

Planning and delivering
service changes for patients



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Planning and delivering service changes for patients

A good practice guide for commissioners on the development of proposals for major service changes and reconfigurations

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Strategy Unit

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Foreword

Ever since the foundation of the NHS, it has worked to improve services and the quality of care available to patients and the public. The NHS has a responsibility to ensure that services are high quality, sustainable and, as a publicly funded institution, one that provides value for money to the taxpayer.

Over the decades since its inception, the improvements in diagnosis and treatment that have occurred in the NHS have been nothing short of remarkable. However, our health system still lags behind internationally in some important areas. There is still too much unwarranted variation in care across the country, exacerbating health inequalities. In some places the NHS is badly letting patients down and this must urgently be put right. The NHS also operates in a society that is constantly changing. We are facing trends that could threaten the sustainability of our health and care system: an ageing population, significant projected rises in long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's history.

The NHS is constantly seeking out ways to modernise services, but there is still more to do to improve health outcomes and reduce health inequalities, and secure the long term sustainability of services. Without transformative change in how services are delivered, a high quality yet free at the point of use health service will not be available to future generations. This means reshaping of services to put patients at the centre and better meet the health needs of the future.

The improvement of services happens on a daily basis, and many of these improvements occur within an existing configuration of services. However, there are times where the level and scale of improvement that can be achieved, and benefits that can be delivered, warrant a major change or reconfiguration of services. This requires a carefully planned approach, with multiple teams and organisations working together, and in full partnership with patients and the public. It is for these large scale changes that this guidance has been produced. It is intended to support commissioners who are developing transformative plans, and to build alignment and understanding with partners, patients and the public.

At the heart of any major service change or reconfiguration must be that the change will improve the quality of care, and that it is clinically-led and based on a clear clinical evidence base. The NHS is accountable to the public, communities and patients that it serves; it has a duty to involve patients and the public in decisions about their care and in any plans to change how that care is delivered. Reconfigurations are often complex, requiring excellent leadership, effective programme management, partnerships and close collaborative working, and extensive and comprehensive engagement.

This guidance provides a high-level framework through which commissioners can plan, develop and implement major service changes. It replaces earlier reconfiguration guidance produced by the Department of Health that was based on the SHA and PCT system architecture. It does not set out a 'one size fits all' approach and is intended to be a framework that can be adapted to local circumstances, but in a way that ensures a consistency of approach across England and that secures the confidence of patients, staff, communities and the wider public.

Commissioners that are considering major service changes are recommended to use this document and to discuss locally with partners - including providers of NHS services, local authorities and groups representing patients - how the guidance will shape proposals and planning arrangements. Where commissioners have an existing proposal that is already advanced in its planning or implementation, they should use the guidance pragmatically. The principles set out here build on earlier guidance and existing good practice, and commissioners should not feel obligated to undertake further reviews of established plans, unless they conclude there are good reasons for doing so.

Reconfigurations of health services are part of a wider spectrum of changes that can deliver higher quality care, better health outcomes and improved population health. The new clinical commissioning system means we should be ambitious in how the delivery of care needs to modernise and in creating a 21st century health and care service for patients. That will be a collective challenge for not only for commissioners but for organisations across the health and care system, and should be the vision and shared purpose which underpins the delivery of change.

Sir David Nicholson

Chief Executive

Executive summary

This guidance outlines a good practice framework for clinical commissioning groups (CCGs) and NHS England to use when developing plans for major service change to improve the quality and sustainability of services for patients. The framework outlines how NHS commissioners should work together, and with communities, providers and local authorities, to ensure that proposals and plans have effective preparation, robust evidence and are based on extensive engagement with staff, patients and the public.

The guidance sets out a process for developing service change proposals that CCGs and NHS England's direct commissioners can follow, which is intended to ensure broad consistency of approach across the NHS commissioning system but in a way that is flexible and proportionate. The process outlined in the following pages is therefore intended to be adapted to meet local circumstances, rather than to be followed rigidly.

Developing, explaining and implementing proposals takes time, collective effort and energy. It is not something that single organisations can, or should, do in isolation. The strongest proposals are those developed collaboratively by commissioners, providers, local authorities, patients and the public. This will ensure that proposals are sound and evidence-based, in the best interest of patients, will improve the quality and sustainability of care, and that people affected will be involved and their feedback will be listened to, and acted upon.

Commissioners are recommended to read this guidance in full at the start of any major service change process, use it to help develop local plans and keep as a reference resource. Whilst there are a number of legislative requirements relating to reconfiguration explained in this guidance¹, and it is essential plans can demonstrate evidence against the Government's 'four tests' and that commissioners are aware of any material legal risks and how they are to be mitigated, the reconfiguration process should not solely be reduced to satisfying checklists. Rather, the process set out in the following pages should be seen as best practice, that aims to help and guide organisations take forward complex programmes of service change, to deliver significant and lasting improvements for the benefits of patients.

A summary of key messages in this guidance is contained overleaf.

¹ A more detailed explanation of the key statutory duties and key statutory powers of CCGs is set out in 'The functions of clinical commissioning group'. A link is available in the Resources section at the end of this guidance.

Summary of key messages in this guidance

- Major service changes and reconfigurations must **put patients and the public first**, by leading to higher quality and more sustainable services. The focus of reconfiguration should be on proposals that lead to improved outcomes, reduced health inequalities and more efficient models of care.
- **Change must be clinically-led** and underpinned by a clear clinical evidence base. It is a key responsibility of senior clinicians leading reconfigurations to construct that evidence base, and to build support within the local clinical community on the case for change.
- There isn't a 'one size fits all' approach to service reconfiguration and this guidance does not mandate a single process. Each proposal and programme should be **tailored to local circumstances**, within the broad principles and framework set out below.
- **Commissioners have a leading role in the design and development of proposals**, so these reflect current and future commissioning intentions.
- **Patients, the public and staff should be engaged throughout** the development of proposals from their very early initiation through to implementation. Engagement should seek to build an on-going dialogue with the public, where they have an opportunity to shape and contribute to proposals, in addition to any formal consultation on options.
- **Local authorities are essential stakeholders** in the reconfiguration process, both through the local authority health scrutiny functions, but also the joint and integrated working between the NHS and local government through health and wellbeing boards. NHS England and clinical commissioning groups should consider how proposals can be developed collaboratively with health and wellbeing boards, and the opportunities for greater integration of services.
- **It is for commissioners to decide how best to secure services that meet patients' needs** and improve the quality and efficiency of services, **including whether to use choice and competition**, beyond the rights set out in the NHS Constitution. Commissioners need to make balanced judgments on a mix of factors, such as delivering care in a more integrated way, ensuring service sustainability and whether there is a range of capable providers.
- Providers will want to bring forward proposals to deliver services in more innovative, higher quality and more sustainable ways – and **effective partnership working** between commissioners and providers underpin successful reconfigurations. Commissioners have a key role in encouraging providers and the wider market to develop new models of service delivery through their commissioning intentions and procurement practices.
- Reconfigurations are often very complex programmes of change. Commissioners should ensure that there is sufficient **capability and capacity**, whether resourced in-house, through commissioning support services, or from joint working with providers and local authorities – or a blend of these approaches – to plan, develop and implement proposals.

Introduction

This guidance outlines principles and a broad process for major service change and reconfiguration, with suggested stages and checkpoints, but which is intended to be applied pragmatically and proportionately. It is a good practice guide, intended to help commissioners shape their own local arrangements, rather than to be followed rigidly. Each service change proposal is different, and the way that proposals are developed and implemented will vary depending on the nature of service change being undertaken. This guidance should therefore be used as a reference to help develop and implement plans, and take forward programmes of service change

Developing, explaining and implementing major service change proposals takes time, collective effort and energy. It is not something that single organisations can, or should, do in isolation. The strongest proposals are those developed collaboratively by commissioners, providers, local authorities, patients and the public. This helps to build understanding and support. This does not mean that proposals will prove non-controversial, rather it means that decisions can be reached through open and transparent discussions, where people are able to influence decisions and see how their feedback has been acted upon.

What does this guidance cover?

- The underpinning principles of major service change and reconfiguration
- The high level process for planning, developing and implementing major service change and reconfiguration proposals
- Good practice on using existing commissioning plans and strategies to shape proposals
- How to construct a proposal and business case
- Models for collaborative working for major service change and how to comply with procurement and competition regulations when working with providers
- An explanation of the Government's 'four tests' for reconfiguration, and how commissioners should assemble evidence in support of the tests
- The legislation underpinning service reconfiguration – including involving patients and the public, and consultation with local authority health scrutiny functions
- The mechanism for external assurance by NHS England of service change proposals
- Good practice on public consultations for service reconfigurations

Who should read this guidance?

- Clinical commissioning groups (CCGs) – when planning major service changes or responding to proposals from providers and other bodies elsewhere in the health system
- NHS England – both as a commissioner of services and in providing support and assurance to clinical commissioning groups and direct commissioners
- Commissioning Support Services – when supporting CCGs and direct commissioners to deliver major service change
- Providers – including NHS trusts and NHS Foundation Trusts – who may wish to bring proposals for discussion with commissioners²
- Local authorities, local Healthwatch and other groups representing patients and the public

Other sources of information and advice

The effective planning and development of service reconfigurations requires commissioners to be familiar with a range of legislation and good practice. This guidance document provides a high level framework that is intended to support commissioners, and signposts to additional sources of advice and information. These are illustrated by footnotes throughout the document and a list of further resources is included on page 43.

This guidance is not intended to apply in circumstances when the Regime for Unsustainable NHS Providers or Foundation Trusts is enacted. These are specific regimes in legislation that are only to be used for those organisations deemed as unsustainable on a clinical, performance and/or financial basis, and under exceptional circumstances. It will be for the Secretary to State, or Monitor in the case of Foundation Trusts, to determine in any instructions issued to a Trust Special Administrator, whether the TSA should pay regard to any aspects this guidance. Links to separate guidance on the two unsustainable provider regimes are available on the Resources page at the end of this document.

² Unless otherwise stated, the term 'commissioners' is used in this guidance to refer to both to clinical commissioning groups and NHS England's direct commissioning functions.

Underpinning principles of major service change

The process outlined below that commissioners should follow when planning and developing major service changes is intended to be proportionate and flexible. However, there are a number of important principles that should underpin all schemes – outlined in this section. This ensures service changes are:

- in the best interests of patients, improving the quality of care that patients receive,
- clinically-led and based on the best available clinical evidence,
- led at the level at which the services under review are commissioned, and
- part of on-going dialogue with patients and the public, and local stakeholders, about services in the area.

Preparation and planning

Proposals for service change can arise from a range of organisations including commissioners, providers and local authorities, and combinations of those bodies working together, as well as from communities themselves. Irrespective of which organisation or group proposes a major service change, there should be a planned and managed approach from the start, which establishes early on clear roles, a shared approach between organisations, and builds alignment on the case for change. Planning and delivery of major service change is a complex task, that will need to balance a very wide variety of considerations and views.

Commissioners should be active in leading service design and change, corresponding with their responsibilities to identify high quality services to meet local population needs. Where providers bring forward proposals, it is essential that commissioners ensure these align with their commissioning intentions and reflect local commissioning plans. Commissioners should also work closely with local authorities, who have an important role, not just in scrutinising proposals, but in contributing to their development through health and wellbeing boards. This early preparation provides a firm foundation for more detailed development of plans.

When developing plans, organisations are recommended to consult the Independent Reconfiguration Panel's report 'Learning from Reviews' (see Box 1 on page 13), which provides further advice.

Evidence

Major service changes should be evidence-based, and informed by how organisations can best meet the health and care needs of local populations within available resources. In 2010, the Government introduced four clear tests for reconfigurations, which are that schemes should demonstrate³:

- strong public and patient engagement;
- consistency with current and prospective need for patient choice;
- a clear clinical evidence base; and

³ The wording of the tests here is as set out in the Government's Mandate to NHS England: April 2014 to March 2015. The Resources section on page 43 contains a link to the Mandate.

- support for proposals from clinical commissioners.

Commissioners should ensure that the tests are embedded within their reconfiguration planning process. The tests form part of the Government's Mandate to NHS England, and the process of assessing proposals against the four tests is set out in this guidance (see pages 23 to 30). In considering evidence to meet the four tests, commissioners should also ensure that proposals will deliver care that is high quality, safe, effective and sustainable. NHS England also expects schemes to be underpinned by robust economic and financial evidence.

Commissioners should set themselves a high bar of evidence for change, in the discussions they hold with providers and local authorities, and that this is underpinned by expert analysis of the respective costs and benefits of options. It is good practice that NHS commissioners work proactively with health and wellbeing boards, so that service change proposals can reflect joint strategic needs assessments and joint health and wellbeing strategies.

Leadership and clinical involvement

Chairs, Accountable Officers, Chief Executives and Medical Directors from across the organisations involved in a service reconfiguration should exercise collective and personal leadership and accountability when considering the development of proposals for major service change. Front line clinicians and other staff should also be involved in developing proposals, and in their engagement and implementation. In the best examples, GP leaders and medical directors have written forewords to consultation documents, clinicians have presented proposals at public meetings, and articles have been written by heads of the relevant clinical service.

Where reconfigurations span health, social care and public health, Directors of Public Health and Directors of Adult Social Services and Directors of Children's Social Services have an important role in bringing their professional perspectives to building and communicating the case for change.

Engagement

Patient participation, insight and the views of the public should be at the heart of the service change process from the start. Proposals for major service change should be part of an on-going dialogue with communities about their needs and the future shape of wider services. It is important that communities are involved throughout the development of proposals, and that proposals are developed with communities, rather than this being limited to a formal consultation on specific configuration options. Proposals will come under scrutiny by patients and carers, communities, clinicians, staff, local authority councillors, MPs and the media. Effective engagement and involvement means being open and transparent about proposals, and that local stakeholders have the opportunity to genuinely influence change.

This guidance sets out good practice in relation to patient and public engagement, and formal consultation, on service reconfiguration proposals. Commissioners are also advised to refer to NHS England's publication 'Transforming Participation in Health and Care', which provides further guidance on the involvement of the public in commissioning decisions and processes. A link is available in the Resources section at the end of this document.

Assurance

NHS England has a remit to spread better commissioning practice and ensure consistently high standards across all areas of NHS commissioning, and therefore has a role both to support and assure the development of proposals by commissioners. External assurance of proposals ensures that there is broad consistency of approach in the development of plans across the country, that plans are high quality, and that the process gains the confidence of staff, patients, communities and the wider public. NHS England's approach is that assurance should be robust and consistent, but also proportionate and constructive. The intention of the service change assurance process is to support commissioners to deliver effective change and to help identify and mitigate risks.

Area teams will support and work alongside CCGs to develop robust planning arrangements to respond to the commissioning and service redesign challenges that CCGs have identified, including reconfigurations. CCGs and area teams will continue to have the option of using the external and independent Health Gateway process (formerly OGC Gateway). The National Clinical Advisory Team (NCAT) and clinical senates have a role in supporting commissioners with the strategic clinical case for change. NHS England and clinical commissioning groups will also work closely with the NHS Trust Development Authority where reconfigurations relate to NHS trusts and the foundation trust pipeline. NHS England will work with Monitor where choice and competition issues arise.

Box 1. Learning from Reviews

The Independent Reconfiguration Panel (IRP) is an advisory body that reviews proposals for health service change on behalf of the Secretary of State for Health. The IRP is usually commissioned by the Secretary of State when he or she has received a referral from a local authority regarding a proposal to change local health services.

The IRP has published a series of papers 'Learning from Reviews' that set out reasons why proposals are referred, so that NHS organisations and local authorities can improve future planning and engagement of reconfigurations. The common factors are:

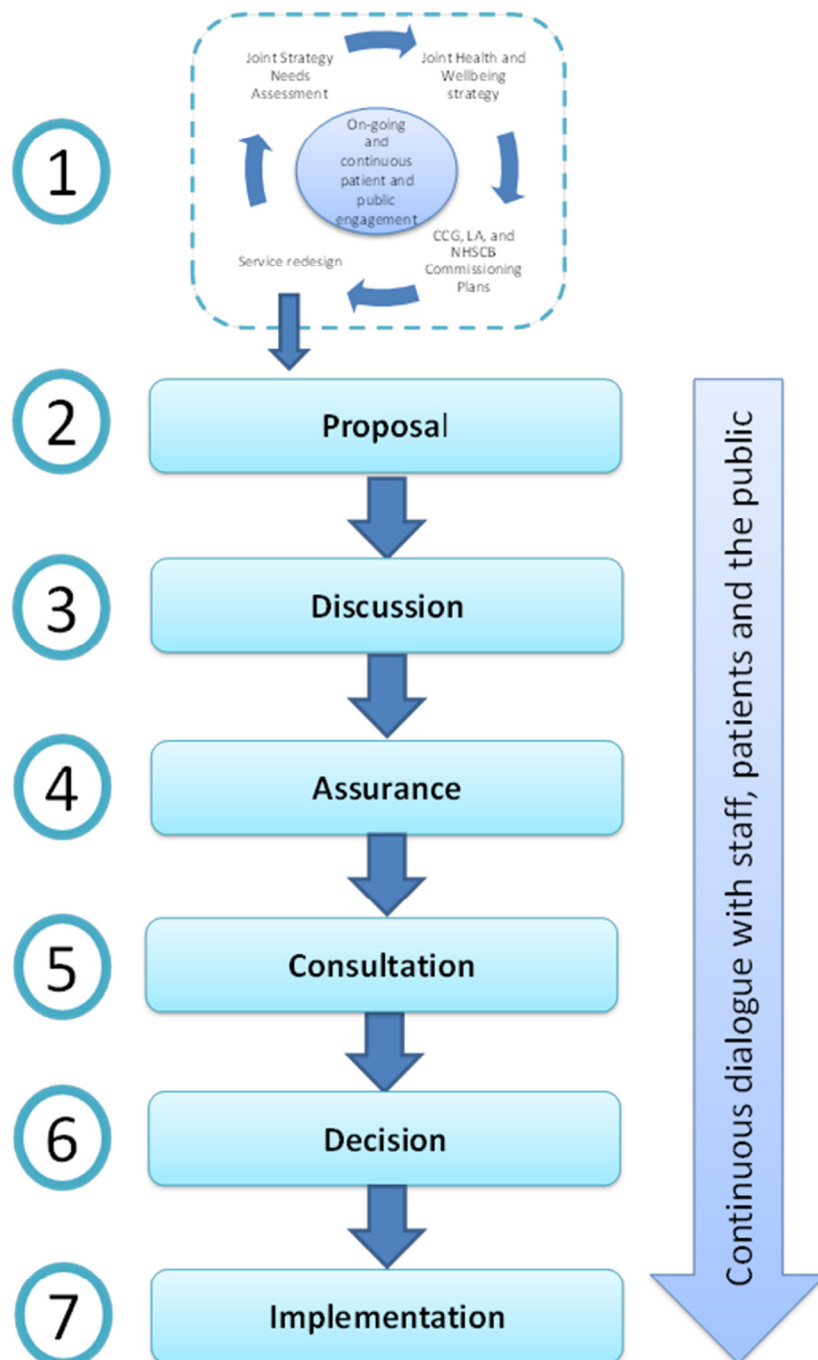
- inadequate community and stakeholder engagement in the early stages of planning change
- the clinical case has not been convincingly described or promoted
- clinical integration across sites and a broader vision of integration into the whole community has been weak
- proposals that emphasise what cannot be done and underplay the benefits of change and plans for additional services
- important content missing from the reconfiguration plans and limited methods of conveying them
- health agencies caught on the back foot about the three issues most likely to excite local opinion - money, transport and emergency care
- inadequate attention given to responses during and after the consultation

Organisations planning reconfigurations should consider how they can incorporate this learning into their programme arrangements. Further information is available at: www.irpanel.org.uk

The process in summary

The following pages describe a high level process which is intended to help shape the planning and development of schemes. This process has been grouped into seven logical stages, that brings together elements found in many standard models of programme and project management – from identification of need and generation of concepts, through development of business cases, detailed analysis planning and delivery, to implementation – but which includes specific considerations relevant to the NHS.

Whilst all reconfiguration programmes should have regard to these stages, and there is a natural sequence in how they are carried out, the planning and development of reconfiguration proposals is rarely linear. The process is intended to be flexible in how each stage is undertaken depending on the nature of the scheme.



1. **Setting the strategic context** – the development of joint strategic needs assessments, joint health and wellbeing strategies, and commissioning plans, should provide an important strategic context for major service change and reconfigurations. Continuous dialogue with health and wellbeing boards, and with communities on local health priorities and needs, can provide a firm foundation for the subsequent development of proposals.
2. **Proposal** – during or following the development of commissioning plans, commissioners may conclude that health outcomes and the quality of care can be improved through a major service change. Commissioners should build their proposal by identifying the range of service changes that could improve outcomes within available resources. Commissioners have a statutory duty⁴ to involve service users in the development of proposals and, as part of this, is good practice that commissioners involve patients and the public, and wider stakeholders, in the early stages of building a case for change.

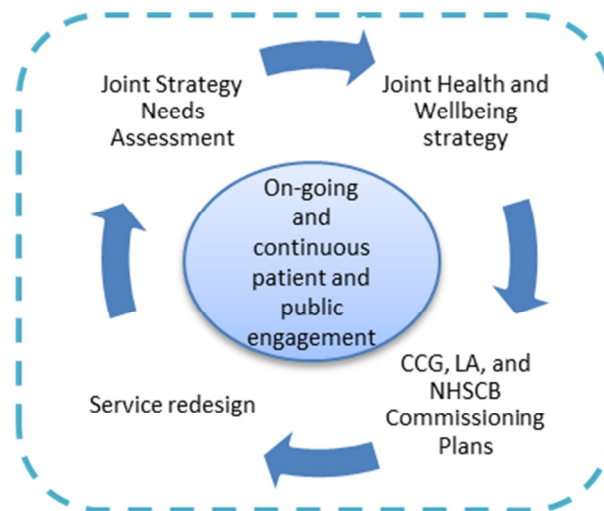
As proposals are developed and refined they should undergo an assessment by commissioners against the Government's 'four tests' as outlined on pages 23 to 30.

3. **Discussion** – when commissioners have a proposal they are satisfied meets the 'four tests', commissioners should discuss formally with local stakeholders, including relevant health and wellbeing boards, and local authority health scrutiny bodies – prior to any wider public consultation. In earlier reconfiguration guidance this was referred to as 'pre-consultation'. This builds alignment on the case for change, avoids proposals being developed in isolation, and that interfaces with the wider health system are considered.
4. **Assurance** – prior to any formal public consultation, reconfiguration programmes should undergo an assurance exercise to review the clinical case for change, the robustness of programme, workforce and financial plans, and the alignment between the proposal and commissioning plans as may be relevant. NHS England will support the assurance of schemes led by clinically commissioning groups and will put in place equivalent arrangements for directly commissioned services.
5. **Consultation** – effective reconfiguration schemes will have continuous engagement with staff, patients and the public throughout their lifecycle. However, commissioners may wish to undertake further public consultation to obtain views and feedback on specific configuration options. This may include a formal consultation exercise, though the Cabinet Office principles for public consultation⁵ allow for a range of approaches to be employed, and engagement should be tailored, targeted and proportionate.
6. **Decision** – at the conclusion of any main consultation phase, the commissioner(s) should determine whether to proceed and which (if any) of the configuration options they wish to pursue. They should notify that decision to all relevant stakeholders, including local authorities discharging health scrutiny functions.
7. **Implementation** – commissioners should ensure there are clear and robust implementation plans, and that they track the delivery of benefits. It is also important to maintain on-going dialogue with patients and the public as new services come on stream, and that organisations seek and act on feedback as these services bed down.

⁴ Sections 13Q and 14Z2 of the Health and Social Care Act 2012

⁵ www.cabinetoffice.gov.uk/resource-library/consultation-principles-guidance

1. Setting the Strategic Context: Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategies and commissioning plans



Front line healthcare is part of an integrated system that includes primary, community, secondary and tertiary care, and also social care, public health, plus wider determinants of health such as education and housing. The most effective proposals for major service change are therefore those that build on wider considerations of the health and wellbeing needs of populations – and reflect existing commissioning plans and strategies.

The health and care system under the NHS Act 2006, as amended by the Health and Social Care Act 2012, enables local clinical leaders and democratically elected leaders to work together – including through health and wellbeing boards—to deliver the high quality health and care services based on the best evidence of local needs. Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) are an important means by which they can achieve this.

JSNAs are local assessments of current and future health and social care needs and assets. They are produced by health and wellbeing boards, and are unique to each local area. JHWSs are strategies for meeting the needs identified in JSNAs, including agreement on the key health and care priorities for the local area. They explain the priorities that health and wellbeing boards have set in order to tackle the needs in the JSNA. Clinical commissioning groups, NHS England, and local authorities' plans for commissioning services will be expected to be informed by relevant JSNAs and JHWSs⁶.

How JSNAs and JHWSs can help inform service redesign

There is a natural progression from analysing local assets and needs, and how current service provision meets those needs, to developing priorities for action, which may include commissioning and providing services in new or different ways. In some cases the JHWSs

⁶ There is a requirement on local authorities and partner CCGs, in exercising any functions, and on NHS England in exercising its commissioning functions in relation to the local area, to have regard to any JSNA and JHWS which is relevant to the exercise of those functions.

may directly lead to service change and redesign. Ensuring there is a common thread from the work of health and wellbeing boards, and development of commissioning strategies, to service reconfiguration plans has a number of key advantages:

- Health and wellbeing boards can bring a multi-service and professional perspective from NHS commissioners, Directors of Public Health, Directors of Children’s Services and Directors of Adult Social Services, alongside the views of elected representatives and local Healthwatch, meaning that proposals can be considered holistically across the local health and care system;
- Health and wellbeing boards must involve local communities, when preparing JSNAs and JHWSs. This will enable them to find out what assets already exist in local communities, what local people want, need and can contribute, what they think about their health and care services and how they think services can be improved;
- Where communities have already been engaged about the current shape of health services in their area, and they can see that their views and feedback have directly influenced plans and investment decisions, it provides a strong platform for more in-depth conversations on potential changes to particular health services; and
- Where there is local consensus about health and care needs and priorities, and how they can be met within local resources, it creates space for conversations on what this could mean for the redesign and configuration of front line services, and potentially mitigates the risk of disagreements on proposals further down the line.

It is important for NHS commissioners to ensure that early conversations are open, honest and transparent about the competing demands and priorities that are faced by the local health system and finite resources within which services are operating. It is therefore also good practice that any proposals have a clear ‘line of sight’ back to the JSNA and JHWS, and have considered how services could be better integrated where this is clinically appropriate and would deliver greater benefits for patients and users. These will be very live issues that will be familiar to health and wellbeing boards and there is an opportunity to look at whole system solutions for the local area.

Whilst not all major service change proposals will arise as a direct result from discussions by the health and wellbeing board(s), it is good practice that commissioners (and through them providers) should ensure that health and wellbeing boards are given an opportunity to comment on and be involved in the development of plans – this is described further on page 31. Providers may bring forward proposals to improve the quality, safety and sustainability of services, which could be additional to any service changes already under consideration by health and wellbeing boards. NHS commissioners should have local mechanisms that enable and support these proposals to come forward for wider discussion.

2. Development of the initial proposal

The objective in developing the proposal is to show how outcomes could be improved through major service change and to determine the range of potential options that could meet population need within available resources (for the purposes of this guidance ‘proposal’ is taken to mean the overall case for change to improve services, and ‘options’ refers to specific service configuration and design options within that broader proposal). For many change proposals, a level of planning and analysis may already have taken place through the development of existing commissioning plans, JSNA and JHWS. However, it is likely that further work will be required to develop:

- a more detailed case for change and evidence base,
- specific service configuration options, and
- the plan for engaging wider stakeholders, staff, patients and the public.

Whilst the format of the proposal, and the process leading to its construction, is a matter for commissioners it is good practice that each proposal incorporates:

- an analysis that considers the full range of potential service changes that could achieve the desired improvement in quality and outcomes (this could include considering whether other providers can offer suitable alternatives in addition to those available from an incumbent provider),
- the development of a range of options based on the above analysis,
- an assessment against legal duties and obligations⁷ including the Public Sector Equality Duty (s.149 of the Equality Act 2010) and the duty to have regard to the need to reduce inequalities (s.14T of the NHS Act 2006) (CCGs) and s13T NHS Act 2006 (NHS England) – see Box 2 for a fuller list of general duties on CCGs,
- dialogue that seeks to align proposals with the plans and priorities of partners,
- consideration of whether proposals represent a substantial service change, including discussion with the relevant local authority in its health scrutiny capacity,
- assessment against the four tests (this is described in more detail from page 23).

Box 2. Commissioner’s general duties under the NHS Act 2006

The National Health Service 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 should understand how these general duties apply in relation to the development of proposals for major service change.

Commissioners' general duties are largely set out at sections 13C to 13Q and 14P to 14Z2 of the National Health Service Act 2006, and also section 116B of the Local Government and Public Involvement in Health Act 2007.

Commissioners should ensure that consider how they meet these general duties in the planning

⁷ A link to further guidance on the general legal duties for CCGs is contained in the Resources section on page 43.

and development of reconfiguration proposals. These include the duties for NHS England and clinical commissioning groups in relation to the following sections in the Health and Social Care Act 2012:

- duty to promote the NHS Constitution (13C and 14P)
- quality (sections 13E and 14R)
- inequality (sections 13G and 14T),
- promotion of patient choice (sections 13I and 14V)
- promotion of integration (sections 13K and 14Z1)
- public involvement (sections 13Q and 14Z2)
- innovation (sections 13K and 14X)
- research (sections 13L and 14Y)
- obtaining advice (sections 13J and 14W)
- the duty to have regard to joint strategic needs assessments and joint health and wellbeing strategies (section 116B of the Local Government and Public Involvement in Health Act 2007)

Commissioners should also ensure they are familiar with Section 244 of the NHS Act 2006 regarding the duty to consult the relevant local authority in its health scrutiny capacity (this is explained further on page 31).

This list is intended as a summary and aid for CCGs on their core powers and duties. It does not claim to include all powers and duties of CCGs, nor is it a substitute for CCGs considering relevant legislation, directions and guidance and seeking legal advice where appropriate. In addition, it does not include all general statutory functions that apply to public bodies. CCGs will also be subject to public law duties that apply to all public bodies. CCGs have a duty to publish a constitution that complies with statutory requirements, which sets out how they will discharge their duties.

CCGs have the flexibility within the legislative framework to decide how far to carry out these functions themselves, in groups (for example through a lead CCG) or in collaboration with local authorities, and how far to use external commissioning support. However, a CCG will always retain legal responsibility for its functions. This can never be delegated.

Commissioners should consider keeping a record of how the duties have been taken into account as part of the decision-making process. This is particularly important if there is a subsequent challenge to the decision making process and/or the final outcome.

Further information on the legal functions of CCGs is available at the following link:
<http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf>

Clinical commissioner leadership and collaborative decision making

A major service change could be proposed by a number of bodies including a CCG or group of CCGs collaborating together, jointly between CCGs and local authorities, by NHS England as a direct commissioner, or by providers. Irrespective of which organisation proposes a service change, commissioners should play a leading role in the planning and development of proposals. This section explains the governance and collaborative working arrangements that should inform that process.

Where a proposal involves a single CCG then it should arrange planning and decision making, subject to what is set out in its Constitution, either through the Governing Body or by creating a specific committee and delegating the exercise of the relevant functions to it.

It is also good practice that a clinically-led group should oversee the design and development of proposals, and commissioners should ensure that clinical ownership and leadership of plans is part of any programme and governance arrangements – whether this is through a formal clinical committee (or equivalent body) of relevant commissioners or through a suitable alternative structure. Where schemes relate exclusively to directly commissioned services, NHS England will make arrangements for senior clinicians to be part of the governance structure for schemes.

Where a proposal may involve multiple commissioning organisations, the Health and Social Care Act 2012 allows for a number of collaborative working models, and these are described in Box 3.

For ease of reference, the organisation or group of organisations leading the development of the proposal - whether a single CCG or area team or multiple commissioners working collaborating - is referred to in this guidance as the 'proposing body'. The proposing body - which should be led by commissioners - may choose to invite other partners to join any working or steering groups as may be required to help the development of plans and alignment across the local health and care system.

Box 3. Collaborative commissioning for service reconfiguration

Collaborative commissioning between CCGs is the process whereby two or more CCGs work together in order to commission effectively some of the services for which they are responsible. CCGs should make a judgement, primarily based on their local knowledge about whether, on balance, it would be in the best interests of their patients to collaborate in a particular circumstance – such as in the planning and delivery of a major service reconfiguration.

CCGs should be clear in advance what responsibilities they have, individually and together, for ensuring full support for a collective decision. In all but the most minor and informal of arrangements, CCGs should set up an oversight board (or similar) on which each of the participating CCGs would be represented and through which agreements are reached. It is also important that all parties should understand what happens when there is lack of consensus on a proposal. There should be advance agreement regarding how these circumstances will be handled, and any conditions that should apply.

Where two or more CCGs engage in collaborative arrangements, the individual CCGs will retain liability for the exercise of their respective statutory functions for their areas. This cannot be delegated or shared, and the arrangements must recognise this.

Section 14(Z)(3) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) allows any two or more clinical commissioning groups to make arrangements for one CCG to exercise any of the commissioning functions of another on its behalf, or for all the clinical commissioning groups to exercise any of their commissioning functions jointly.

A CCG may make provision:

- for the appointment of committees or sub-committees of the clinical commissioning group, and
- for any such committees to consist of or include persons other than members or employees of the clinical commissioning group.

In respect of multiple CCG involvement, although Section 14(Z)(3) does not allow CCGs to exercise functions jointly by way of a joint committee, each CCG can delegate any functions

required for developing service reconfiguration proposals to a committee (in accordance with the CCG's constitution) consisting of its members or employees and those from other CCGs involved in the reconfiguration. That would enable all involved CCGs to have Committees consisting of the same people and those Committees could then meet in common for the purposes of decision making. This is informally referred to as the 'committee in common' model.

It is important that each CCG Committee is clear that it is making its own decision in respect of the service reconfiguration under consideration.

It is good practice that membership of the 'committee in common' is drawn from Clinical Commissioning Group (CCG) Chairs or Accountable Officers (where these are GPs) or a nominated senior clinical GP lead from each CCG, and the Medical Director of the relevant area team(s) where schemes have a component of direct commissioning.

In creating the above process for decision making, it is also good practice that the CCGs consider whether they establish a separate programme (or advisory) board consisting of commissioners, providers, local authorities and other relevant stakeholders to make sure that all relevant information is fed into the reconfiguration process. It is important to note that such a programme board would not be able under the terms of Section 14(Z)(3) to exercise any function on behalf of any CCG, but could be invaluable for the development shared proposals and in providing recommendations to the 'committee in common' or CCG Governing Bodies.

The 'committee in common' model is one approach that CCGs may wish to explore when developing collaborative arrangements to underpin proposals. Further advice on collaborative commissioning is available from:

www.england.nhs.uk/wp-content/uploads/2012/03/collab-commiss-frame.pdf

Developing the proposal

The level of planning, clinical and management input should be proportionate to the scale and complexity of the change being proposed. Operational changes to particular services and pathways that are small in scale, and where the location of care does not change, should not need the same level of engagement, assurance or dialogue as a proposal, for example, to relocate an entire service to a different site. Clinical commissioning groups should approach NHS England for advice if they require any clarification. Where proposals may have a significant impact on the performance, viability or delivery of NHS trusts, it is important this is also discussed with the NHS Trust Development Authority, and with Monitor in respect of NHS Foundation Trusts.

Taking account of choice, competition and procurement issues

The Health and Social Care Act 2012 requires commissioners to ensure good practice and to promote and protect patient choice. Choice and competition are among many tools that a commissioner may decide to use to improve services for patients.

It is for commissioners to decide how best to secure services that meet patients' needs and improve the quality and efficiency of services, including whether to use choice and competition. Commissioners need to make balanced judgments on a mix of factors, such as delivering care in a more integrated way, ensuring service sustainability and whether there is a range of capable providers. However, patients and their interests should always

come first, and nothing in legislation requires commissioners to take a decision in respect of competition issues that conflicts with this.

It is also for commissioners to decide whether to use local patient choice as a means of improving services (for example through reconfiguration), beyond patients' rights to choice set out in the NHS Constitution. In major reconfigurations, it might be appropriate to reduce the number of providers if it is in the interest of patients by, for example, securing the safety, quality and sustainability of services.

Commissioners need to consider carefully the approach they adopt for determining which providers will deliver the services affected by major changes or reconfiguration, including whether a competitive approach between providers is appropriate and likely to produce the best solution to meet patient needs. Commissioners need to ensure equality of treatment between providers and be able to objectively justify their decisions under whichever approach they decide to take. These principles will be set out further in the forthcoming Choice and Competition Framework published by NHS England and Monitor.

In the early proposal stage, commissioners should also consider whether the nature of the change would warrant letting a new contract or whether this is a variation to existing contracts – so that the commissioner is compliant with relevant procurement law. Detailed procurement guidance to commissioners will be made available by NHS England during 2013-14.

Where an incumbent provider wishes to bring forward a proposal, the commissioner should assess the proposal's alignment with local joint strategies, commissioning plans and existing contracts. The commissioner should also consider whether the market should be tested for alternative proposals from other providers, if the commissioner concludes that could secure the best services for patients. This is not just about testing the market, but considering whether there may be more innovative and transformative forms of delivery available. For example, where it is proposed by an incumbent provider to reconfigure an existing acute or community service, this could include exploring, through the market, opportunities to deliver care closer to home – such as through taking advantage of technologies such as telehealth and telecare.

Building the case for change

Wherever possible, organisations involved in reconfiguration should agree on the evidence base underpinning the case for change, so there is alignment on how that information helps to support particular configuration options. The analysis and evidence that services could benefit from redesign and reconfiguration should precede development of a set of specific change proposals. Retrospectively attempting to fit evidence around a pre-determined change to a particular service is not good practice.

Commissioners should assure themselves that they have sought a comprehensive range of perspectives on the case for change - including with relevant local authorities who may consider these proposals represent a substantial service change - before deciding whether to work up detailed design options for further development and public engagement. If the commissioner is content that these options will improve quality and are viable, it should then progress with undertaking an assessment of these proposals against the 'four tests'.

The Four Tests

In 2010, the Government introduced four tests that are intended to apply in all cases of major NHS service change during normal stable operations (different circumstances may need to apply during the instigation of an unsustainable provider regime⁸). It is the responsibility of organisations involved in developing service change proposals to work together to assure themselves and their communities of the strength of evidence for each of the tests. The relevant commissioner(s) should lead this assessment.

The four tests – as set out in the 2014/15 Mandate from the Government to NHS England - are that proposed service changes should be able to demonstrate evidence of:

- strong public and patient engagement;
- consistency with current and prospective need for patient choice;
- a clear clinical evidence base; and
- support for proposals from clinical commissioners.

NHS England has a statutory duty to seek to achieve the objectives in the Mandate. CCGs in turn have a statutory duty to exercise their commissioning functions consistently with the objectives in the Mandate (under s.3(1F) of the NHS Act 2006 as amended by the Health and Social Care Act 2012).

In building evidence in support of these tests, commissioners should assess how proposals will improve the quality, effectiveness and safety of care for patients, and whether proposals will deliver services that are clinically sustainable within available resources.

It is good practice that an initial assessment against the tests should take place at the early planning stage and then be repeated at intervals during the life cycle of a scheme, to ensure that any findings from stakeholder and public engagement, and any new evidence that is developed, continues to support the case for change. This helps to demonstrate compliance with the Public Sector Equality Duty and Duty as to reducing inequalities. It also ensures that the application and assessment of the 'four tests' is an on-going and iterative part of the wider reconfiguration process.

Developing the case for change to meet the four tests

To inform assessment of proposals against the four tests, the proposing body should develop a business case setting out the clinical and patient benefits for all options under consideration, and including a robust assessment of all options against an agreed set of criteria, including an economic and financial appraisal. In many cases, the lead commissioner(s) will prepare the business case, though this is for local determination and the detailed technical development could be undertaken by a relevant provider or commissioning support service – with the commissioner(s) undertaking an oversight and approval role.

⁸ The nature of the application of the four tests will be for the Secretary of State to determine in the case of the Unsustainable Provider Regime for NHS Trusts and Monitor for other NHS providers including Foundation Trusts. These regimes are not within the scope of this guidance.

The exact form of the business case will also vary according to the changes being considered, but good practice is that it should:

- be clear about the impact in terms of outcomes;
- be explicit about the number of people – patients and staff – affected and the resultant benefits for each group, having due regard for the need to advance equality of opportunity;
- outline how patients, the public and other community stakeholders have been involved to date and how their views have informed and influenced the development of the options that will be consulted on;
- show that options are affordable and clinically viable by demonstrating an evaluation of options against a clear set of criteria which demonstrate both affordability and value for money (including projections on income and expenditure and capital costs/receipts for affected bodies) demonstrate that proposals are affordable in terms of any necessary enabling capital investment, its deliverability on site, and its transitional and recurrent revenue impact;
- show that any planned savings that may arise are realistic and achievable within the specified timetable;
- include an analysis of travelling times and distances, identifying the impact on pedestrians and public and private transport users, as well as the ambulance service where relevant;
- outline how the proposed service changes will promote equality and tackle health inequalities;
- demonstrate links to relevant JSNAs and JHWSs, and CCG and NHS England commissioning plans;
- explain how the proposed changes impact on local government services (where applicable) and the response of local government where appropriate;
- have identified and considered choice and competition issues (where applicable) which may impact on the different options; and
- demonstrate how the proposals meets the four tests.

Box 4. Preparing for an assessment against the four tests – key questions

In preparing proposals for assessment against the four tests, commissioners and other bodies involved in the process may find it helpful to consider the following questions.

It may not be necessary to have definitive answers to all questions during the early planning stages, if it is expected will be clarified as proposals are developed further. The application of the four tests should provide a helpful mechanism for assuring the robustness of plans throughout the process.

1. Can I demonstrate these proposals will deliver real benefits to patients?
2. Do I have strong and clear evidence that the proposals improve outcomes, will deliver higher quality care and are clinically sustainable within available resources?
3. Can I quantify with statistically robust evidence the nature and scale of any shortcomings with the current configuration, and can I quantify the extent of the improvement and efficiencies that would be expected from reconfiguration?
4. Are there viable solutions other than reconfiguration? Could I achieve the same outcomes through revising pathways or rotas within the current configuration?

5. How will performance of current services be sustained throughout the lifecycle of the reconfiguration programme?
6. What alternative options are there in the market? Could the services be provided by the other NHS providers, the independent or third sectors, and through new and more innovative methods of delivery?
7. Do the proposals reflect national and international best clinical practice? Have I sought the advice of my local clinical networks and clinical senate?
8. What plans have I put in place to engage relevant health and wellbeing board(s), and to consult relevant local authorities in their health scrutiny capacity? Do proposals align with local joint strategic needs assessments and joint health and wellbeing strategies? Have I considered the impact on neighbouring or related services and organisations?
9. Is there a clear business case that demonstrates clinical viability, affordability and financial sustainability, and how options would be staffed? Have I fully considered the likely activity and capacity implications of the proposed reconfiguration, and can I demonstrate that assumptions relating to future capacity (and capital) requirements are reasonable? Does the modelling including sensitivity analysis (e.g. does it account for uncertainty in any of the variables)?
10. Have I undertaken a thorough risk analysis of the proposals, and have developed an appropriate to mitigate identified risks, which could cover clinical, engagement, operational, financial and legal risks?
11. Do the proposals demonstrate good alignment with the development of other health and care services, and I have considered whether the proposals support better integration of services?
12. Have I considered issues of patient access and transport, particularly if the location where services are provided may change? Is a potential increase in travel times for any groups of patients outweighed by the clinical benefits?
13. Have I considered the potential equalities impact of the proposals on different groups of users, including those with protected characteristics, and whether the proposals will help to reduce health inequalities?
14. Have I considered how the development of proposals complies with my organisations legal duties and how I have considered and mitigated material legal risks (see Box 1 on page 18 for a summary of duties for NHS England and clinical commissioning groups)?
15. Can I communicate the proposals to staff, patients and the public in a way that is compelling and persuasive? What communication and media handling plans are in place and/or have I identified where I will secure any external communications support?
16. Have I identified local champions who are trusted and respected by the community and can be strong advocates for the proposals?
17. Have I engaged any Members of Parliament who may be interested in the proposals?

In addressing the questions above, commissioners may find it helpful to discuss with providers and local authorities. CCGs may also wish to seek the advice of NHS England. Depending on the nature of the issue and the specific changes under consideration, commissioners may also want to refer to advice and guidance from other national bodies including Monitor, NHS Trust Development Authority, the Care Quality Commission, Health Education England, Public Health England, the National Institute for Health and Care Excellence, and the Royal Colleges.

It is also important that organisations have regard to the Public Sector Equality Duty, which came into force in 2011. By understanding the effect of a proposed reconfiguration on different groups of people, and how the NHS can be inclusive in supporting and open up people's opportunities (including mitigating action to minimise any adverse impact), this will lead to services that are both more efficient and effective. The Equality Delivery System (EDS) provides a toolkit that can help NHS organisations improve the services

they provide for their local communities and provide better working environments, while meeting the requirements of the Equality Act 2010. Further information on the EDS is contained in the resources section on page 43.

Commissioners and their partners may also find it useful to apply the NHS Change Model in developing their proposal and more detailed programme plans. The Model builds on the evidence and best practice from across the health system and elsewhere, and from existing improvement models and theories, on how organisations can successfully deliver large scale change. Further information is available at: www.changemodel.nhs.uk

Robust patient and public engagement test

Under NHS Act 2006 (as amended by the Health and Social Care Act 2012⁹), clinical commissioning groups and NHS England must make arrangements that secure the involvement of people who use, or may use, services in:

- planning the provision of services;
- the development and consideration of proposals for change in the way those services are provided – where the implementation of the proposals would have an impact on the manner in which the services are delivered or the range of services that are delivered;
- decisions to be made by the NHS organisation affecting the operation of services.

Providers of NHS-funded services continue have a separate but similar legal duty regarding the involvement of service users under Section 242 of the NHS Act 2006.

Clinical commissioning groups are required in their constitutions to include a description of the arrangements they will make to involve people and a statement of principles the CCG will follow in implementing those arrangements.

It is important that involvement is an integral part of the service change process. The best proposals are characterised by early and on-going engagement through all stages of the process, where communities are involved as partners in actively developing proposals rather than as passive recipients. Effective engagement both helps to build public support for proposals but also ensures that proposals are genuinely shaped around patients' needs. Commissioners (where appropriate in partnership with providers and local authorities) should ensure they spend time and effort in explaining and building the case for change from the outset, and in a language that can be understood by service users. Further guidance on public participation is available in NHS England's guidance 'Transforming Participation in Health and Care'¹⁰.

When planning to involve patients and the public, commissioners should think about proportionality and appropriateness, understand and use a spectrum of involvement activity. There are a number of different activities which range from giving information through to active participation in planning the provision of services. Activity should be proactive and reach out to local populations, are engaged in ways that are accessible and convenient for them, and takes account of the different information and communication needs, and preferences of audiences. As plans should be clinically-evidence based,

⁹ For the full description of the duty see Health and Social Care Act 2012, Section 14Z2

¹⁰This is available at <http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf>

engagement plans should consider how clinicians can be involved in reaching out to communities.

Assessment of proposals against this test should be iterative, given that there should be on-going engagement during the planning and development of proposals. Commissioners should assure themselves that they have taken an appropriate and proportionate level of engagement for each stage of the process. The business case should include clear engagement plans setting out subsequent phases of engagement (whether or not there is a formal consultation phase), so that the patients, the public and wider stakeholders are clear how they will be able to feed into the process and decision-making.

Commissioners should also seek the input of local Healthwatch (LHW) organisations when developing plans, as LHW can perform a valuable role in ensuring plans are shaped around the needs and views of users. Direct engagement of patients, carers, communities and local voluntary and community groups – in addition to LHW – remains a key part of the process, but LHW organisations can play an important coordinating role.

Consistency with current and prospective need for patient choice test

Where there are a range of different, clinically appropriate and evidence based treatments available on the NHS, people should be able to choose the care that is right for them, supported by information about the benefits and risks. For most first outpatient appointments and selected community services, this means being able to choose from any organisation in England that offers a service that is clinically appropriate, meets the quality standards expected from providers of NHS-funded services, and can deliver services within NHS prices.

The same principles should apply to major service changes. Patients should have access to the right treatment, at the right place and at the right time, and be offered a choice of treatment as a matter of course, except where this is clinically inappropriate or unfeasible. It would not be sensible for patients to be able to choose services that fell far short of modern healthcare standards, or where services are not able to treat patients safely.

When considering proposals for service change, commissioners should examine the potential impact on patient choice. This may require careful and balanced judgement so that the choice is one of high quality services. The NHS should use existing patient feedback routes to determine whether patients are having their say and address patient concerns over decisions about their care and treatment.

In March 2013, NHS England and Monitor published a joint statement¹¹ on choice and competition in commissioning clinical services in the NHS, emphasising the key principles that:

- patients and their interests always come first: nothing will require any decision to be made that conflicts with this;
- it is for commissioners to decide if and when to introduce choice and competition when it is in the interests of patients, beyond the rights set out in the NHS Constitution;

¹¹ <http://www.england.nhs.uk/wp-content/uploads/2013/03/choice-comp-note.pdf>

- the introduction of choice and competition should be informed by the evidence, as it emerges over time, of where they can be used to help improve patient outcomes, rather than be regarded as an end in themselves; and
- commissioners are expected to consider the full range of tools at their disposal to bring about improvement where services are underperforming, including giving due consideration to choice and competition where the evidence supports their introduction.

A clear clinical evidence base test

The objective of this test is to ensure that service change proposals are underpinned by a clear clinical evidence and align with up to date clinical guidelines and best practice.

CCGs (and NHS England for directly commissioned services) should oversee development of the clinical case for change, ensuring it aligns with the best available evidence, and has considered relevant innovations and technological improvements, that could deliver further benefits for patients. The Medical Directors and Heads of Clinical Service of any provider organisations involved in the reconfiguration can also help build the clinical evidence base, providing this does not lead to any conflicts of interest in cases of a competitive tendering exercise.

In many cases, there will be a range of options, and service change proposals should set out clearly the clinical benefits and evidence of each option. Where the merits between different options are finely balanced, clinical leaders should make a reasoned judgement how the weight of clinical evidence supports a particular option. It is good practice to describe how that judgement has been arrived in any subsequent public engagement, so that patients and the public can see the development of options has been rigorous, open and transparent.

It is important also that front-line clinicians affected by the proposed changes are engaged, and commissioners should work towards achieving a clinical consensus on the proposal. Doctors, nurses and other healthcare professionals can be powerful advocates, and have an important role to play in communicating the change to the wider community.

Where there are different clinical perspectives on how services could be improved, these should preferably be resolved through the development and refinement of the proposal. It is neither in the interests of patients nor the reputation of local health services, if any differences of clinical opinion over a proposed change become a matter of public dispute.

Assessment against this test should be overseen by an appropriate clinical lead (either within the CCG or committee subject to any Constitutional or collaborative arrangements already in place), or lead Area Team in the case of services directly commissioned by NHS England. This clinical lead should engage other specialists as necessary but, where possible, should include views from senior clinicians not directly connected with the services under review – as this brings a level of independence to the assessment process. For complex, multi-disciplinary and large scale change, commissioners should consider approaching the local clinical senate for strategic advice. The National Clinical Advisory Team (NCAT) can also provide an external expert clinical perspective on proposed service changes, and this is described further in the section on Assurance.

Where a proposal concerns integration across the NHS, social services or public health, the relevant local authority directors of social services (adult social services and children's social services) and directors of public health should be involved in the process, and able to contribute to and evaluate the case for change.

Support for proposals from clinical commissioners test

Commissioners (both CCGs and NHS England in its direct commissioning functions) have a lead role in planning and reconfiguring services, based on assessing the needs of local populations and securing services that meet the reasonable requirements of the people they are responsible for. It is for commissioners to agree which reconfiguration option is implemented following the outcome of the planning and consultation (including where proposals have been brought forward by providers).

Commissioners should therefore assure themselves that proposals:

- align with commissioning intentions and expenditure plans,
- will meet the current and future healthcare needs of their patients,
- will deliver high quality care, and
- will put in place services that have long term sustainability.

It follows that any proposals for service change for CCG commissioned services should have the support of clinical commissioners. This applies to those commissioners who are involved in commissioning the services that may change through the reconfiguration proposal.

For services which they commission, CCGs are central to developing and testing the case for change, whether proposals emerge as part of commissioning plans; as a consequence of a joint health and wellbeing strategy; or are put forward by providers. CCGs are membership organisations, accountable to their member practices, and therefore CCGs should also assure themselves that those proposals have the support of their member practices. It will be for CCGs to determine how that support is secured based on the arrangements for wider decision making outlined in their Constitutions, but each CCG should ensure it has arrangements in place to evidence how the first test is met. Commissioners also need to be sensitive to any actual or perceived conflicts of interest, and ensure these are managed in a way that does not undermine or call into question the probity and accountability of the organisation¹².

Where NHS England is leading a reconfiguration of directly commissioned services, area teams should ensure that proposals have support of their Medical Directors and that changes to any services commissioned by NHS England to which GP practices could refer are discussed with clinical commissioning groups.

In reaching an assessment of clinical commissioner support, the body proposing the service change (for example a CCG committee with delegated authority or 'committee in common' structure) will need to make a balanced assessment of how that support can be

¹² NHS England has published separate guidance for CCGs on managing conflicts of interest available at <http://www.england.nhs.uk/wp-content/uploads/2013/03/manage-con-int.pdf>

evidenced. There may be a range of views on the most effective course of action to secure improvements in the quality and sustainability of services. Proposing bodies should make every reasonable effort to consider alternatives. However, it may not be possible to obtain unanimous support from all CCGs or member practices participating in a scheme, in which case the proposing body should apply a 'test of reasonableness' on whether to proceed. Disputes should be acted upon in accordance with the CCG's dispute resolution process as set out in its Constitution, or in the terms of reference of any collaborative arrangements between CCGs.

Concluding the assessment of proposals against the four tests

When assessing evidence against the tests, the commissioner(s) should apply a 'test of reasonableness'. It may not be possible to achieve full consensus on all aspects of a proposal. Commissioners should be sensitive to any concerns raised and, where these cannot be resolved, commissioners should consider whether the balance of evidence and views supports proceeding with the proposal – based on the outcome they conclude will deliver high quality, safe and sustainable services. It is important this decision is recorded and can be made available for public scrutiny if necessary. It is not the case that if one individual or group challenges or opposes the proposals then the tests are not met.

As proposals are developed and assessed against the tests, the initial list of early options may be refined with certain options demonstrating stronger evidence to meet the case for change than others. Whilst it is sensible to refine options (particularly where there was initially a long list), commissioners should be aware of the drawbacks of ruling out options on which it may be helpful to undertake subsequent wider stakeholder and public engagement, and on which it could be reasonably anticipated that the public would want to be able to provide views and feedback.

CCGs should seek the advice of area teams when determining the evidence against the four tests, and a similar arrangement will apply for directly commissioned services – where area teams will liaise with regions.

If the commissioner(s) is content that the outline proposals meet the four tests, and they (and other partners as may be relevant) can evidence that they have sought and acted upon the feedback, they should progress to a formal presentation of proposals as outlined in the next section. If the commissioner does not believe the proposal has strong evidence in support of the four tests, it may be necessary to revisit the plans, discuss further with its partners (for example in the case of provider-proposed service change), or consider whether an alternative proposal should be considered.

3. Discussion of formal proposal with local authorities

The previous stages of the process should lead to the development of a formal proposal, which has undergone an assessment against the four tests, and which the proposing body concludes is ready for wider consultation – both with local authorities and with the public. The purpose of this stage is therefore to:

- Ensure legislative requirements on consulting local authorities discharging health scrutiny functions are met; and
- Follow good practice that health and wellbeing boards have an opportunity to feed into the development of, and comment on, proposals, if this has not already taken place.

Health scrutiny

Local authority health scrutiny bodies are important stakeholders in the development of reconfiguration proposals. Health scrutiny is a mechanism for ensuring the health and care system is genuinely accountable to patients and the public, and it brings local democratic legitimacy for service changes.

NHS bodies have a legal duty to consult local authority health scrutiny functions in respect of major service changes (see Box 5 overleaf for a summary of these duties). It is good practice that local authority scrutiny functions are involved in the development of proposals in the early stages of the process. However, as proposals will be refined as detailed configuration options are worked up, commissioners should hold a separate formal discussion with local authorities on the final set of proposals (and any configuration options within those proposals) they plan to test through wider public engagement. This is often referred to as ‘pre-consultation’.

The objective of ‘pre-consultation’ is to seek to build alignment between NHS commissioners and local authorities on the underlying case for change, and to ensure that proposals are holistic, have considered all viable options (that are clinically appropriate within available resources) and the benefits and impact on service users. NHS bodies and local authorities should work collaboratively with the aim of reaching broad agreement on the proposals. This does not mean there needs to be consensus on any particular configuration options at this stage - as it is important there is genuine engagement on the options with staff, patients and the public, and an opportunity for communities to contribute their views and shape final decisions.

Health and wellbeing boards

Unlike consultation with local authority health scrutiny, the engagement of health and wellbeing boards on service reconfiguration proposals is not a legal requirement in the same way, but is best practice and ensures that local partners can discuss evidence of alignment with JSNAs, JHWSs, and (where relevant) joint commissioning plans. Health and wellbeing boards could provide invaluable insights and feedback to the planning process, in way that is complementary to the discussions with health scrutiny. Commissioners should therefore consider how health and wellbeing boards will be

engaged on any formal proposals. This is a matter for commissioners to determine, as this will vary depending on local circumstances and the level of prior engagement.

Box 5. Local authority scrutiny of health services

Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, local authorities may:

- review and scrutinise any matter relating to the planning, provision and operation of the health service in their area;
- require information to be provided by relevant NHS bodies (e.g. commissioners) and providers of health services about the planning, provision and operation of health services – in relation to the local authority's area which the authority may reasonably require in order to discharge health scrutiny functions;
- require attendance of any member of employee of a responsible person (such as a clinical commissioning group) before them to answer questions necessary for discharging health scrutiny functions;
- make reports and recommendations to certain NHS bodies and expect a response within 28 days;
- set up joint overview and scrutiny committees with other local authorities;
- refer NHS substantial development or variation proposals (e.g. reconfiguration proposals) relating to the health service to the Secretary of State.

Local authorities have flexibility in how they discharge their health scrutiny functions – which may be through an overview and scrutiny committee (OSC) or through another structure. Where a proposal crosses local authority boundaries, the Regulations require authorities to form a joint overview and scrutiny committee for the purposes of consultation on the proposal.

Health scrutiny is relevant to service reconfigurations as relevant health service commissioners and providers (referred to in the Regulations as 'responsible persons') are required to consult with the relevant local authority scrutiny body on proposals for:

- 1) a substantial development of the health service in the area of a local authority or
- 2) for a substantial variation in the provision of such service.

The Regulations do not define 'substantial development' or 'substantial variation'. The responsible person and the relevant health scrutiny body should discuss locally which proposals they consider will fall within these definitions. The term 'proposal' - in the context of the health scrutiny regulations – can mean both an overarching proposal that contains a package of configuration options within it or a single specific configuration option that a commissioner may be considering following engagement and consultation.

The legal duty to consult local authority health scrutiny bodies is distinct from the separate duties in the NHS Act 2006 (as inserted by the Health and Social Care Act 2012) on clinical commissioning groups and NHS England to involve service users in the development of proposals for service change. Engagement of patients and the public – whether through public consultation or through other means – is a separate activity in legislation from consultation by the NHS with local authority health scrutiny bodies; and it is important that the two duties are not confused or conflated.

Where the 'responsible person' is a service provider and the proposal relates to services which a clinical commissioning group(s) or NHS England is responsible for arranging the provision of, functions relating to consultation with the local authority must be discharged by the NHS England

or clinical commissioning group(s) on behalf of the provider. The Regulations do not specify who should lead in carrying out this function (e.g. who should attend and engage local authority health scrutiny). However, it is good practice that this should be led by an appropriate senior clinical commissioning representative(s). This also does not preclude managers or clinicians from provider organisations involved in the proposal from giving additional support or evidence alongside the commissioner.

The responsible person (in most cases a NHS commissioner), is required to notify the local authority of:

- the proposed date by which the responsible person intends to decide whether to proceed with the proposal (for example, this could be the date of a CCG Governing Body meeting to review the outcome of a public consultation) and,
- the date by which the responsible person requires the authority to provide any comments.

If the local authority health scrutiny functions are not content a substantial service change proposal is in the interests of the local health service, or are content that consultation by the responsible person with the local authority has been inadequate, the Regulations allow for the proposal to be referred to the Secretary of State (see pages 40 and 41).

This is a brief summary of health scrutiny and is not intended to be a definitive guide to the Regulations. Detailed guidance – “Local Authority Health Scrutiny: a guide to health scrutiny regulations 2013” - will be published by the Department of Health during 2013-14, and commissioners are advised to ensure they have also consulted that document during the early reconfiguration planning process.

4. Service Change Assurance

Major service change programmes are highly complex, often involving multiple services that cross organisational and geographical boundaries, and attract high levels of public interest. The clinical and management challenge associated with these programmes is considerable, which is why it is important there are clear mechanisms in place to support the development of schemes, and assure that schemes are high quality, clinically and financially sustainable, align with best practice and will deliver the benefits expected. Assurance should not conflict with the local autonomy and freedoms of organisations; rather it should support local planning and help to build confidence with staff, patients and the public that major service changes have robust arrangements.

Under the health system established by the Health and Social Care Act 2012, it is appropriate that assurance of schemes is undertaken by the relevant commissioning bodies, with CCGs supported by NHS England, and with access to independent and external sources of expert advice. Effective assurance will secure consistency across the NHS commissioning system in respect of:

- the principles and standards that should underpin service change proposals;
- the strength of business cases, clinical evidence and public engagement;
- proposals having regard to relevant national guidance and comply with legislation; and
- the programme management that underpinning the planning and delivery of schemes.

Clinical commissioning groups will be able to access a range of support, including from NHS England, from commissioning support units or other commissioning support providers, and from the National Clinical Advisory Team (NCAT) and clinical senates. The Trust Development Authority will support and advise commissioners in respect of the implications of proposals for NHS trusts. These measures taken together ensure there is a consistency in the quality and planning of schemes across the country and so that good practice and any lessons learnt are shared.

Internal self-assurance

It is good practice that proposing bodies leading reconfiguration schemes will put in place their own internal self-assurance arrangements as part of programme governance. This is so that the proposing body (such as a ‘committee in common’ of CCGs) is satisfied it has – for example - robust programme and risk management arrangements, a clear process for making and approving decisions, and agreement within the programme on evidence for the change.

CCGs can seek the advice of area teams if required when putting in place these arrangements.

External assurance

External assurance is intended to build upon any local self-assurance arrangements. The precise timing of the external assurance phase will vary. Local commissioners may decide

to seek external assurance early in the planning process, to help the development of proposals to start on a firm footing, sound assumptions and robust programme management arrangements. However, as a minimum, an external assurance exercise should be followed before proposals progress to any formal public engagement or consultation, as this may identify issues and risks that commissioners will want to consider and address first.

NHS England will operate an external service change assurance process to support commissioners, in a way that is proportionate to the scale of the proposal, and with the aim of avoiding additional bureaucracy. NHS England will apply a principle of subsidiarity, with external assurance being exercised as locally as possible to the scheme in question. Area teams will help CCGs so that proposals are robust, evidence-based and underpinned by effective patient and public engagement. This includes helping assess that proposals comply with relevant legislation and regulatory requirements. Area Teams (or Regions for schemes with a very wide geographical footprint) can also support CCGs to identify the wider impact of service change on the sustainability of the whole system, including neighbouring health economies.

NHS England will operate a two stage assurance process, consisting of:

- 1) a strategic sense check, and
- 2) an assurance checkpoint.

NHS England will be publishing separate detailed guidance on the operation of the service change assurance process for CCGs and area teams. The following is a brief summary for reference only.

Strategic sense check

The strategic sense check should take place once the commissioner concludes they have a sufficiently robust service change proposal and set of options, and will involve a formal discussion between commissioners leading the change and NHS England at the most appropriate level (usually the Area Team).

The purpose of the Strategic Sense Check is to explore the case for change and the level of consensus for change; ensure a full range of options are being considered and that potential risks are identified and mitigated. The alignment between the proposed change and strategic commissioning intentions, alignment with priorities (such as the NHS Outcomes Framework) and impact on neighbouring commissioners will also be considered. Assurance that an assessment against the 'four tests' has taken place will be a core requirement, with other best practice checks applied proportionally.

The strategic sense check is an opportunity to discuss organisational roles (particularly relevant for complex multi-organisation schemes); the level of key stakeholder involvement and support to date, and on-going engagement plans; likely resource and support requirements; any financial and legal considerations; and interdependencies with other commissioning plans or services.

For a number of small scale and low risk schemes it may be agreed at the strategic sense check that existing assurance is sufficient and no second stage is required. However, for

the majority of schemes, it is expected these will undergo a subsequent assurance checkpoint. The strategic sense check will also determine the subsequent level of independent external advice that will be obtained – as a step to inform the assurance checkpoint.

Independent advice to inform the assurance process

Obtaining independent advice from experts outside the local reconfiguration process has been a key element of previous reconfiguration frameworks, but it is important – as with any part of the wider assurance process – it is employed proportionately depending on the nature of the scheme and any inherent risks.

There are broadly two main components to independent advice for service reconfiguration assurance:

- to assess the programme management arrangements and strength of the business case; and
- to assess the strength of the clinical case for change and alignment with clinical guidelines and best practice.

External programme management advice is available through the Health Gateway Review process. Gateway reviews assess the robustness of the business and financial case for change in order to highlight key risks and issues which if not addressed could threaten successful delivery of the scheme. Proposing bodies should consider how Gateway could help to strengthen local arrangements, and the strategic sense check is designed to facilitate that decision. A link to the Health Gateway website is included on the Resources page at the end of this document.

The aim of clinical assurance is to establish whether the proposed changes are supported by a clear clinical evidence base and will improve the quality of the service provided. The decision to request an external clinical assurance review should follow discussions between the relevant commissioner(s), area teams at the strategic sense check – with input where required from the local clinical senate, who can bring multi-disciplinary strategic advice to the development of proposals. For relatively small and non-contentious changes, the strategic sense check may conclude a further external clinical assurance is not required. However, where the clinical case for change is more complex, commissioners and senates will be able to draw upon a pool of external reviewers. At the time of writing, this function is undertaken by the National Clinical Advisory Team (NCAT).

Stage 2 – Assurance checkpoint

The purpose of the second stage is to undertake formal assurance of commissioner proposals, in advance of any wider public consultation or decision to proceed with a particular option. The scope of this stage will reflect the discussions held during at the strategic sense check. In most cases this will involve assurance of the evidence provided by commissioners against the four tests and the NHS England's best practice checks. It will also incorporate independent input from senates, NCAT and/or Gateway if this was agreed at the strategic sense check.

The operation of the assurance checkpoint may take place at area team, regional or national level depending on the nature, scale and complexity of the scheme. An assurance panel will be convened that will consider the evidence presented by the proposing body, and any reports or findings received from external or independent advisory bodies. The assurance panel will need to consider whether it was assured, partially assured or not assured against each of the agreed criteria. This would then form the basis of the panel's report, along with any risks, issues or other recommendations they identified. For proposals that are advised not to proceed as currently constructed, NHS England would then initiate further discussions with the lead commissioners on how best to proceed. In exceptional circumstances, NHS England may need to consider the use of a more formal process to either support organisations to improve proposals or act to use intervention powers where the quality of patient care was considered to be at potential risk.

Assurance of directly commissioned services

Proposed major changes to directly commissioned services will require a separate assurance approach to that in place for CCG-commissioned services, to avoid internal conflicts of interest and ensure the process remains impartial. Assurance will need to be undertaken and overseen by an NHS England team who are not otherwise involved in the development of the proposals. However, the broad framework and level of assurance required will follow the same principles as for CCG-commissioned proposals – with self-assurance, supported by a strategic sense check and with independent input where deemed necessary.

Where services are commissioned by area teams, assurance will be overseen by the relevant regional team. The method used for discharging this assurance may include regional team review, peer review by another area team, or the establishment of an independent assurance function including – where necessary – representatives from outside NHS England.

National oversight of the assurance framework

The effective on-going application of the assurance framework across the NHS commissioning system, and an overview of schemes being assured, will be maintained by a sub-group of NHS England's Operations Executive – the Service Reconfiguration Oversight Group. This will ensure the application of the assurance framework is consistent both for major changes to CCG commissioned and directly commissioned services. Where appropriate the Group will also act as the national assurance checkpoint panel, and may refer the outcome of its consideration to the Operations Executive or Board of NHS England for final decision.

5. Public Consultation

Following the assurance process, and pre-consultation discussions with local authorities, the proposing body may then decide to progress to formal public consultation on the range of options that will be tested with staff, patients and the public.

The NHS Act 2006 (as amended by the Health and Social Care Act 2012) places legal duties on NHS England and CCGs respectively to make arrangements to involve service users in the development and consideration of proposals for changes in commissioning arrangements, where this will impact on how services are delivered or the range of service that will be available. The Act does not specify how NHS England and CCGs should involve service users, and it is important that a range of engagement approaches are employed depending on the nature of the proposals and the most effective means of engaging service users. Commissioners may want to undertake this in partnership with providers, local authorities and patients' groups, but this should be determined locally.

As described in the previous section on the patient and public engagement test, it is best practice that staff, patients and the public will have been engaged throughout the development of initial proposals. However, the purpose of this stage is to gather views and feedback on the specific and detailed configuration options that commissioners consider could be implemented and will improve services. For example, this may include asking the public specifically about options on where services could be relocated to.

It is for commissioners to decide the most effective means for engaging their communities. The nature and methods of communication and engagement will vary depending on the proposal and the audience. This includes written, on-line and face-to-face communications, and messages should be tailored to the information preferences of the audience. In addition to traditional written documents and leaflets, and public events, modern digital communications, such as social media, provide opportunities for an interactive dialogue with different groups of service users. Any material produced should contain specific, relevant and clear information presented in languages and formats that are accessible and will enable patients and users of services to be able to contribute.

It is good practice that when undertaking formal engagement on a specific set of configuration options, proposing bodies have:

- An effective public communication and media handling plan that articulates clearly and consistently the case for change, and the benefits;
- A detailed plan for reaching all groups who will be interested in the change;
- Staff engagement plans;
- Clear, compelling and straightforward information on the range of options being tested, that is accessible and that will address the needs of those being engaged.

Clinical commissioning groups and Area Teams should consider how commissioning support services can both help develop and deliver the communications plan.

In developing communications and engagement plans, commissioners and their partners should also pay careful attention to issues which are most likely to be of interest to patients

and the public. Evidence from previous NHS reconfigurations indicate that schemes have struggled to build public support where they have not adequately addressed public concerns and perceptions that:

- the proposals are perceived to be purely financially driven;
- patients and their carers perceive they will need to make long and/or expensive journeys that may deter patients from attending and reduce the opportunities for visiting; and
- emergency services will be too far away and very sick people will be put at risk.

In addition, the most successful engagement programmes have recognised that staff can be powerful advocates for change in their local communities, as they are also local residents, patients and stakeholders. Employers should therefore ensure that staff are continuously engaged in the development of proposals and implementation of service changes. Early engagement of staff side representatives can be invaluable in understanding any initial questions or concerns that need to be addressed.

Further guidance on involving the public in commissioning processes and decisions is available from NHS England's publication 'Transforming Participation in Health and Care'.¹³

¹³ <http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf>

6. Decision

At the conclusion of the main public consultation phase, the proposing body (for example the lead commissioner) should decide the option that has the best balance of evidence and public support, based on all the discussions and information gathered during the previous stages of the process. The proposing body should ensure they have a clear audit trail to evidence how that decision was reached, and the considerations undertaken. The decision on the options chosen rests with commissioners, reflecting their legal responsibility to secure services to meet the reasonable needs of the people for whom they are responsible.

The proposing organisation should then announce the decision and communicate this to relevant stakeholders and partners. It is good practice that there are dedicated communications to:

- patients and the public
- staff
- the Media – which should follow an existing dedicated media handling plan
- health and wellbeing board(s)
- local authorities discharging health scrutiny functions or a joint overview and scrutiny committee if one has been formed
- local Healthwatch and other relevant groups representing patients
- Members of Parliament

Following receipt of the decision, relevant local authorities exercising their scrutiny function will decide whether they are content with the decision, or whether they have outstanding concerns (see Dispute Resolution).

Once the proposing body is satisfied that has concluded the planning and development phases, it should proceed to putting the final proposal into action.

Box 6. Dispute resolution

Situations may arise where consensus over a service change cannot be agreed between the relevant NHS body or health service provider and the relevant local authority. The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require responsible persons (i.e. NHS bodies) and local authorities to take certain steps to try to resolve issues first. If a local authority (discharging health scrutiny functions) concludes that all reasonable practicable steps at local resolution have been exhausted and it still has outstanding concerns, it has the option to refer the proposal to the Secretary of State for Health.

The Regulations permits local authority referrals on the following grounds, where:

- The local authority is not satisfied that the NHS's consultation with the local authority scrutiny function was adequate in terms of content or time allowed;

- The local authority concludes that the proposals would not be in the interests of the local health service;
- In a case where the NHS did not consult because a decision was needed without time for consultation with the local authority (because of an immediate risk to safety or welfare of patients or staff), but where the local authority is not content that the reasons given for this are adequate

In referring proposals to the Secretary of State, the Regulations requires that local authorities set out:

- (a) an explanation of the proposal to which the report (the referral) relates;
- (b) the reasons why the authority is not satisfied that consultation has been adequate or that reasons given for lack of consultation have been adequate (where this applies);
- (c) a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area;
- (d) an explanation of any steps that the health scrutiny body has taken to try and reach agreement with the relevant NHS body or health service provider
- (e) an explanation of the reasons for the making of the report;
- (f) evidence in support of the those reasons;
- (g) evidence to demonstrate that the authority has complied with the applicable conditions for referral

Upon receipt of a local authority referral, the Secretary of State has the option to seek advice from the Independent Reconfiguration Panel (IRP). In providing advice, the IRP will consider whether the proposals will provide safe, sustainable and accessible services for the local population, and make recommendations to the Secretary of State regarding any further action that may resolve the matter.

This section is intended as a summary for reference only. The Department of Health's forthcoming guidance "Local Authority Health Scrutiny: a guide to health scrutiny regulations 2013" provides further information and specific guidance on the above points.

7. Implementation

When a clear option has been determined through public engagement and agreement has been reached to enact the proposal, the project should proceed towards implementation.

An implementation plan should set out how the detailed changes will be taken forward, when and by whom. This should have been set out in the proposal documentation, but individual organisations will need to maintain detailed operational implementation plans, for example covering the construction or redesign of specific parts of a hospital estate. The plan should identify a clear benefits realisation timetable with key milestones against which progress can be monitored.

At the conclusion of the formal programme, an appropriate individual or senior responsible office (subject to the governance arrangements that have been put in place) should sign off that aims and objectives have been met, and that good practice and lessons learnt are documented and disseminated. Commissioners may wish to undertake further Gateway reviews to help assure on-going programme implementation and provide evidence for benefits realisation.

It is good practice that the health and wellbeing board(s) involved, and the local authority (discharging health scrutiny functions), be kept updated on the progress of the implementation phase, so that they and the wider public can assess whether the benefits have been realised. Commissioners and the provider organisations implementing the change should also continue to engage with patients and the public during implementation, particularly in communicating when new services come on stream and how they can be accessed. It is also important that communities can see how the changes are delivering the improvements set out during any formal engagement exercise.

Resources and further information

The functions of clinical commissioning groups

This paper sets out the range of core clinical commissioning group (CCG) functions as set out in legislation. It distinguishes between:

- the key statutory duties of CCGs – the “must dos” that CCGs will be legally responsible for delivering, and their
- key statutory powers – i.e. the things that CCGs have the freedom to do, if they wish, to help meet these duties.

<http://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf>

The Mandate

A mandate from the Government to NHS England: April 2014 to March 2015

The Mandate sets out the Government’s expectation that where local clinicians are proposing significant change to services, there should be better informed local decision-making about services, in which the public are fully consulted and involved. NHS England’s objective is to ensure that proposed changes meet four tests: (i) strong public and patient engagement; ii) consistency with current and prospective need for patient choice; iii) a clear clinical evidence base; and iv) support for proposals from clinical commissioners.

<https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015>

Transforming Participation in Health and Care

This guide will help clinical commissioning groups (CCGs) and other commissioners of health and care services to involve: patients and carers in decisions relating to care and treatment, and the public in commissioning processes and decisions.

<http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf>

Cabinet Office guidance on Consultation Principles

This guidance sets out the principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation. It replaces the Code of Practice on Consultation issued in July 2008. It is not a ‘how to’ guide but aims to help policy makers make the right judgments about when, with whom and how to consult. The governing principle is proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken, and thought should be given to achieving real engagement rather than merely following bureaucratic process. Consultation forms part of wider engagement and decisions on whether and how to consult should in part depend on the wider scheme of engagement.

<https://www.gov.uk/government/publications/consultation-principles-guidance>

Equality Delivery System

The purpose of the Equality Delivery System (EDS) is to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED). An updated version – EDS2 – was published in November 2013 and can be access at the links below.

<http://www.england.nhs.uk/ourwork/gov/edc/eds/>

<http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf>

Health Gateway

The Health Gateway Review Process provides all NHS and other health public sector organisations with free and confidential independent peer review support for their projects and programmes. Supported by the Cabinet Office and managed by a dedicated team in the Department of Health, Health Gateway Reviews provide assurance to programme and project owners that their project is on course to deliver the desired outcomes, on time and within budget.

<http://healthgatewayreviews.org.uk/>

NHS Change model

The NHS Change Model has been created to support the NHS to adopt a shared approach to leading change and transformation. It brings together collective improvement knowledge and experience from across the NHS.

<http://www.changemodel.nhs.uk/pg/dashboard>

Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts

<http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-5>

Statutory guidance for Trust Special Administrators appointed to NHS Trusts

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212850/statutory-guidance-trust-special-administrators.pdf