NHS
County Durham and Darlington

A PROCESS FOR STAKEHOLDER ENGAGEMENT IN SERVICE RECONFIGURATION FOR NHS COUNTY DURHAM AND DARLINGTON

> **"**You have the right to be involved, directly or through representatives, in the planning of healthcare services, in the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.**" (NHS Constitution, March 2010)**

1. Introduction

The purpose of this process guidance is to outline the NHS County Durham and Darlington approach to stakeholder engagement where there are to be re-configurations in health service provision that will impact on the residents of County Durham and Darlington. The approach set out is informed by:

- New rules on reconfiguration in the *Revision to the Operating Framework for the NHS in England 2010/11* published in June 2010.
- The NHS White Paper *Equity and Excellence: Liberating the NHS,* July 2010.
- Processes and procedures adopted by the organisation, in particular those contained in the *Process for Considering Service Reconfiguration* agreed by the PCT Management Group in August 2008.
- Legislation and statutory guidance in particular that relating to patient and public involvement, the role of health overview and scrutiny committees and requirements for statutory consultation.
- Learning and experience from national and local service reconfigurations;
- The document: *A protocol for working together in relation to plans to make changes in health and social care services* agreed with Durham County Council and County Durham Local Involvement Network.

2. Background to changes in services

NHS commissioners and providers are required to consult and involve patients and the public if a proposal or a decision would have an impact on the manner in which health services are delivered to users of those services, or the range of health services available to those users.

NHS bodies also have a statutory duty to consult local Overview and Scrutiny committees on any proposals for significant development or substantial variation of health services. Significant development or substantial variations in services are not defined in regulations, however is should be presumed that changes are significant or substantial unless it is agreed that they are not, and the agreement of local health scrutiny committees must be sought in determining this – see Appendix 1. A change in service could vary in scope from a change in a local service to a major hospital reconfiguration and it is how patients/service users and the public experience or access the service that needs to be central to considerations within this process.

The new rules on reconfiguration contained in the revision to the Operating Framework for 2010-11 require proposals for service redesign and reconfiguration to meet four tests before they can proceed. These are set out in Section 4 below.

3. Legislative context to stakeholder engagement in service change

Engaging stakeholders including patients and the public is an essential component in the process of modernising public services. This approach is supported by duties introduced by a number of pieces of legislation:

- Section 242 of the NHS Act 2006 (formerly Section 11 Health and Social Care Act 2001) places a statutory duty on both commissioners and providers of services to make arrangements to consult and involve patients and the public – see Section 5.

- Section 244 of the NHS Act 2006 (formerly Section 7 of the Health and Social Care Act 2001), local NHS bodies have a statutory duty to consult local Overview and Scrutiny committees on any proposals for significant development and substantial variation of health services – see Section 7.

The introduction of Local Involvement Networks (LINks) in the Local Government and Public Involvement in Health Act 2007 is part of the process of achieving effective engagement. LINks are charged with facilitating the proactive involvement of service users and local people across health and social care organisations, to inform commissioners and providers, and have powers to refer matters to local overview and scrutiny committees.

It should be noted that external assurance such as through the Gateway process may be used by providers to strengthen their processes including stakeholder engagement.

This process guidance will ensure that NHS County Durham and Darlington effectively meets legislative requirements and effectively engages with stakeholders as part of modernising NHS services.

4. New rules on reconfiguration

The new rules on reconfiguration contained in the revision to the Operating Framework for 2010-11 require proposals for service redesign and reconfiguration to meet four tests before they can proceed. The tests are designed to build confidence within the service being reconfigured and with patients and communities. The tests will require reconfiguration proposals to demonstrate:

- Support from GP commissioners;
- Strengthened public and patient engagement;
- Clarity on the clinical evidence base;
- Consistency with current and prospective patient choice.

Standards in relation to these are also to be included in the terms of reference for the Independent Reconfiguration Panel - see section 8 below – to inform their consideration of schemes referred to them by the Secretary of State following formal referral by local Overview and Scrutiny Committees – see section 7 below.

Proposals will need to demonstrate that GP commissioners support the proposals, and the proposals for reconfiguration should demonstrate how they extend and promote patient choice which is given emphasis in the NHS White Paper which also indicates that further guidance on this will be forthcoming by the end of 2010.

5. Processes of the commissioning organisation

There may be a number of reasons for proposals being made for service reconfiguration, including those arising as part of the organisations Business Commissioning Flow and reviews driven by health and healthcare providers and issues arising from national (e.g. Department of Health) work.

Business Commissioning Flow

The PCT Business Commissioning Flow process requires stakeholder engagement throughout the various aspects of the process in particular the following elements:

- Strategy Priorities and Planning;
- Simple development;
- Simple procurement;
- Procurement of complex services.

Formal stakeholder consultation is likely to be required where significant service change will arise from the above process and the *Process for Considering Service Reconfiguration* model must be followed. [1 & 2]

Process for Considering Service Reconfiguration

The PCT, as the commissioner of local health and healthcare, has an agreed a process which ensures understanding of any potential reconfiguration and manages the local health and healthcare system to ensure any changes are congruent with local needs. The *Process for Considering Service Reconfiguration* was agreed by the PCTs Management Group in August 2008 and is set out in Appendix 3. In these circumstances NHS County Durham and Darlington will:

- Assess the impact of the proposed changes in terms of fit with the PCT's strategic direction and process adherence to Darzi and other principles.
- Assess any risk or resources issues arising from the proposed change.
- Determine the process and ownership of any consultation necessary to develop and deliver the change. *In any instance where there is whole systems impact, the PCT as commissioner, will lead on this.*

1. Appendix 2 - The business commissioning flow process includes the following checklist: Engaging Overview and Scrutiny and other key stakeholders where there are changes in services.
2. Appendix 3 – Process for Considering Service Reconfiguration.

The following steps are detailed in the process model:

- Planning and Needs Assessment
- Pre-consultation
- Consultation
- Analysis and Decision
- Health Overview & Scrutiny
- Independent Review Panel (if needed)
- Gateway Review / National Clinical Action Team (if needed)
- Public, Carer and Patient Involvement

The involvement of GP commissioning arrangements will need to be clearly demonstrated as part of this model.

This process guidance is about how we will deliver stakeholder engagement through the steps set out *in the Process for Considering Service Reconfiguration*. This guidance does not replace but builds on the model and process in Appendix 3 and draws on national and local learning to demonstrate **how we will go about delivering** our agreed process.

6. Patient carer and public involvement and the Duty to Involve

Formal duties to involve have been placed on NHS organisations and local government to embed a culture of engagement and empowerment within these organisations.

Section 242 of the NHS Act 2006 (formerly Section 11 Health and Social Care Act 2001) came into force on 3 November 2008 and applies to NHS organisations. It places a statutory duty on both commissioners and providers of services to make arrangements to consult and involve patients and the public in:

- planning of the provision of services;
- the development and consideration of proposals for changes in the way those services are provided, and
- decisions affecting the operation of services.

The duty applies if implementation of the proposal, or a decision (if made) would have an impact on the manner in which the services are delivered to users of those services, or the range of health services available to those users.

Further information can be found in *Refer to Real Involvement – Working with people to improve health, 2008.*

7. Involving Overview and Scrutiny Committees

In relation to local authority functions, the role of overview and scrutiny committees is to scrutinise the Councils Executive holding them to account for their decisions. In relation to the NHS this scrutiny role is broadened to consider issues affecting the health of local people (the overview role) and to hold the NHS to account on behalf of local communities (the scrutiny role).

Health Overview and Scrutiny Committees have an important role to play in relation to service change proposals. Under Section 244 of the NHS Act 2006 (formerly Section 7 of the Health and Social Care Act 2001), local NHS bodies have a statutory duty to consult local Overview and Scrutiny committees on any proposals for significant development and substantial variation of health services.

It is important to appreciate the different the roles of Executive and non Executive councillors (councillors involved in overview and scrutiny) as overview and scrutiny is required to scrutinise the Executive. Centre for Public Scrutiny Guidance[3] points out that:

It is important that NHS bodies recognise the difference between Executive members and OSC members within a local authority. If a proposal for change impacts upon the provision of social care or other local authority services, it is likely that early discussions will have included staff and councillors with an interest in these services. It should not be assumed that this involvement would have included OSCs.

Lead commissioning PCTs have responsibility to advise Overview and Scrutiny Committees at the earliest opportunity of proposals for service change, and evidence suggests that a strong ongoing relationship with the local overview and scrutiny committee can provide helpful challenge rather than present a barrier in relations to proposals for change. Indeed local experience suggests that overview and scrutiny committees can become advocates for change and may be able to support the NHS in delivering change.

The local overview and scrutiny committees are:

- Durham County Councils Adults Well-being and Health Overview and Scrutiny Committee;
- Darlington Borough Councils Health and Well Being Scrutiny Committee.

Joint Scrutiny committees may also be formed by the local authorities concerned where there are proposals for substantial variation or developments to services affecting more than one overview and scrutiny committee area to enable the consulting OSC to consult with all the OSCs affected.

In relation to service change overview and scrutiny committees will be interested in:

- The rationale and evidence supporting proposals for change (OSCs may refer a proposal to the Secretary of State if they considers a proposal is not in the interests of health services in an area).
- The adequacy of public consultation undertaken. The quality of consultation is important - where stakeholder engagement in the development of the proposals is robust OSCs may agree to consultation of less than the statutory 12 weeks recommended.

3. Substantial variations and developments of health services – a guide – December 2005

8. Learning and Experience

The model set out in Section 10 is informed by national and local learning and experience.

8.1 The national perspective

The *Independent Reconfiguration Panel* was established in 2003 to give formal advice to the Secretary of State for Health on contested proposals for reconfiguring health services. The Panel offers ongoing support and guidance to the NHS, overview and scrutiny committees and other interested organisations on achieving successful change in health services. It may be useful to note that this advice is free and informal.

Learning from reviews to date has given rise to a 'critical list' on why reconfiguration proposals have been referred:

- Inadequate community and stakeholder engagement, before options are published in a formal consultation.
- Important content missing from reconfiguration plans – local communities want to know what services will be provided, where and how they will access them.
- Mixed messages about clinical issues – if doctors in an area publicly disagree, their patients are entitled to be sceptical about proposed changes.
- Proposals that emphasize what cannot be done and underplay the benefits of change and plans for additional services.
- Health agencies caught on the back foot about the three issues most likely to excite local opinion – emergency care, transport and money.

The NHS Confederation has examined case study evidence from PCTs as well as evidence from the Independent Reconfiguration Panel[4]. Common themes to consider include:

- **Consult early** – formal consultation published on an unprepared community, at a late stage in the planning process, can provoke a hostile reaction. Proposals need to take account of how the public sees local priorities for healthcare.
- **Target the right stakeholders** – those most relevant to the proposals. A strong ongoing relationship with the local overview and scrutiny committee can provide helpful challenge rather than present a barrier.
- **Develop proposals in partnership with healthcare professionals** – public confidence will be enhanced if proposals are presented jointly by local healthcare professionals and PCT the leadership.
- **Communicate a strong narrative** – strong messages about the benefits of change should be presented by local NHS players with a single voice, and sufficient detail should be provided about how and where future services will be provided.

  As a commissioner of services NHS County Durham and Darlington will need to be clear that it must determine its final views on the proposals after it has considered public and stakeholder opinions expressed as part of any consultation undertaken.

4. Talking it through: the importance of communications when discussing local service change.

- **Be open to the evidence and demonstrate genuine involvement** – where feasible PCTs should be clear about opportunities to shape proposals and where the detail can be influenced.

- **Make personal leadership a priority** – relevant NHS leaders should be present at public meetings to be a public face of proposals for change.

- **Be prepared for further dialogue with a hostile audience -** PCTs should be prepared for the potential for large hostile responses from the public – and should be adequately prepared for questioning about resources as proposals may be viewed as about cost-cutting.

- **Continue discussions post consultation** – after formal consultation has ended as a means of taking account of responses received during consultation.

8.2 <u>The local perspective – learning from service reconfigurations in County Durham and Darlington</u>

A number of recent service reconfiguration/service change proposals have given rise to the following local learning:

- Pre-consultation engagement with stakeholders by commissioners or providers needs to be strengthened. Evidence has found that this is often weak or has not been undertaken. This can lead to a need for full statutory consultation.

- Clear early engagement with overview and scrutiny committees is very important. Whilst overview and scrutiny can provide significant challenge – it is essential in the process of developing a shared understanding of drivers for change and can produce advocates to support NHS proposals. Notification at the earliest opportunity to building relationships and understanding of drivers for change is invaluable in helping any process of consultation.

- There should be adequate notice, before a consultation commences, that it is about to begin. Consultation has sometimes started before formal notification has been provided to interested stakeholders.

- Consultation proposals should contain an adequate amount of evidence on which a lay person would be able to make an informed comment. Tthere have been examples of consultations where information has been at a very ‘high-level’ setting out principles for change but lacks detail, and other examples where the possible future services are not clearly set out.

- Consultations should ensure that communities concerned are consulted – there have been examples where this has not been the case.

- Consultation proposals should offer a genuine choice. Proposals sometimes offer too narrow a set of choices or options which appear unbalanced.

- Language used should be easy to understand – sometimes too much jargon is used.

- Consultation plans and approaches (models of engagement) have not liked in with existing local networks – such networks can provide the most effective way of constructing consultation mechanisms that most effectively capture the views of interested local stakeholders.

- Commissioners and providers must acknowledge that the provision of service must be related to the communities being served, that is, the location of a service is not separate to the needs of those who will be using it - proposals should therefore consider the wider implications for service users, or 'whole-system' implications:

    - strategies, plans and proposals should be developed by a PCT (or providing organisation) with cognisance to those being developed by neighbouring PCTs to avoid confusion, duplication or gaps in consultation or planned provision;
    - access and transport implications arising from proposals should be acknowledged in proposals or in the consultation undertaken, and prior consideration of possible solutions should be demonstrated

- Open and up front discussion of the drivers for change of a well thought through proposal is more likely to engender support amongst key decision makers for the proposals.

- Opportunities for key stakeholders to undertake visits to sites or locations affected by the proposals for change have proved invaluable.

- The demonstration of clinical rather than organisational drivers for change are more likely to be persuasive.

- It has been noted that Health Impact Assessments may be most useful if developed as part of the evidence in the case for change. It is noted that such information can be lacking.

- Impacts of the proposals on other agencies such as local authority social care provision or the voluntary sector should form part of the proposal where possible, or should explicitly be sought as part of the consultation process.

- The impact of service changes in relation to key policy drivers must be clearly demonstrated e.g. in relation to providing care closer to home.

9. Implementing the proposals for change

The end of the formal consultation on service change/reconfiguration proposals will be followed by decisions about implementing the proposals by NHS County Durham and Darlington and by the provider organisation(s) where relevant.

This should not be the end of the process of stakeholder engagement - in implementing the proposals there is a need to continue to keep people informed. Consideration should be given to the adoption of a stakeholder implementation oversight board approach which should be led by NHS County Durham and Darlington. There are examples of where this approach has been effective[5]. The following remit should be considered when taking such an approach:

- Overseeing delivery of the detailed implementation plan.

- Monitoring and ensure delivery of the plan, including ensuring that its delivery does not negatively impact upon provider performance against key performance indicators, especially those relating to patient experience.

- Ensure that patient safety and clinical quality is maintained.

5. Seizing the Future Stakeholder Implementation and Oversight Board/Talking it through: the importance of communications when discussing local service change- NHS Confederation; 2010

- Ensure that recommendations made as part of the stakeholder consultation process are incorporated into the plan and implemented to agreed timescales.
- Consider and advise on any proposed changes to the plans.
- Advise on, agree and monitor the delivery of a detailed supporting communications and engagement plan.
- Report back to and represent the views of member organisations.
- To ensure the actions agreed with overview and scrutiny committee(s) are delivered.
- To ensure effective and co-ordinated communications with key stakeholders, the public and media.

10. Process guidance: stakeholder engagement in service re-configuration for NHS County Durham and Darlington

Once it is determined that a reconfiguration proposal is to be taken forward – the following aspects must be carefully considered and clearly demonstrated:

Good practice in the commissioner – led process:

1. Pre-consultation engagement

- On-going and/or pre-consultation engagement with interested stakeholders is advised including with user groups and overview and scrutiny committees. Such engagement will help with the development of proposals for change, as well helping to build relationships on which the success of further engagement or consultation will be built. Evidence of such on-going engagement may help to make the following process more manageable.

2. Early and robust project planning

- A full and early scoping exercise must take place to identify all issues that need to be addressed in taking the reconfiguration proposal through public consultation. This should include an assessment of an appropriate approach to stakeholder communications and engagement activity that may be required and ensuring that project management arrangements are clearly understood in terms of project leadership; timescales and milestones and so on.
- Consideration should be given to whether specialist consultancy support is required to deliver part, or all, of the reconfiguration proposal.
- Consideration should be given to taking advice from the Independent Reconfiguration Panel.

3. Prepare a strong case for change

- Well thought through proposals, well presented, should be the basis for consulting with stakeholders. The rationale, evidence base (including the clinical evidence base), and benefits of the proposed changes (including how they develop and support patient choice) should be presented in as transparent a way as possible.
- The proposals should state which services will change and how and where they will be provided in future.
- The implications for patients, the public, staff and other stakeholders should be covered.

4. The proposals take account of wider implications

- There is a need to ensure that proposals and plans are considered in a regional commissioning context, or in relation to those of neighbouring commissioning PCTs so that opportunities for strategic linkages or complementary consultations are properly exploited, and the potential for duplication or confusion is mitigated.
- Other impacts from proposals for change such as in relation to access and transport implications arising should be also form part of the proposals with adequate consideration given to potential solutions. This will require work with local authorities, and in some cases neighbouring local authorities, to help ensure that the services we commission are accessible to local communities and that **planning and transport** considerations form part of our thinking. In addressing planning requirements and discussing transport solutions this will require work with distinctly separate functions of the local authority, and as such should be regarded as separate but linked tasks.
- The proposals have considered the implications for other care providers such a local authority social care provision or services of the voluntary sector.

5. Involvement of Overview and Scrutiny Committees and Local Involvement Networks

Early engagement:

- Overview and Scrutiny Committees (and Local Involvement Networks) should be advised at the earliest possible stage.
- Early engagement with Overview and Scrutiny Committees must recognise that the role of local authority scrutiny is different to the role of the Executive (Cabinet).
- Overview and Scrutiny Committees may agree to consultation of less than the statutory 12 weeks that is recommended in circumstances of significant change, but this will depend on the extent of stakeholder engagement in the early development of the proposals.

Ongoing engagement:

- Evidence suggests that a strong ongoing relationship with the local Overview and Scrutiny Committees (OSCs) can provide helpful challenge rather than present a barrier in relation to proposals for change.

6. Communications and stakeholder engagement

- Early and ongoing engagement of all relevant stakeholders is essential to help people provide new evidence and arguments which will allow proposals to be adapted. It should be noted that such early stakeholder engagement must go beyond a Trusts Membership or Member Governors to include other stakeholders such as service users their families or carers.

- A communications strategy and plan should be prepared and made available to stakeholders in advance of consultation commencing. The communications strategy must fully consider engagement of other organisations and well as service users and members of the public.

- The advice of PCPE experts must be sought to help shape the approach to engagement – and whilst public engagement may be part of everyone's job – there are specialist skills in planning and delivering public engagement activities that require professional PCPE involvement. In organising stakeholder events, consideration should be given to targeting those who are part of existing networks and engagement structures as those that are most likely to have informed opinions to help shape proposals.

7. Use plain language

- Research has shown that some commonly used terms can be poorly understood by members of the public – examples include:

- 'Clinicians' - it may be better to use the term 'medical professional' or 'doctors, nurses and other healthcare professionals'

- 'Safety' – the public sometimes question why a PCT would need to refer to services as 'safe', often assuming that this meant that they were not, in fact, safe at all.

8. Implementing the proposals for change (service reconfiguration)

- Consideration of the formation of an Implementation and Oversight Board as a mechanism for continuing dialogue with interested stakeholders and as a means for overseeing delivery of implementation plans and addressing with ongoing concerns as they arise. Such an approach may only be required in circumstances of major service re-configuration.

Appendix 1

A protocol for working together in relation to plans to make changes in health and social care services between:

- NHS County Durham
- County Durham Local Involvement Network
- Durham County Council
  (Adults, Well Being and Health Service Group and Assistant Chief Executive's Office [Overview and Scrutiny Unit] taking lead responsibility)

This protocol has been developed by the above parties in recognition of the importance placed on working together effectively to plan and/or review changes in services that are provided to communities, that there are shared and mutual benefits of doing so, and in recognition of the legal duties and responsibilities placed on organisations in relation to instances of service change.

1. Purpose and outcomes

1.1 The **purpose** of this protocol is to establish a clear framework for action by each of the parties to this protocol in relation to plans, policies, strategies and reviews that will lead to changes in services for the people of County Durham. This framework will help to:

- Achieve effective working relationships across all parties.
- Enable effective communication across all parties.
- Improve and better co-ordinate the way in which we engage with users, carers and the wider public.
- Enable collaborative and constructive working across all parties.
- Improve co-operation between all parties to bring about the best outcomes for service users.

1.2 The **outcome** from this protocol will be improved decision making by the parties to this protocol in relation to service changes, which is evidence based and reflects the views of patients, users and the public. This will help contribute to improvements in health and well-being for the people of County Durham.

2. Making changes in health and social care services and consultation

Where a service change is a 'significant development' or a 'substantial variation' in service

2.1 Parties to this protocol agree that changes to services that are being proposed in plans, policies, strategies, or are the subject of review, will be dealt with in line with the provisions of this protocol.

2.2 Parties to this protocol recognise that NHS commissioners and providers are required to consult and involve patients and the public if a proposal or a decision would have an impact on the manner in which health services are delivered to users of those services, or the range of health services available to those users – the statutory duties are set out in more detail in Appendix 1 (A1.2).

2.3 Parties to this protocol recognise that duties are placed on local government to consult and involve patients and the public in the development, planning and provision of services – the duty is set out in more detail in Appendix 1 (A1.4).

2.4 NHS bodies will consult Durham County Council's Adults, Well Being and Health Overview and Scrutiny Committee on proposals for changing the provision of health services. See Appendix 2 for an explanation of when a change in service is a 'significant development' or 'substantial variation' requiring scrutiny to be consulted (A2.1) and the process for doing so (A2.4). The key elements of this process are:

- The involvement of patients, users and the public in the development of the proposals.
- Early notification to Durham County Council's Adults, Well Being and Health Overview and Scrutiny Committee of the development of a proposal.
- Reaching an agreement with the scrutiny committee that is based on the provision of adequate information in relation to the service change.

3. Working together: relationships and behaviours

3.1 All parties recognise that they share the common objective of ensuring that the public of County Durham, including service users and carers, have a voice in determining the priorities and shape, and the quality and outcomes, of health, well-being and social care services and will work together to achieve this, and meet the commitments for engagement set out in section 5 below.

3.2 All parties to this protocol recognise and respect the legitimate and important contribution that other parties can make to the development or review of plans, policies and strategies for changes to the services provided to communities in County Durham.

3.3 All parties commit to communicate with each other in a timely manner, to co-operate and where possible to collaborate, in relation to engagement and consultation on service changes. All parties will meet the commitments set out for effective communication in Section 4 and to statutory responsibilities and powers placed on them that are set out in Appendix 3.

3.4 All parties to this protocol commit to working together to review the effectiveness of this protocol on a six monthly basis through the organisations represented on the on joint project group that developed the protocol. Reviews will take account of legislative changes or relevant guidance that impact on this protocol.

3.5 All parties to this protocol commit to take steps to ensure that it becomes embedded within their own organisations, and externally with those whom it commissions to provide services for it, and commit to advocating for it and promoting it.

4. Working together: communication

To achieve the purpose and outcomes of this protocol:

4.1 All parties will develop and maintain clear lines of communication with each other and nominate a senior member of staff as the principal point of contact for communicating issues relating to plans for service changes, or other aspects of this protocol. The principal contact will be of sufficient seniority within each organisation in order for issues to be communicated between organisations to achieve strategic-level awareness and linkages and to ensure information is cascaded appropriately.

4.2 All parties to this protocol will seek to communicate information with each other in a way that enables each organisation to carry out its functions effectively. Partners to this protocol will reserve the right to define what constitutes relevant information in the context of forward and strategic planning within their own organisation however the basis of this protocol is a presumption that information is to be shared.

4.3 Parties to this protocol will endeavour to share information relating to circumstances where changes to services are to be made – as set out in Section 2.

4.4 All parties are committed to keeping each other informed of proposed public or user/carer engagement and consultation plans and activities.

4.5 Information will be communicated in plain language, in an appropriate format and exclude the use of jargon, acronyms, concepts, and so on that are not generally understood by partners and/or our local population.

4.6 Information will be communicated in a timely way ensuring adherence to good practice/existing compacts and agreements or legislative timescales on consultation.

4.7 Each party will confirm with other parties before claiming their endorsement or support for plans, policies, strategies and reviews, for example in relation to press releases being issued.

4.8 Each party will share draft reports where appropriate with other parties to this protocol in order to ensure accuracy.

4.9 Each party will make minutes and agendas of relevant meetings publicly available.

4.10 Each party to this protocol will ensure that it pro-actively communicates this protocol to achieve 3.5 above.

5. Working together: engaging with users, carers and the wider public in relation to changes in services

5.1 All parties to this protocol acknowledge the principle of putting patients, carers and local people at the centre of everything we do through embedding patient carer public engagement activity at all levels and as part of everyday practice.

5.2 All parties to this protocol recognise that they have both joint and separate approaches to engaging with service users/carers, members of the public or its own members. Wherever possible all parties will ensure that such health, well-being and social care engagement activity is jointly planned and co-ordinated within the joint/partnership and individual frameworks of the parties, to ensure maximum coverage and capacity, to avoid duplication and 'consultation fatigue' and to ensure appropriate quality and outcomes.

5.3 Where appropriate significant health, well-being and social care issues arising from engagement activity is shared with other parties to this protocol.

5.4 All parties to this protocol will carry out engagement and involvement activity in such a way that requirements of the Duty to Involve set out in Appendix 1 are met.

6. Signatories

We the undersigned commit our organisations adhere to the content of this Protocol:

NHS County Durham:
……(DATE)……
County Durham Local Involvement Network:
……(DATE)……
Durham County Council:
……(DATE)……
Adults Wellbeing and Health Service Group
……(DATE)……
Assistant Chief Executive's Office (Overview and Scrutiny Unit)

Appendix 1 – Duties to involve

A1.1 Formal duties to involve have been placed on NHS organisations and local government to embed a culture of engagement and empowerment within these organisations.

A1.2 Section 242 of the NHS Act 2006 (formerly Section 11 Health and Social Care Act 2001) came into force on 3 November 2008 and applies to NHS organisations. It places a statutory duty on both commissioners and providers of services to make arrangements to consult and involve patients and the public in:

- planning of the provision of services;
- the development and consideration of proposals for changes in the way those services are provided, and
- decisions affecting the operation of services.

A1.3 The duty applies if implementation of the proposal, or a decision (if made) would have an impact on the manner in which the services are delivered to users of those services, or the range of health services available to those users.

A1.4 Part 7 section 138 of the Local Government and Public Involvement in Health Act 2007 came into force on 1 April 2009 and applies to local government (and is in addition to any other existing legislative requirements). It places a duty on local authorities to take those steps they consider appropriate to involve representatives of local persons (anyone affected by or interested in a particular local authority function) in the following ways:

- influencing or directly participating in decision making;
- providing feedback on decisions, services, policies and outcomes;
- co-design/work with authority in designing polices and services;
- co-produce/carry out some aspects of services for themselves
- work with the authority in assessing services (including co-option on scrutiny committees).

A1.5 Under the Local Government and Public Involvement in Health Act 2007 Local Involvement Networks have been established. County Durham Local Involvement Network (LINK) is charged with facilitating proactive involvement of service users and local people across health and social care organisations in the County. It will gather information from communities which it can pass on to commissioners, providers and Durham County Council's Adults, Well Being and Health Scrutiny Committee for the purpose of improving their accountability and responsiveness to users. LINKs also have statutory powers that are set out in Appendix 3.

Appendix 2 – Significant development and substantial variations in services and statutory consultation

A2.1 Under Section 244 of the NHS Act 2006 (formerly Section 7 of the Health and Social Care Act 2001), local NHS bodies have a statutory duty to consult local Overview and Scrutiny committees on any proposals for significant development and substantial variation of health services. Significant development and substantial variations in services are not defined in regulations (see examples from Case Law in A.2.4 below), however this protocol outlines an approach to assessing if a proposal is considered significant or substantial – see *Process for assessing if a proposal is a Significant Development or Substantial Variation in service A2.4 below.*

A2.2 Formal consultation is required where there is a significant development and substantial variation in service. The Adults, Well Being and Health Overview and Scrutiny Committee will seek to reach agreement with the NHS over the timing and extent of formal consultation taking into account that:

A2.2.1 Whilst Cabinet Office guidelines recommend that full consultations should last a minimum of twelve weeks and this will be normal practice, guidance supporting Overview and Scrutiny committees provides for some flexibility in the length of time a consultation will last.

A2.2.2 Agreement to vary the scope of consultation will depend on:

- the extent to which patients, users and the public have been involved in the development of proposals for change or variation of services, and the general duties to involve - set out in A1.2

- supporting information provided in relation to the key criteria (A2.4.4) as part of the process of assessing a proposal (A2.4) below.

A2.3 It should be noted that the Adults, Well Being and Health Overview and Scrutiny Committee may decide that it does not wish to be formally consulted on proposals because in its opinion they do not constitute a significant development or substantial variation in service. It may deem a proposal is significant or substantial and still not want to be formally consulted on proposals because it feels the NHS has demonstrated adequate engagement and involvement with patients, the public and other stakeholders in the formulation of the proposals (in line with the process set out in A2.4 below).

A2.4 In line with NHS County Durham's Process for Considering Service Configurations the commissioner (NHS County Durham) will lead consultation where there is considered to be a 'whole system impact' (where the proposal may impact upon a persons experience of healthcare across the whole healthcare system) and the provider organisation will lead consultation where this is not the case.

A2.4 Process for assessing if a proposal is a Significant Development or Substantial Variation in service

For NHS bodies this protocol presumes that a change in service should be presumed to be a significant development or substantial variation in service unless it is agree that it is not and the agreement of Adults, Well Being and Health Overview and Scrutiny Committee must to be sought in determining this.

A change in service could vary in scope from a change in a local service to a major hospital reconfiguration – but it is how patients/service users and the public experience or access the service that needs to be central to considerations within this process.

Examples from Case Law where proposals have been considered 'significant developments' or 'substantial variations' in services':

- A relocation of patients from one hospital to another where a hospital or ward is closing.
- A 'temporary' ward or hospital closure has been deemed substantial if it is considered likely to become permanent (but not if it is actually only temporary).
- The removal of a service from a local community.

NHS County Durham will take the following steps in order to determine if a service proposal is a Significant Development or Substantial Variation in service.

A2.4.1 Step 1: Pre-notification activity

NHS County Durham will undertake such activity as is necessary in order to provide information in respect of the Key Criteria (A4.2.4 below), and the Further Information (A4.2.6 below) prior to notification to the Adults, Well Being and Health Overview and Scrutiny Committee of a proposal to change a service.

A key element of this supporting evidence and information is the extent to which patients, users and the public have been involved in the development of proposals for change or variation of services, and the general duties to involve - set out in Appendix 1 above - have been met by the NHS and the local authority.

A2.4.2 Step 2: Early notification

NHS County Durham will make early notification to the Adults, Well Being and Health Overview and Scrutiny Committee during the development of a proposal within the context of ongoing dialogue between all parties and to avoid delays in considering a proposal.

The notification should include a *statement of whether the proposal **is, or is not,** considered substantial or significant* and on what basis this assertion is made taking into account the key criteria set out in A4.4 and any further supporting information.

This early notification should be made by NHS County Durham as commissioner.

The Local Involvement Network should also be advised as part of patient, carer and public involvement as part of the duty to involve.

In relation to Key Decisions affecting Durham County Councils Adults Wellbeing and Health Service – these are communicated through the Council's Forward Plan.

A2.4.3 Step 3: Reaching agreement

It is recognised that the *agreement of Adults, Well Being and Health Overview and Scrutiny Committee must to be sought* in order to determine if a proposal is significant or substantial. Agreement will depend on whether:

- the above steps have been followed;
- the supporting information is sufficient to enable the committee to properly assess if a proposal is significant or substantial;
- further information is required;

The Adults, Well Being and Health Overview and Scrutiny Committee will formally respond to the notification indicating:

- if it agrees with the statement about the significance or substantial nature of the proposal; or
- if it disagrees with the statement about the significance or substantial nature and on what grounds, and what further action it feels should be taken.

If NHS County Durham does not agree to that further steps are required then the Adults, Well Being and Health Overview and Scrutiny Committee will consider what action it wishes to take in line with its powers under legislation.

It should be noted that the Adults, Well Being and Health Overview and Scrutiny Committee may decide that it does not wish to be formally consulted on proposals because in its opinion they do not constitute a significant development or substantial variation in service. It may deem a proposal is significant or substantial and still not want to be formally consulted on proposals because it feels the NHS has demonstrated adequate engagement and involvement with patients, the public and other stakeholders in the formulation of the proposals.

A2.4.4 Supporting information - the key criteria

Department of Health guidance, and good practice, indicates that in deciding whether a proposal is significant or substantial, the following key issues should be considered:

a) changes in accessibility of services;
b) impact of the service on the wider community and other services, including economic impact, transport and regeneration;
c) number of patients affected, changes may affect the whole population of a geographical area or a small group. If a change affects a small group of patients it may still be 'substantial', especially if patients need to continue to access that service for many years;
d) changes to methods of service delivery, e.g. moving a particular service into a community setting from an acute hospital setting.
e) is the proposal likely to be considered controversial to local people' i.e. where historically services have been provided in a particular way or at a particular location;
f) are there changes to governance where NHS bodies relationships with the public or Scrutiny may change.

In addition, further supporting information should be considered for inclusion see below (see A2.4.6).

A2.4.5 Criteria for key decisions which the Executive of the Council

Criteria for key decisions by Durham County Council's Executive are similar to the criteria set out in a) to f) above (which may require public consultation), and will require the Adult, Well Being and Health Service Group to report to the Executive, are those likely:

- To have a significant impact on the amenity of the community or quality of service provided by the Council to a significant number of people living or working in the locality affected;
- To be perceived as being in conflict with any plan, policy or strategy approved by the Council, or
- To be perceived as being in conflict with one or more of the Council's strategic objectives/priorities for improvement or
- To have significant budgetary implications.

A2.4.6 Further supporting information:

Criteria for assessment	Yes/No /N/A	Comments/supporting evidence
Case for Change 1) Is there clarity about the need for change? (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement). 2) Has the impact of the change on service users, their carers and the public been assessed? 3) Are supporting local health needs assessments or health equity audits available? 4) Do these include: a) Demographic considerations? b) Changes in morbidity or incidence of a particular condition? c) Health equality considerations? d) Potential reductions in care needs? (e.g. falling birth rates) e) Comparative performance? 5) Has the evidence base supporting the change proposed been defined? This should cover both with national service improvement programmes (e.g. NSFs, modernisation agenda) and the development of clinical best practice, to enhance service quality or the patient experience? 6) Have the clinicians affected contributed to the development of the proposal? 7) Is any aspect of the proposal contested by the clinicians affected?		
Impact on Services Users 8) Will there be changes in access to services as a result of the changes proposed? 9) Can these be defined in terms of: a) waiting times? b) transport? (public and private) c) travel time?		

d) other? 10) Has the impact be on vulnerable people using these services now and in the future been assessed (this should include an Equalities Impact Assessment)? 11) Does the proposal extend the choice available to the population affected? 12) Does the proposal improve the quality of care provided to service users? 13) Have the service users affected contributed to the development of the proposal? 14) Is any aspect of the proposal contested by the service users affected?		
Engagement and Involvement (Duty to involve) 15) Were key stakeholders involved in the development of the proposal? 16) Is there information regarding the involvement of: a) Service users, their carers or families? (including hard to reach) b) Other service providers in the area affected? c) The Local Involvement Network? d) Staff affected? e) Other interested parties? 17) Is the proposal supported by the key stakeholders? 18) Is there any aspect of the proposal that is contested by the stakeholders? If so what action has been taken to resolve this?		
Options for change 19) Are a range of options identified to deliver the intended change? 20) Were the risks and benefits of the options assessed when developing the proposal?		

21) Have changes in technology, including new drugs been taken into account? 22) Has the impact of the proposal on other service providers been evaluated? 23) Will the proposal impact on the wider community and if so has the impact been evaluated (e.g. transport, housing environment)? 24) Have the workforce implications associated with the proposal been assessed? 25) Have the financial implications of the change been assessed in terms of: a) Capital? b) Revenue? c) Affordability? e) Risks? 26) Will the change contribute to the delivery of national/local targets?		

Appendix 3 – Responsibilities and powers of organisations

A3.1 Local Involvement Network powers to refer to Overview and Scrutiny

Powers to refer health and social care issues to Adult Well Being and Health Overview and Scrutiny Committee:

- The LINk can refer a matter relating to health and social care services* to an overview and scrutiny committee of a local authority.
- The overview and scrutiny committee must acknowledge receipt of the referral within 20 working days (beginning on the date the referral was made).
- The committee must then decide on whether any of its powers are exercisable in relation to the matter referred.
- If the committee is of the view that it does have powers that are exercisable in relation to the matter, it must decide whether or not to exercise that power in relation to the matter.
- If the committee does decide to exercise those powers in relation to the matter, it must take into account any relevant information provided by the LINk.
- The committee must keep the referrer (i.e. the LINk) informed of its actions ion relation to the matter.

* *Local Authority (Overview and Scrutiny Functions) Regulations 2002 (SI 2002 No 3048) [following the Health and Social Care Act 2001]*
Local Involvement Network Regulations 2008 (SI 2008 No 528) [following and the LGPIH Act 2007] – amends regulations in SI 2002 No 3048.

A3.2 Overview and Scrutiny may refer to the Local Involvement Network

The Adults Well Being and Health Overview and Scrutiny Committee may make requests to the LINk to investigate issues and to support its own investigations. In considering whether to make such a request the OSC will take account of the LINKs remit and powers under legislation. Requests will be made in writing to the LINk who will acknowledge receipt of requests.

Requests will be considered by the LINk Management Committee. In deciding whether to accept the request the Management Committee will consider the resources available to respond to the request; and existing commitments under its workplan. The LINk will keep OSC informed of action being taken regarding the request.

A3.3 Local Involvement Network – Powers to enter and view social care service premises

The LINk has policies and procedures in relation to enter and view that are shared all parties to this protocol. The LINk has appointed authorised representatives to enter the premises of health and social care service providers that are publicly funded. Children's social care services are exempted from this duty to allow access (Local Government and Public Involvement in Health Act 2007).

LINk representatives will possess the necessary skills and undergo a Criminal Records Bureau check in line with section 113A of the Police Act 1997. The LINk will make publicly available a comprehensive and accurate list of all authorised representatives.

A3.4 Local Involvement Network – Powers to request information

The Local Involvement Network may request information from any health or social care commissioner or provider subject to exemptions of the Local Government and Public Involvement in Health Act 2007.

There is a 20 working day rule for response to LINk requests for information except where it is agreed to be waived for reasons of practicality. Where requests for information have been received but not responded to, the LINk reserves the right to refer matters to the regulator or Overview and Scrutiny Committee. However, this will only happen after all other options have been exhausted.

A3.5 Scrutiny powers to refer to Secretary of State

The Adults Well Being and health Overview and Scrutiny committee may refer to the Secretary of State matters relating to:

- Adequacy of public consultation – the OSC can report to the Secretary of State where it is not satisfied that consultation in relation to an NHS proposal for a substantial development of the health service or a substantial variation in the provision of a service. Further consultation may then be required by the Secretary of State.

- Circumstances where an OSC considers that the proposal would not be in the interests of the health service in the area where this can be reported to the Secretary of State to make a decision.

A3.6 Scrutiny powers in relation to Durham County Council's Executive

Where policy issues are concerned, including consultations about substantial changes in relation to health services it will report matters to the Council's Executive for information – for social care matters reports are presented to the Council's Executive for consideration.

Appendix 2

NHS
County Durham and Darlington

Business Commissioning Flow Checklist: Engaging Overview and Scrutiny and other key stakeholders where there are changes in services

The aim of this checklist is to ensure that Overview and Scrutiny and other key stakeholders are engaged appropriately in the business commissioning process.

Explanatory note:

Where there are plans/proposals for a significant development or substantial variation to services NHS bodies have a statutory duty to consult local overview and scrutiny committees (OSCs):

- Durham County Councils Adults Well-being and Health Overview and Scrutiny Committee;
- Darlington Borough Councils Health and Well Being Scrutiny Committee

Overview and Scrutiny committees will be interested in:

- the rationale and evidence supporting proposals for change (OSCs may refer a proposal to the Secretary of State if they considers a proposal is not in the interests of health services in an area).
- the adequacy of public consultation undertaken (where stakeholder engagement in the development of the proposals is robust OSCs may agree to consultation of less than the statutory 12 weeks recommended);

For further information – please refer to:

- *A protocol for working together in relation to plans to make changes in health and social care services (NHS/DCC/LINK) - December 2009*
- *Process for Considering Service Reconfiguration – Management Group – August 2008*

IMPORTANT:

Where there is a need to engage/inform a scrutiny committee - the Lead Director must be contacted initially **before an OSCs is contacted.** The Lead Director will advise on sharing information or attendance at an OSC. Please refer to G*uidance for NHS Staff – Protocol for Working with Overview and Scrutiny Committees in Durham and Darlington* for further information.

Lead Directors for Overview and Scrutiny Committees are:

- Durham County Council – David Gallagher – Director of Partnerships and Services
- Darlington Borough Council – Miriam Davidson – Locality Director of Public Health

Checklist for engaging Overview and Scrutiny:

Does the following apply:	Action to be taken:
Strategy Priorities and Planning	
Developing a strategy **(Box 5)**	Advise Overview and Scrutiny and request their involvement as a stakeholder
Completed a strategy **(Box 7)**	Advise Overview and Scrutiny and request that information is shared with them appropriately
Prioritising delivery including decommissioning (informing AOP**) (Box 8)**	Advise Overview and Scrutiny and request that information is shared with them appropriately
Simple development	
Designing future state **(Box 4)**	Advise Overview and Scrutiny and request their involvement as a stakeholder
Simple procurement	
Will simple procurement lead to a change in service? (General)	If procurement will lead to a change in service – see below*
Complex procurement	
Local consultation and engagement with stakeholders **(Box 4)**	If procurement will lead to a change in service – see below*

Where there is a proposed change in service:*

Does the following apply:	Action to be taken:
Is there potential for a change in service? **Note:** A change in provider organisation will not constitute a change in service (in this context) if the level of service is to be maintained or enhanced.	Refer to - *A protocol for working together in relation to plans to make changes in health and social care services:* - Ensure robust engagement with patients, users and the public – see Appendix 1 - Seek to define if there is a substantial or significant change in service – see A2.4.4 Appendix 2 - Consider what further supporting information may be required – see A 2.4.6 - Appendix 2
Initially it should be assumed that any change is significant/substantial	- Early notification to Overview and Scrutiny Committees - Include statement stating whether a change is, or is not considered to be significant or substantial – taking into account A2.4.4-Appendix 2 - Reach agreement with Overview and Scrutiny about whether a change is significant or substantial and the consultation that needs to take place.

Appendix 3

Process for Considering Service Reconfiguration

1. PURPOSE

As leaders of the local NHS, one of the issues the PCT will need to deal with is a range of service reconfigurations, instigated by provider organisations, commissioning plans or other external work or reviews. This paper outlines a process to be used to:

- Assess the impact of the proposed changes in terms of fit with the PCT's strategic direction and process adherence to Darzi and other principles.
- Assess any risk or resources issues arising from the proposed change
- Determine the process and ownership of any consultation necessary to develop and deliver the change.

2. BACKGROUND

There may be a number of reasons for proposals being made for service reconfiguration, including service reviews driven by the PCT as commissioner, reviews driven by health and healthcare providers and issues arising from national (e.g. Department of Health) work. In any instance, the PCT as the commissioner of local health and healthcare, needs a process which ensures understanding of any potential reconfiguration and manages the local health and healthcare system to ensure any changes are congruent with local needs.

3. PROCESS

Appendix 1 is a flow chart of the process to be used. The stages relate to a process advocated in work for the Department of Health by Price Waterhouse Cooper.

3.1 Stage 1 Planning and Needs Assessment

The initial stage will be undertaken as part of developing the case for change. This must include robust stakeholder involvement and will articulate the drivers for change and develop options for delivery.

At this early stage the issue should be shared with overview and scrutiny by the service provider (community services, acute hospitals FT, mental health or ambulance trust) and the PCT to ensure that they are aware of it and, if relevant to them, it can be incorporated within their work plan. Similarly, as part of public, carer and patient involvement, LINKs should be made aware and included in discussions.

The SHA should be alerted to the issue at this early stage by the service provider or PCT. They may decide to log it with the National Reconfiguration Grid. The SHA should inform the PCT that they are aware of the issue, seek PCT views on the issue and indicate if it will be logged or not.

3.2 Stage 2 Pre-consultation

Once developed, the case for change and any proposed consultation will be presented to commissioners, usually through the PCT board.

The case will be assessed:

- In terms of process, for compliance with Darzi principles and particularly *Changes for the Better (DH 2008)* (checklist attached as appendix 2)
- In terms of content, to ensure fit with the strategic direction and plan.

If the case for change is approved, the board will decide who will lead public consultation. In any instance where there is whole systems impact, the PCT as commissioner, will lead on this.

3.3 Stage 3 Consultation

The agreed party will lead on formal consultation, normally for a 13 week period.

3.4 Stage 4 Analysis and Decision

The outcome of consultation and resulting proposals for change will be presented back to commissioners, usually to the board. The proposed change will be considered and either approved or rejected. Where approval is obtained, a detailed implementation plan will be developed and actioned. In giving approval to proceed, the PCT board will be explicit about the nature of approval, e.g. whether this is in principle pending further detailed financial analysis.

3.5 Stage 5 Health Overview & Scrutiny (HOSC) / Joint Overview and Scrutiny Referral (JOSH) if needed.

Formal referral to the OSC is required for any “substantial variation”. While this might occur at this stage, the preferred approach is for continual engagement with them throughout the process. One of the considerations by commissioners at stage 2 will be the degree of engagement that has taken place.

3.6 Independent Review Panel (if needed)

In instances where the OSC disagree with the decision made, this could be referred to the Independent Review Panel.

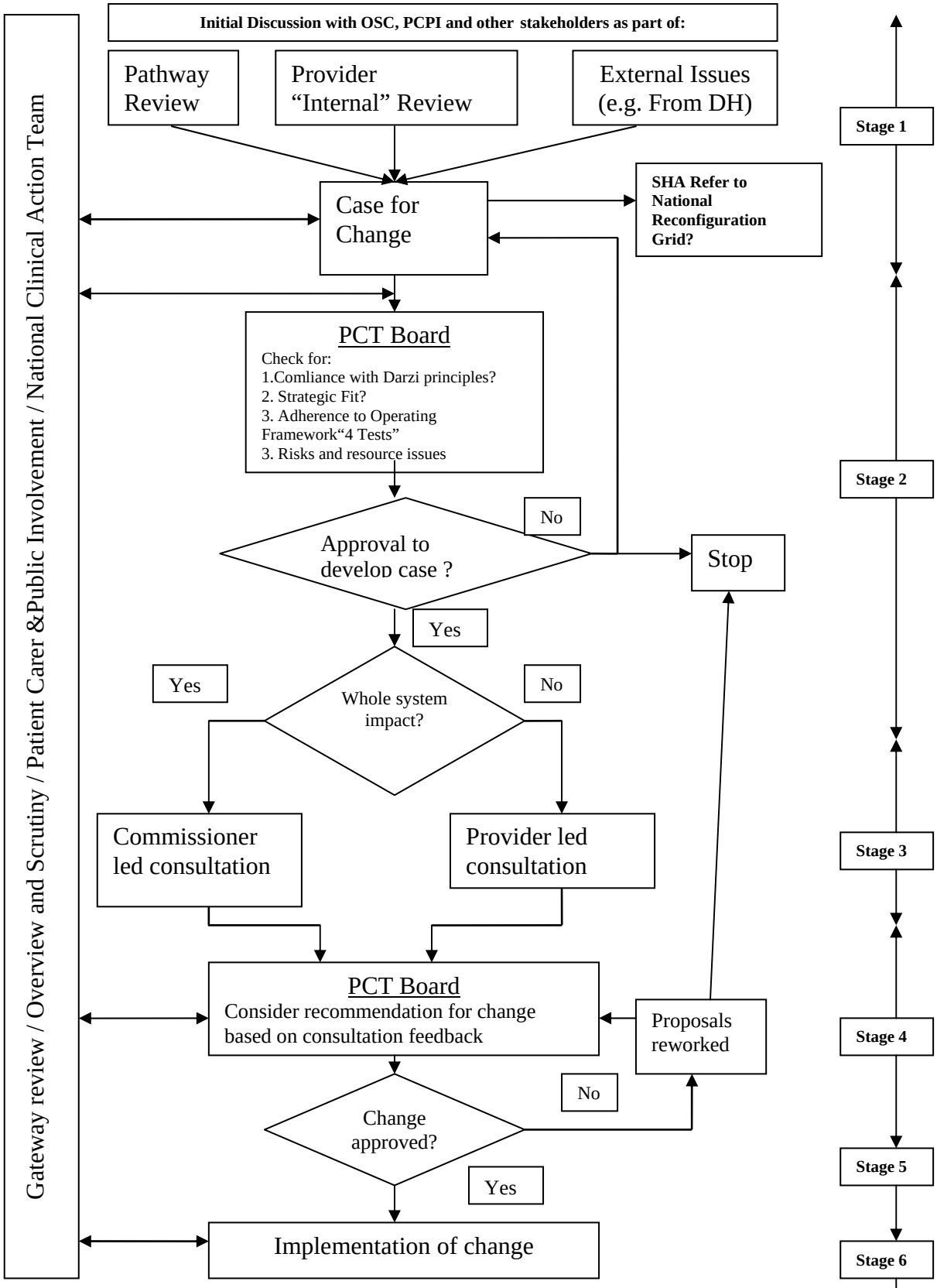
3.7 Gateway Review / National Clinical Action Team

In proposals which suggest the need for significant service reconfiguration, a Gateway Review, review from the National Clinical Action Team, or both may be commissioned. Both provide an external, objective and expert view of the process and possible outcomes, which can, where appropriate, be used throughout the process, but would have particular benefit at stage 1 and 2 and then through into implementation.

3.8 Public, Carer and Patient Involvement

As with OSC engagement, public, carer and patient involvement must be undertaken throughout the whole process and not just through formal consultation. The NHS has a statutory obligation to ensure involvement through the Health and Social Care Act 2001.

APPENDIX 1 - Service Reconfiguration Flow Chart



"Price Waterhouse Cooper Stages"

Stage 1: Planning & Needs Assessment: Stage 2: Pre-consultation Stage 3: Consultation
Stage 4: Analysis and Decision Stage 5: HOSC / JOSC Referral (if needed)
Stage 6: Independent Review Panel (if needed)

Appendix 2

Checklist for Major Service Change Programmes

Checklist	Yes / No	Details / Evidence
Programme Leadership		
Is there a senior clinical lead?		
Is there a senior programme manager?		
Stakeholder Involvement		
Do plans account for the number of people affected?		
Has there been public involvement in generating options?		
Has there been staff involvement in generating options?		
Have patients been involved in generating options?		
Have other stakeholders been involved in generating options?		
Option viability		
Are the options for change clinically viable?		
Do the options for change demonstrate value for money?		
Are any savings generated realistic?		
Are any savings generated achievable?		
Strategic Fit		
Do the options address health inequalities?		
Do the options address		

JSNA issues?		
Do the options address LAA issues?		
Do the options meet PCT commissioning requirements?		
Impact on partners		
Is there any impact on local authority services?		
Is there any impact on other public services?		
Implementation plans		
Are implementation plans realistically achievable?		
Are implementation plans affordable?		
Do implementation plans include clear benefits in terms of improved quality of service?		
Is there a detailed communications plan?		
Is there a clear plan outlining process, key dates, risk management and contingency plans?		
Are there clear and robust governance arrangements in place which outline accountabilities and the decision making process?		