

Public Involvement Toolkit

Welcome and meet the team

Welcome to the NHS Sheffield CCG's Public Involvement toolkit

This toolkit is a practical resource to help you understand the legal duties around public involvement and equality, and develop clear, effective involvement activity with the public and other stakeholders.

It is aimed to support people who are new to public involvement but also to improve knowledge and skills of people with more experience.

The Toolkit will help you to consider all the key stages of planning and undertaking activities, with advice on best approaches and techniques depending on the type of work you are undertaking.

The engagement team are available to support staff.

You can contact the team on the details below:

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We are based at NHS Sheffield CCG, 722 Prince of Wales Road

What support can we offer?

The engagement team provide guidance, support and advice that all staff can use to help with involving the public in their work. This ranges from identifying the proportionate level of need to involve the public, to planning and undertaking public involvement activity. We are here to advise, offer suggestions of best practice and maintain an overview of involvement work happening across the organisation.

They can help you:

- Create an involvement plan
- Plan appropriate methods of involvement activity
- Identify key stakeholders
- By providing community insight from previous involvement activity
- By advising on completing an equality impact assessment

What is involvement and consultation?

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

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

Both involvement and consultation involve:

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

Why involve patients and the public?

There are many reasons for involving patients, users, carers, communities and the public including:

Because we have to

There are a number of pieces of legislation that support the implementation of public involvement, in particular, The Health & Social Care Act of 2012. This placed duties on Clinical Commissioning Groups (CCGs) and NHS England to promote the involvement of patients and carers in decisions which relate to their care or treatment. The Act also places a requirement on CCGs to ensure public involvement and consultation in commissioning processes and decisions.

The NHS Standard Contract, that is applicable to any provider of NHS services, also states that providers must actively involve the public and involve them in service redesign and implementation of new developments.

The evidence is that it makes interventions more effective and efficient

There is increasing evidence that patients who are involved in making decisions about their own condition show faster rates of recovery. It has also been shown that involving people in all aspects of the development and provision of health services makes it more effective and makes sure that services are designed to fit around the requirements of patients and their carers.

Because it is the right thing to do

It is increasingly recognised that it is ethical to involve patients and their carers in any decision that affects their health care. Involving the public at all levels of health helps to create a culture of openness and transparency.

Increases a sense of wellbeing amongst the public

Involving people can make a contribution to the general wellbeing of society. Carers and families who are closely involved in sharing the management of a health condition have a greater understanding of the issues and the choices available and as a result are less stressed.

Volunteering generally has been found to be beneficial to general sense of well-being. The social nature of the activity and the sense of contributing altruistically to the greater good of society helps to alleviate loneliness and develop a stronger feeling of usefulness. Those who are involved in the health sector as volunteers or as public contributors also benefit and report an increased sense of wellbeing.

Health services that meet the needs of the public

A public that is involved at all stages of design and implementation are more likely to understand the restraints on the provision of healthcare. The NHS Long Term Plan aims to establish a culture of greater control for patients over their own health. This can only be done if there is a culture of involvement and inclusivity.

Other benefits of involvement and consultation for the CCG include:

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

- Increasing public awareness and education about NHS services

Patient and Public Involvement Legislation

NHS clinical commissioning groups have a legal duty¹ to involve patients and the public (by means of “providing information, consultation, or in other ways”) in:

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



NHS England Guidance²

- NHS England has a remit to assure CCGs against their statutory duties and other responsibilities under the CCG Assurance Framework. It has a role to both support and assure the development of proposals by commissioners
- Where substantial development or variation changes are proposed to NHS services, there is a separate requirement to consult the local authority³. This is in addition to the duties on commissioners for involvement and consultation. It is a local authority which can trigger a referral to the Secretary of State for Health and the Independent Reconfiguration Panel
- There is no legal definition of ‘substantial development or variation’ and for any particular proposed service change commissioners and providers should seek to reach agreement with the local authority on whether the duty is triggered. Regular local authority involvement should continue through the lifecycle of service change
- Service reconfiguration and service decommissioning are types of service change
- Change of site from which services are delivered, even with no changes to the services provided, would normally be a substantial change and would therefore require consultation with the local authority and public
- All service change should be assured against the government’s five tests:
 - Strong public and patient involvement
 - Consistency with current and prospective need for patient choice
 - A clear, clinical evidence base
 - Support for proposals from clinical commissioners
 - Where appropriate, service change which proposes plans significantly to reduce hospital bed numbers should meet NHS England’s test for proposed bed closures

¹ <https://www.legislation.gov.uk/ukpga/2006/41/section/14Z2>

² <https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>

³ <https://www.legislation.gov.uk/ukpga/2006/41/section/244>

Gunning principles

The Gunning principles are a set of fundamental consultation principles that have been confirmed as applicable to all public consultations by the Court of Appeal and must underpin every public consultation that takes place in the UK.

The Gunning principles are that:

Consultation must take place when the proposal is still at a formative stage: Decision-makers cannot consult on a decision that has already been made. If the outcome has been pre-determined, the consultation is not only unfair, but it is also pointless.

This principle does not mean that the decision-maker has to consult on all possible options of achieving a particular objective. A decision-maker can consult on a 'preferred option', and even a 'decision in principle', so long as its mind is genuinely open - *'to have an open mind does not mean an empty mind.'*

If a decision-maker has formed a provisional view as to the course to be adopted, or is 'minded' to take a particular course subject to the outcome of consultations, those being consulted should be informed of this *'so as to better focus their responses'*.

Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response: Consultees should be made aware of the basis on which a proposal for consultation has been considered and will thereafter be considered. Those consulted should be aware of the criteria that will be applied when considering proposals and what factors will be considered 'decisive' or 'of substantial importance' at the end of the process.

Adequate time must be given for consideration and response: Unless statutory time requirements are prescribed, there is no necessary time frame within which the consultation must take place. The decision-maker may adopt a policy as to the necessary time-frame (e.g. Cabinet Office guidance, or compact with the voluntary sector), and if it wishes to depart from that policy it should have a good reason for doing so. Otherwise, it may be guilty of a breach of a legitimate expectation that the policy will be adhered to.

The product of consultation must be conscientiously taken into account: If the decision-maker does not properly consider the material produced by the consultation, then it can be accused of having made up its mind; or of failing to take into account a relevant consideration.

Section 244 – Consulting with the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Where substantial development or variation changes are proposed to NHS services, there is a separate requirement to consult the local authority under the Local Authority made under section 244 of the NHS Act 2006. This is in addition to the duties on commissioners and providers for

involvement and consultation set out above and it is a local authority which can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel.

[Details about Sheffield's Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee can be found here.](#)

There is no legal definition of 'substantial development or variation' and for any particular proposed service change we should work with Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee to determine whether the change proposed is substantial.

Public consultation is usually required when the requirement to consult a local authority is triggered under the section 244 regulations because the proposal under consideration would involve a substantial change to NHS services.

Terminology

The words associated with public involvement are used interchangeably which can be confusing. Here is a guide to some key terms defined by our Strategic Public Engagement, Experience and Equality Committee.

<i>Collaborate</i>	To work together
<i>Communicate</i>	Information is giving out (one way) and communication is getting through. Good communication needs to be two-way and when it works, it makes an appeal to join in the conversation (the involvement).
<i>Consult</i>	To ask for opinions and views and take into account.
<i>Co-create</i>	To create together
<i>Co-produce</i>	Producing a service or document together. Requires an equal power share at every stage of decision making which cannot be replicated in the governance arrangements of the CCG.
<i>Diversity</i>	Diversity is about recognising and valuing difference in its broadest sense.
<i>Engagement</i>	The act of reaching out to inform, consult, involve. It can be one way.
<i>Equality</i>	Equality is about ensuring that every individual has an equal opportunity to make the most of their lives and talents. It is also the belief that no one should have poorer life chances because of the way they were born, where they come from, what they believe, or whether they have a disability. Equality recognises that historically certain groups of people with protected characteristics such as race, disability, sex and sexual orientation have experienced discrimination. Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential.
<i>Equity</i>	Equitable provision according to the need of the person.
<i>Involvement</i>	To include a person or people in a process i.e. on boards, reference groups.
<i>Inform</i>	To provide information (one way traffic).
<i>Participate</i>	To take part (in a process)
<i>Patient experience</i>	When we consider patient experience we focus on people's feedback about the care that they received and how that care made them feel

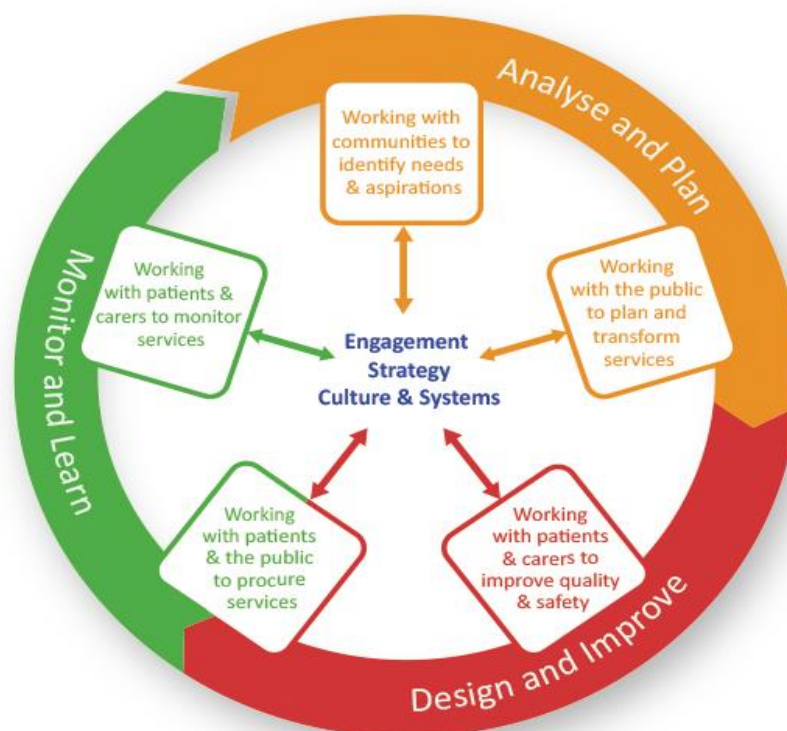
A wider glossary of terms, acronyms and initialisms can be found on the NHS Sheffield CCG website at www.sheffieldccg.nhs.uk/about-us/glossary-of-terms.htm.

When should I involve people?

We should always strive to involve people at the earliest possible opportunity and then continuously throughout the commissioning cycle. The Engagement Cycle is a strategic tool that helps commissioning teams understand who needs to do what, in order to involve communities, patients and the public at each stage of commissioning.

It identifies five different stages when patients and the public can and should be involved in commissioning decisions:

- Community involvement to identify needs and aspirations.
- Public involvement to develop priorities, strategies and plans.
- Patient and carer involvement to improve services.
- Patient, carer and public involvement to procure services.
- Patient and carer involvement to monitor services.



Planning and scheduling involvement and consultations

All consultations and involvement activities need to be planned. For every CCG priority there should be a communication and involvement plan which sets out the activities that are required to involve

and communicate with the public and patients about any proposals or developments. Even if a priority or significant activity of the CCG does not necessarily need a consultation, it should have a communication and involvement plan, and within that consideration given to involving patients and the public, and communicating to patients (whether this is specific patient groups) or the public in general.

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

When will we involve or consult?

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

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

Level	Issue	Type of Activity
Level 1*	<p>Consultation must take place if the implementation of a proposal will have an impact on:</p> <ul style="list-style-type: none"> a. the manner in which the services are delivered to users or; b. The range of health services available to those users. <ul style="list-style-type: none"> • Strategic decisions that impact on what, where or how services are provided. • Longer term intentions. • Sensitive issues which may receive significant stakeholder or media attention. • Substantial developments 	<p>Public consultation The full process can take a year, including at least 12 weeks when the consultation is open to the public.</p> <p>Requires:</p> <ul style="list-style-type: none"> • Full pre-consultation process • Full consultation documents outlining options and constraints • Public meetings • Public and Patient User Groups • Stakeholder workshops • HOSC input • Healthwatch • MPs • Councillors • Parish councils • Voluntary groups • Others <p>Open to all members of the public to respond</p>

Level 2*	<p>Less significant changes in the way a service is delivered, for example:</p> <ul style="list-style-type: none"> • Developing a service operational policy; • Redesigning patient pathway to improve service quality; • Retendering for a service with minimal changes to the contract other than a 'refresh' to bring it in line with national and regional guidelines. 	<p>Involvement - Not subject to the 12 week public consultation period. Requires:</p> <ul style="list-style-type: none"> - Information documents - HOSC updates - Service user focus groups - Surveys - Patient & Public User Groups - Patient / advocacy groups - Healthwatch Sheffield - Staff involvement Open to all service users and stakeholders.
Level 3	<p>Minor changes within an aspect of a service, for example:</p> <ul style="list-style-type: none"> - Changes to a day service timetable; - Developing / reviewing information leaflets; - Changes to clinic booking procedures. 	<p>Involvement – Service specific consultation. Requires:</p> <ul style="list-style-type: none"> - User group discussion - Staff involvement - Patient survey - Posters or leaflets <p>This may be open to all patients affected or a sample group depending on the numbers of patients affected</p>

How do I involve?

1. Decide which piece of work you want to involve people in and which methods would help you achieve what you want to achieve. Think about what can/ cannot be achieved by involving people in this way.

2. Identify the resources you have available:

- Staffing – who will be managing the project?
- Funding – have you the resources to pay travel expenses and/or their time (see section on Payment)
- Timing – involving people properly takes longer. What is your time-line?
- Identifying suitable people – what kind of selection process would be fair and appropriate?

3. Develop a role description which clearly states the skills required, the time commitment expected from your public contributors, the length of their involvement and payment details (See Useful Resources section for a sample role description). It is good practice to identify an end date when their involvement will come to an end. Depending on the frequency of involvement in the role, a maximum of two years is advised to allow for fresh skills and new perspectives to be introduced. This should be made clear at the outset.

4. Involve your patients or public as early as possible in the process. Be honest if you are treading new ground and that you are learning as you go along. This way they will learn with you and won't be feeling at a disadvantage.

5. Identify where power imbalances can exist and take steps to minimise them. For example don't have meetings at a time that excludes public contributors from attending and from taking part in the background thinking and development of a project.

6. Work with a wide range of people, using different people for different pieces of work for the greatest range of perspectives.

7. Offer a range of methods to maximise involvement. While face to face is ideal, this may not always be possible. Offer telephone conferences, Skype, email or phone calls. This may work best when the project is in 'full flow' rather than at set-up.

Methods of engaging

	What is it?	Pros	Cons	What do I need to do?	Tips
Involve Me	The CCG has a network of patients, public and staff who receive regular communication from us and are interested in taking part in consultations, surveys and focus groups, among other involvement activities.	<ul style="list-style-type: none"> • Involve Me can be used for consultation, engaging or intelligence gathering • A group of people who have already expressed an interest in health services and have a basic level of knowledge • Broadly supportive of the CCG 	<ul style="list-style-type: none"> • Do not cover a wide demographic - largely white middle-class and older • Some members are very well informed, so their views may be atypical or unrepresentative 	<ul style="list-style-type: none"> • Contact the engagement team if you have a piece of work which you'd like to gather public opinion on - you may be able to consult with the membership • Encourage patients and public to sign up as members of Involve Me if they want to become more involved with our work 	<ul style="list-style-type: none"> • Think about your objectives and what the public can add to your project or plan

Focus groups	Facilitated focus groups of patients and public used to gain their input to a particular service or issue.	<ul style="list-style-type: none"> • Small focussed groups, usually made up of people with a specific interest in your subject • Can be run according to your preference • The engagement team can advise on how to set up and facilitate • Gives rich, qualitative data • Can probe for more information as views 	<ul style="list-style-type: none"> • Can be difficult to identify patients to take part • Due to small sample size, can't generalise views to the wider population 	<ul style="list-style-type: none"> • Contact the engagement team if you want to run a focus group but don't know how 	<ul style="list-style-type: none"> • Focus groups are best used for a specific subject. If you have an issue you want to address and need patient input, a focus group could be the best option
Surveys	Surveys can be carried out with patient and public groups to gather opinions and developments and inform change.	<ul style="list-style-type: none"> • A good way to gather information from a lot of people • Good questioning can result in useful quantitative and qualitative data • If sample is large enough, can disagree 	<ul style="list-style-type: none"> • Not useful for all groups-children, visually impaired, learning disabled and elderly people can find them harder to complete • Use is limited by the question 	<ul style="list-style-type: none"> • Contact the engagement team if you'd like to use a survey to inform your work – we can advise on best approach 	<ul style="list-style-type: none"> • Surveys are best used when you need input from a large number of people, mostly in quantitative format. • Focus groups are

		gate the data to see differences in opinion by audience	ns you ask		better for qualitative feedback
Consultation	Public consultation is required for planned changes to services which will impact on the manner in which the services are delivered or the range of health services available.	<ul style="list-style-type: none"> • A structured way to get a wide range of public opinion on proposals • Ensures patient involvement 	<ul style="list-style-type: none"> • Time-consuming and costly to organise • Requires a long lead in time 	<ul style="list-style-type: none"> • Contact the engagement team to get advice on whether your piece of work will require formal consultation 	<ul style="list-style-type: none"> • Projects that require consultations can typically expect to see an additional 6 – 9 months to be planned and delivered
Involvement existing patient groups	Meetings with existing support groups, interest groups and GP patient participation groups to share information and gather feedback	<ul style="list-style-type: none"> • An opportunity to involve special interest groups on your subject • Working with people who already have a knowledge of the subject 	<ul style="list-style-type: none"> • Inflexible – usually have to fit in with pre-arranged meeting times • There can be a pre-determined agenda among the group • Can require sensitiv 	<ul style="list-style-type: none"> • Consider whether involving specialist interest groups may benefit your project • Contact the engagement team if you need contacts or help in 	

			e handlin g	identifi ing groups	
Patient representa tives	Members of the public who can be recruited and trained to act as patient representatives within our organisation. These people can: <ul style="list-style-type: none"> • Sit on boards, committees and project groups as patient reps • Undertake procurement evaluations • Sit on job interview panels as patient reps • Take part in site visits and inspections as patient reps 	<ul style="list-style-type: none"> • A great way to incorporate patient opinion into your work 	<ul style="list-style-type: none"> • Require additional support and training to participate • Only work when you really want and need their opinions- not just 'for show' 	<ul style="list-style-type: none"> • Consider whether your review or meeting might benefit from a patient viewpoint • Contact the engagement team if you require a patient representative to sit on a group, interview panel or take part in review work 	<ul style="list-style-type: none"> • Familiarise yourself with the volunteer policy to understand the implications of supporting a patient representative, including whether payment may be required
Communit y asset model	Funding community groups to undertake involvement work with their own communities	<ul style="list-style-type: none"> • Can reach diverse groups • Benefits social value and our communities • Can outsource 	<ul style="list-style-type: none"> • Can be costly and time consuming • Requires control to be handed over 	<ul style="list-style-type: none"> • Identify a budget 	<ul style="list-style-type: none"> • Allow time

		involve ment activity <ul style="list-style-type: none"> • Empow ers commu nities 			
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Who do I involve?

Identifying stakeholders

Suggested stakeholders

Working with the public

Dos and don'ts for successful meetings

- Check whether attendees require any special adjustments to be able to take part in the meeting
- Make new members feel welcome – a friendly smile goes a long way
- Do introduce yourself
- Don't use jargon and acronyms without explaining what they are first
- Don't assume everyone shares the same knowledge
- Encourage a culture of 'It's OK to ask'
- Make sure papers are sent out beforehand
- Check whether public members would like hard copies printed out for them
- Offer to brief members before meetings and debrief after the meetings

Working with volunteers

Appropriately supporting local people to have their say and genuinely influence our commissioning decisions is a priority for us.

We believe that [our values and behaviours](#) speak louder than words and have developed a Volunteering Policy to ensure staff offer consistent and appropriate support to individuals who help our work. This includes reimbursement of out of pocket expenses tailored to an individual's circumstances, but as standard for travel, caring responsibilities and subsistence costs.

We make sure that volunteers have the appropriate level of training and knowledge required to undertake any tasks they are involved in. Examples of this support include:

- We have benefited from having people involved in choosing the providers of services that we buy. All participants receive a briefing and training session beforehand on the expectations of them and introducing the technical aspects of the work.

- *The public voice representatives on our Strategic Public Engagement Experience Equality Committee receive a full induction, regular supervisions and access to training and development opportunities throughout their two-year term.*

[You can find our full Volunteering policy here.](#)

Strategic Patient Engagement, Experience and Equality Committee (SPEEEC)

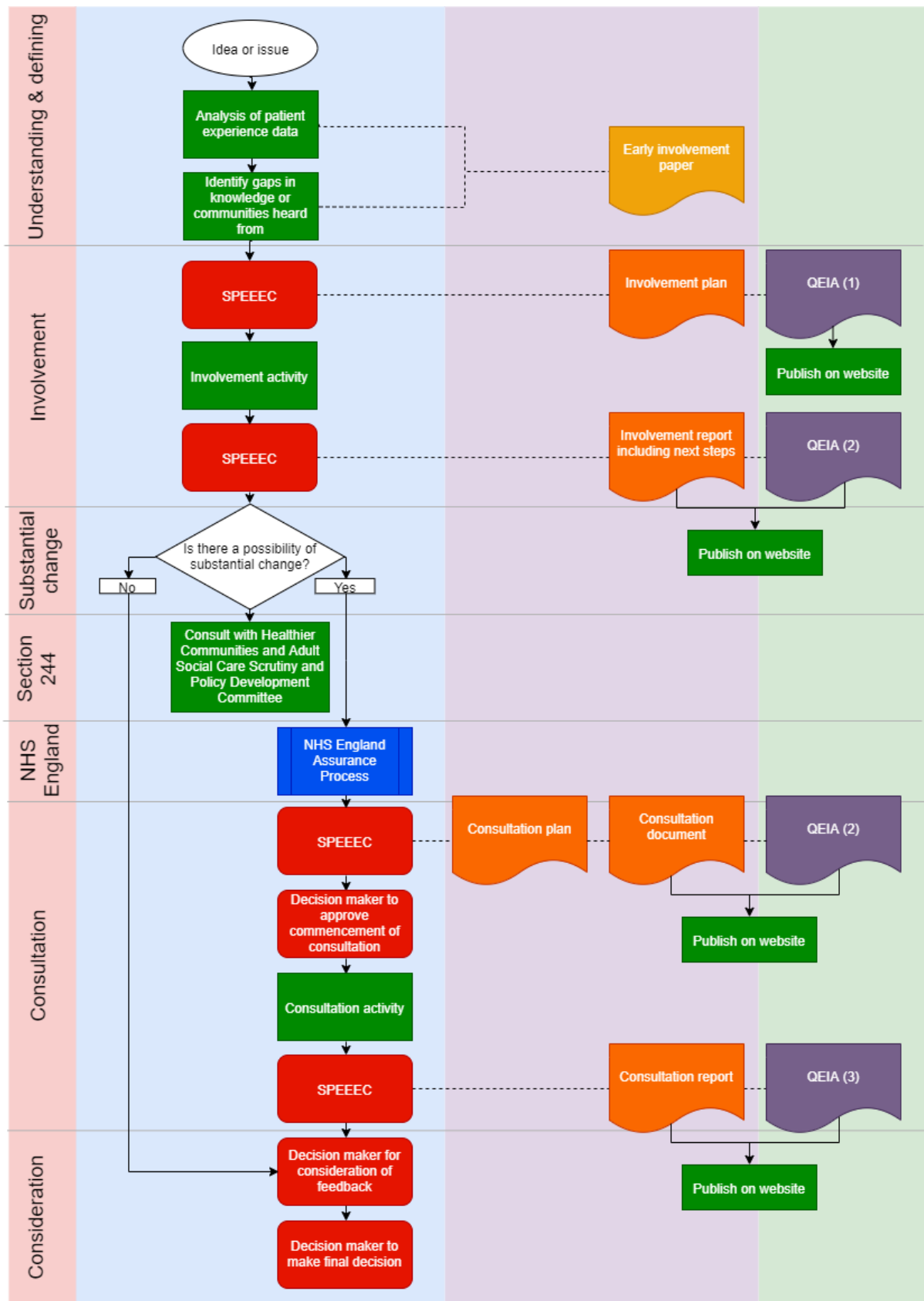
The purpose of SPEEEC is:

- To gain assurance that involvement, patient experience and equality and diversity activity is being carried out in line with statutory requirements and to a high standard by the CCG and its providers
- To gain assurance that information from this activity is used appropriately to influence commissioning
- To oversee equalities, involvement and experience activity
- To assure work in these areas is effectively joined up with partners

When will I need to go to SPEEEC?

The flow chart below details the governance procedure for assuring involvement activity including when updates, and what documents, are required at SPEEEC.

A full list of dates for the committee and paper deadlines can be provided by the Engagement team. If papers are not received and signed off by the relevant sponsor director by the stated deadline they will not be tabled at the meeting.



What will SPEEEC ask of presenters?

In order to gain assurance that the organisation is meeting its legal duties around involvement and equality, questions based around the suggestions below may be asked of presenters to the committee.

Public Law - Involvement and Consultation		Types of questions to ask when assuring a process or making a decision	"I statements" for SPEEEC members
Gunning ⁴ principles	1. Proposals must be at a formative stage	<p>How have patient/ public's views and feedback shaped the proposal(s)?</p> <p>How has the quality, equality, impact assessment (QEIA) shaped the proposal(s)?</p> <p>Has this been discussed or agreed at any formal committees to date?</p> <p>How will the information collected through patient and public participation be used to influence the plan/activity?</p> <p>Briefly describe how your involvement activity will be fair and proportionate?</p> <p>What sources of patient experience data have you explored? e.g. compliments, complaints, service data etc. What did it tell you? Have you timetabled a discussion with the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee??</p>	I am assured that a decision on this proposal has not been made elsewhere, that involvement / consultation activity can meaningfully influence the final decision and that proposals are in their formative stage.
	2. Consultors must provide sufficient information to allow consultees 'intelligent consideration' of the proposals	<p>How has the quality, equality, impact assessment (QEIA) influenced the involvement plan? How have involvement activities been tailored to the needs of different communities? Will information be available in different formats?</p> <p>What information is currently in the public domain?</p> <p>Is all the information that you based your proposals on available to the public? (e.g. transport, bed closures, finances, clinical, QEIA)</p>	I am assured that information is available in an appropriate range of formats to meet the needs of those identified within the QEIA and that the information is accessible and comprehensive.
	3. Consultors must allow sufficient	<p>What timeframe will be available for people to contribute?</p> <p>Which communities will be harder to reach? Is there an appropriate and proportionate plan to hear from seldom</p>	I am assured that appropriate steps have been taken to allow sufficient

⁴ Page 25 - <https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf>

Section 14Z2	time	<p>heard communities with relevant timescales?</p> <p>Have you considered if the time and environment are relevant for the audience? (e.g. not involving teachers during school holidays)</p>	time for all communities of interest to consider and contribute.
	4. Consultors must conscientiously consider the output of the feedback	<p>What's the timeframe for analysing feedback?</p> <p>What time have you allowed for decision makers to conscientiously consider the feedback before making a decision?</p> <p>Which internal and external committees need to be involved in the decision making process and what is the timetable?</p> <p>Did you reach all the audiences you set out to reach?</p> <p>How will you make the information available to them (including the raw data if necessary) so they can make an informed decision?</p> <p>How will the decision makers have "due regard" to equalities? What information will you provide them with to enable this to happen?</p> <p>How will you demonstrate that the decision makers have 'conscientiously' taken all relevant equalities information and public feedback into account?</p> <p>How will you feedback to those people who contributed?</p> <p>How will you assess the ongoing impact of the change on patients and the public after it has been completed?</p>	I am assured that the process of involvement and consultation has been robust and proportionate, that the decision makers will have appropriate information to be able to make an informed decision and that the process is in place for them to conscientiously take into account all relevant feedback
	Involve patients and the public in planning commissioning arrangements	How have patients and the public influenced the development of this element of the commissioning cycle?	I am assured that patients and the public have been involved in planning the commissioning arrangements of the CCG
	Involve patients and the public in the development and consideration of proposals	How have patients and the public influenced the development of the proposal?	I am assured that patients and the public have been involved in the development and consideration of these proposals

	for changes		
	Involve patients and the public in decisions where the implementation would have an impact on them	How have patients and the public influenced the decisions of this work?	I am assured that patients and the public who could be impacted by this decision have been involved

Public Law – Equality		Types of questions to ask when assuring a process or making a decision	“I statements” for SPEEEC members
Brown Principles	Decision maker must be aware of his/her duty to have “due regard”	How have you considered the following and what impact has this had on your planning: Seldom heard communities? Nine protected characteristics? Carers? Health inequalities? What did the Equality Impact Assessment tell you? What action have you taken?	I am aware of the equality duties and understand the implications of the duty in this circumstance
	“Due Regard” must be fulfilled before and at the time a particular decision is considered	How, in your planning, have you had “due regard” to different communities? What action have you undertaken to demonstrate that you have had “due regard” throughout the implementation process? Which is the decision making committee (GB or PCCC) and have you scheduled when the final decision will be made? What information do the decision makers need to be aware of, so the organisation can legally demonstrate we have had “due regard”?	I have consciously considered the equality duties and I am assured that their aims are being met in this process. I recommend to the decision makers that ‘due regard’ has been met
	The duty must be exercised in substance, with rigour and an open mind	What have you done to ensure the aims of the Equality Act are met? How have you fostered good relations and ensured that different communities have appropriate opportunities to contribute? Regarding access to care, what impact on inequalities will	I have exercised a conscious approach and state of mind in my decision making.

		<p>this have?</p> <p>With regard to service provision, how will this reduce inequalities?</p>	
	The duty is a continuing one	<p>Has the QEIA been updated throughout the process?</p> <p>How will you consider the impact of this decision on those who are affected in the future?</p>	I am assured that equalities have been considered throughout the process of involvement, have been updated accordingly and will continue to be considered after a decision is made.
	It is good practice to keep an adequate record showing the duty has been considered	<p>What audit trail do you have in place to demonstrate that the CCG has considered its Equality Duties in the decision making process?</p> <p>How do you intend to demonstrate that the CCG has specifically considered the impact of this decision on seldom heard communities, 9 protected characteristics and those who face greatest health inequalities?</p>	I am assured that adequate and proportionate record keeping is in place and that the CCG can demonstrate it has conscientiously taken into account its Equality Duties.

What constitutes “significant” or major service change?

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

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

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

1. Impact on patients and carers

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

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

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

2. Change in the accessibility of services

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

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

3. Emergency or unscheduled care services

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

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

4. Public or political concern

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

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

5. Conflict with national policy

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

6. Change in the method of service delivery

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

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

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

7. Financial implications

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

8. Related changes in recent years

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

9. Consequences for other services

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

Gateway and NCAT reviews

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

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

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

Who will we involve or consult with?

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

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

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

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

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

Consultation

Public consultation

Public consultation is a rigorous and tightly governed process. The CCG has a duty to inform both the local area team for NHS England and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee (HOSC) for agreement to proceed before a consultation is launched.

It is often regarded as a 12 week process where proposals are presented to the community for feedback. In reality the process takes far longer, and in many instances, a public consultation can take a year from start to finish. Appendix one shows a sample consultation timeline which gives an

indication of all the considerations that need to be taken into account when planning a formal consultation.

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

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

The Pre-consultation business case (PCBC)

The PCBC will vary, however typically, it should:

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

The Public Consultation Process

While the communication and engagement team have reviewed our commissioning intentions, and scoped the potential communication, involvement and consultation requirements; it is inevitable

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

If a service change is going ahead then a business case should be developed with an accompanying involvement or consultation plan and timeline alongside it. This should then be presented to Clinical Commissioning Committee (CCC), before going to the Governing Body or Primary Care Commissioning Committee. A case for service change should clearly set out the clinical benefits of making the changes and how it will improve outcomes for patients. This will form the basis of the clinical evidence required should a service change go to public consultation.

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

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

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

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

It is good practice for an independent analysis of the consultation responses, and to provide a steer throughout the consultation and provide a feedback report at the end of the consultation. The CCG has a number of sources of support for this.

Four reconfiguration tests must be applied to the pre-consultation process going ahead with a public consultation. They are:

- Support from GPs
- Strengthened public and patient involvement
- Clarity on clinical evidence base
- Consistency with current and prospective patient choice

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

Post Consultation

Once the 12 week consultation period is closed it does not stop there. This is still a period of close scrutiny and any decision and announcements need to be managed and handled carefully. A post

consultation timeline should be developed taking all the key meetings and announcements into account and making sure that they are managed appropriately.

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

What to present to Governing Body for decision after consultation

- All raw feedback data. This should be anonymised if any individuals can be identified.
- Consultation report of activity (e.g. what you did, why you did it, when, how etc)
- Analysis of demographics by group (staff / public etc)
- An overall analysis including themes and trends
- An analysis of feedback from different groups including themes and trends
- Anything that emerged / that was suggested that wasn't included in the original document and what you're doing to do with it
- QEIA
- What the information means for the strategy / programme and next steps
- Timetable for next steps

It is important that there's a clear line of sight between the feedback received and the decisions made, including those suggestions that you don't take on board – a "you said, we did" approach.

Pre-Consultation, Consultation and Post-consultation Proposed Timelines

Planning phase	Time scale
Project set up, with patient representatives or establishment of patient reference group and updates for communication and involvement	This could be as little as a month or as long as 6-12 months
Establishment of (1) issues/challenges (2) current service model (3) clinical perspectives (4) best practice/research evidence/service usage data including patient satisfaction and insight data	
Establishment of case for change	
Draft proposal or options paper	
Draft business case	
Internal governance around draft business case, options and case for change	1- 3 months
Internal governance to agree consultation or involvement	
Test pre consultation materials with community / patient groups	
Period of pre consultation to test out messages and materials and feedback mechanisms	2- 6 weeks

Brief relevant stakeholders and subject to internal and external governance and assurances OSC Health and Wellbeing Committee Area Team NHSE NCAT if large scale system reconfiguration MP/Council Briefings	2-6 weeks
Design and production for formal consultation materials, surveys, PR , briefing, web and social media	2 - 4 weeks
Launch formal consultation	1-3 months
Post consultation period including: <ul style="list-style-type: none"> • Analysis of feedback • Feedback Report production • Independent/External review of report 	1 -4 weeks
Consultation Report to Governing Body or Primary Care Commissioning	1-4 weeks
Recommendations Paper to Governing Body or Primary Care Commissioning Committee for decision	1 – 4 weeks
Announcement of decision	1 week
Implementation and mobilization period	

Equality and Diversity

Why we do Equality Impact Assessments

Equality Impact Assessments allow us to record our decision making, specifically where we have considered:

- if there are any unintended consequences for some groups
- if the policy or service will be fully effective for all target groups.

Considering these issues allows us to make better, more informed decisions that will result in more appropriate, accessible and improved services for the people who will, or may need to, use them.

EIAs draw upon a range of data, research, and information and insight from involvement and consultations. This helps our decision makers to identify potential impacts – both positive and negative that can be used to help understand the issues and look at ways to mitigate negative impacts. The assessment tool helps the CCG show how they are meeting their duties under the Public Sector Equality Act 2010 in a transparent and evidence based way. This is important in giving due regard to the needs of those with protected characteristics during our decision making.

Public Sector Equality Duty

The Public Sector Equality Duty is set out in section 149 of the Equality Act 2010.

In summary, the Duty requires the CCG to 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.

The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Act describes fostering good relations as tackling prejudice and promoting understanding between people from different groups. It states that compliance with the equality duty may involve treating some people more favourably than others.

Protected Characteristics

The protected characteristics include:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership (in the workplace)
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

Other vulnerable groups that are often considered in order to give regard to reducing health inequalities include, but are not exclusive to:

- Carers
- People experiencing homelessness
- Deprived communities
- People seeking asylum / refugees

Brown and Bracking Principles

To help support organisations to meet their public sector equality duties a set of principles have been detailed in case law. These are referred to as the Brown Principles.

The Bracking Principles have also been included here as they are relevant for a public body in fulfilling its duty to have 'due regard' and to have enough evidence to demonstrate that it has discharged the duty.

Brown Principles:

- An organisation must be aware of its duty
- Due regard is fulfilled before and at the time any change is considered as well as at the time a decision is taken. Due regard involves a conscious approach and state of mind
- The duty cannot be satisfied by justifying a decision after it has been taken
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision
- The duty is a non-delegable one
- The duty is a continuing one

Bracking Principles:

- The equality duty is an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation
- The duty is upon the decision maker personally. What matters is what he or she took into account and what he or she knew
- A body must assess the risk and extent of any adverse impact and the ways in which such risk may be eliminated before the adoption of a proposed policy

How to complete an Equality Impact Assessment

Identifying potential impacts requires an understanding of how the city is made up, who uses our health services, and the issues that people face. To help identify possible impacts and to help shape and inform the Equality Impact Assessment process there are various sources of data that can be called upon.

- Previous EIAs
- Evidence gathered through previous consultation and involvement activities
- Targeted involvement with identified affected communities
- Demographic monitoring information that we hold

- Usage and equality data from providers
- Sheffield Joint Strategic Needs Assessment and other Health Needs Assessments
- National and local research and datasets

A wide range of evidence is collated on the CCG website for reference at www.sheffieldccg.nhs.uk/understanding-our-communities.htm.

Once the data has been gathered together in one place it now needs to be considered for its likely impact (benefit, neutral, adverse impact, or unknown) on people's experiences, outcomes or opportunities.

The EIA captures whether protected characteristic groups currently use or access the service.

Some of the significant issues that may be relevant to our service users and staff are detailed below, this is not an exhaustive list but should be a good start;

- What equality data do you ask for from Providers to support that all people who are potential users of the service are able to, or do access them, i.e. is their service user data representative of the community as a whole, or of the proportion of the population eligible for it? Are there any representation/data gaps?
- How is the service advertised and promoted– is it in accessible formats, with representative images, in locations likely to be seen by people not being reached or who are under-represented have we ensured providers are required to do this?
- What timing has the service been commissioned for; is this when the service is needed or can be accessed by people who may have different needs, parents of school age children, people of different religions and older and younger people?
- Have you required the provider to consider any different needs people may have, interpreters, accessible information, suitable catering and locations that are accessible by public transport and have accessible parking bays?
- When commissioning services have you incorporated the requirement to involve service users in service design, delivery and feedback mechanisms.
- To be able to measure progress in equality for our communities and staff we need to appreciate the outcomes, rather than the input, so the 'what difference will this make' part allows for consideration of the likely outcomes.

The EIA asks how many people will be affected from each protected characteristic. Where this figure is available from current data, this can easily be put in. If this figure is not available an informed estimate can be made using a mixture of available data including the demographic make-up of the population of Sheffield and usage data.

Evidence is required to record why the impact has been chosen. This consists of two parts, the first part asks what are the identified issues, the second – 'what are you going to do about it'; this forms the core of the analysis.

An impact score is given based upon the type of impact, number of people affected and how many protected characteristic groups are affected.

The EIA template asks whether each protected characteristic group has been involved in the specific piece of work.

Action planning

- Give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Include here any action to address specific equality issues and data gaps that need to be addressed through consultation or further research. If neutral, have you challenged yourself sufficiently? If negative, how will the gaps be address?
- Ensure the actions are specific, measureable, achievable, realistic and have a timescale.

QEIA's and Strategic Patient Engagement, Experience and Equality Committee (SPEEEC)

QEIA's will form part of all involvement plans and reports and be presented as a key piece of evidence to show that knowledge of our communities is appropriately influencing our approach to involvement activity. SPEEEC will provide feedback on the equality aspects of the QEIA including whether:

- communities have been considered
- impacts have been reflected and recorded
- mitigations have been considered.

Equality monitoring our involvement activity

All our involvement activity should be equality monitored to make sure that we are reaching all our communities. We do this by including an equality monitoring form with all our surveys and at all of our involvement events. This information is regularly reviewed so we can target communities who we are not hearing from. This helps us to provide the best services for all of our communities, and to make sure that we do not knowingly discriminate against any section of our community.

The engagement team can provide you with the latest copy of our equality monitoring form.

The Pre-election period

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

The Government issue guidance for a pre-election period which is available here:

<http://www.parliament.uk/business/publications/research/briefing-papers/SN05262/election-purdah-or-the-preelection-period>

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

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

- a. Particular care should be taken over official support, and the use of public resources, including publicity, for Ministerial or official announcements which could have a bearing on matters relevant to the elections. In some cases it may be better to defer an announcement until after the elections, but this would need to be balanced

carefully against any implication that deferral could itself influence the political outcome – each case should be considered on its merits;

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

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