Durham Dales, Easington and Sedgefield Clinical Commissioning Group

APPENDIX 2

Primary Care Service Consultation, Communication and Engagement Plan

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This document can be made available in different languages and formats on request
Please contact the Engagement Team on 0191-3713222

Contents

	health Overview and Scrutiny Committee Appendix 3: Communications plan Appendix 4: Proposed consultation activities Appendix 5: Media handling plan Appendix 6: Consultation communications and engagement action plan Appendix 7 – NHS Assurance Self-Assessment – DDES CCG 5 Tests	

SECTION ONE - CONTEXT

1.1 Introduction

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) is reviewing their primary care, same day need services to ensure patients are treated in the right place at the right time and by the right health care professional wherever possible. The CCG has an overarching Engagement Strategy but it recognises that certain transformation projects require bespoke communications/engagement plans to be in place. The aim of this communications and engagement plan is to inform the development of Primary Care Services in the DDES area that will appropriately meet the needs of the population now and into the future.

The CCG comprises three localities, all with specific and varying needs. DDES is one organisation, but the locality focus has enabled specific input from communities to inform the options that have been designed for the public to consult on. All options can be flexible to meet the needs of each community.

1.2 Background

In spring 2016, DDES CCG undertook a public consultation in relation to urgent care services.

Three options were considered as part of the public consultation as set out below:

	Minor Injury Units	Urgent Care	Out-of-hours services	Existing GP services	Enhanced GP services
Option 1	MI units available 12 hours per day (instead of 24 hours per day)	No Urgent Care Centre in hours	OOH services (out of hours urgent care) remain local 8pm-8am weekdays and 24/7 weekends	GP practices open longer, 8am-8pm weekdays and 8am-1pm Saturday and Sunday (or provided in a hub arrangement)	
Option 2	MI units available 12 hours per day (instead of 24 hours per day)	No Urgent Care Centre in hours	OOH services (out of hours urgent care) remain local 8pm-8am weekdays and 24/7 weekends	GP practices open longer, 8am-8pm weekdays and 8am-1pm Saturday and Sunday (or provided in a hub arrangement)	**Option 1 PLUS** Enhanced GP Service - Urgent care provided from your GP practice or in a hub arrangement 8am–8pm
Option 3	**Option 1 + 2 PLUS** MI units available 24 hours per day	No Urgent Care Centre in hours	OOH services (out of hours urgent care) remain local 8pm-8am weekdays and 24/7 weekends	GP practices open longer, 8am-8pm weekdays and 8am-1pm Saturday and Sunday (or provided in a hub arrangement)	**Option 1 PLUS** Enhanced GP Service - Urgent care provided from your GP practice or in a hub arrangement 8am–8pm

Option three received the most public support and was also supported by the CCG Executive and the Governing Body. As a result the new service model was implemented in April 2017.

During the consultation, the CCG also engaged with the public on the locations of the extended and enhanced GP opening times. As a result nine hubs were developed in the following

locations, with each providing appointments up to 8pm on week nights and 8am -1pm on Saturday and Sunday.

Sedgefield - 6pm - 8pm weekdays and 8am-1pm weekends
Newton Aycliffe – Jubilee Practice
Spennymoor – Spennymoor Health Centre
Sedgefield – Skerne Medical Practice

Dales - 6pm - 8pm weekdays and 8am-1pm weekends
Bishop Auckland – Bishop Auckland Hospital
Upper Dales – Weardale Practice
Lower Dales – Richardson Community Hospital

Easington - 8am - 8pm weekdays and 8am-1pm weekends
Seaham – Seaham Primary Care Centre
Peterlee – Peterlee Health Centre
Easington - Healthworks

There is a high prevalence of long term conditions with a history of poor health outcomes for the population of DDES. The design of any future urgent care service must ensure that we have the best services that enable the best treatment of our patients. We feel that this should start and stay, wherever possible, in primary care where treatment is proactive, holistic, preventative and patient-centred. *We also need to develop services that are financially sustainable*

A key change was that services would be accessible via appointment rather than as a 'walk in' service.

In Sedgefield and Dales, demand for patients that previously attended urgent care centres during weekdays (8am-6pm) would be seen by their GP practice. In Easington, GPs did not feel that they could cope with this additional demand, as services saw an average of 11 patients per practice per day. As a result, three hubs were opened during weekdays from 8am to 8pm to meet the historic demand seen in this area.

1.3 Setting the context of the project

The CCG engages extensively and regularly through Patient Reference Groups (PRGs), Health Networks, Area Action Partnerships (AAPs) and various community groups. The Health and Wellbeing Board and Adults Overview and Scrutiny are also regularly kept up to date. This is important as it engages on its commissioning priorities and the CCG's strong beliefs and commitment to put local communities at the heart of everything they do.

An initial period of pre-engagement was conducted to help the CCG to understand the experience of people using Primary Care Services.

More detailed information about the engagement carried out around Primary Care Services can be found in Appendix one of this document.

These engagement activities helped to inform the development of a number of possible Primary Care Service 'options'. These options are ideas on how services could be further developed or delivered differently to best meet the needs of local people.

Importantly, throughout the pre-engagement, and changes to the models to deliver Primary Care Service, an on-going dialogue was maintained with the local health Overview and Scrutiny Committee (OSC).

In particular, the rationale for the proposed changes to Primary Care Services were presented at a meeting on 6th July 2018, and a full consultation plan (including Communications and Engagement Plan and briefing documents) will be shared and discussed at the OSC meeting on 7th September 2018.

To give some context; during the urgent care consultation the public stated a preference for nine delivery sites. Data would suggest that this has created too much provision across too many sites. The service review as documented in the next section evidences this.

1.4 The case for change

It was agreed that the CCG would report back to the Health Overview and Scrutiny Committee (OSC) six months post implementation (on the original service change) to feedback on the impact of the redesign. This was an opportunity to highlight any issues that have arisen and how the CCG was responding to any issues.

At the six month review stage it was identified that despite a few minor issues relating to signposting from the NHS 111 service in the first weekend, the changes had been made successfully with minimal disruption to the 'system'.

It was also agreed as part of the changes to service made in April 2017 that a review would be carried out once services were embedded. The feedback at the six month point was useful, but it was considered too early at this point to make any changes to services, particularly as the services had not operated during the winter period where demand for urgent appointments can be higher.

It was clear at the six month point that the available capacity was not being fully utilised although the issues were slightly different in each locality. Service providers were highlighting at this point the impact of this in retaining staff, as staff wanted to feel that they were being fully utilised. The low utilisation rates have raised concerns about value for money of the Primary Care Service (PCS).

At the time that the initial service changes were made there was limited information (other than clinical audit) to enable a split between attendances for minor injury and illness. As services are delivered differently now, much more detailed information is available on the true demand for appointments for minor illness during core GP opening hours.

As part of the service changes practices were required to carry out an audit to understand how they were matching capacity to demand and act upon the impact of these findings. A number of practices have changed how they offer access to patients as a result which may also be impacting on demand for PCS.

There have been changes in demand for out of area services. There were changes to services in Hartlepool and Stockton that took place at the same time as the changes in DDES with Urgent Treatment Centres (UTCs) opening at North Tees and Hartlepool Hospitals. Sunderland CCG is currently consulting on changes to the urgent care service they commission that border the DDES area, such as Houghton. Sunderland CCG are proposing to reduce urgent care centres, increase primary care access and to change access arrangements so they are appointment based as opposed to walk in services.

The CCG confirmed its intention to OSC to carry out further engagement with patients to gain insight into the new services to help to identify why services were not being utilised as expected. Feedback has been gathered from patients using PCS and also patients using out of area services. Additional targeted work was carried out with identified patient groups such as the Gypsy Romany Traveller (GRT) community.

The business case covers specific sections in more detail, noting this has already been presented and sets the case for change and evidence to support.

This document will focus on what is next to include all engagement and consultation plans and our key messages

SECTION TWO – PRE ENGAGEMENT

2.1 Aims and methodology

The pre-engagement activity took place over a nine week period from the middle of December 2017 to the end of February 2018. However this is ongoing at the request of the local Overview and Scrutiny Committee.

The aim of the engagement work was to gather the views from patients and carers who accessed the primary care services in the Durham Dales, Easington and Sedgefield CCG area and those who went out of the DDES area into Urgent Care Centres or A&E Departments.

There was a requirement to do some further data analysis and patient engagement to understand whether the way the service is current set up is giving patients the best service. We engaged with patients and stakeholders to find out about their experiences of using the Primary Care Services but also to aim to reach those who have not. If they are not using the PCS, then where are they going? What services are they using?

Stakeholders were also engaged to give them the chance to feed into this process and give them the opportunity to aid in the development of and decisions about new options for service delivery. We wanted to find out what else patients think we should be offering, whether this is, for example: home visits, telephone calls so they can be seen on the same day if they have an urgent need.

The stakeholders we engaged included many of those who were involved in the original Urgent Care consultation. We worked with our Patient Reference Groups (PRGs), Health Networks and other partners who could help us to reach as many potential service users as possible. We also worked with harder to reach groups such as Gypsy Romany Traveller Groups (please see feedback detailed in appendix one), Investing in Children eXtreme Group and also the Young People's Health Group.

All of the pre-engagement activity has been recorded and is shown in the evidence log – see appendix one.

The Engagement Team, supported by the CCG Commissioning Team, attended each Primary Care Service (the nine hubs, three in each locality), and spoke to patients about their experiences of the services and completed questionnaires.

This team worked with staff within the centres to distribute questionnaires over the next four to six weeks to capture a good range of feedback. All questionnaires were put into a sealed envelope by the patient and stored in a confidential box.

The CCG commissioning team collected these periodically and a member of the corporate admin team entered the responses onto survey monkey to remain impartial.

2.2 Who was engaged?

This pre engagement has now been extended and will continue throughout August to give a greater sample size. However, please note this pre-engagement is not the only driver for change, the main driver is from the conclusion of the robust review.

We have extensively engaged the public and patients / carers from a variety of different backgrounds, experiences, groups and communities over the two years of reviewing and implementing new services. We also worked with groups who included those from the nine protected characteristic groups.

We worked with extensively with Clinicians, GP Practices, GP Federations and Commissioners to truly understand the service need the need to change services and their feedback and recommendations are covered in detail in the following section.
We spoke to patients using the primary care services and also those who were accessing care from outside the DDES area, with the aim to find out why they weren't using their local services. In addition to this the Commissioners have been working with the out of hours providers to ensure our patients are redirected back to their own services to support patient education and behavioural change.

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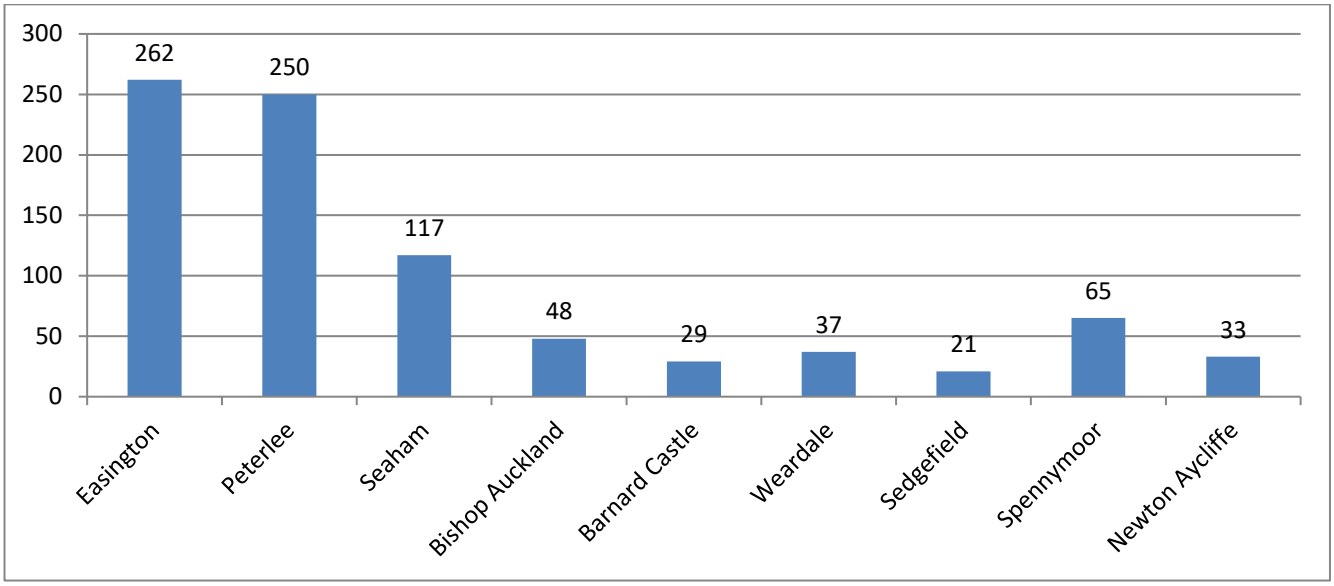
All of the engagement activity has been recorded and is shown in the evidence log, which can be found at appendix one.

2.3 Summary of key findings

Summary of key findings from the survey results around the service model. Over 862 patients from across the Durham Dales, Easington and Sedgefield (DDES) CCG were engaged over the period; the responses were recorded through an on line survey.

The sites which received the most patient feedback were Easington with 30% and Peterlee with 29% of the 862 patients who completed a survey.

The actual number of surveys returned from each hub site is detailed below; this will be update as new feedback is received.


300
250
200
150
100
50
0
262
250
117
48
29
37
21
65
33
Easington
Peterlee
Seaham
Bishop Auckland
Barnard Castle
Weardale
Sedgefield
Spennymoor
Newton Aycliffe

SECTION 3 CONSULTATION

3.1 Options Development

Following the review of Primary Care Services, the next stage was to develop some options that would address all of the concerns and issues raised from the finding.

This process was robust and included the input from the Director of Commissioning, Commissioning Managers, a lead clinician/GP from every GP practice across DDES, every Practice Manager and our patient reference groups across all localities, this includes our Locality Clinical Chairs, Rushi Mudalagiri, Dilys Waller and Winny Jose.

A business case paper was prepared on the options for the service review and potential changes were presented to the DDES CCG Confidential Executive Meeting. The Executive Team who supported the commissioners to move to the next stage. The next stage was to engage with the practices and our patients groups initially.

To aid the discussion, the Commissioning Team put forward a range of potential options to the Primary Care Home (PCH) GP Practice Groups in April, however it was highlighted these were not exhaustive. The Clinical Chairs led on this piece of work and facilitated the session with their own locality practices, to ensure recommendations were built on clinical need.

The Primary Care Home membership consists of one GP lead from each practice and their practice manager. These members are at the meetings representing their GP practice, partners and their own registered patients.

These potential options were discussed and included the following:

Options appraisal (Durham Dales used as an example)

Option	Advantages	Disadvantages
1. No changes to current service delivery	• Maintains status quo • Provides access equally across the area • Public support for services in rural areas	• Poor value for money • Staff morale and retention issues • Unable to have a GP on all sites due to availability/funding Public perception of value for money of service
2. Reduce to two sites (Bishop Auckland and one rural site)	• Provides more access in the rural areas • Public support for services in rural areas	• Poor value for money • Staff morale and retention issues • Unable to have a GP on all sites due to availability/funding • Public perception of value for money of services • Difficulty identifying the rural site due to geography
3. Reduce to one site (Bishop Auckland)	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Close to MIU and out of hours	• Distance to travel for rural patients • Difficulties with access for frail/house bound patients • Patient perception of loss of services in rural areas

	service • Provides value for money	
4. Reduce to one site (Bishop Auckland), but change/extend weekend opening hours	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Close to MIU and out of hours service • Offers more patient choice	• Distance to travel for rural patients • Difficulties with access for frail/house bound patients • Patient perception of loss of services in rural areas • Duplication of service with the • Urgent Treatment Centre/Out of • Hours service
5. Reduce to one site (Bishop Auckland) with outreach services for frail/housebound patients	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Improves access for housebound patients, but is more value for money • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Close to MIU and out of hours service • Provides value for money	• Distance to travel for non- house • bound rural patients • Patient perception of loss of • services in rural areas

We agreed some ground rules with the group which included:

- Not to think about or talk about money
- Not to think about current providers of services
- Start with a blank piece of paper and discuss what is now needed

We shared the 'must do's' that we are mandated to provide

An output of this service is it needs to provide GP Access, we must provide 45 minutes per 1000 patient population of extended GP/Clinical appointments, this equates to 217 hours required in additional capacity to meet the target across the full DDES area.

We also need to ensure:

- We provide planned and unplanned appointments for patients
- We meet the public's/ patient's needs around access
- We provide a service that supports the Urgent Treatment Centres (UTCs) standards.

We shared the activity per site

We shared the outcome of the engagement report for each locality specifically.
The aim was to get some options from the locality and for the CCG to record the outcomes/options agreed. This took place and encouraged some healthy debate and discussion and an outcome was put forward to the CCG on the preferred option.

As a backup and to absolutely ensure we captured all practices views. We then followed up the meeting with a practice questionnaire to ensure each practice had a voice and that and shared their view. This was sent out and collated via email communications. This included the key

questions around, how many hubs do we need to serve your locality? Where should these hubs be? What else do we need to consider moving forward with the recommendation?

The next step was for the CCG to present back at the next Primary Care Home (PCH) meeting what the practices had requested, this took place at the May PCH meeting and was agreed/ signed off this then gave the commissioner the mandate to work up and move forward with the recommendation.

In summary

- DDES executive committee have supported the model
- GP leads and clinicians from 41 GP practices have worked on the options to develop the recommendation
- Patient reference group members have supported the piece of work
- Locality and PCH Clinical leads have agreed the model.

3.2 Recommended options

Durham Dales recommendation

Recommendation	Positive impact	Potential negative impact
Reduce to one site (Bishop Auckland) with outreach services for frail/housebound patients including home visits and pre bookable appointments	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Improves access for housebound patients, but is more value for money • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Close to MIU and out of hours service • Provides value for money • Provides a pre bookable appointment system • Use of patient transport could be developed	• Distance to travel for non-house bound rural patients • Patient perception of loss of services in rural areas

Outcomes locality specific - Durham Dales

- From the information gathered via the surveys, Bishop Auckland is the busiest site with the majority of people attending on a weekend.
- The main reasons people attended was they felt they got a better service/it was easier to get an appointment, they couldn't get a GP appointment or the practice was closed. This was not unexpected as the additional service covered the period when their practice is usually closed.
- The majority of patients got an appointment via NHS 111 and had a positive experience of the service.
- Most people would be prepared to travel around 10-15 miles to a PCS service.
- The majority found that the current opening times are convenient and didn't think the service could be improved.

Activity

Averages

Per weekday 8-6pm - 0.4

Per weekday evenings 6pm-8pm - 6.4

Weekend / bank holiday 8am-1pm - 57 per weekend

Average activity Per site

Locality of site	Site	Weekday 8am – 6pm	Weekday 6pm – 8pm	Weekends / bank holidays
Durham Dales	RCH	0.01	0.6	7
	SVMC / BAGH	0.2	4.5	33
	Weardale Practice	0.0	0.4	6
	Site unknown	0.1	1	11

Sedgefield recommendation

Recommendation	**Positive impact**	**Potential negative impact**
Reduce to two sites (Spennymoor and Newton Aycliffe) during weekday evening and retain three sites at weekends, provide pre bookable appointments and offer an outreach provision	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Offers more patient choice • Provide booked appointments • Provides value for money • Offers local capacity at weekends and an alternative to hospital based services • Provides a pre bookable appointment system • Use of patient transport could be developed	• Patient perception of loss of services in a certain town or building • Distance to travel for non- house bound patients

Outcomes locality specific - Sedgefield

- Spennymoor had the highest return of surveys, with the majority of people attending after 6pm and on a weekend.
- The main reasons why patients attended was because they couldn't get an appointment with their GP / or their GP practice was closed again this is when the service is provided outside of GP practice opening times.
- The majority of patients got an appointment via NHS 111 and said their experience of the service was good or great.
- When asked about their opinion on changing the number of sites, 45% of those said that they would be happy with change as long it was somewhere convenient. 88% of patients stated they would travel 5+ miles to a PCS service, with 55% of those happy to travel 10+ miles.
- 92% of patients felt that the current opening times are convenient.
- The majority of respondents did not think there was a better way to deliver PCS

Activity

Averages

Per weekday 8-6pm - 1.2
Per weekday evenings 6pm-8pm - 6
Weekend / bank holiday 8am-1pm - 75 per weekend

Average Activity per site

Locality of site	Site	Weekday 8am – 6pm	Weekday 6pm – 8pm	Weekends / bank holidays
Sedgfield	Newton Aycliffe	0.9	3	30
	Sedgefield	0.1	0.8	14.5
	Spennymoor	0.1	2.4	26
	Site unknown	0.1	0.1	6

Easington recommendation

Recommendation	Positive impact	Potential negative impact
Reduce to two sites on a weekend (8am – 1pm) and one site during the week (12 noon – 8pm), to act as an overflow to GP Practices through the week. So if the GP Practice has no appointments then they will book patients into this service acting as an overflow. This service will provide outreach / home visiting additional service across the full locality, based on the outcome of the consultation.	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Geographically close to MIU and out of hours service • Provides value for money • Provides access for frail and house bound pts • Provides a home visiting element • Provides a backup service for general practice • Provides a pre bookable appointment system until 8pm on an evening and on weekends • Use of patient transport could be developed	• Public perception of value for money of services • Public perception of the loss of service in their own area • Travel time to hubs

Activity

Averages
Weekday 8-6pm – **34**
Weekday evenings 6pm-8pm- **14**
Weekend / bank holiday 8am-1pm - **97** per weekend

Average activity per site

Locality of site	Site	Weekday 8am – 6pm	Weekday 6pm – 8pm	Weekends / bank holidays
Easington	Healthworks	10	4	33
	Peterlee Health Centre	19	7	43
	Seaham Primary Care Centre	5	3	21
	Site unknown	0	0	0

Easington practices will start to take all same day access activity however provide an additional overflow service for weekday activity via one central hub operating from 12 noon until 8pm (the town with the highest demand and transport links would be suggested). This reflects the fact that there has always been greater provision and therefore higher activity in the Easington area.

We recommend the overflow will cover all weekday evening activity and provide a service on a weekend and bank holidays; all services should be available to NHS 111 to book in direct appointments. In addition the service should provide an outreach service for housebound patients, those most vulnerable including home visiting and access for those in other towns that currently have a service.

We recommend one overflow hub is in place during weekdays (12pm – 8pm) and two hubs are in place during weekends/bank holidays. It is also recommended that Further engagement is done with Easington practices and patients to understand any further outreach arrangements required.

The CCG would also recommend that all localities include some pre booked capacity to meet the GP access standards and provides at least the minimum level of access based on the standards. We would also promote the use of our transport facilities more widely to patients and the practices to ensure that patients can access centralised services.

It is proposed that a 6-8 week consultation is undertaken with patients/public/stakeholders and that this covers the whole DDES population, but focusses on the areas where change is proposed.

Outcomes locality specific – Easington

- From the information gathered via the surveys, Peterlee was the busiest site with the majority of people attending between 8am and 6pm.
- The main reasons why patients attended was because they couldn't get an appointment with their GP or it was out of hours which is how this service was set up in Easington
- The majority of patients received an appointment via NHS 111 and had a positive experience of the service.
- When asked about their opinion on the sites, 41% of those that commented said they would be happy with change.
- The majority of people said that the current opening times were and convenient and they would be prepared to travel around 5-15 miles to a PCS service, with Seaham patients less willing to travel.

3.3 Consultation messages and questions

Messages

- On the 1st April 2017 DDES CCG implemented an extension of Primary Care Services based on clinical opinion and the views of the local population following a robust period of consultation. At this time there was an acknowledgment that the provision put in place was over and above the optimum level required. However it was agreed to implement and review during the subsequent six to 12 months. This was agreed by DDES Executive and OSC.
- The review of the provision currently in place has determined that services are not being fully utilised as well as they could be and in effect we are currently commissioning too much activity. DDES CCG have used robust data to evidence under utilisation but have also conducted a period of pre engagement with people who attend Primary Care Services as well as those who attend A&E and Primary Care Centres..
- Pre-engagement took place over a nine week period from December 2017 until the end of February 2018. However noting that this has been extended
- The information gathered has informed the development of a recommended service model for each locality
- Durham Dales will reduced to one site based at Bishop Auckland with outreach services for frail / house bound patients including home visits and pre-bookable appointments
- Sedgefield will reduced to two sites based at Spennymoor and Newton Aycliffe during weekday evening and retain three sites at weekends. The model will enable pre bookable appointments as well as outreach provision
- Easington will reduce to two sites on a weekend based in Peterlee and Seaham and one overflow at Peterlee throughout the week from 12 – 8pm with additional capacity and services created to include a same day and pre bookable appointment system. The model will also provide outreach service/ home visiting and anything else that is highlighted as needed as a result of the consultation process if appropriate to serve the whole of the Easington locality. We want to know where this service should be based to provide service to the Easington locality equitably and is there anything that we have missed? The above recommendation was made based on data and intelligence and would suggest the most suitable/ central and equitable option for patients and will support the best use of public money.

  DDES CCG would like to communicate to its local population the new times and locations of the primary care services model.

  DDES CCG would like to consult on the further services which may be delivered as part of this new provision and ensure equitable access to the patients across the localities.

Questions we will ask are:

- Do you understand why we are proposing the changes in your locality?
- Would these changes still allow you to have timely and convenient access for booked and same day appointments albeit, from a different location in some instances? (this depends on your clinical need)

- Do you have any suggestions that could enhance these proposals for you?

“The Four Tests” – NHS Mandate 2013-15 (carried forward through NHS Mandate 2015-16)

NHS England expects ALL service change proposals to comply with the Department of Health’s four tests for service change (referenced in the NHS Mandate Para 3.4 and ‘Putting Patients First’) throughout the pre-consultation, consultation and post-consultation phases of a service change programme.

The four tests are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners.

As a proposal is developed and refined commissioners should ensure it undergoes a rigorous self-assessment against the four tests. This has already been developed in partnership with NHS England and is attached in Appendix 7.

3.4 Consultation activity

Appendix six provides further details on the CCG's planned communications and engagement /consultation activities.

3.5 Stakeholders

A stakeholder is anyone who is effected by or can affect, the project. The CCG needs the right information to inform decisions for its community. It continually strives to maintain and strengthen its strong working relationships with its stakeholders.

In order to establish the most appropriate means of communicating with our stakeholders, further analysis is required to better understand each one in terms of:

- Their level of influence over the project
- The impact of the project on them

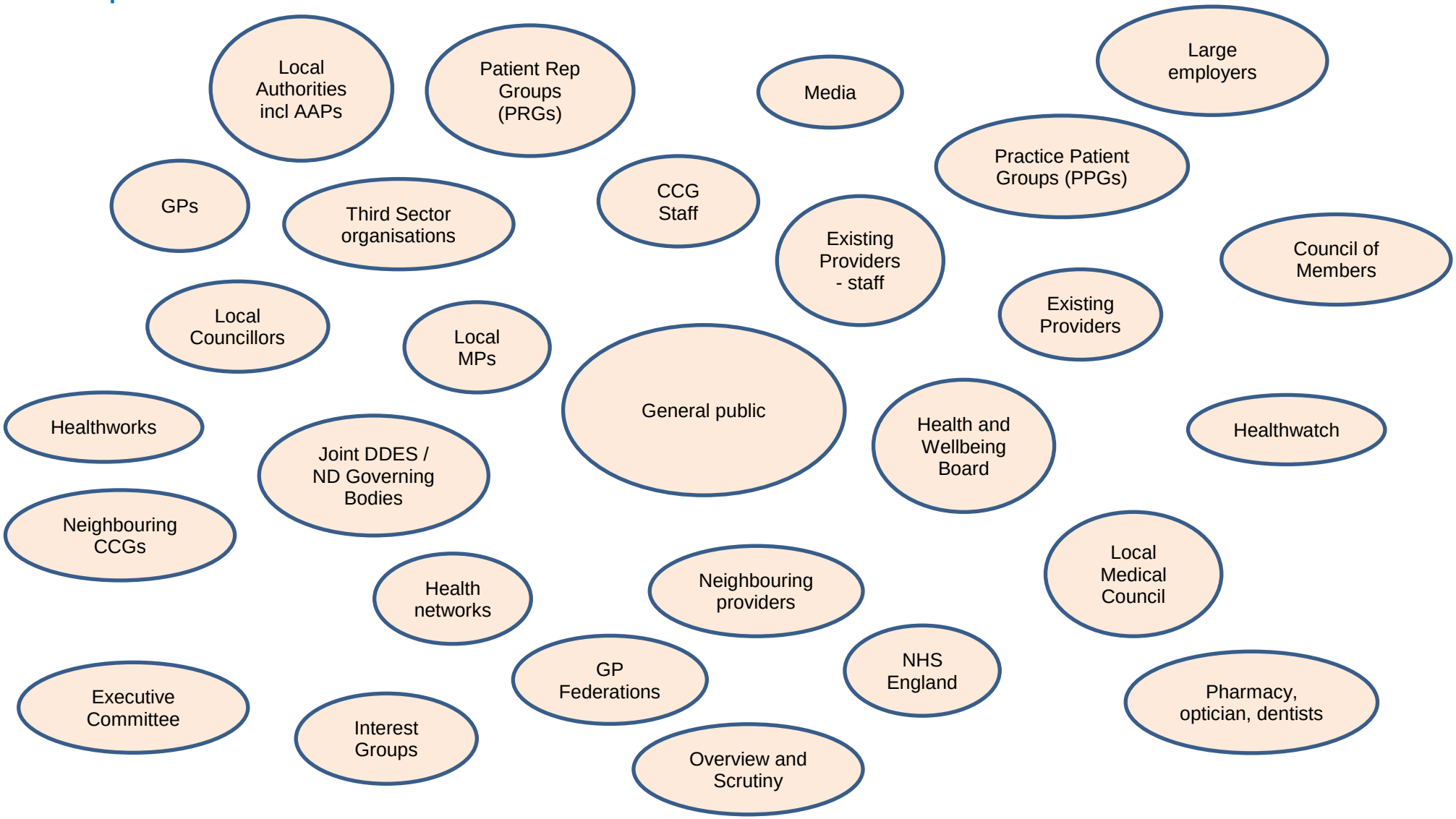
This enables the CCG to formulate a bespoke communications plan based on influence and impact, increasing the chances of the communications and engagement plan being successful.

The communications engagement process will also includes a focus on disadvantaged, marginalised and minority groups and communities, who may not always have the opportunity to have their say in decisions that affect them. This is particularly important in the DDES area due to high levels of deprivation and health inequalities, as well as the diverse make-up of the local population. The engagement team will work to establish links with these groups.

Healtwatch and Patient Reference Groups (PRGs) are onboard with this work and will support the CCG with the communications and consultation work to ensure that we simplify messages and don't use jargon and to act as critical friends throughout the process.

A stakeholder map is shown on the next page.

Stakeholder Map



3.6 Consultation briefing document

A consultation narrative document will be developed, that will detail:

- The background to the consultation
- The case for change
- The options for change
- Feedback from the public
- The rationale for the options
- How people can participate in the consultation and give their views e.g. by attending public meetings, via e-mail or via the CCG's website

Those engaged throughout the consultation dialogue period will be from a variety of backgrounds, and will have different experiences, skills and needs. For this reason, the consultation documents will be made available with different levels of detail and in different languages and formats as required. A discussion pack will be compiled to provide key messages and information to local communities in an easily digestible format. This will include the briefing document (which can be tailored according to particular audiences) and a brief, introductory video providing a context to local health services. All of this information will be available on a dedicated section of the CCG's website and will be promoted via social media channels such as Facebook, Twitter and YouTube.

Support will be offered to those who need it to ensure that they are able to understand the information contained within this document, and to ensure that all participants have enough information to give informed consideration to the options contained within the consultation narrative.

3.7 Standard formats of information

All information produced as part of the consultation will be written in language that can be understood by members of the public. Technical phrases and acronyms will be avoided, and information will be produced in other formats as required, to reflect the needs of the diverse DDES population. This may include, but is not limited to:

- Large print
- Audio
- Braille
- Different languages
- Computer disk
- Interpreters at public events
- Short animations

Suppliers will be identified as part of the development work to provide these formats of information when they are required.

3.8 Documentation and resources

Development work will include consideration of required documentation and resources. This will include, but is not limited to:

- Consultation briefing documents and questionnaires
- Posters
- Video?
- Website
- Flyers
- Leaflets (including leaflet drop)
- Stand-up banners
- Venues for public events

3.9 Generic CCG Communications and engagement objectives

Regular and consistent communications and engagement is crucial in ensuring that the CCG commissions services that are of good quality, value for money and meet the needs of local people.

For this Primary Care Service consultation, the communications and engagement objectives reflect those described in the DDES CCG Communications Strategy and the DDES CCG Engagement Strategy 2016-2018:

- Communicating clearly, effectively and honestly with local communities in order to build trust and confidence in the NHS and health professionals;
- Engaging effectively with every segment of the population in order to ensure that local people are given the opportunity to consider and comment on the options for new models of Primary Care Service in the DDES area;
- Using the comments and feedback from the local communities to inform consideration by the CCG as to how it should provide Primary Care Service to best meet the needs of the population of the DDES area;
- Inform CCG commissioning responsibilities in relation to, and the procurement of, Primary Care Services.
- Ensuring that the CCG is complying with all its legal obligations in relation to public consultations and engagement (see section 13 of this report for further details of these specific requirements).

Primary Care Services Communications and Engagement Objectives

- To communicate the recommended service model for each locality clearly and effectively with all identified stakeholders
- To consult the local population on the development of further services to be delivered as part of the provision outlined as part of the process
- To ensure that all voices are heard and that views are used to inform future service delivery
- To ensure messages from the local community are heard and used to inform decision making. Feedback will be given in a timely manner based on the ‘you said, we did’ methodology.

3.10 Risks and Mitigation

Risk and risk mitigation will be managed by the Primary Care Service task and finish group, Risks will be identified and regularly reviewed and assessed throughout the consultation development and implementation.

Risk	Mitigation
Failure to engage with relevant stakeholders and meet statutory duties / stakeholders feel they have not been fully involved	Communications engagement plan developed identifying stakeholders and partners with detailed communications activity, Ensure all stakeholders receive appropriate updates and feedback Ensure appropriate stakeholders are invited to participate in a way that is accessible to them Ensure clear communications of messages through robust communications plan, including updates on CCG website, newsletters, bulletins and through MY NHS
CCG does not engage with marginalised, disadvantaged and protected groups	Communications and Engagement plan identifies relevant groups and organisations Also work with local voluntary sector groups, community organisations and partners to access these groups and communities Targeted engagement will be undertaken where necessary e.g. potential risk was highlighted through the pre-engagement with patients from the Gypsy Roma and Traveller Communities and other BME communities in

	the area. Proposed changes to the Primary Care Service could result in these groups attending A&E if they are not aware of changes to the services.
Lack of response / “buy in”	Ensure adequate publicity and support
Accessibility of activities and appropriate feedback mechanisms to those taking part	Ensure clear contact for translations or alternative format Include appropriate feedback mechanisms in plan that are accessible to people with varying needs and abilities
Managing expectations of members of the pubic	Ensure adherence to communications plan and advise CCG of any issues
The consultation and options may be perceived by members of the public as a “cost cutting” exercise	Ensure clear rational for change is communicated within the consultation briefing document
The consultation may be subject to challenge	Appropriate governance policies/standards will be put in place to ensure correct procedure and equality analysis are maintained throughout the consultation

3.11 Legal

CCG's in England are required to ensure that they meet their legal obligations in relation to public consultations. These legal requirements are varied and are summarised by source below:

NHS Act 2006 (As Amended by Health and Social Care Act 2012)

The NHS Act 2006 (including as amended by the Health and Social Care Act 2012) sets out the range of general duties on clinical commissioning groups and NHS England.
Commissioners' general duties are largely set out at s13C to s13Q and s14P to s14Z2 of the NHS Act 2006, and also s116B of the Local Government and Public Involvement in Health Act 2007:

- Duty to promote the NHS Constitution (13C and 14P)
- Quality (13E and 14R)
- Inequality (13G and 14T)
- Promotion of patient choice (13I and 14V)
- Promotion of integration ((13K and 14Z1)
- Public involvement (13Q and 14Z2)
    - Under S14Z2 NHS Act 2006 (as amended by the Health and Social Care Act 2012) the CCG has a duty, for health services that it commissions, to make arrangements to ensure that users of these health services are involved at the different stages of the commissioning process including:
        - In planning commissioning arrangements
        - In the development and consideration of proposals for changes to services
        - In decisions which would have an impact on the way in which services are delivered or the range of services available; and
        - In decisions affecting the operation of commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

S.244 NHS Act 2006 (as amended)

The Act also updates s244 of the consolidated NHS Act 2006, which requires NHS organisations to consult relevant Local Authority Overview and Scrutiny Committees on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

S.149 Equality Act 2010

(1)A public authority must, in the exercise of its functions, have due regard to the need to—
(a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
(b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
(2) A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).
(3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
(a) Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
(b) Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
(c) Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
(4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.
(5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
(a) Tackle prejudice, and
(b) Promote understanding.
(6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.
(7) The relevant protected characteristics are—

- Age

- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation.

S.3a NHS Constitution

The NHS Constitution sets out a number of rights and pledges to patients. In the context of this project, the following are particularly relevant:
Right: You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, 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.

Pledge: The NHS commits to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services.
(Section 3a of the NHS Constitution)

S.82 NHS Act 2006 - Co-operation between NHS bodies and local authorities

In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

Mental Capacity Act 2005

The MCA says:

- Everyone has the right to make his or her own decisions. Health and care professionals should always assume an individual has the capacity to make a decision themselves, unless it is proved otherwise through a capacity assessment.
- Individuals must be given help to make a decision themselves. This might include, for example, providing the person with information in a format that is easier for them to understand.
- Just because someone makes what those caring for them consider to be an "unwise" decision, they should not be treated as lacking the capacity to make that decision. Everyone has the right to make their own life choices, where they have the capacity to do so.
- Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The principles:

(1) The following principles apply for the purposes of this Act.
(2) A person must be assumed to have capacity unless it is established that he lacks capacity.
(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Human Rights Act 1998

The Human Rights Act places an obligation on public bodies such as local authorities and NHS bodies to work in accordance with the rights set out under the European Convention on Human Rights (‘ECHR’). This means that individuals working for public authorities, whether in the delivery or services to the public or devising policies and procedures, must ensure that they take the ECHR into account when carrying out their day to day work.

The Gunning Principles

R v London Borough of Brent ex parte Gunning [1985] proposed a set of consultation principles that were later confirmed by the Court of Appeal in 2001.

The Gunning principles are now applicable to all public consultations that take place in the UK. Failure to adhere to the Gunning principles may underpin a challenge relating to consultation process that may be considered through judicial review.

The principles are as follows:

1. When proposals are still at a formative stage
Public bodies need to have an open mind during a consultation and not already made the decision, but have some ideas about the proposals.

2. Sufficient reasons for proposals to permit 'intelligent consideration'
People involved in the consultation need to have enough information to make an intelligent choice and input into the process. Equality Assessments should take place at the beginning of the consultation and be published alongside the document.

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

4. Must be conscientiously taken into account
Decision-makers must take consultation responses into account to inform decision-making. The way in which this is done should also be recorded to evidence that conscientious consideration has taken place.

"The Four Tests" – NHS Mandate 2013-15 (carried forward through NHS Mandate 2015-16)

NHS England expects ALL service change proposals to comply with the Department of Health's four tests for service change (referenced in the NHS Mandate Para 3.4 and 'Putting Patients First') throughout the pre-consultation, consultation and post-consultation phases of a service change programme.

The four tests are:

- Strong public and patient engagement

- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners.

As a proposal is developed and refined commissioners should ensure it undergoes a rigorous self-assessment against the four tests. This has already been developed in partnership with NHS England.

Planning, Assuring and Delivering Service Change for Patients – NHS England Guidance

Guidance from NHS England sets out the required assurance process that commissioners should follow when conducting service configuration.

Section 4.4 of the guidance refers to involvement of patients and the public, stating that "*it is critical that patients and the public are involved throughout the development, planning and decision making of proposals for service reconfiguration. Early involvement with the diverse communities, local Healthwatch organisations, and the local voluntary sector is essential… Early involvement will give early warning of issues likely to raise concerns in local communities and give commissioners time to work on the best solutions to meet those needs."*

Transforming Participation in Health and Care – NHS England Guidance

Transforming Participation contains guidance from NHS England to help commissioners to involve patients and carers in decisions relating to care and treatment and the public in commissioning processes and decisions.

Equality Analysis

The CCG has a duty to meet its public sector equality duty, as defined by S.149 of the Equality Act 2010. The CCG's Business Case for Primary Care Services sets out our Equality Impact Analysis and provides further information.

In summary, in the exercise of its functions, the CCG must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not

- Foster good relations between people who share a protected characteristic and those who do not

Targeted engagement has ensured that people from all groups with protected characteristics, defined within the Equalities Act (see 6.3 above), have had the opportunity to participate in the three phases of pre-engagement and the development of potential new Primary Care Service models.

To ensure that the CCG is fully meeting this duty, an equalities analysis has also been undertaken and is in the process of being validated and further informed through continuing engagement.

The equality analysis has considered potential impacts that any change to the extended Primary Care Services may have on people from groups with protected characteristics.

To validate these perceived impacts, people from these groups have been engaged and asked about their perception of how any change to service might have an impact on them, whether this be positive or negative.

The equalities analysis will be reviewed throughout the consultation process, and additional engagement will be conducted around this as required.

3.12 Data analysis

The consultation activity will result in a number of streams of quantitative and qualitative data. Due to the size and nature of the consultation, it is anticipated that the amount of data will be significant.

As the data and feedback from the public will inform the decision-making of the CCG in relation to potential changes and developments to the extended Primary Care Services, it is essential that the data and feedback is subject to robust, independent analysis.

We will be working with Healthwatch to oversee and approve our process however, in order to ensure that all public money goes into NHS services. The CCG Team will analyse the outcome and provide a report linking to the services evaluation.

3.13 Reporting and feedback

The consultation feedback will be received and reviewed by the CCG before any final decisions are made about future services. It is anticipated that the consultation feedback will enable the CCG to make informed decisions about commissioning services that reflect public need.

Following a period of consideration, the CCG will then make a decision on any changes to extended Primary Care Services. This decision will be published and communicated to stakeholders, along with the rationale for making that decision and the reasons that other options were not taken forward.

This will be assured and signed off by NHS England.

Evaluation will be on-going throughout the consultation period and beyond, overseen by the Primary Care Service Task and Finish Group.

Once the consultation has closed, a full evaluation of the consultation, including development and implementation, will be conducted.