Joined Up Care
Derbyshire

Guide to Patient & Public Involvement in our ICS

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

CONTEXT

This is a guide to the legal obligations for service change programmes in Joined Up Care Derbyshire (JUCD), Derbyshire's Integrated Care System (ICS).

It can be costly and time-consuming when commissioners and providers of services do not act on these obligations. The worst-case scenario is that legal challenges can stop proposed service changes from being implemented altogether.

This guide has been developed for those considering, and involved in, service change to help them navigate the common legal and policy issues from the very start of a service change programme through to the final decision-making. This includes NHS commissioners and providers, as well as ICS leads and partners. It describes the current legal framework and the likely steps required to discharge legal duties when making changes to services.

Within this document:

Engagement is about having an open conversation with the public which allows them to input their views and ideas in the planning, design, and development of options for change. It is about establishing the issues, e.g., possible scenarios for change and the potential impact on services and describes a continuing and on-going process of developing relationships and partnerships so that the voice of service users, carers, local people, and their communities is heard.

Public Consultation is governed by law and seeks the views of the public on a set of proposals put forward for the substantial development of health services. It is a prescribed and time-limited piece of work.

Service Change is 'any change to the provision of services which involves a shift in the way front line health services are delivered'. Service change usually involves a change in the range of services available or a change to the location from which services are delivered. Most of the legal duties apply to any change that meets this description. There is no single, generally accepted definition of service change and in particular no legal definition, so each case should be assessed on its specific attributes and in discussion with the Engagement Team.

Significant or Substantial Service Change. The Engagement Team will establish whether a change is 'significant' or 'substantial' enough to mean that public consultation is required, and formal assurance from NHS England (NHSE). This will be done in consultation with the local Health Overview and Scrutiny Committee (HOSC). There is no single definition of what constitutes a 'significant' or 'substantial' service change; hence each case should be examined individually. Commissioners, providers, and system leads should continue to involve the public in service changes or service improvements, even where it is decided that formal public consultation is not required.

The benefits of engagement:

- **Improved health outcomes:** Helps to ensure services meet people's needs. People have the knowledge, skills, experiences, and connections to support their health and wellbeing.
- **Value for money:** Services designed with people are more likely to meet their needs, reducing the need for additional care and/or treatment which is a better use of NHS resources.
- **Better decision-making:** When local insight and knowledge are used alongside financial and clinical information, it can add practical weight and context to statistical data and fills gaps.
- **Improved quality:** Services can be designed and delivered more appropriately because they are personalised to meet the needs of local people. It also improves safety, ensuring people can raise problems that can be addressed early and consistently.
- **Accountability and transparency:** Explain how decisions have been made and how the views of local people have been taken on board. Transparent decision-making, with people and communities involved in governance, helps make the NHS accountable to communities.
- **Participating for health:** Can reduce isolation, increase confidence, and improve motivation towards wellbeing.
- **Meeting legal duties:** Although not the primary motivation, failure to meet, risks legal challenge, with substantial costs/delays and it can damage relationships, trust, and confidence with people and communities.

SUMMARY OF LEGAL DUTIES

Guidance exists to inform how the NHS should handle service change.

- 'Planning, assuring and delivering service change for patients NHS England 2018'
- Addendum to planning assuring and delivering service change for patients
- Legal Duties for Service Change: A Guide
- Statutory Guidance for Integrated Care Boards, NHS Trusts, NHS Foundation Trusts and NHS England
- Equality Act 2010: summary guidance on services, public functions and associations
- Major Service Change Interactive Handbook (2022) - Service Change and Reconfiguration - Integrated Care (future.nhs.uk) – This can be found on the NHS Futures Platform. This is a free and open workspace, but you will need to create a login to access the content. You do not need an NHS email.

Please note: Although this guide takes into account some of the changes brought about by the Health and Care Act 2022, there will be further changes to make. The purpose of the Act is to establish a legislative framework that supports collaboration rather than competition. This guide will be reviewed and refreshed in the coming months to take into account any legal changes brought about by the Act.

In summary, current legal duties include:

- NHS bodies have a legal duty to involve patients and members of the public who might use services, in the:
  - planning of services
  - developing and considering proposals for changes to services (from the patient's point of view)
  - decisions about services
- Where proposed changes to services are **significant**, 'public consultation' is normally part of the approach to discharging that duty
- Where the changes proposed are substantial in the view of the local authority whose area they affect, NHS bodies have a duty to consult the local authority via the Health Overview and Scrutiny Committee (HOSC)

- Where the proposal is initiated by the service provider, they must consult the local authority HOSC through the commissioner of the service in question
- NHS bodies must have what the law calls 'due regard' to the need to eliminate the types of conduct which are prohibited under the Equality Act 2010 and to advance equality of opportunity and foster good relations between those who have protected characteristics and those who don't. This is called the 'public sector equality duty (PSED)'
- NHS bodies have a legal duty to consistently have regard to the need to reduce health inequalities when exercising their functions:
  - Reduce inequalities between patients with respect to their ability to access health services
  - Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services
- A significant change brought about by the Health and Care Act 2022 is that the description of people to be involved has been extended from 'individuals to whom the services are being or may be provided' to also include 'their carers and representatives (if any)'
- Changes can be made temporarily due to a risk to safety and welfare of patients or staff, without public involvement or consultation, **however the decision to make a temporary change permanent, must follow the full process set out in this guidance***

*Additional note: Temporary Changes

NHS bodies may decide to change a service without allowing time for public involvement or consultation where they are genuinely satisfied there is an imminent risk to the safety or welfare of patients or staff. Other duties will still apply and should be addressed appropriately.

It is not acceptable for NHS bodies to delay addressing fragile service situations that might lead to such a risk occurring until they are so urgent that an imminent risk exists.

In these cases, NHS bodies should:

- Keep good records of the factors they considered in making these decisions.
- Communicate the changes to affected people; and
- Inform the local authority HOSC about the changes and reasons for not consulting them under the regulations.

You can find a more detailed information about implementing a temporary service change in Appendix Four.

Other Principles and Tests

It is important to be aware of other principles and tests that also need to be followed, set by case law, the Government or NHSE:

Gunning Principles

Case Law: The Gunning Principles consist of four rules, which if followed, are designed to make consultation fair and a worthwhile exercise:

Gunning 1 – Consultation must be at a time when proposals are still at a formative stage. Public bodies need to have an open mind during a consultation and decisions cannot already be made.

Gunning 2 – Sufficient reasons must be put forward for any proposal to permit "intelligent consideration" and response. People involved in the consultation need to have enough information to make an intelligent input into the process.

Gunning 3 – Adequate time must be given for consideration and response. Timing is crucial; is it an appropriate time and environment, was enough time given for people to make an informed decision and then provide that feedback, and is there enough time to analyse those results and make the final decision?

Gunning 4 – The product of consultation is conscientiously taken into account by the decision maker(s). Think about how to prove decision-makers have taken consultation responses into account.

The Four Tests of Service Change

The Government's four tests of service change are:

1. Strong public and patient engagement

2. Consistency with current and prospective need for patient choice

3. Clear, clinical evidence base *

4. Support for proposals from GP/clinical commissioners. **

* In applying test 3 to new models of care, NHSE recognises that the evidence base may be emerging.

** In applying test 4 to system-led change, NHSE will seek to understand the level of clinical support beyond clinical senior leaders within the system. For example, NHSE may ask to see 'Letters of Support' from neighbouring commissioners or providers that will be affected by the proposed service change.

In addition to these four tests, for any proposal that includes plans to significantly reduce hospital bed numbers, NHSE will expect systems to be able to evidence that they can meet NHSE's fifth test otherwise known as:

'NHS England's Patient Care Test' or the 'NHS Beds Test'

To provide assurance against this test, systems must be able to demonstrate their proposals meet at least one of the following three conditions:

1. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
2. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
3. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

It is for NHSE to decide via the assurance process if these tests have been met.

What can happen if NHS bodies fail to discharge their legal duties?

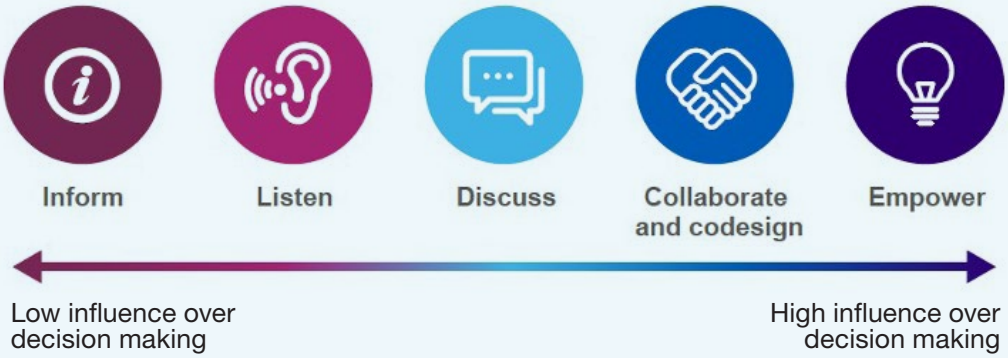
NHS bodies must act in accordance with the law as it applies to them. The legal requirements are designed to make sure NHS bodies take all relevant factors into account in decisions to commission and provide the best services possible. If stakeholders are dissatisfied with a service change decision made by an NHS body, there are two formal ways in which the thinking and process behind the decision can be tested publicly:

1. **Referral to the Secretary of State** - The matter may be referred to the Secretary of State for review. This avenue is open only to local authorities in the affected area using powers given under HOSC legislation. The Secretary of State may take independent advice on the matter and respond setting out the course of action to be followed.
2. **Judicial Review** - Anyone with an interest may bring a claim for Judicial Review if they consider that the NHS body has failed to act in accordance with the law. They cannot challenge the decision itself, only whether the process that they followed to reach the decision was lawful. In this legal process a judge will review the facts of the case by examining programme documents and considering written witness statements to determine if the NHS body has followed a legal process. The court can quash decisions if a judge finds they have not been made in accordance with the law, i.e., overturn a decision or action under review, rendering it legally void, or the court may compel a public body to do something, e.g., to remake a decision within a designated period of time.

OUR ENGAGEMENT STRATEGY

Our Engagement Strategy aims to ensure that patient and public involvement is embedded at the heart of decision-making around service change within the ICS. It is an essential part of making sure that effective and efficient health and care services are delivered, by reaching out, listening to, involving, and empowering our people and communities to have a voice.

Engagement isn't a rigid process; it requires a lot of flexibility. It should be seen as a spectrum of activity that involves different methods and approaches. To get it right it's best to think about it as a continuum:



Our aim should always be:

- To give patients and the public the highest influence possible within the time and resources available
- To ensure engagement is meaningful and genuine, feeding into the decision-making process. It should never be just to tick a box. Therefore, the earlier discussions are started the better
- To inform participants how their feedback has been used and acted on. It is unethical to engage with people and then fail to use the information in your decision making
- To be clear with people about any areas that are not negotiable, or that cannot be influenced for whatever reason, for example, it is nationally directed.

ENGAGEMENT MODEL

At the heart of this strategy is our Engagement Model. This model walks decision makers through the key stages of any service change process and outlines the requirements necessary to meet our legal obligations in terms of patient and public involvement.

The full model can be found here.

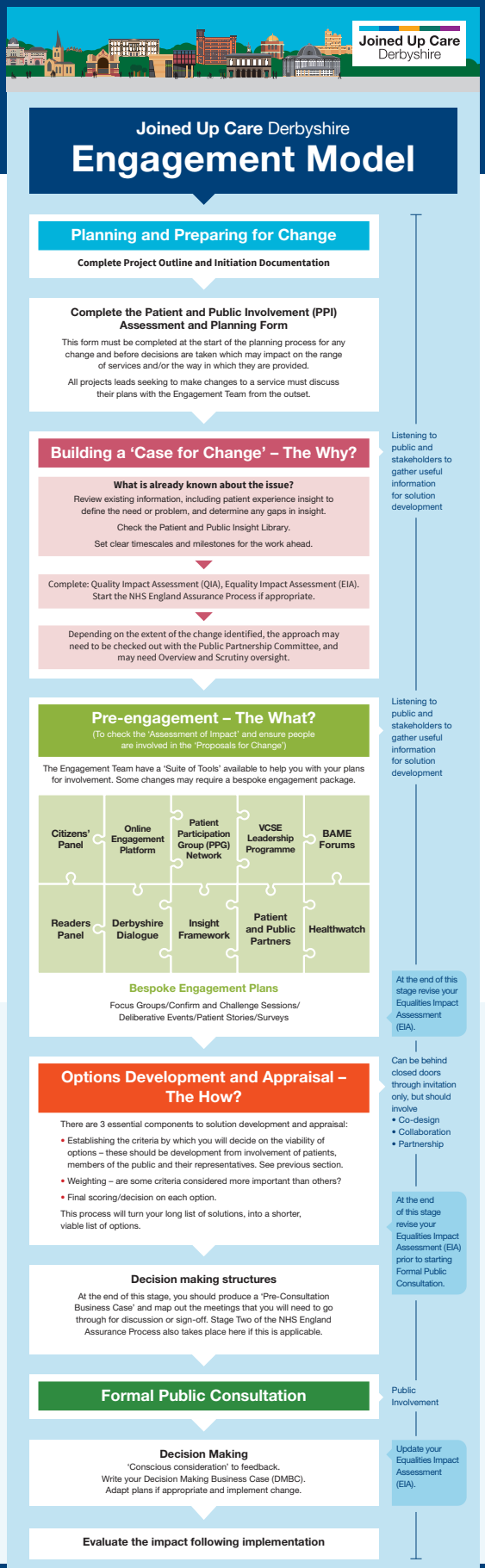
The Engagement Model focuses on 5 main stages:

1. Building a Case for Change
2. Pre-Engagement
3. Option Development and Option Appraisal
4. Formal Consultation
5. Decision Making

Not all stages will be required in full for every service change. Our legal duty requires us to either inform, involve, or formally consult with patients and members of the public. The Engagement Team will advise on the level of involvement based on what is considered 'fair and proportionate' to the change taking place. The level of involvement will be assured through the Public Partnership Committee and with HOSC, where required.

Please note: Given the complexity of legislative requirements and case law all projects seeking to make changes to a service must discuss their plans with the Engagement Team from the outset. The team will provide you with specialist advice to ensure you are able to deliver any change within the law. Teams are not permitted to undertake their own public engagement or consultation without the explicit support of the Engagement Team.

The first step in this process is to fill in the Patient and Public Involvement (PPI) Assessment and Planning Form, see next section.



Patient and Public Involvement (PPI) Assessment and Planning Form

To assess what is 'fair and proportionate' we ask that commissioners, providers, and ICS leads fill in our 'Patient and Public Involvement (PPI) Assessment and Planning Form' which can be found here. This has previously been known as the S14Z2 form.

This form must be completed at the start of the planning process for any change and before operational decisions are taken which may impact on the range of services and/or the way in which they are provided.

Please note: These checklists occur throughout this guidance document at the end of key sections to aid you in assessing your compliance with legal and moral duties to involve patients and members of the public in service change.

Checklist	✓
Have you completed the PPI Form?	
Has this been discussed and signed off by the Engagement Team?	

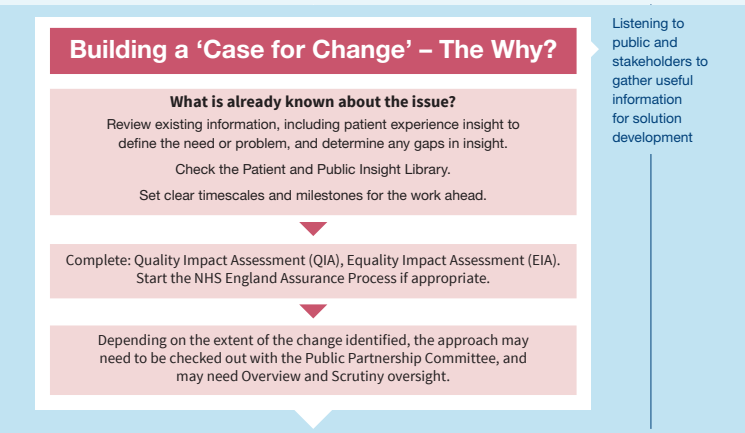
Following completion of this form you will be advised about the level of involvement required and guided through the legal requirements as outlined in this guide.

Please note: It may not be clear from the beginning if 'formal public consultation' will be required, as this may be determined by the options that are drawn up during the planning process. If it is unclear, we advise that you follow the process as though it will be required to ensure that you have factored this into your timeline, and to ensure that a robust process has been put in place which will meet all legal requirements should 'formal public consultation' be needed.

It is also important that you do not promise a formal public consultation or indicate that there will be a consultation until it has been agreed following the options development and appraisal process, as should you do so, this could lead to a legitimate expectation on the part of patients and users of the service that a consultation will take place, when this might not be the most appropriate course of action in the circumstances.

Building a Case for Change – The Why?

The focus at this stage should be on enabling people, including members of the public, to understand the evidence that creates the 'case for change', and what the financial or other resource restrictions are, so they can help develop the best options for change.



To start with:

– Draw together all the information you already know about the proposed change and why it needs to happen.

– Consider all existing sources of feedback and insight on the views and experiences of different groups of people. A review of existing information can save time and money and point towards gaps in insight. This helps to ensure that any future public involvement is focused and meaningful, rather than being generic and imposing an unnecessary burden on people.

To gather this information together, you might consider insight from the following sources:

- The Integrated Care Board (ICB) Patient Experience Team ddicb.patientexperience@nhs.net
- The ICB Business Intelligence Team ddicb.derbyshirebi@nhs.net
- The Joined Up Care Derbyshire (JUCD) Patient and Public Insight Library Joined Up Care Derbyshire Public and Patient Insight Library - FutureNHS Collaboration Platform. This is housed on the NHS Futures Platform, so you will need to create a login in if you do not have one already
- Healthwatch (Derby and Derbyshire) - Healthwatch hold, and are keen to share, a wealth of patient feedback and information which covers a range of perspectives and voices. Healthwatch Derbyshire enquiries@healthwatchderbyshire.co.uk Healthwatch Derby info@healthwatchderby.co.uk
- Previous engagement/consultations – available from the ICB Engagement team ddicb.engagement@nhs.net
- Local organisations such as the Voluntary, Community and Social Enterprise (VCSE) sector
- Derbyshire Observatory (data and statistics for Derbyshire)
- NICE guidelines
- Care Quality Commission (CQC) reviews
- Other national guidance or research evidence

- Patient Experience Library have a comprehensive overview of the UK's collective intelligence on patient experience. Some of this is accessible for free. But for a fee, you can request a bespoke search of their library around selected areas, services, or health conditions. They will also do an in-depth analysis of qualitative evidence on services and conditions from the patient perspective. The library also provides the Patient Survey Tracker below
- Patient Survey Tracker gives you instant access to all the patient experience data for NHS Trusts in England, all on one page. The cross-section function also gives you a quick and easy overview of common themes emerging from different datasets.

– Complete your stakeholder mapping before beginning engagement on your case for change, to help you identify who should review it. We recommend that programmes talk to residents, people who access care and support, and unpaid carers, about the drivers for change. This might include:

- Patient and carer support groups
- Voluntary, Community and Social Enterprise (VCSE) sector
- Healthwatch
- The seldom heard and/or marginalised groups who access the service
- Protected characteristics groups
- Additional groups identified as being disproportionately impacted
- Campaigners (groups and individuals)
- Trust membership networks
- GP patient participation groups
- Local authority citizen and residents' groups
- Local employers and business groups/forums
- Faith groups.

– Plan your case for change, it might be helpful to start with a case for change workshop, including regional team members, system colleagues, key health and care professionals, and experts by experience. A workshop is a compelling way of identifying the reasoning underpinning the case for change and reaching consensus on the key challenges.

– Pull this all together in the case for change document which clearly introduces the reasons that you are seeking to make a service change. Points to consider in the document:
  - Comprehensively describe the current and future needs of the local population, the performance of current local services and the key challenges facing the health and care system
  - Provide a compelling picture of what needs to change and why
  - Do not include any proposal for future service change at this point, just why change is needed
  - You can find further guidance on pages 25-28 of the Major Service Change: An Interactive Handbook

At this point it's also important to consider who should be aware of the case for change, and meet the governance and assurance requirements, **these may include:**

– **Public Partnership Committee (formerly known as Engagement Committee)** – The Public Partnership Committee sits jointly below the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP), due to the responsibility for statutory duties siting with the ICB. It is designed to assess risk and seek assurance in relation to delivery of statutory duties to inform, involve and consult as defined within the Health and Social Care Act 2022 and the NHS Act 2006. In addition to getting involved in developing the strategy for engagement at the beginning, the Public Partnership Committee can also review the intelligence gathered at the end of this process to check if the strategy has been implemented correctly and that the intelligence gathered has influenced the solutions/proposals for change. The committee meets bi-monthly, and enquires should be sent to ddicb.engagement@nhs.net

– **Health Overview and Scrutiny Committee** – The 2013 Health Scrutiny Regulations place a statutory duty on NHS commissioners to formally consult a local authority where the NHS (commissioner or provider) has under consideration any proposal for a substantial development of the health service in the area of that local authority, or for a substantial variation in the provision of such a service. This element of the process requires a high level of preparation, co-operation, and exchange of information, as it is important that the local authority feel they have all the information to make informed decisions. Derbyshire has two local authorities, and hence two Health Overview and Scrutiny Committees. Local authorities have the power to refer a proposed substantial development or variation to the Secretary of State for review if:
  - It is not satisfied with the adequacy of content of, or time allowed to consult it (not the public) on the proposal
  - It considers that the proposal would not be in the interests of the health service in its area
  - It has not been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

While it's good practice for a commissioner to seek the views of the local HOSC as to whether a service change is substantial enough to warrant public consultation, it's the commissioner who has the final say about whether formal public consultation is or is not required. Regular local authority engagement should continue through the lifecycle of service change.

Proposals should be presented to the HOSC at an early stage. This can be facilitated through the Engagement Team at ddicb.engagement@nhs.net. Meetings take place bi-monthly or quarterly.

– **NHSE Assurance Process** - The aim of NHSE's assurance process is to help commissioners apply a best practice approach when planning **complex programmes of service change** and to mitigate the risk of successful legal challenge which might otherwise significantly delay or derail service change proposals.

An effective assurance process also gives patients, staff, and the public confidence that service change proposals are well thought through, have taken on board their views and will deliver real benefits.

For NHSE to assure a set of service change proposals, there must be confidence that a proposal satisfies the government's four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks, and legal duties and is affordable in capital and revenue terms. Assurance checks, both formal and informal, will look at service change with regard to the above, as well as its impact on other organisations in the wider health and social care system. NHSE has a role to both support and assure the development of proposals by commissioners. To start this process, it is important to contact the regional team at an early stage in any development of **substantial** service change proposals, so they can provide informal advice, check and challenge, and links to best practice. Assurance is always applied proportionately to the scale of the change being proposed, with the level of assurance tailored to the service change.

Whether or not the change will need national assurance is determined by the criteria below:

- The reconfiguration scheme requires transition or transaction support of more than £20m from NHSE funds (not including ICB funds); or
- The total turnover of the affected services (for all sites impacted by the transition, at current prices) is above £500m in any one year; or
- The likely capital value of the scheme is above £100m (gross capital value of the scheme, even if the actual value is lower because it is funded through capital receipts); or
- The proposed service change impacts on any provider in special measures.

All proposed **substantial** service changes undergo regional assurance in the first instance. This helps decide whether national assurance is also required. Before national assurance is sought, however, there are two stages to regional assurance. The regional teams can help with understanding the requirements of each of these stages, as well as what is needed to secure assurance.

Stage 1 of the regional assurance process should take place now. This consists of a formal

discussion between programme leads and the Chief Executive leading the change and the area team from NHS England. There will be an exploration of the case for change to ensure there is clarity and strength in the rationale for transformation and that potential risks are identified and mitigated. One of the objectives will be to ensure that the transformation complements relevant national and regional strategies and does not negatively impact on neighbouring ICS boundaries.

The strategic sense check will define NHS England's expectations in terms of assurance and the use of a best practice approach. The use of external independent advice, for example Clinical Senates, should be discussed and agreed at this stage.

Documents required for review at this stage will include:

- Equality and Health Inequality Impact Assessments
- Quality Impact Assessment
- Case for Change
- Communications and Engagement plan for pre-engagement

Clinical Senates

Clinical Senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent.

There are 10 Clinical Senates across England – Find out more information about the East Midlands Clinical Senate here https://midlandssenates.nhs.uk/ or email: england.eastmidlandsclinicalsenate@nhs.net

You might also want to approach our local Clinical and Professional Leadership Group (CPLG) which is made up of representation across health and social care providers who meet on a fortnightly basis. This group can act as the collective clinical and care professional point of reference to support service developments and delivery by providing a senate/council approach to scrutinise and approve transformation proposals in the early stages. Contact Abi Ingram abigail.ingram@nhs.net Joined Up Care Derbyshire Programme Officer, to submit any items for consideration on the CPLG agenda.

The extent of assurance – NHS England's decision tool

– **QEIA Panel** - the purpose of the Quality and Equality Impact Assessment (QEIA) Panel is to ensure quality and equality remain at the heart of any proposal for service change, business case, efficiency plans or commissioning/decommissioning intentions. The panel ensures that quality is not compromised beyond safe or effective levels by any proposal and the process supports the continual cycle of change and improvements including ensuring lessons are learnt. The panel guarantees that consideration is taken on the impact of possible changes to those accessing services and the staff providing these and that those with a protected characteristic are not disproportionately affected. The panel must be consulted on:

- Commissioning/decommissioning decisions
- Significant service redesign and pathway development (including workforce redevelopment)
- Efficiency and cost improvement plans
- Any other plans for change that are likely to impact on the work or structure of the system including national drivers and identified public health concerns or initiatives.

Support and advice regarding attending the panel, or completing the Quality Impact Assessment (QIA) aspect of the tool is available by emailing ddicb.qeiajucd@nhs.net

The QEIA Assessment Form can be found here.

Equality Impact Assessment (EIA) – included in the QEIA tool is the EIA. Organisations must have 'due regard' to the Equalities Act 2010. Section 149 contains the Public Sector Equalities Duty (PSED), which states that during all stages of any engagement and consultation process there must be commitment to eliminate discrimination and advance equality of opportunity. Organisations need to be working towards a less unequal society, planning future investments to be inclusive, and managing change to avoid discrimination and disadvantage. Engagement of stakeholders and members of the public needs to consider the protected characteristics, and organisations should be actively seeking their views. Spokespeople and community leaders can be used for advice, and the focus should be on the quality of engagement, not the quantity. The assessment should also address the cumulative impacts, i.e., some research should be done into what other public bodies are doing at the same time, in case this could worsen the impact, e.g. cuts to transport happening at time when services are being moved to another location.

To support this process, it is important to collect diversity information on questionnaires and during engagement activities.

An EIA is a live document that should be reviewed and developed at intervals throughout the life of the project and beyond:

- Version 1 - when it is agreed a change needs to happen this EIA outlines the potential impact of moving from the status quo. Provides information to inform discussion and debate. Identifies gaps in knowledge and understanding to inform the comms and engagement plan
- Version 2 - continues from version 1 and takes place after discussion and debate about solution exploration during the pre-engagement stage to help agree options. You can update the potential impacts and mitigating actions outlined in version 1 based on the discussion and debate that has been had during pre-engagement

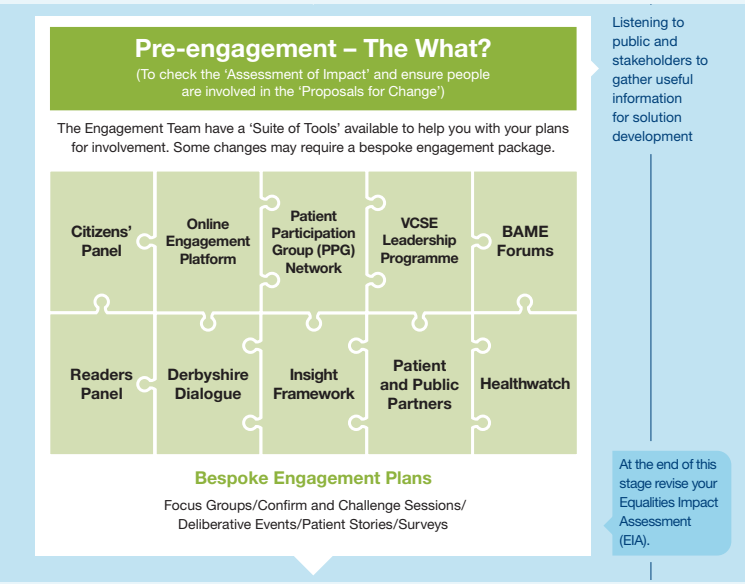
- Version 3 - updated prior to any public consultation process and outlines an accumulation of what has been learned and considered and what the actual, likely, and potential impacts might be for each option proposed, to allow these to be discussed, debated, and considered
- Version 4 – completed following public consultation, and should include everything that has been learned, all the impacts that should be considered alongside mitigating actions putting decision makers in a position where they can make an informed decision and display due regard
- Version 5 - this should be completed after the decision has been made to reflect the decision made, how it was made (considered) and, detail and explain any mitigations for negative impacts.

Support and advice regarding completing the EIA, is available from Claire Haynes claire.haynes2@nhs.net or by emailing ddicb.engagement@nhs.net if Claire is unavailable.

Checklist	✔
Is there clear evidence for the case for change? I.e., what is the reason for changing from the existing situation to a new one? This could be cut in funding, inability to recruit qualified staff, technological advances, changes in demand, etc.	
Have you researched insight that is already available using the sources outlined above?	
Has this been pulled together into a 'case for change' document? Clearly evidencing what you know already and how you know it.	
Have the initial impact assessments been carried out?	
Have other stakeholders been involved in developing the case for change? It's important to involve the key influencers (who will affect the development), and the key stakeholders (who will be affected by the development) from the beginning. However, full public involvement is not needed at this stage, it can be proportionate.	
Have you completed your stakeholder mapping?	
Is there a written Communications and Engagement Plan? This will need to be updated once the 'options' are agreed as the options will dictate whether there is a need for consultation. This plan will need to include plans to circulate information to patients, members of the public and other stakeholders about the case for change and how they can be involved?	
Have you enquired if this needs to be scrutinised by the Health Overview and Scrutiny Committee either in Derby or Derbyshire or both?	
Have you enquired if this needs to be considered by the Public Partnership Committee?	
Have you considered if this needs to go through the NHSE Assurance Process? If so, this would be the time to start the conversation.	

Pre-Engagement

This stage is about **testing** the 'case for change' determined in the previous stage and developing a plan to solve the issues.



Start by:

Using your 'case for change' document to kick start the conversation. Ensure that this document clearly outlines the rationale for change, and the key challenges, drivers and issues that have led to a change being considered. At this stage you want to:

- Gather information about how the service is currently provided and where people feel change is needed
- Encourage ideas as to what the change might be (at this stage we must be open to ideas, and not curtail the debate to choices already made)
- Gather information about who is going to be most affected by change and why
- Promote transparency
- Invite and value early involvement

The case for change document can then be updated with issues collected through the pre-engagement, i.e., from an external perspective.

This stage will help to test the early development of solutions and their likely impact, and feed into and provide some of the criteria and rationale for the next stage 'options development and options appraisal'. **It is important that it is documented how this stage has influenced the next stage.**

There are no strict rules for this stage, it's about:

- Listening
- Fact finding
- Meaningful dialogue and debate
- Quality of engagement, not quantity
- Exploring impacts, and how negative impacts can be mitigated against

It is preferable to talk to people who have something worthwhile to contribute at this stage but should include those most likely to be impacted according to the impact assessments you have conducted and be representative of protected characteristics.

Before you get started it is important to clarify and agree what questions and prompts will provide the information that is useful to the decisions being made. Ask yourself, what do you need to know to help you agree on possible solutions?

Involving people who use care and support in proposal development can be done through a range of methodologies, for example:

- o Surveys
- o Co-production workshops involving service users, carers, and staff
- o Focus groups
- o Outreach meetings with patient and community groups
- o Having experts by experience, lay representatives on working groups/boards
- o Interviews.

To support with this stage of the process we have developed a 'continuous engagement infrastructure'. This infrastructure provides tools to help you have conversations with patients and members of the public. You can find out more information about all these tools in Appendix Five. To access these tools please speak to a member of the Engagement Team via ddicb.engagement@nhs.net

Ensure you differentiate your engagement activity according to your stakeholder map as one size doesn't fit all. New tech and social media offer an ever-wider choice of engagement mechanisms but it's important to be aware of digital exclusion and hence, the need to use other methods.

Show you have heard what people have said, by pulling the information together into a report and feeding back on how this information has been used to inform the options that have been developed, and also the criteria used to judge the options.

Checklist	✓
Has the case for change document been used to outline the issues to be addressed by the change and start dialogue with patients and members of the public?	
Have the impact assessments been used to influence the stakeholder mapping for this engagement exercise and identify sections of the community that should be prioritised for engagement at this stage?	
Have appropriate methods of engagement been used for each group? Has a clear audit trail of engagement activities been created and maintained?	
Has this stage been used to develop potential options to explore in the options development stage?	
Has relevant information been put in the public domain? The more information that is published and the more transparent the process is, the better. This should include the outputs and feedback from this stage.	
Have the impact assessments been updated with new information accumulated during this stage?	

Option Development and Option Appraisal

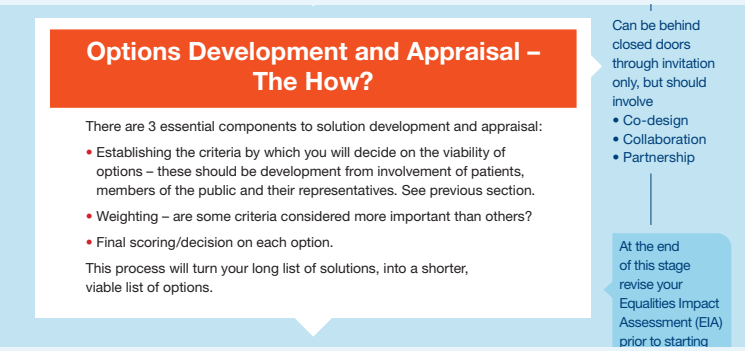
This is where information from the pre-engagement is used as the starting point for developing 'options for change'.

The options development and option appraisal stages are heavily scrutinised in court.

It is advised that you use co-production to decide on solutions, using a variety of stakeholders, including members of the public, and recent patients, as this process should be open and transparent.

Options development and appraisal can be by invitation only.

The options development and appraisal process is to help people decide between different options to identify viable options or where appropriate a preferred way forward that will address the issues identified in the case for change.



Co-production
Co-production is about giving patients, members of the public and wider stakeholders an equal voice during the earliest stages of service design and development. Co-production acknowledges that people with 'lived experience' are often best placed to advise on the services that will make a positive difference to their lives. To ensure a robust challenge free process, it is vital that a wide range of stakeholders, including recent patients and members of the public have an equal opportunity to influence scoring and decisions.

A strong options development process:
– Gives due consideration to all options
– Reduces the options to a manageable number as quickly as possible
– Supports the weighing up of different options

Options development can result in a 'long list' of options that will need to be appraised to decide which should be taken forward. To do this follow these steps:

1. Establishing the criteria to decide on the viability of options – these should be developed from involvement of patients, members of the public and their representatives in the previous stage.

2. These criteria can be used to get the long list of options down to a short list. One or two hurdle criteria can be agreed if there is a really long list, e.g., financial viability, will there be sufficient workforce and safety/quality considerations, which makes the process of whittling them down easier. This stage can be done by a smaller group of people, e.g., a task and finish group. You want to end up ideally with 8 or less for the options appraisal workshop. Ensure it is clearly recorded how decisions have been reached regarding which options to take forward.

   Examples of criteria: Equity of provision, safety, financial viability, accessibility, tackling existing inequalities, impact (positive/negative), etc.

3. Consider whether you need to 'weight' some of the criteria. The criteria can be weighted if some are considered more important than others. To decide on the weighting give a group of people 100 points and ask them to divide those points between the criteria in order of importance.

4. Final scoring/decision on each option. To reach a decision using the criteria you can use a consensus approach (ok if not too many people) or a scoring approach (needed if more than 20 people). The scoring/decisions can be obtained in the room, or afterwards by email. At this stage there should be a balanced room of people, avoiding anyone with a conflict of interest. Ensure there is a good proportion of patients, members of the public and their representatives, so it's not staff heavy. The number of people will depend on what you feel you need for the room to be balanced and representative of all stakeholders.

   Make sure the participants have all the information needed for each option to make an informed decision, e.g., detailed Strengths, Weakness, Opportunities and Threat {SWOT} analysis, relevant research, impact assessments. This information should clearly outline how the service is delivered currently, and how the option will improve the service, addressing any challenges/issues identified. Make sure people know how the criteria have been arrived at to judge the options. Send the information out before the workshop to be sure all the information can be given proper consideration.

The Major Services Change Interactive Handbook advises that you should follow the approach set out in the Treasury Green Book. The five-case model requires a minimum of four shortlisted options to be included in every Business Case:

1. a 'BAU' option,
2. a 'Do Minimum' option,
3. a 'Preferred Way Forwards' option
4. a 'More ambitious / Less ambitious' option.

It's helpful to evaluate these four models as part of the appraisal process, so that you can evidence that you have considered these in your future business case.

The options development and appraisal processes are advisory, it's still the decision of the ICB Board to make the final decision. However, should the ICB Board choose not to take forward the advice in their decision making, they would need to provide a clear rationale as to why this was the case, with explicit evidence to back up the decision provided.

At the end of this stage, you should produce a 'Pre-Consultation Business Case'.

Pre-Consultation Business Case

The pre-consultation business case (PCBC) is the legal document on which the commissioner/provider/system lead decides to consult. It contains all the information needed to make this decision. The PCBC is also used to inform assessment of proposals against the government's four tests of service change, NHSE, and other best practice checks. The document should focus on the narrative of your change – the who, what, when, where and why of what you are proposing. You can find suggested content on page 44-48 of the Major Service Change Handbook.

The PCBC is:

- The document to show that you have properly considered the options, undertaken pre-consultation engagement, submitted to the required HOSC and met the four (or five) tests
- The legal document that will be closely scrutinised so it must be complete and correct
- A formal Board document which presents the business case for any changes on which the decision-making organisation agrees to consult
- The basis upon which you will build further relevant business cases, such as your decision-making business case, and any additional capital business cases.

It is not the final business case. Instead, following consultation, a Decision-Making Business Case (DMBC) will be produced which will be the basis for the final decision to proceed with changes.

NHSE Assurance

Stage Two Assurance takes place here before formal public consultation begins; it includes a full review of all materials by the regional team including:

- PCBC
- Updated EIA
- Updated QIA
- Draft consultation document
- Draft consultation questionnaire
- Draft communications plan
- Draft engagement delivery plan

The regional NHSE Panel would need to consider whether it was assured, partially assured or not assured against each of the four or five key tests. NHSE will provide a formal response after the meeting with any recommendations and the decision on the level of assurance.

Decision Making Structures

Spend time early on mapping out the meetings that the PCBC will need to go through for discussion or sign-off. This might include:

- System Leadership Team
- Provider Boards
- Clinical and Lay Commissioning Committee
- ICB Board
- QEIA Panel
- Public Partnership Committee
- Health Overview and Scrutiny Committee

Option Development Checklist	✓
Have you created and documented a 'long list' of options based on the information you have collected together so far?	
Has options development included public, patient, and stakeholder representation? If yes, to what extent and what involvement did they have?	
Were 'impacts' considered in development of each option?	
Does what is included in the options ensure that the service being redesigned still meets patients' needs and in the interest of patients?	
To what extent has each option been costed to ensure it is viable? Only viable options should be considered in options appraisal.	

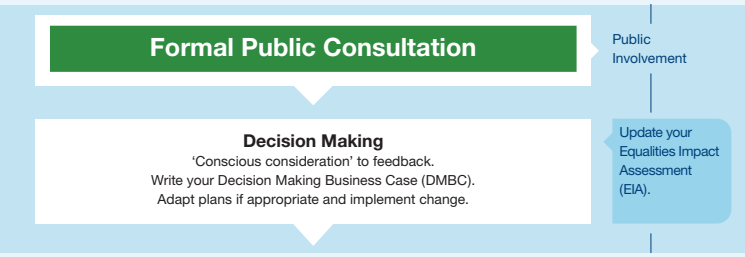
Option Appraisal Checklist	✓
Have you set the criteria and weighting for appraisal? How have the criteria and weightings been agreed? Was this a robust process involving stakeholders?	
What method is being used for appraisal? Does it seem robust, fair, unbiased, and able to withstand scrutiny? i.e., scoring or consensus approach.	
Do you have a balanced room of people at the appraisal stage that is representative of all the stakeholders impacted by this change, including patients, public and their representatives?	
Have you put together a detailed pack of information which contains SWOTs, impacts, research for each option, and information about how the criteria has been arrived at? This should be sent out prior to the workshop taking place.	
Have you agreed how you will present the information for each option, and discuss and take questions on the day?	
Have you agreed how you will ask people to make their decisions or score, i.e., during the workshop, or after?	
Have you written your pre-consultation business case and presented this at appropriate decision-making forums?	
Have you been through the NHS Assurance Process if appropriate?	

Formal Public Consultation

Please note: Given the complexity of legislative requirements and case law all projects seeking to make changes to a service must discuss their formal public consultation plans with the Engagement Team from the outset. The team will provide you with specialist advice to ensure you are able to deliver any change within the law. Teams are not permitted to undertake their own public consultation without the explicit support of the Engagement Team.

This is where the viable options agreed from the previous stage are presented to the wider population for their views to help make better informed decisions.

The information should include the reasons why the options are being proposed.



The public should be able to influence the decisions at this point and decision makers must be prepared to change their opinion.

Should there be only one viable option it is essential that it is clearly demonstrated how this decision has been arrived at, and that there is evidence that other options have been carefully considered.

Public consultation is a self-correcting process so if it comes to light that something is incorrect, it's ok to be transparent about it by making sure people are informed and carry on with the new information. Ensure processes are in place to identify and correct inaccuracies and mistakes quickly and adjust the consultation period accordingly.

This stage is legally binding and needs to be formal. It is governed by:

- Common Law – rules of behaviour accepted by society on the basis of established 'custom and practice' as evidenced by decisions in court
- Statute Law – legislation contained in precise written statements of requirements emanating from parliament, e.g., equalities analysis.

Public consultation is required for substantial changes, or where a small profile are highly impacted:

- When there is a statutory requirement, e.g., as required by the Health and Social Care Act 2022
- When there is a precedent – others are consulting on it
- When there is a legitimate expectation – the NHS has said they will – must follow relevant guidance that has been produced
- To ensure fairness – i.e., because there is a significant impact on the community, or people have been accustomed to it as 'normal' or 'their right'.

It's important that in multiple service closures, each service is looked at separately in terms of the impact it will have, and who needs to be consulted. E.g., a local authority wanting to close 3 of its Adult Social Care Day Centres in different locations, would need to consult with users of each centre, in order to understand the specific impact on those users, and in turn separate impact assessments would be needed for each location (the precedent for this is illustrated in R (LH) v Shropshire County Council [2014] EWCA Civ 404).

It is advisable to allow at least a minimum of 12 weeks for responses to be received for a public consultation. It's good practice not to run a public consultation during the school holidays (Jul - Aug) or Christmas (Dec - Jan) when people may not be able or available to respond to the public consultation. Alternatively, you could consider adapting or extending the length of the public consultation to take this into account.

It's good practice not to start a (new) public consultation in the run-up to government elections, during the pre-election period of sensitivity, this is referred to as purdah. However, an existing public consultation can continue to run during this period. You may want to consider adapting or extending the length of the public consultation to take this into account. NHS England will often produce guidance for the NHS during this time, which will be based on the guidance issued by the Cabinet Office. All NHS bodies should take that into account for decisions on how to proceed with any service reconfiguration programme.

Ensure all impact assessments have been updated at this stage, e.g., update your QEIA.

There must be an appropriate 'Consultation Document', ideally supported by an easy read version, possibly in other appropriate formats for equality characteristics and more detailed documents online. See Appendix One for more information on what this should contain.

There is no guidance on the number of people that should be involved but should be proportionate to the decision being made. Every attempt must be made to involve the people who need to be involved, i.e., people must have had a reasonable opportunity. You should clearly document how you have attempted to reach those potentially impacted by the change.

Build in regular review points to check what feedback is being received and from whom, so that work can be done to target people who are not engaging with the process. A final review of activity and responses from those you would expect to have an interest such as service users or local community and the equalities groups that could be impacted by the proposal must take place and if there are gaps, or low representation, every effort must be made to engage, with a clear paper trail, to promote the consultation and encourage participation.

Checklist	✓
Has the communications and engagement plan been updated to reflect the need for formal consultation?	
Is the timescale for the consultation proportionate to the impact, and realistic, to allow a considered response from all stakeholders? Has it taken into account the time of year, etc.? There is no set timescale, but 8-12 weeks is considered good practice. Four weeks and under could be challenged.	
Is clear information available on the case for change and information about the pre-engagement and option appraisal stage?	
Is the public consultation accessible, including anyone who is directly affected by the proposed change, as well as the wider public who may access the service now or in the future? This stage should be open to a wide public audience.	
Are the options presented in a way that can be easily understood?	
Are there multiple methods for accessing the information, suitable to the target audience? i.e., do not restrict to online access only, ensure hard copies are available.	
Can people request the information in different languages and other formats if required?	
Is it clear how people can respond to and give their views on the proposals?	
Have all the impact assessments been updated and are they available for people to view?	
Has the target audience for the consultation been agreed through stakeholder mapping? Has advice been sought on protected characteristics and how they will be impacted?	
Are there a variety of opportunities available for the public to discuss the options? Genuine open dialogue and discussion is key and should not be seen as less important than questionnaires.	
Have the effective and appropriate methods of consultation been designed to reach all groups?	
If there have been any changes to the proposal or related information, has this been made available to the public?	
Is it clear how people will be kept informed and involved in future developments?	
Is there any evidence of pre-determination or bias? This could be found in meeting minutes, tender documents, planning decisions, media interviews, Facebook postings etc.	
Do the questions asked allow people to influence thinking, share their views, i.e., not just yes/no? New information should be able to be learned from this process.	
Does the consultation document meet the requirements in Appendix One?	

Decision Making

Consultation responses need to be collated, analysed and a report produced. You may want to consider using an independent provider, to verify the findings of the report, to reduce the risk of bias. Data used to produce the report may include online, phone and written survey responses, notes from meetings, petitions, submissions, and letters. A final report of the findings from the public consultation needs to be written, reviewed, and published. You should continue to engage with the public so that the next steps are clear to all respondents. Once the consultation is closed, responses have been analysed, and considered, you'll need to begin writing the Decision-Making Business Case (DMBC).

Adequate time needs to be set aside post consultation to consider the findings of the consultation and use them to inform any decisions. The process for doing this should be well documented and communicated to stakeholders; where public views have not been taken on board, there needs to be a clear and honest account of why this is the case.

Decision-making business case (DMBC)

This document should show how views captured by consultation have informed the final proposal. The DMBC should demonstrate how the proposed change is sustainable in service, economic and financial terms and can be delivered within the planned capital total. You should think about everything that's come before this point and build your DMBC from your case for change narrative and your PCBC. Make sure to also include subsequent stakeholder engagement, as well as your consultation analysis and discussions.

The decision on whether the DMBC needs to be formally assured by NHSE will be discussed at the pre-consultation assurance checkpoint. This is to ensure that any major deviation from the original proposals is given proper consideration and to assure that the proposals remain clinically sound and financially viable.

You should be prepared to communicate this decision to a variety of audiences, such as:

- Patients and the public
- Staff
- The media
- The local authority, or authorities
- Your local voluntary, community, and social enterprise sector stakeholders

How you do this is important. You should be able to clearly articulate how your proposal reflects the extensive engagement you've already undertaken with all of these audiences, and why you have come to the decision that you've arrived at, and what that means for the service. You should be realistic about when you will be able to implement this change, too.

Governance, Approval and Risk Management

The governance and approval route for engagement and consultation may vary depending on the type and scale of the project. Engagement programmes and consultation processes are usually approved through the Derbyshire Public Partnership Committee and sometimes the ICB Board. It is also routine to take the results of engagement and consultation back to the Health Overview and Scrutiny Committee. In addition, the decision-making process may also involve other groups, such as Delivery Boards or Capital Project Groups. You should discuss the decision-making process with the Communications and Engagement Team before the start of the engagement or consultation. Any identification or escalation of risks relating to engagement or consultation activity will be logged and recorded on the Derbyshire Public Partnership Committee risk register.

Post Decision Engagement

Once the DMBC has gone through the correct governance and the decision has been made, it is imperative that the public and key stakeholders are informed of the decision, through a similar range of activities and communications as during the public consultation. Anyone who shared their details should be informed, all forums should receive a verbal or written update, and all stakeholders should receive a verbal or written briefing. Where mitigations or recommendations have been agreed, a further communication may be required in the future with an update on the progress of the mitigations.

Checklist	✔
Has the process for considering the findings been clearly communicated to the public?	
Has the final decision been clearly communicated to the public, alongside how the feedback from the public has informed the final decision?	
If the decision is different from the majority of public opinion, has this been explained and a rationale given?	
Are the findings of the consultation easily accessible to the public?	
Is it clear what is going to happen next?	
Was the decision very fast following the closure of the consultation? Fast decisions do not show consideration for the feedback.	

Evaluation

It's crucial that you pay serious attention to identifying, evaluating, and analysing the outcomes of the change you have implemented. Not only will this support you to demonstrate the successes of the programme, but doing so will help support the wider, contextual issues which you addressed at the very start of your change programme.

As your change proposals have been developed and evaluated, you will have already identified criteria with which to evaluate the benefits of the change you have implemented.

These could focus on such things as:

- Clinical outcomes and quality
- Financial issues
- Patient experience
- Access to services
- Workforce issues
- Research and education
- Reducing health inequalities

As with the rest of the programme, this final stage of service change should incorporate a wide range of stakeholders.

- Involve residents and people who use care and support in your evaluation - how have they been impacted by this change?
- Are VCSE partners, local government colleagues and fellow providers and commissioners conscious of the benefits of this implementation, and in support of its outcomes?
- Can the data and modelling used at the start of your programme demonstrate improvements as a result of implementation?

Business Cases

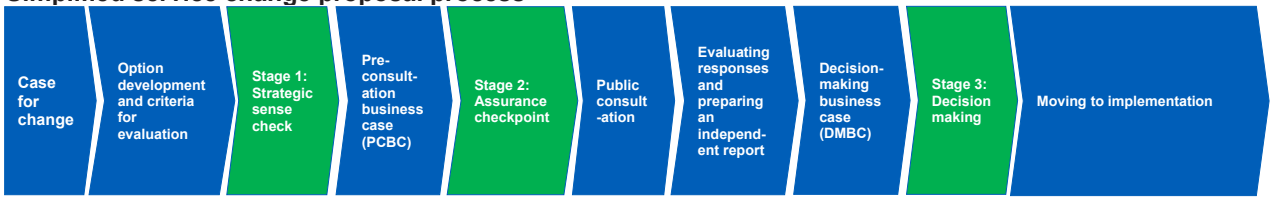
Some service changes will require further business cases to progress implementation of new models once the outcome of a consultation is decided. There are several different types of business cases, including:

- Capital Business Case
- Strategic Outline Case
- Outline Business Case
- Full Business Case

You can find guidance on writing your Business Case here. You can also find guidance on pages 65-73 of the Major Service Change Interactive Handbook.

Name of business case	Description
Pre-Consultation Business Case (PCBC)	This is the business case on which the commissioner decides to consult. Contains information about case for change, clinical model and review, options appraisal, evidence of pre-consultation engagement, evidence of how proposals meet the five NHSE tests. Forms the basis of further business cases and will be the document that local government scrutinises.
Decision-Making Business Case (DMBC)	Developed after public consultation. Analyses consultation responses and sets out agreed way forward for proposed changes. Demonstrates how preferred option meets the challenges identified in the case for change, and how it is sustainable in service, economic and financial terms. If capital is required, the DMBC informs development of the SOC.
Capital business cases	
All capital business cases must comply with the requirements of the Treasury Green Book. This means they must describe the five 'cases', or dimensions, which constitute the proposed service change: strategic, economic, commercial, financial, management.	
Strategic Outline Case (SOC)	Robust economic and financial analysis of all longlisted and shortlisted options from options appraisal process.
Outline Business Case (OBC)	Builds on the SOC. Sets out a more detailed financial and economic analysis of shortlisted options and identifies a preferred option. Evidences how preferred option meets needs identified in case for change.
Full Business Case (FBC)	Follows procurement process for the delivery of preferred option identified in DMBC. Preferred option is described in the fullest detail here. This business case will also likely detail commercial and contractual arrangements for delivery, in addition to management arrangements.

Simplified service change proposal process



Simplified capital proposal process

APPENDICES

Appendix One - What should be in a consultation document?

This document must be objective, not a sales document trying to lead someone into picking a particular option.

If the information is not contained in the consultation document itself, it should be clear where the information can be found, i.e., a link to the website (although hard copies must be provided if requested).

The consultation document should be seen as just the tip of the iceberg, with further information being available elsewhere. Consultees must be able to access all the information they need in order to make an informed decision and propose a different option if they wish.

This document needs to be aimed at majority population.

Ensure there is:

- Fair access to the document
- It's transparent, i.e., the whole truth and nothing but the truth
- There is a clear rationale behind the proposals
- The options are clearly communicated
- Impact of the proposals is communicated, negative as well as positive.

Checklist for Consultation Document	✔
The story so far	
Explanation of why change is necessary and clear evidence to support it, i.e., the issues. Have a clear rationale.	
Explanation of external drivers of change.	
Information of what has been learned in earlier engagement, such as the pre-consultation stage, i.e., this is what you have told us.	
What has been considered at different stages, i.e., the options? What's been included, what's been discarded and why?	
What are the pro's and con's for each option proposed, give clear evidence for these.	
If there is a preferred option, clearly state why.	
A clear vision of future services.	
Explanation of the consequences of change 'v' maintaining the status quo on quality, safety, accessibility, and proximity of services.	
In the case of hospitals, explanation of how services will in future be provided within an integrated service model.	
Evidence to support any proposal to concentrate services on a single site.	
Evidence of support from clinicians (professionals) and GPs for any proposed change.	
How sustainable staffing levels are to be achieved.	
In the case of changes promoted by clinical governance issues, an explanation of how these have been tested (through independent review). Research and technical information.	
Any risks and how they will be managed.	
A clear picture of the financial implications of the different proposals.	
Who will be affected by the proposals and how their interests will be protected.	
An explanation of how any change and benefit will be evaluated after implementation.	
Initiation to propose alternative solutions.	
Where additional and more detailed information can be found.	
How to participate in the consultation.	
Notice of availability of appropriate formats – easy read, large print, braille, BSL, audio etc.	
The information should be understandable, and accessible.	

Appendix Two – Timeline

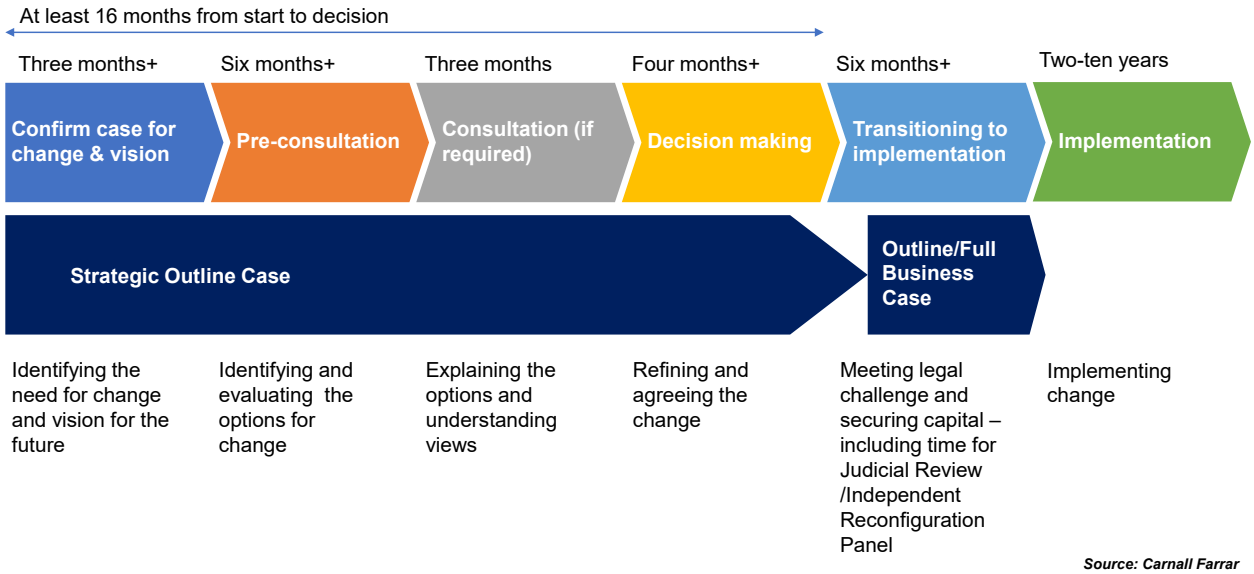
Public consultation is a lengthy process; with all the required milestones and governance it can take between **18-24 months** from the initial Case for Change to the final endorsement of the Business Case by Health Oversight Scrutiny Committee. Here is an example of a timeline:

	Action	Timescale
1.	**Project Brief** This is completed by the C&E team in order to allocate resource from within the team to any given project.	Complete at the beginning of the project to receive resource from the C&E team
2.	**Complete PPI Assessment and Planning Form (previously known as S14Z2)** This is the process to determine the level of patient and public involvement required i.e., inform, engage, consult.	Complete at the beginning of the project to inform the C&E Plan. May need to be re-visited at intervals e.g., following the QEIA panel, and Options Appraisal.
3.	**Gather current insight available and identify any gaps** Need to know gaps in insight to inform pre-engagement. Collate information together in 'case for change' document	Allow 2 - 3 months
4.	**Communications and Engagement plan** Start to pull together a C&E Plan, to outline the plan for pre-engagement. This will need to be updated following Options Appraisal/Before Formal Consultation.	Following case for change process.
5.	**Take through Governance Structures** • Public Partnership Committee • Health Overview and Scrutiny • QEIA	Depending on the meeting cycle this can take anything from 4-8 weeks.
6.	**Pre-engagement/solutions development** Gather insight and stakeholder feedback to support the case for change narrative and develop potential solutions. • Pre-engagement tools will need to be developed (survey, focus groups, online engagement platform etc). • Report will need to be written to outline the themes that have emerged from the pre-engagement	Allow at least 2-3 months for pre-engagement.

	Action	Timescale
7.	**Options Development** • Following pre-engagement, it is then possible to start to work up detailed options for consideration. • The pre-engagement stage should provide insight to inform the criteria used to judge the options.	Allow 2-3 months for options development and appraisal.
8.	**Quality and Equality Impact Assessment** • Once options have been chosen QEIA paperwork will need updating. • This will then need to go to the QEIA panel for each option to be discussed. • This information will be part of the options appraisal information.	The QEIA Panel takes place every 2 weeks, but should the project be considered high risk you would need to allow for an escalation to Quality and Performance Committee.
9.	**Options Appraisal** • Set up workshop to present all the information for each option with a balanced room of stakeholders including representatives of patients and members of the public to score or reach a consensus on the options to take forward based on the criteria agreed.	Included in 2-3 months above.
10.	**Update PPI Form** • Update PPI Form based on the options agreed, to determine whether there is a need to inform, engage or consult.	
11.	Write the pre-consultation business case and present through Governance: • **Public Partnership Committee** • **HOSC** • **ICB Board** • **Provider Boards**	Depending on the meeting cycle this can take anything from 4-8 weeks.
12.	**Develop consultation materials.**	Allow 1-2 months pull together consultation resources and plans.

	Action	Timescale
13.	**Launch of engagement/consultation:** • It is suggested 3 months is the best period to allow for a good wealth of feedback for any significant change.	3 months
14.	**Mid way review:** • Check feedback approximately 6 weeks in to ensure methodology is working to gather enough feedback. • This will ensure effort can be re-focused if needed.	
15.	**Engagement/consultation report** • Analysis of feedback and write formal report.	Allow 2 months to write the report and consider the findings.
16.	**Review of findings in decision making**	Allow 1 month.
17.	**Present to governance structures**	Depending on the meeting cycle this can take anything from 4-8 weeks.
18.	**Feedback to all stakeholders and implementation**	

Overview of the stages of a change programme



Source: Carnall Farrar

Appendix Three – Team Contacts

- **Karen Lloyd** – Head of Engagement
- **Claire Haynes** – Engagement Manager
- **Katy Hyde** – Engagement Manager
- **Hannah Morton** – Comms and Involvement Specialist
- **Lee Mellor** – Comms and Involvement Specialist
- **Leni Robson** – Comms and Involvement Officer

Email: ddicb.engagement@nhs.net

Appendix Four - Understanding and managing temporary service change

Examples of temporary service change

Weston General Hospital closure of A&E overnight i.e., reduction from 24/7 to 14/7 service, opening from 08.00 –20.00

- Triggered on safety grounds due to specialist staffing levels, reinforced by CQC findings
- Temporary change instigated in July 2017; permanent changes made October 2019

Transfer of acute stroke services from Medway Hospital to Maidstone Hospital and Darent Valley Hospital.

- Triggered on safety grounds due to specialist staffing levels at Medway Hospital
- Temporary change instigated in July 2020, ahead of final outcome of wider consultation for permanent change in November 2021

Changes to service delivery at Trafford General Hospital as part of system management of COVID-19 pandemic

- Stepping Trafford General Hospital down as the Greater Manchester 'green' site, enabling staff to be redeployed to areas of highest pressure across Manchester University NHS Foundation Trust
- Reviewed on a daily basis by the trust and Greater Manchester 'Gold', and monitored by the regional team
- Temporary change now reverted to business-as-usual model

Legal Duties

- NHS bodies may decide to change a service without allowing time for consultation with the relevant local authority, where they are genuinely satisfied there is an imminent risk to the safety or welfare of patients or staff.
- This is the only specific exception to the statutory duties for urgent changes. Other duties will still apply and should be addressed appropriately.
- It is not acceptable for NHS bodies to delay addressing fragile service situations that might lead to such a risk occurring until they are so urgent that an imminent risk exists.
- Where services need to be closed or suspended at short notice, NHS bodies and their partners should act in accordance with the Joint Working Protocol.
- In such a case the NHS must notify the local authority (HOSC) immediately of the decision taken and the reason why no consultation has taken place.
- A local authority may still choose to refer the matter to the Secretary of State for Health and Social Care for review if it is considered that the reasons given for not carrying out a consultation are inadequate.

Even with a clear exemption on the duty to consult…

- NHS bodies should ensure they keep good records of the factors that have been considered in making these decisions, and where and how and through which governance route the decision was made – the decision can still be legally challenged or referred.
- There should be a clear, planned, and comprehensive communications and engagement approach with key stakeholders, including staff, system partners, regulators, local politicians, Healthwatch, service users, etc. Regardless of whether there is consultation or not.
- Even with a short lead time there will be some planning time before implementation of the change. This should be explored to assess the extent to which some patient, public, staff and stakeholder engagement activity could take place to gather insights to feed into the planning and to ensure stakeholders understand the rationale for urgent change.
- There should be consideration around whether, how and when any emergency/temporary change would revert, and the data and information required to support decision-making. Or how any temporary change could be made permanent after immediate operational changes and issues have been addressed. Temporary changes can only be made permanent by following the full process set out in law.

Making a temporary change permanent - or not

Once you have addressed the immediate/urgent patient and/or staff safety and welfare issues through a temporary or emergency change, you must then review your service position and either:

- Agree a fixed end point for the temporary change and plan to move services back, or
- Go through the recognised process for making a permanent change in discussion with HOSC and NHSE. This may warrant a pre-consultation business case and consultation, or you may agree with HOSC that a proportionate and appropriate process is focussed on information provision and an engagement period with the affected patient and community groups and stakeholders. Outline proposals and a clear sense of the extent of the impact of the change will guide your discussion with HOSC and NHSE and inform the process you should follow.
- Engage and communicate well with system partners, staff, patients, public and stakeholders at every stage, whichever path you take.

Appendix Five – Continuous Engagement Infrastructure

This infrastructure provides tools to help you have conversations with patients and members of the public. You can find out more information here, or by contacting a member of the Engagement Team ddicb.engagement@nhs.net.