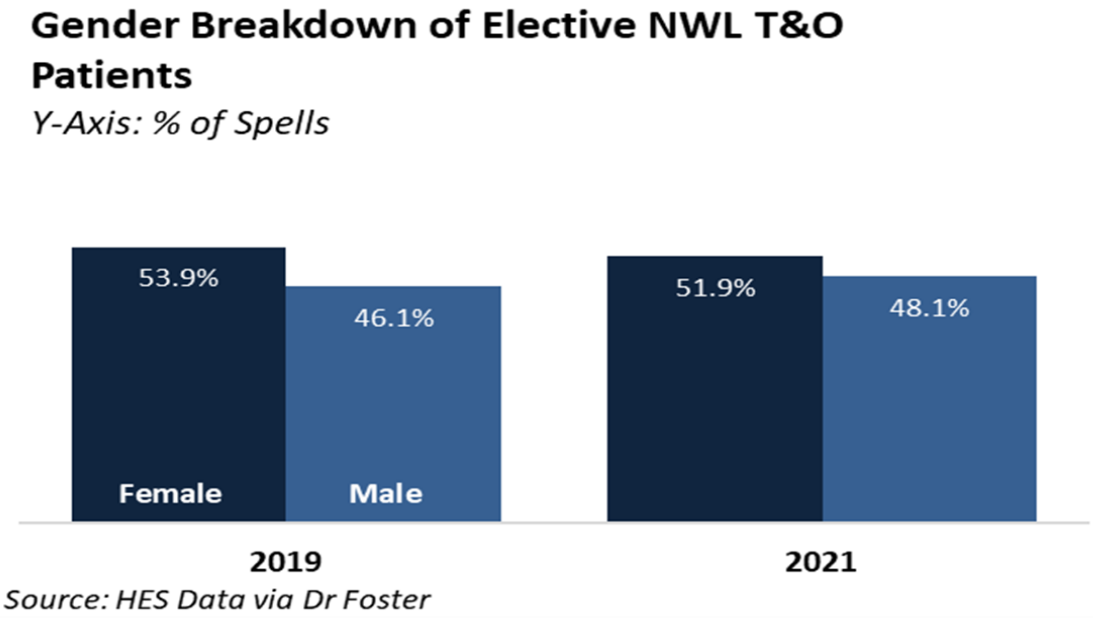
Some research for specific religious groups found lack of providers' understanding of patients' religious and cultural beliefs; language-related patient-provider communication barriers; patients' modesty needs; patients' lack of understanding of disease processes and the healthcare system; patients' lack of trust and suspicion about the healthcare system, including providers; and system-related barriers. Mitigation - Although religion and cultural awareness was not raised as specific issues within the patient interview insights, it is worth noting in relation to inclusion with any cultural awareness training included in the recommendations.

For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

11. Sex Consider and detail evidence on men and women. This could include access to services and employment.

Known higher life expectancy for women could be shown over representation on the waiting list for elective care. It is worth noting that men and women make very different use of primary care (with adult women having substantially greater consultation rates across all illness categories and women being more likely than men to consult if they have an illness episode). Ref. Do men consult less than women? An analysis of routinely collected UK general practice data. (Wang et al, 2013)).

There is an interaction between gender and ethnicity as it is often reported that women in some minority groups find it especially important to see a female doctor, but this cannot always be assumed there is no difference between different ethnic groups as it is an issue of gender, not ethnicity. (Ref. Attitudes to and perceived use of health care services among Asian and non-Asian patients in Leicester (Rashid and Jagger, 1992)).



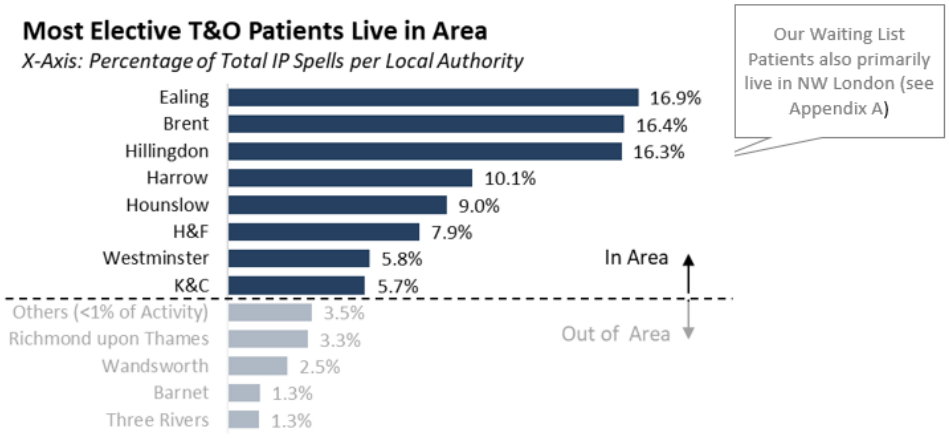
12. Sexual orientation Consider and detail evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.

Almost one in four lesbian, gay, bi-sexual and trans (LGBT) people (23 per cent) have witnessed discriminatory or negative remarks against LGBT people by healthcare staff. In 2018 six per cent of LGBT people – including 20 per cent of trans people – have witnessed these remarks. One in eight LGBT people (13 per cent) have experienced some form of unequal treatment from healthcare staff because they're LGBT. One in seven LGBT people (14 per cent) have avoided treatment for fear of discrimination because they're LGBT (Ref. LGBT in Britain – Health. Stonewall, 2018).

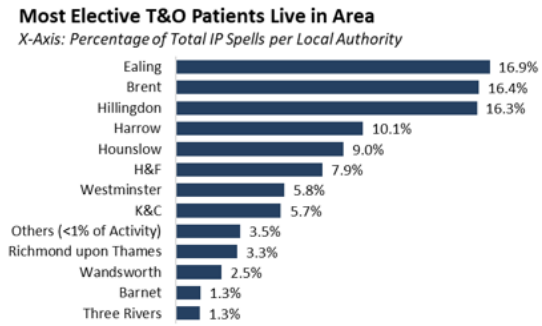
For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

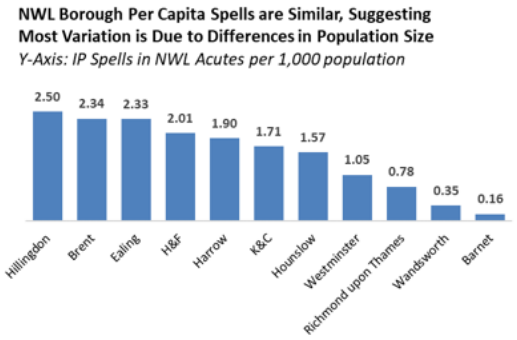
13. Other identified groups Consider and detail evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, Carers, geographical area inequality, income, resident status (migrants, asylum seekers).

Geography and access:
90% of the elective orthopaedic centre's target population lives in the boroughs of NWL and shows the expected travel times to NWL trust sites by public transport and car. Central Middlesex Hospital, the most likely location for the elective orthopaedic centre, has the shortest average travel time by car, and the second shortest average travel time (second to St Mary's Hospital) by public transport.

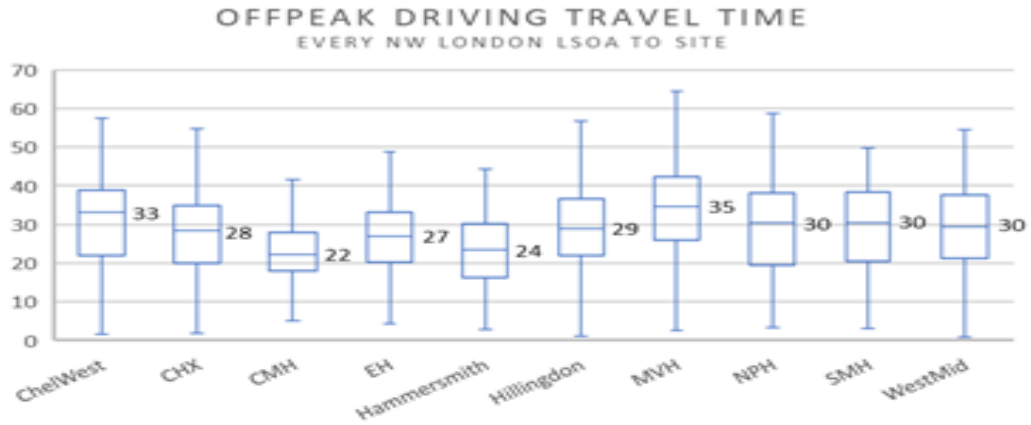


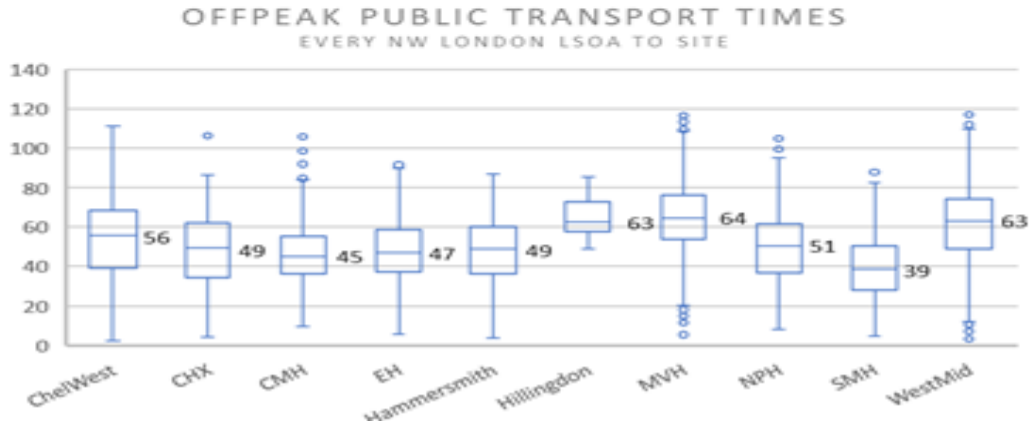
Source: HES Data (Dr Foster)





Source: HES Data (Dr Foster); GLA Housing Led Projections 2020





Deprivation:

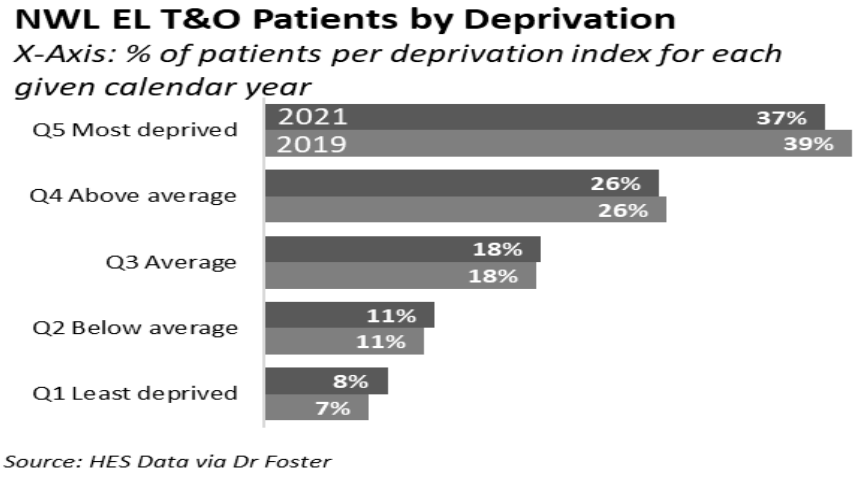
Deprivation can be a barrier to access to healthcare. In the study 'Divided by choice? For profit providers, patient choice and mechanisms of patient sorting the English National Health Service' (Beckert and Kelly, 2021). analysed whether deprivation impacted access / choice to NHS-funded hip replacement in the independent sector. Their analysis found that patients in the top three quintiles of the wealth distribution6

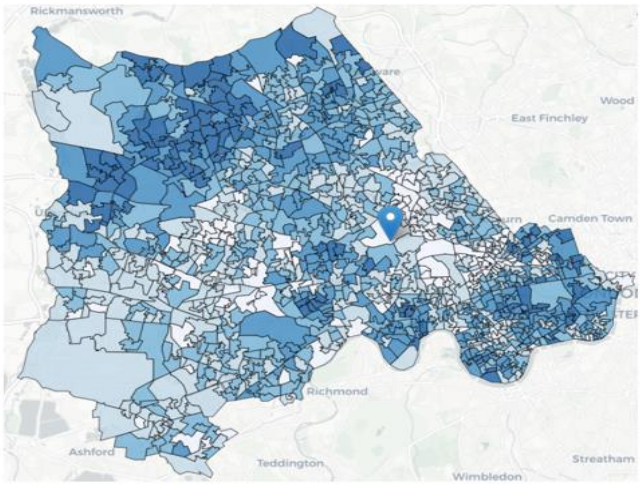
benefit twice (thrice) as much as those in bottom fourth (fifth) quintile; and have more choice of where they have their hip replacement surgery eg. access to NHS funded independent providers, while the two bottom quintiles do not). As the deep dive analysis were unable to access waiting times or activity data for the independent sector used for HVLC hubs it was difficult to explore this further.

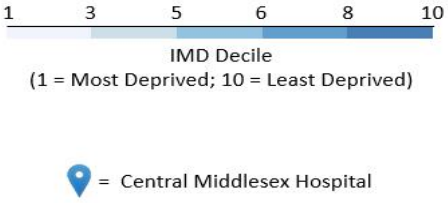
Based upon the areas covered by the 5 Integrated Care System areas in London, previous data has been analysed to identify if patients living in more deprived areas have equity of access to surgery in the six specialties (including orthopaedics). Analysing the number of total hip replacements and total knee replacement (per 100,000 population) carried out on patients living in the most deprived and least deprived Index of Multiple Deprivation (IMD) deciles for each ICS. This found that in 2020 South West London (SWL) and North West London ICS have patients living in deprived areas who are less likely receive their hip replacement compared to London and national average. However, this could be due to more stringent referral management process

Graphs below show that over half of the NWL London population are more deprived than the national average, with a particular concentration of high deprivation in the middle of the NWL sector.

Analysis of travel times shows that residents of the most deprived parts of the NWL sector have significantly reduced travel times to Central Middlesex Hospital, by car and public transport.

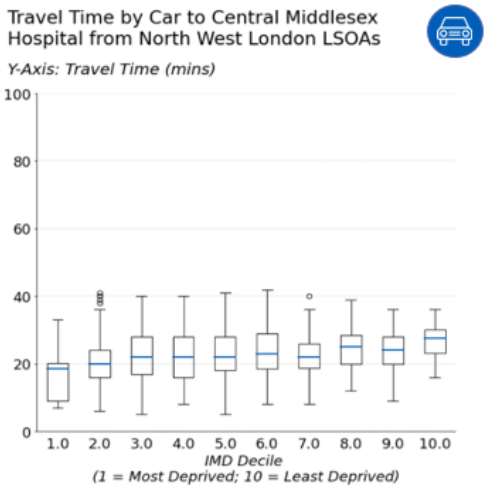


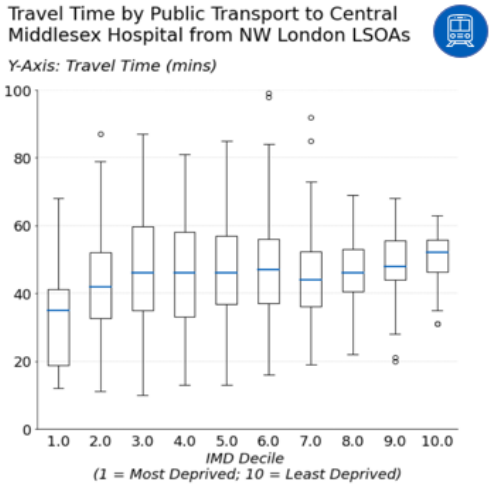




Source ONS: 2019 IMDs by LSOA

Deprivation | The most deprived LSOAs have statistically significantly reduced travel times to CMH by car and public transport





At an individual level, those from deprived areas may not necessarily have improved access as it depends on numerous other factors e.g. car ownership, and ability to pay for transport, parking and/or ULEZ

14. Engagement & Involvement

How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

The engagement plan is summarised in Appendix A.

15. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impacts, if so state whether adverse or positive and for which groups and/or individuals. How you will mitigate any negative impacts? How you will include certain protected groups in services or expand their participation in public life?

Previous research, and local analysis, suggests potential negative impacts for patients for whom access to a healthcare setting is a challenge, in particular:

Elderly patients
Disabled patients
Black and Minority Ethnic patients for whom English is a second language
Patients from deprived areas

Consideration has been given to these groups in the option appraisal for a preferred site within NWL, and Central Middlesex Hospital has been shown to be the most accessible viable site for an elective orthopaedic centre.

As the centre plans for implementation it will develop detailed operational policies to address the specific needs of patients, for example virtual pre-operative assessment to avoid hospital attendance where appropriate.

Staff's needs will be considered by the workforce group, which is developing an employment model. Best human resource practice will be followed in any negotiations or consultations with affected staff.

The following are recommended to mitigate the impact on patients (ref "Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics" – Health Innovation Network South London and Imperial College Health Partners, Dec 2021):

- Improved population level data dashboard should be set up at ICS level to analyse patient data (including co-morbidities) to provide assurance that HVLC hubs are not creating health inequalities, particularly those with communication issues, translation needs, serious mental illness, learning disabilities and deprivation
- Ensure consistent application of the HVLC criteria so that patients are prioritised based upon their clinical requirements, with a particular focus on better preparation for surgery patients with co-morbidities requiring additional medical intervention from both primary care and pre-operative team to stabilise their long-term condition.
- Improved monitoring of waiting lists for HVLC procedures to ensure all patients are seen in a reasonable and equitable time period. Action should be taken to monitor and mitigate against greater impact upon certain groups that face inequalities (e.g., patients with disabilities, economic deprivation and lack of support network).

16. Eliminate discrimination, harassment and victimisation

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).

17. Advance equality of opportunity

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).

18. Promote good relations between groups

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).

19. Risk Scoring

You will also need to score each of your negative impacts from the information/data for each Protected Characteristic and from the outcome of Engagement & Involvement exercise and record the scoring in your Action Plan.

Use the Matrix below

Matrix for Full Equality Impact Assessments

1. PROBABILITY -What is the likelihood of the service, policy or function having an impact on staff or patients of the Trust? Use the table below to assign this incident a category code.

MEASURES OF PROBABILITY		
Descriptor	**Level**	**Description**
Rare	1	The service, policy or function will only impact under exceptional circumstances
Unlikely	2	The service, policy or function is not expected to have an impact but will do in some circumstances
Possible	3	The service, policy or function may have an impact on occasion
Likely	4	The service, policy or function is likely to impact, but not on a persistent basis
Almost Certain	5	The service, policy or function is likely to impact on many occasions and on a persistent basis

2. SEVERITY OF IMPACT -Identify the highest possible impact of the service, policy or function. (Use this table as a general guide)

Examples of Discrimination according to descriptor

Descriptor	
Negligible 1	Patient complaining that their dignity has been infringed due to having to wait in reception after eyes being dilated.
Low 2	Temporary relocation of Clinic due to refurbishment. Patients required to travel longer distance to attend clinic.
Medium 3	Uneven surfaces making it dangerous for wheelchair users to manoeuvre across.
High 4	Service excludes particular patients due to their religious requirements.
Very High 5	Emergency Fire Escape: Lack of accessible escape routes for disabled patients.

Action Plan

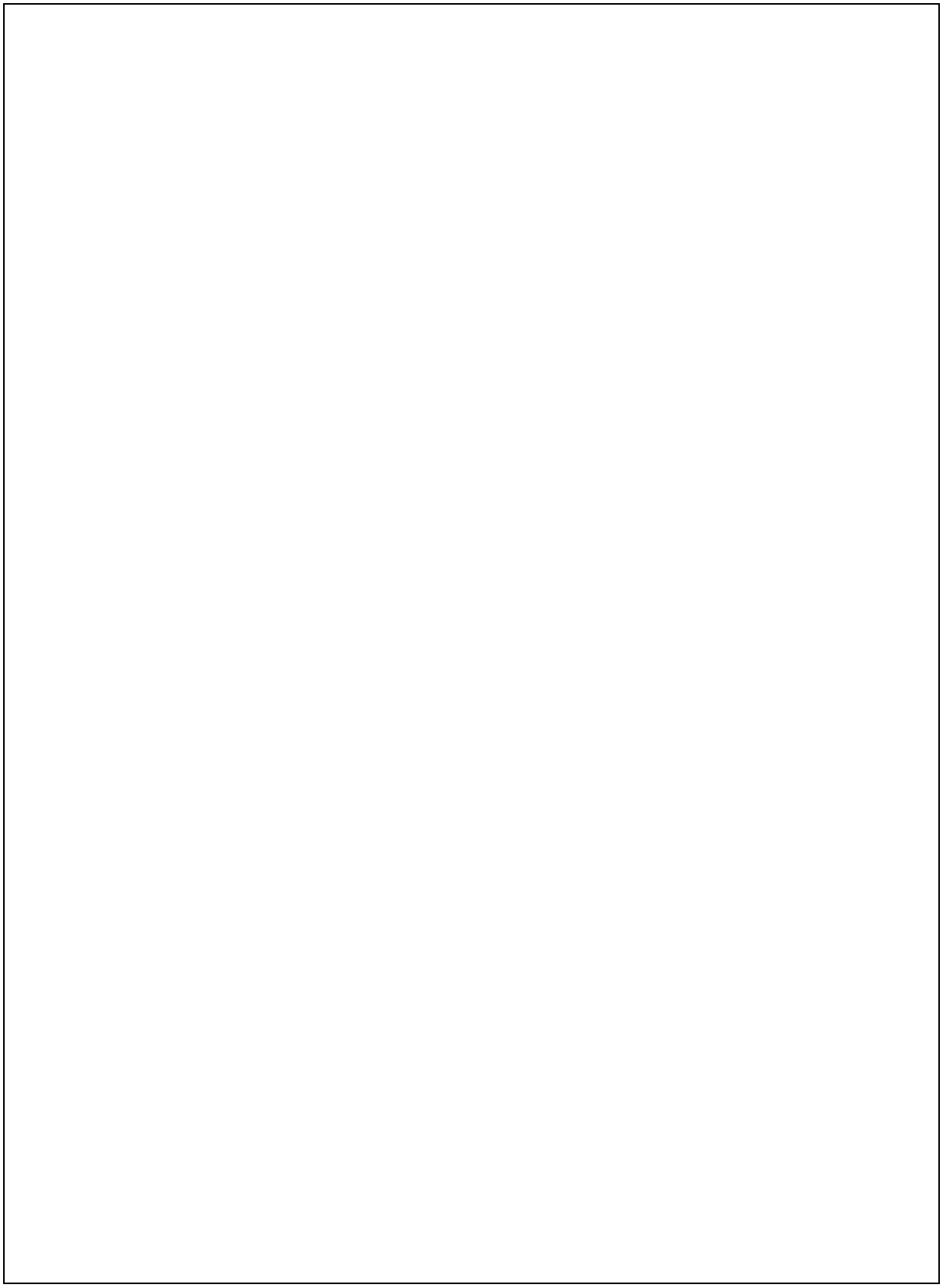
Equality Impact Score - Use the matrix below to grade the risk. E.g. 2 x 4 = 8 = Yellow or 5 x 5 = 25 = Red

	Severity of Impact				
Probability	**Negligible 1**	**Low 2**	**Medium 3**	**High 4**	**Very High 5**
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

What is the negative/adverse impact?	Risk Score Current Target	Actions required to reduce/eliminate negative impact	Resources required	Who will lead on the action?	Target completion date
Older patients experiencing difficulty accessing the centre	4x3=12 Target 4x2=8	• Minimise visits to centre, i.e., outpatient care provided at local trust • Virtual pre-operative assessment where suitable • Centre design compliant with current legislation • Collaboration with community colleagues to ensure effective discharge from hospital	• 7 day therapy services • Virtual POA package • Discharge SOPs • Targeted wayfinding in the EOC	EOC Managing Director Acting Director of Estates, LNWH	Spring 2023
Disabled patients experiencing difficulty accessing the centre	4x3=12 Target 4x2=8	• Minimise visits to centre, i.e., outpatient care provided at local trust • Virtual pre-operative assessment where suitable • Centre design compliant with current legislation, including disabled access/parking • Collaboration with community colleagues to ensure effective discharge from hospital	• 7 day therapy services • Virtual POA package • Discharge SOPs • Targeted wayfinding in the EOC • Disabled access to all facilities	EOC Managing Director Acting Director of Estates, LNWH	Spring 2023
Patients whose first language is not English facing barriers to accessing the service	4x3=12 Target 4x2=8	• Written and virtual material in multiple languages • End-to-end pathway designed with NWL musculoskeletal network • Links to local community partners	• EOC partnership board with MSK and community membership • Comms team support	EOC Managing Director LNWH EDI Lead	Spring 2023

			• Trust equality and diversity expert input		
Patients experiencing longer journey to their inpatient orthopaedic acute provider	3x3=9 Target 3x2=6	• Minimise visits to centre, i.e., outpatient care provided at local trust • Virtual pre-operative assessment where suitable • Adequate car parking • Public transport links	• Virtual POA package • Clear directions and written materials at all stages of the pathway	Acting Director of Estates, LNWH	Spring 2023
Patients experiencing deprivation facing additional barriers to accessing care	3x3=9 Target 3x2=6	• Hospital transport available • Adequate car parking • Public transport links • Pre-operative assessment to address access barriers	• Suitable POA package • Hospital transport contract for whole of NWL	EOC Managing Director Acting Director of Estates, LNWH	Spring 2023
Staff experiencing longer journeys to work impacting on caring responsibilities	3x3=9 Target 3x2=6	• Staff consultation for those affected in accordance with best practice • Employer flexibility where possible • Adequate car parking • Public transport links	• ICS-wide staff consultation process	HR Director, ICHT (EOC workforce lead)	December 2022

Descriptor	Potential Impact on Individual(s)	The Potential for complaint/ Litigation	Potential Impact on Organisation
Negligible 1	• No impact or adverse outcome	• Unlikely to cause complaint/ litigation	• No risk at all to organisation
Low 2	• Short term impact	• Complaint possible • Litigation unlikely	• Minimal risk to organisation
Medium 3	• Semi-permanent impact	• Litigation possible but not certain. • High potential for complaint.	• Needs careful PR • Reportable to SHA • External investigation (e.g. HSE)
High 4	• Permanent impact	• Litigation certain expected to be settled for < £1M	• Service closure • Threat to Divisional/Directorate objectives/priorities • Local publicity
Very High 5	• Permanent and severe impact	• Litigation certain expected to be settled for > £1M	• National adverse publicity • Threat to Trust objectives/priorities



Appendix A: Draft Engagement and Involvement Plan

Emerging proposal to develop a north west London elective orthopaedic centre

1. Background

The north west London integrated care system through a collaboration of its four acute provider trusts is building on the concept of fast-track surgical hubs to develop a more strategic, larger-scale approach to improving our provision of 'high volume, low complexity' surgery across the sector, beginning with orthopaedic surgery. The driver is to improve quality as well as to significantly expand access and shorten waiting times over the next few years. We have been exploring how we might best establish an elective orthopaedic centre for north west London alongside maximising our planned surgery capacity overall. We think the best existing location is likely to be the Central Middlesex Hospital – it is amongst our best quality estate, it is one of only two sites that do not provide urgent and emergency care services at all and there is good potential to expand and remodel existing facilities.

A high level core narrative to support exploration of an elective orthopaedic centre has been developed and presented to key stakeholders at the NWL Joint Health Overview and Scrutiny Committee. This narrative sets out the case for change and work required to develop a fuller proposal, including putting in place effective project management, governance and a programme of engagement and involvement. Read the high level narrative as part of the acute care programme briefing: Exploring a north west London elective orthopaedic centre

This engagement and involvement planning document aims to set out the core activities and deliverables required for all key phases including pre-consultation engagement, as well as formal public consultation, with key stakeholders.

2. Objectives

- To ensure the proposals for the NW London elective orthopaedic centre reflect and respond to the needs and views of all users (patients, carers, staff, NHS partners, local authorities and wider stakeholders) by enabling opportunities to influence and co-design key elements including the clinical pathway and workforce model and with a particular focus on addressing health inequalities
- To build widespread support for the change and investment required
- To ensure all statutory requirements for service change engagement/consultation are met

3. Engagement and involvement timeline

Timeline	Activity	Objectives/other comments	Responsible
March 2022	Draft service change/develop options report for acute care programme board with	*Covered through engagement involved in development of the OBC*	Project team – *completed*

	approval to move to pre-consultation/informal engagement		
March 2022	Initial approach to key stakeholders at Joint Health Overview and Scrutiny Committee (JHOSC) on emerging proposals for NWLEOC Informal discussions with other stakeholders through one-to-one meetings and sharing paper on emerging proposals – HFSON, Healthwatch, MPs and councillors	• Gain support to continue developing detailed proposals • Commitment to developing an engagement/involvement programme and to return to JHOSC with fuller proposals	Acute care comms group – *completed*
March 2022	Early communications with all staff to introduce the emerging proposal and intention to engage further	• Publication of acute care briefing • Item in staff briefings *(completed at ICHT)* • Video for staff briefing (CCG/ICS*)*	
March 2022	Alert NHS England London to our approach and future need for consultation Explore advice of specialist consultation experts on same (possibly Consultation Institute)	To check and get support for approach	
March 2022	Align/coordinate engagement approach with other MSK/T&O developments in NWL – develop a high level narrative?		
March 2022	Agree involvement approach and establish support, including administrative support to deliver engagement activities	Scheduling and invitations for virtual meetings, agenda, note-taking	
March 2022	Gather and collate existing user data/insights, with special focus on health inequalities impact	Findings to inform detailed involvement plan and approach	
March 2022	Share/check high level engagement approach with strategic lay forum and equivalent	Validate the plan	

March 2022	Set up a steering/reference group to focus on engagement, define ToRs and include: • operational leads • clinical leads • workforce leads • representation from all providers (general managers/service managers) • Healthwatch/patient representatives • lay partners.	• Use the group to check/challenge ongoing engagement plans • Requires dynamic leadership to chair and enable inclusion of a variety of voices • Project team to support with identifying invitees	
April to mid-May 2022	***Electoral period (purdah) – restrictions on engagement with stakeholders***	***Period to be used for involvement, to inform more formal proposal for next JHOSC***	
April 2022	Hold first steering group meeting and agree terms of reference, frequency and work streams • Recommended four meetings - kick off to input to draft involvement plan – including sharing initial user insights work - second to discuss findings and inform plans for formal consultation - third ahead of formal consultation to validate plans - fourth to review consultation outcome report, to guide implementation plans		
April 2022	Set-up small communications working group with leads from each trust/ICS and include a lead for user insights	Lead on ensuring communications actions/activities for respective trusts and CCQ/ICS are carried out	

April 2022	Design involvement plan based on areas of interest and concern emerging from existing user insights e.g. series of themed workshops/focus groups/interviews Develop a set of broad, open-ended questions for testing, based on collated user insights sets of broad and open-ended questions to accompany the collateral - tailored sets for public/patients and for staff groups	Other channels available: • A north west London-wide 'collaborative space' virtual event – open forum for discussion around proposals for the entire MSK pathways	
April 2022	Commission external communications agency to produce collateral for engagement with patient/public groups and staff, which includes: • an explainer of what we are trying to achieve • what possible change models can look like • supplementary content to use as promotion for websites/intranet/social media (should include proposal for what suggested workforce model might be).	• Aligned with narrative around MSK pathways • NCL have produced a video that can be used as a guide	
April 2022	Commission qualitative researchers to carry out the involvement activities		
April 2022	Identify and create lists of patients/public groups for pre-consultation engagement. Target these groups via all four trusts and CCG/ICS channels to promote involvement activities (all four trusts and CCG/ICS channels)	• Understand the need and benefits • Raise concerns • Opportunity to feed into design principles for ideal elective orthopaedic centre	
April 2022	Identify and create lists of multi-disciplinary staff for engagement including:	• Opportunity for staff to understand how proposals will affect	

	• staff likely to be directly affected • staff indirectly affected • staff representatives and trade unions Targeted communications to promote involvement activities	them and raise concerns • Enable co-design of the work force model Dependency – baselining of staff affected from each Trust	
April 2022	Agree, establish and brief clinical leads for engagement with all stakeholders	• Assert clinical gravitas behind emerging proposal	
Involvement period			
April-May 2022	Carry out involvement activities with public and patients Carry out involvement activities with staff groups	Opportunity for groups to raise issues/concerns and contribute ideas towards the design of MSK pathways	
June 2022	Forward planning for imminent public consultation including all documents (full, summary and easy-read documents) and start preparing materials for consultation activities.	Build on collateral already developed during the involvement phase	
June 2022	Organise NHSE assurance activities including required evidence and documents	Visits and reports by clinical senate and programme assurance teams	
End June – early July 2022	Findings of involvement activities to inform worked up proposals/outline business case for the NWLEOC to be presented back to JHOSC and other elected stakeholders (via existing Trust contact programmes). Potential deliverables include updated narrative, report from involvement activities and briefs documents	• Next JHOSC meeting to be held in July (dates TBC) • Official decision on level of public consultation required – expected to be the full 12-week period for a service change of this size	
End June – early July 2022	Report to acute care programme and ICS board with recommendations for moving to consultation		
End June – early	Final approval to launch full public consultation from ICS		

July 2022			
End June – early July 2022	Final sign off for consultation documentation		
Formal public consultation			
Mid-July	**Launch public consultation with possible deliverables:** • Consultees database • Content for website section/interactive response form • Content for Intranet section/internal channels • PowerPoint presentations: internal/external • Newsletter articles • Email address/Freepost address • Consultation documentation • Distribution of consultation materials • Launch introductory letter/email • Newspaper advertisements • Internal staff meeting events • Attend OSC meeting • Programme of consultee/stakeholder meetings • Patient/user group meeting/s • Public meeting/s • News releases • Social media channels		
Mid July 2022	12-week public consultation period	NB – possibility we may be asked to carry out a 14 week consultation as this falls during the summer months	
Mid July 2022	Undertake formal staff consultation process aligned with change management	Notify trade unions of upcoming staff consultation ahead of undertaking	

	policy and processes across the four trusts		
Mid Sept 2022	Consultation period closes		
Post-consultation period			
Mid – Sept – mid Oct 2022	Analysis of consultation responses to inform a consultation outcome report and final business case	To be presented to steering group to formulate response and outline implementation plan	
Mid – Sept – mid Oct 2022	Consultation outcome report to go through governance channels with recommendations, for response and decision-making business case • Acute care programme board • ICS board • All trust boards?		
October 2022	Inform consultees of response and decision		
October 2022	Produce consultation outcome/response publication		
October – Nov 2022	Implementation of decision for service change/development – construction of elective orthopaedic centre	Eight months for construction of centre (building new theatres as per emerging proposals)	
TBC	Develop detailed communications plan to support implementation of the centre, including potential staff recruitment campaign		
TBC	Commission and open centre to receive sector wide patients and teams		

Appendix 5

Equality Analysis – Due regard process

LNWH as a public body has a duty to have Due Regard to the need to:

1. Eliminate discrimination, harassment and victimisation and any other conduct prohibited by the Equality Act 2010
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not.
   This involves considering the need to:
   - Remove or minimise disadvantages suffered by people due to their protected characteristics
   - Take steps to meet the needs of people with protected characteristics that are different from the needs of people who do not share them
   - Encourage people with protected characteristics to participate in public life or in other activities where their participation is law
3. Foster good relations between people from different groups. This involves tackling prejudice and promoting understanding between people from different groups.

It is necessary to actively seek opportunities to fulfil the above duties.

Protected Characteristics

- Age
- Disability (& carers)
- Gender Re-assignment
- Marriage & Civil Partnership
- Pregnancy & Maternity
- Race
- Religion & Belief
- Sex
- Sexual Orientation

Questions to consider

- Does Due Regard apply and why/why not?
- Which Protected Characteristics / Human Rights could potentially be impacted negatively?
- What is the potential impact?
- What data and information sources would you use to inform your work to help apply Due Regard?
- Who do you need to talk to / involve?
- What are the relevant factors?
- Have all views been considered?
- What mitigations could be considered? Are they practical/ doable?
- If the mitigations are not practical / doable, what is the justification?

Human Rights; 5 principles

- **F**airness
- **R**espect
- **E**quality
- **D**ignity
- **A**utonomy

Think NHS Constitution;

- Duty to protect and promote Human Rights for every individual

If challenged:

Are you confident that the decisions made and the outcomes of this project are:

- ✓ Non discriminatory
- ✓ Promote equality of opportunity
- ✓ Foster good relations between people with any of the protected characteristics

- Can you produce evidence that Due Regard has been conscientiously and proportionately undertaken and all the necessary views have been considered before any decisions were agreed?
- Can you, if after starting a course of action and a problem relating to a protected characteristic materialises, evidence that Due Regard was then undertaken and used to determine whether to continue or not and therefore influencing the decision?
- Can you evidence that the substance and reasoning of any decisions are not based upon personal bias and values and can be fully supported with documented evidence?