Communication, engagement and consultation to support service change

A Guide for Commissioners

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What is engagement and consultation?

Engagement and consultation is a two-way conversation that allows the public, patients, voluntary and community sectors a realistic and timely opportunity to understand proposals, ideas, thinking and plans in their formative stages and to contribute to these so as to influence decisions being taken by the CCG.

CCGs are required to engage with patients, carers and the public when redesigning or reconfiguring healthcare services and they need to demonstrate how this has informed decisions. Both engagement and consultation involve:

- Seeking opinions on proposals or options before decisions are reached
- Seeking to increase the involvement of patients, local people, communities and voluntary sector in important decisions which impact on them
- Listening to, and learning from local people and communities
- Making decisions in partnership between patients, the public, clinicians and the organisation

Why do we need engagement and consultation guidelines?

This document provides a clear process for planning and managing engagement and consultations. It serves to reassure staff and the public that the CCG is committed to undertaking best practice in policy formation and service changes. It also ensures that public consultations conform to regulations and are accountable to NHS England, the public and regulatory bodies.

The guidelines are also aimed at making sure that any consultation and engagement we do is timely, transparent and robust so that we are taking every possible step to avoid the risk of judicial review.

Benefits of engagement and consultation

There are many benefits to engagement and consultation for the CCG including:

- Developing a patient focused service – we know where patients are involved they can provide a deeper understanding of the needs of other patients, they can help make sense of the challenges, and they can come up with excellent ideas for improving care
- Allowing greater public participation – the NHS belongs to everyone, through taxation and use – involving patients in the decision making gives additional ownership to patients
- Creating more realistic and robust commissioning that better reflects people’s needs and wishes
- Helping to plan, prioritise and deliver better services
- Strengthening the CCG’s reputation in the community
- Generating new ideas
- Testing out ideas or assumptions
- Increasing public awareness and education about NHS services
The duty to consult and engage

Health and Social Care Act 2001

- Regulations under the Health and Social Care Act 2001 created duties on the NHS which mirror the powers conferred on local authorities. These duties are carried forward into the new legislation (published in June 2014 ‘Local Authority Health Scrutiny’), and require the NHS to:
- Provide information about the planning, provision and operation of health services as reasonably required by local authorities to enable them to carry out health scrutiny.
- Attend before local authorities to answer questions necessary for local authorities to carry out health scrutiny.
- Consult on any proposed substantial developments or variations in the provision of the health service. This requirement is subject to exemption when a decision has to be taken by the health commissioner which does not allow time for consultation where there is believed to be a risk to safety or welfare of patients or staff e.g. closure of a ward due to a viral outbreak.
- Respond to health scrutiny reports and recommendations: NHS service commissioners and providers have a duty to respond in writing to a report or recommendation where health scrutiny requests this, within 28 days of the request. This applies to requests from individual health scrutiny committees or sub-committees, from local authorities and from joint health scrutiny committees or sub-committees.

These requirements apply to CCGs, NHS England, local authorities as providers of NHS or public health services and providers of NHS and public health services commissioned by CCGs, NHS England and local authorities, including GPs.

NHS Act 2006 (as amended by the Health and Social Care Act 2012)

Section 14Z2 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) states:

14Z2 Public involvement and consultation by clinical commissioning groups

In plain English, the CCG is required to involve the public in decisions that we are going to make about the services that will be provided to them. Simply informing the public that we have decided to close services, e.g. community hospitals, even if there are very strong arguments in favour of closure, does not meet the language of the statute.

1. This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions (“commissioning arrangements”).

2. The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

   a. in the planning of the commissioning arrangements by the group,

   b. in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.
Other legal requirements

There are a range of legal requirements on commissioning bodies that directly impact on the duty of the NHS to consult with the patients and the wider public. CCGs are required to comply with this legislation and policy too. In summary these are:

- Equity and Excellence: Liberating the NHS ‘no decision about me without me’
- Health and Social Care Act 2012, sections 13Q and 14Z2, which mirror the Real Involvement guidance, Section 242, and apply to CCGs
- Section 11 of the Health and Social Care Act 2001
- Formal consultation, incorporating the four reconfiguration tests (August 2010)
- Requirement to carry out impact and equality assessments
- Everyone Counts: Planning for Patients 2014/15 to 2018/19
- Transforming Participation in Health and Care September 2013
- Local Authority Health Scrutiny June 2014

Who consults?

In the case of substantial developments or variations to services which are the commissioning responsibility of CCGs or NHS England, consultation is to be done by NHS commissioners rather than providers i.e. by the relevant CCG or NHS England. When these providers have a development or variation ‘under consideration’ they will need to inform commissioners at a very early stage so that commissioners can comply with the requirements to consult as soon as proposals are under development. Consultation in the case of a provider change would be led by the CCG on behalf of the provider.

What constitutes “significant” or major service change?

There is no single, accepted definition of major service change. It is generally understood to involve a significant shift in the way front line health services are delivered, usually involving a change in the geographical location where services are delivered In health scrutiny regulations, NHS commissioners must consult local authorities where there is a ‘substantial development of the health service’, or for ‘a substantial variation in the provision of such a service’. This might mean service users experience a different service model or have to travel to another site for their services. Given there is no single definition, each case should be examined individually. Local definitions have evolved via custom and practice in health communities. For these purposes service change is not organisational change (mergers, transfers of responsibility for services), or operational change (e.g. movement of services between wards in same site). (Effective Service Change A support and guidance toolkit, Publications Gateway Reference 00814).

Given that the decision to determine what is a major service change is often a judgement - the following checklist can help determine if the proposed change is significant or major:

The following issues should be considered when identifying whether a proposed service change ought to be regarded as major. They are intended simply to provide a framework for discussion. Please note that these issues are not ranked in order of importance. Some of the issues may appear to overlap, but each should be considered. Any evaluation as to what extent these issues apply will involve a level of subjectivity. It is intended that commissioning leads, staff and partners, working with providers and other stakeholders should consider each of the issues in the context of the particular local circumstances. As a general rule, the more issues that apply, the more likely it is that a service change should be considered as major. There are prompts under each of the issues. These are not intended to be exhaustive:

1. Impact on patients and carers
Consider the number of patients that will be affected as a proportion of the local population, and assess the likely level of impact on those patients, together with any consequential impact on their carers.

Where it appears that a relatively small number of patients is affected, it may still be necessary to consider the level of impact on those individuals, particularly where their health needs are such that they are likely to require to continue to access the service over a longer period of time.

The particular impact of the proposed change on patients that may experience discrimination or social exclusion should also be taken into account. Undertaking an equality impact assessment will help understand who may be negatively affected through exclusion or discrimination.

2. Change in the accessibility of services

Consider whether the proposed change involves relocation, reduction or withdrawal of a service.

Assess the likely impact of the proposed change in terms of transport (in relation to patients, carers, staff, goods and supplies).

3. Emergency or unscheduled care services

Consider whether the proposals involve, or are likely to have a significant impact on, emergency or unscheduled care services, such as Accident and Emergency, Urgent Care, Minor Injuries Units, Out-of-Hours or maternity services.

Assess the potential impact on the delivery of services provided by the Ambulance Service.

4. Public or political concern

Assess the likelihood that the proposals will attract a substantial level of public concern, whether across the local population, or amongst particular patient groups.

- Take account of any views expressed by the Patient Partners Board, PPG networks, HealthWatch, OSCs or local community groups or elected representatives.
- Consider any views reflected in the local media, online and on social media.
- Are there likely to be complex evidence issues that could be open to challenge or dispute?

5. Conflict with national policy

Do the proposals run counter to national policy, for example, the presumption against the centralisation of health services?

6. Change in the method of service delivery

Do the proposals involve the use of new or contentious technology? Are changes proposed in relation to practitioner roles?

Might there be changes in settings, such as moving a service from a hospital to a community setting, or vice versa; or other changes in the care process e.g. moving to ‘one stop clinics’ for services which have traditionally been provided separately?

Has the proposed change been demonstrated to work in other areas? Identify whether there are examples of working models elsewhere, which would help to inform discussions.

7. Financial implications

- Consider in broad terms the level of investment, or savings, associated with the proposed changes
• Take account of the implications for the NHS, social care and for other agencies, including local authorities.

8. Related changes in recent years

• Take account of the cumulative effect of the proposed changes, when considered alongside other changes that have taken place over recent years.

9. Consequences for other services

• Consider the effect the proposals could have on decisions about the development or location of other services.
• Identify whether the proposals will impact on other NHS, social care, local authority, third sector organisations.

Planning and scheduling engagement and consultations

All consultations and engagement activities need to be planned. For every CCG priority there should be a communication and engagement plan which sets out the activities that are required in to engage and communicate with the public and patients about any proposals or developments. Even if a priority or significant activity of the CCG does not necessarily need a consultation, it should have a communication and engagement plan, and within that consideration given to involving patients and the public, and communicating to patients (whether this is specific patient groups) or the public in general.

A guiding principle for any form of change process is that patients, carers, and members of the public should be involved in developments from the outset. The diagram below shows the phases of a reconfiguration or large scale change; but could equally be adopted for any commissioning priority.

The reconfiguration process has several phases from setting the strategic context to implementation.

[Diagram showing phases of reconfiguration process]

*Formal Consultation may not be required in every case, and this decision should be made in collaboration with the local OSC.

The planning and development of reconfiguration proposals are rarely linear. The most successful proposals ensure continuous discussion and involvement of the local population and key stakeholders throughout the process.
## Types of engagement and consultation

Engagement and consultation can take a number of forms as can be seen in the table below:

<table>
<thead>
<tr>
<th>Type</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>Involving</td>
<td>Communities are invited to exercise choice and/or influence over the decision making process.</td>
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</table>
| Informing             | Communities are informed of decisions that have been made and are invited to discuss these by indicating their ideas or by raising issues or indicating unforeseen circumstances that may occur because of the decision.  
                          | Whilst this type of engagement may not impact upon the central decision, it will inform the implementation of change.                                                                                     |
| Engaging              | A continual process building good relationships with partners and stakeholders through regular group and one-to-one meetings. It should be a two-way dialogue of questions, answers and updates.                              |
| Co-production         | A process whereby clinical commissioners, patients and the public work together, with the result that whatever is produced or whatever the outcome is, it is one that is shared and developed together.                          |
| Delegated authority   | This is where an organisation has delegated its authority over decisions and budgets to patient groups and representatives.                                                                                  |
| Pre-consultation      | This is an initial step in the process of securing public input into the decision making or planning process during a public consultation.                                                                     
                          | At this stage, all options are considered, no option is disregarded. As such, levels of opposition are often at their highest. Pre-consultation can be a protracted process and needs very careful planning and management. Even the best planned, managed and considered schemes can go wrong if the process is poorly handled. |
| Public consultation   | A formal process lasting at least 12 weeks where information or proposals will have been stated in a public consultation document. The main purpose of the document is to invite comments and allow us to listen to what people have to say. 
                          | If the public consultation period takes place over holiday periods (Easter, Christmas or summer holidays) then extra time must be allocated to ensure everyone has an opportunity to offer an opinion. Consultations have to adhere to pre-election guidance if they fall within the purdah period for a local or general election. Guidance on this is available from the communication and engagement team. |
| Post-consultation     | This is the final stage of a public consultation. The views gathered during the exercise must be analysed and any decisions taken must take these views into account. A final report must then be widely publicised explaining these decisions. |
Engagement

As can be seen from the above descriptions engagement can cover a wide range of activities. It should not be considered as an informal method of communication as the activities must be planned, reported and feedback reviewed on a regular basis. It is good practice to ensure that patient and public engagement begins at the earliest possible stage, even if only initial ideas or challenges are being considered as patients and the public can bring a new perspective and a fresh, unblinking pair of eyes on the challenges we face and any solutions or ideas to respond to these. An ideal model for any commissioning development is to have either patient representatives (minimum of two) or a patient reference group which can be a powerful sounding board.

The model for engagement is to consider patient involvement and experience, clinical expertise and best available evidence on good practice as a triple lock to ensure that what is developed and ultimately commissioned is rigorous, sound and sustainable.

Public Consultation

Public consultation is a rigorous and tightly governed process. The CCG has a duty to inform both the local area team for NHS England and the Health Overview and Scrutiny Committee (HOSC) for agreement to proceed before a consultation is launched.

It is often regarded as a 12 week process where proposals are presented to the community for feedback. In reality the process takes far longer, and in many instances, a public consultation can take a year from start to finish. Appendix one shows a sample consultation timeline which gives an indication of all the considerations that need to be taken into account when planning a formal consultation.

Options for consultation should be based on sound clinical evidence and what is in the best interests of patients. They must be explained to users in a way they can understand so that any feedback they offer is relevant to the consultation. Appendix two outlines other information/evidence that needs to be robust and made available before proceeding to public consultation.

When running a public consultation, be prepared to make changes to the original plan as the process progresses. Proposals not decisions should have been made prior to the start of the consultation. Public consultations require some form of internal oversight of the process to be established, typically a steering group or project board, at the very start of the exercise to provide oversight and assurance of the process.
**When will we engage or consult?**

It is necessary to identify at an early stage the correct level of engagement required for a service development or variation. It is possible to escalate an engagement exercise to a public consultation, but timescales will need to be reviewed to ensure due process is followed.

The following table has been created to help identify the level of consultation required:

* Always consult with the HOSC to establish whether a project requires a full consultation or if a local engagement programme is satisfactory. This will be facilitated by the communication and engagement team.

<table>
<thead>
<tr>
<th>Level</th>
<th>Issue</th>
<th>Type of Activity</th>
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| Level 1* | Consultation must take place if the implementation of a proposal will have an impact on:  
a. the manner in which the services are delivered to users or;  
b. The range of health services available to those users.  
• Strategic decisions that impact on what, where or how services are provided.  
• Longer term intentions.  
• Sensitive issues which may receive significant stakeholder or media attention.  
• Substantial developments | **Public consultation** The full process can take a year, including at least 12 weeks when the consultation is open to the public. Requires:  
- Full pre-consultation process  
- Full consultation documents outlining options and constraints  
- Public meetings  
- Public and Patient User Groups  
- Stakeholder workshops  
- HOSC input  
- Healthwatch  
- MPs  
- Councillors  
- Parish councils  
- Voluntary groups  
- Others  
Open to all members of the public to respond |
| Level 2* | Less significant changes in the way a service is delivered, for example:  
• Developing a service operational policy;  
• Redesigning patient pathway to improve service quality;  
• Retendering for a service with minimal changes to the contract other than a ‘refresh’ to bring it in line with national and regional guidelines. | **Engagement** - Not subject to the 12 week public consultation period. Requires:  
- Information documents  
- HOSC updates  
- Service user focus groups  
- Questionnaires  
- Patient & Public User Groups  
- User / advocacy groups  
- Healthwatch  
- Staff engagement Open to all service users and stakeholders. |
| Level 3 | Minor changes within an aspect of a service, for example:  
- Changes to a day service timetable;  
- Developing / reviewing information leaflets;  
- Changes to clinic booking procedures. | **Involvement** – Service specific consultation. Requires:  
- User group discussion  
- Staff engagement  
- User questionnaire  
- Posters or leaflets  
This may be open to all patients affected or a sample group depending on the numbers of patients affected |
Gateway and NCAT reviews

National assurance on a consultation or engagement exercise can be provided by the Gateway Review process which ensures that a consultation or engagement process is consistent with national policy and advises on the process being followed. As part of the Lansley tests, it was made mandatory to commission a Gateway and NCAT review on all major service reconfigurations that involved a public consultation.

The National Clinical Advisory Team was initiated by Sir George Alberti to provide clinical advice to the process of reconfiguration. The team consists of senior clinicians from many specialities who have often been involved with reconfiguration, or have held senior NHS positions. An NCAT visit is a required part of the assurance process for reconfiguration and the team will often conduct its visits at the same time, or thereabouts, as the Department of Health Gateway Review team.

NCAT’s role is to ensure that the reconfiguration plans make sense and that there is clinical justification for the reconfiguration with an evidence base. They ensure that the reconfiguration scheme has the support of local senior clinicians and GPs, and that public and patients have been appropriately engaged.

Who will we engage or consult with?

To engage or consult effectively a target audience must be clearly identified before the dialogue begins. The communication and engagement team holds an updated list of the CCG’s current stakeholders and partners.

Identifying the key stakeholders, including groups that could be affected by any changes implemented to a service, at an early stage will also guide the communication and engagement team as to the best methods for communicating with these groups and make sure that any information produced by the communication and engagement team is accessible to them.

Specific efforts will be taken to ensure that the engagement or consultation exercise is clear, concise and accessible. Where necessary consultation documents must be adapted to suit the needs of the different user groups identified, for example people with learning difficulties may require an easy to read version with pictures, translated versions must be available on request. All materials must carry the CCG logo.

Engagement and consultations should be clearly targeted at those people that could be affected by the service change. The CCG will actively try to reach seldom heard groups to hear their views.

CCG staff will always be included in engagement and consultation exercises. This is separate to statutory requirements to consult with staff on any type of organisational change that affects them or their working conditions.

Promoting and communicating

Public Consultations (Level 1)

A public consultation must be publicised as widely as possible to ensure all interested groups have the opportunity to have their say and share their views. A communications and engagement plan will need to be developed, with the communication and engagement team.

Engagement (Levels 2 and 3)

Engagement and involvement exercises do not need to be publicised widely but will still need to be carefully targeted at the relevant stakeholders.
Engagement projects should have a clear communications and engagement plan which includes involving stakeholders routinely and regularly throughout the lifecycle of the service improvement programme.

The communication and engagement team will offer guidance on appropriate methods for carrying out effective engagement, of which there are many powerful and useful methods. The key is to involve patients from the outset, continuously and in such ways as to empower and support patients to contribute equally to the process.

Media relations
All media relations during a consultation exercise will be planned and co-ordinated by the communication and engagement team and approved as part of the overall engagement and communications plan by the a project or steering group. This will ensure the CCG has an effective communication plan in place to respond to, and where necessary correct, any misleading information which enters the public domain, and to promote an effective understanding of the proposals for change.

Strong links with the media will be encouraged from the outset.

Typically, the lead clinician and project lead will act as spokespeople when required during the consultation process. Where clinical leaders genuinely develop and support proposals, they play a vital role in building public and patient confidence.

The communication and engagement team can offer advice on how to talk to the media or to unfamiliar audiences if requested.

Training
The communication and engagement team will offer training sessions to staff that will be fronting the discussions with users in public consultations to ensure they are fully prepared for the process.

The consultation

Consultation Principles and Guidelines
The CCG complies with the Cabinet Office code of practice on consultations which sets out the basic minimum principles for conducting effective consultations. See Appendix three for the criteria and principles we follow.

The Pre-consultation business case (PCBC)
The PCBC will vary, however typically, it should:

- be clear about the impact in terms of outcomes;
- outline how stakeholders, patients and the public have been involved, proposed further approaches and how their views have informed options;
- outline the case for change;
- identify governance and decision making arrangements;
- be explicit about the number of people affected and the benefits to them;
- identify indicative implementation timelines;
- include an analysis of travelling times and distances;
- outline how the proposed service changes will promote equality, tackle health inequalities and demonstrate how the commissioners have met PSED;
- explain how the proposed changes impact on local government services and the response of local government;
- demonstrate how the proposals meet the four tests;
• demonstrate links to relevant JSNAs and JHWSs, and CCG and NHS England commissioning plans;
• summarise information governance issues identified by the privacy impact assessment;
• identify any clinical co-dependency issues, including any potential impact on the current or future commissioning or provision of specialised or other services; and
• show that options are affordable, clinically viable and deliverable:
• demonstrate evaluation of options against a clear set of criteria.
• demonstrate affordability and value for money (including projections on income and expenditure and capital costs/receipts for affected bodies).
• demonstrate proposals are affordable in terms of capital investment, deliverability on site, and transitional and recurrent revenue impact.

The Public Consultation Process
While the communication and engagement team have reviewed our commissioning intentions, and scoped the potential communication, engagement and consultation requirements; it is inevitable that as ideas are formed, in some cases a project can move from improvements within a care pathway to wholesale redesign and change to a service. Because of the iterative nature of commissioning; this means that it is important for each priority, project, programme or workstream to regularly review its position with regard to the impact of its work. Commissioning leads are responsible for identifying proposed service changes within their departments. Once a service change has been identified then advice should always be sought from the communication and engagement team about what is the most appropriate approach to take.

If a service change is going ahead then a business case should be developed with an accompanying engagement or consultation plan and timeline alongside it. This should then be presented to the CCG Senior Management Team (SMT), Executive, the LDG, before going to the Governing Body or a relevant sub committee for final approval. A case for service change should clearly set out the clinical benefits of making the changes and how it will improve outcomes for patients. This will form the basis of the clinical evidence required should a service change go to public consultation.

A public consultation cannot proceed to pre-consultation stage without approval at a Governing Body or a sub committee meeting in private. Once approval for consultation is given a steering group will be set up and the project will move to the pre-consultation stage.

The communication and engagement team will lead on the consultation process element of the project but will work closely alongside the project team to ensure that all elements tie together.

The communication and engagement team will manage the mandatory Gateway and NCAT processes which offer independent assurance that a consultation is being conducted following national guidelines and will be a robust process.

The team will also make sure that the area team of NHS England are notified of any plans and that the Lancashire Health Overview and Scrutiny Committee are notified and agree with the proposed approach.

It is good practice for an independent analysis of the consultation responses, and to provide a steer throughout the consultation and provide a feedback report at the end of the consultation. The CCG has a number of sources of support for this. It commissions communication and engagement support from NHS Midlands and Lancashire CSU; and it also is a member of the Infusion Consultation Panel, which offers independent support, and analysis.

Four reconfiguration tests must be applied to the pre-consultation process going ahead with a public consultation. They are:
• Support from GPs
• Strengthened public and patient engagement
• Clarity on clinical evidence base
• Consistency with current and prospective patient choice

Evidence needs to be gathered to show that the CCG has complied with the four tests.

The Pre-election period
If a consultation is being planned then one of the first things to check is whether or not the consultation will fall during a pre-election period, this can be for district, borough or county elections; European Parliament elections or a general election. The communication and engagement team can offer advice on this.

The Government issue guidance for a pre-election period which is available here: http://www.parliament.uk/business/publications/research/briefing-papers/SN05262/election-purdah-or-the-preelection-period

In general the pre-election period starts once an election has been announced until after an election has been held.

The guidance sets out the general principles that should be observed by all civil servants, including special advisers, during this period:

a. Particular care should be taken over official support, and the use of public resources, including publicity, for Ministerial or official announcements which could have a bearing on matters relevant to the elections. In some cases it may be better to defer an announcement until after the elections, but this would need to be balanced carefully against any implication that deferral could itself influence the political outcome – each case should be considered on its merits;

b. care should also be taken in relation to proposed visits;
c. special care should be taken in respect of paid publicity campaigns and to ensure that publicity is not open to the criticism that it is being undertaken for party political purposes;
d. there should be even-handedness in meeting information requests from the different political parties and campaigning groups.
e. officials should not be asked to provide new arguments for use in election campaign debates

In general the advice is that you should not start a consultation during a pre-election period but you can continue with a consultation which has already started. As an additional precaution we usually advise that any public meetings being held as part of a consultation should not be held during the pre-election period.

Post Consultation
Once the 12 week consultation period is closed it does not stop there. This is still a period of close scrutiny and any decision and announcements need to be managed and handled carefully. A post consultation timeline should be developed taking all the key meetings and announcements into account and making sure that they are managed appropriately.

In some circumstances it may be necessary to develop a decision-making process as part of the post consultation work to help evaluate the options and the results of the consultation process into some recommendations. These are then presented to a Governing Body meeting held in public for them to make a final decision on the outcome of the consultation.
## Appendix One

### Pre-Consultation, Consultation and Post-consultation Proposed Timelines

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<tr>
<th>No.</th>
<th>Planning phase</th>
<th>Time scale</th>
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<tbody>
<tr>
<td>1</td>
<td>Project set up, with patient representatives or establishment of patient reference group and updates for communication and engagement</td>
<td>This could be as little as a month or as long as 6-12 months</td>
</tr>
<tr>
<td>2</td>
<td>Establishment of (1) issues/challenges  (2) current service model (3) clinical perspectives (4) best practice/research evidence/service usage data including patient satisfaction and insight data</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Establishment of case for change</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Draft proposal or options paper</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Draft business case</td>
<td></td>
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<tr>
<td>5</td>
<td>Internal governance around draft business case, options and case for change</td>
<td></td>
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<tr>
<td>6</td>
<td>Internal governance to agree consultation or engagement</td>
<td>1- 3 months</td>
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<tr>
<td>7</td>
<td>Agree pre consultation materials with patient reference group/patient reps and take to Patient Partners Board</td>
<td></td>
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<tr>
<td>8</td>
<td>Period of pre consultation to test out messages and materials and feedback mechanisms</td>
<td>2- 6 weeks</td>
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<tr>
<td>9</td>
<td>Brief relevant stakeholders and subject to internal and external governance and assurances</td>
<td>2-6 weeks</td>
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<td>OSC</td>
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<td>Health and Wellbeing Committee</td>
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<td>Area Team NHSE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NCAT if large scale system reconfiguration</td>
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<td></td>
<td>MP/Council Briefings</td>
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<tr>
<td>10</td>
<td>Design and production for formal consultation materials, surveys, PR, briefing, web and social media</td>
<td>2 - 4 weeks</td>
</tr>
<tr>
<td>11</td>
<td>Launch formal consultation</td>
<td>1-3 months</td>
</tr>
<tr>
<td>12</td>
<td>Post consultation period including:</td>
<td>1 -4 weeks</td>
</tr>
<tr>
<td></td>
<td>- Analysis of feedback</td>
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<td>- Feedback Report production</td>
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<td>- Independent/External review of report</td>
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<tr>
<td>13</td>
<td>Consultation Report to Governing Body or relevant sub committee</td>
<td>1-4 weeks</td>
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<tr>
<td>50</td>
<td>Recommendations Paper to Governing Body or relevant subcommittee for decision</td>
<td>1 – 4 weeks</td>
</tr>
<tr>
<td>55</td>
<td>Announcement of decision</td>
<td>1 week</td>
</tr>
<tr>
<td>56</td>
<td>Implementation and mobilization period</td>
<td></td>
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Appendix Two: Preparation for consultation

Before proceeding to public consultation the provider organisation should make sure that they submit the following to the commissioner to ensure a robust consultation process:

- A detailed outline of proposals
- The objectives to be achieved with clearly defined outcome benefits for patients, carers and the wider community
- Full financial information about the current service; the cost of delivering service change and the cost of the final service
- Plans detailing how any changes will be implemented, including establishment of services to support the change, such as transport strategies, and resourcing (including staffing) requirements
- A staff communications and engagement strategy
- A risk assessment and management strategy and associated contingency arrangements
- An equality impact assessment
- Evidence of how the proposed service changes will comply with the four reconfiguration tests
Appendix three: Consultation principles and criteria

Consultation Criteria
NHS East Lancashire CCG complies with the Cabinet Office code of practice on consultations which sets out the basic minimum principles for conducting effective consultations.

The seven formal public consultation criteria are:

1. **When to consult**
   Formal consultation should take place at a stage when there is scope to influence the policy outcome.

2. **Duration of consultation exercises**
   Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

3. **Clarity of scope and impact**
   Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

4. ** Accessibility of consultation exercises**
   Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

5. **The burden of consultation**
   Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees’ buy-in to the process is to be obtained.

6. **Responsiveness of consultation exercises**
   Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

7. **Capacity to consult**
   Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

These criteria should be reproduced in consultation document.
Consultation Principles
All public consultation will follow the principles of The Consultation Charter, which are:

- **Integrity**
  Honest intention, willing to listen and prepared to be influenced

- **Visibility**
  All those with a justifiable right to participate should be made reasonably aware of the exercise

- **Accessibility**
  Consultation methods must be appropriate for the intended audience, and that effective means are used to cater for the special needs of seldom heard groups and others with special requirements

- **Transparency**
  The principle of Transparency and the Freedom of Information Act 2000 requires that stakeholder invitation lists, responses and consultation results be published. But this will only occur with the express or implied consent of participants. NHS East Lancashire will ensure that this is understood by all participants

- **Disclosure**
  NHS East Lancashire is under a duty to disclose information which could materially influence the nature and extent of responses. In particular, areas where decisions have effectively already been taken, and where views cannot influence the situation, should be disclosed

- **Fair interpretation**
  Information and viewpoints gathered throughout the exercise should be collated and assessed objectively. NHS East Lancashire will draw on external assessors to ensure this to be the case

- **Publication**
  Participants have a proper expectation that they will see both the outcomes and the impact these have had on the final decisions. NHS East Lancashire will clearly promote the publication to all stakeholders within a reasonable time after the conclusion of the exercise
Appendix four: Should I engage with patients?

Will this result in a change to services or patient expertise?

NO

UNSURE

Has this been assessed & and is there evidence of this?
Commissioner to keep C&E informed of progress

YES

Comms & Engagement plans & strategy
Core Script
Stakeholder analysis
Patient Reps
Sense check with patients and clinicians

Comms & Engagement plans & strategy
Equality Impact Assessment
Core Script
Stakeholder analysis
Patient Reps
Patient Reference Group
Co-production
Seek patient views as service users/or public if wider than a service
Appendix five: Flow Chart Detailing the Process of consultation

**INITIAL PROPOSAL DEVELOPMENT**
- Strategic case for change (Joint Strategic Needs Assessment, Joint Health & Wellbeing Strategy, CCG strategies)
- Clinical Evidence
- Review any relevant PPI feedback already received
- CCG Chair or Chief Officer to decide whether or not major Discussion with partners.
- Decision to be published.

**DISCUSSION OF DRAFT PROPOSALS SMT, Execs, LDG**
- Include assessment against national ‘4 tests’ for service change
- Decision on whether to proceed with taking forward proposals
- CCG Chair or Chief Officer to decide if Governing Body should take decision on whether or not to proceed to next stage

**PRE-CONSULTATION AND PRE-ASSURANCE PUBLIC DISCUSSION**
With patients, the public and other stakeholders on draft proposals. These may also include:
- CCG member practices
- NHS organisations (NHS England, providers, other CCGs)
- Health & Wellbeing Board and Public Health
- Health Scrutiny Committee
- Clinical evidence and ‘4 tests’ assessment to be shared

**FORMAL PROPOSALS DEVELOPED**
- Reflecting pre-consultation discussions and external advice (if sought)
- Clinical Operational Executive to approve proposals for submission to NHS England for assurance, public consultation stage and also stakeholder engagement approach
- CCG Chair or Chief Officer to decide if Governing Body should take decision on whether or not to proceed to next stage

**NHS ENGLAND ASSURANCE**
To be decided by NHS England

**PUBLIC CONSULTATION**

**DECISION ON NEXT STEPS**
To be taken by SMT & Executive in light of
- feedback from consultation and assurance stages
- CCG Chair or Chief Officer to decide if Governing Body should take decision on whether or not to proceed to next stage

**Notification to PROCEED**
- Inform NHS England, Public Health & Health Scrutiny Committee and other stakeholders
- Scrutiny Committee to decide if positive substantial variation

**Notification NOT to PROCEED**
Inform NHS England, Public Health & Health Scrutiny Committee and other stakeholders

**AMEND Proposals**
Revised proposals to be agreed by SMT, Executive, Senior Clinicians, LDG, and Governing Body