Healthier Together

Improving health and care in Bristol,
North Somerset and South Gloucestershire

DRAFT
Proposed Public Consultation Plan

February 2021

1.1. Consultation process

Legal requirements

As an NHS commissioner we are required to show how the proposals we are putting forward meet the four tests for service change laid down by the Secretary of State for Health and the fifth test set by NHSE. These are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base to support the proposals
- Support for the proposals from clinical commissioners
- Assurance that any significant hospital bed closures can meet one of three conditions:
    - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
    - Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
    - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

There is also a legal duty on NHS organisations to involve patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate:

- **Section 242, of the NHS Act 2006**, places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.

- **Section 244** requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to Overview and Scrutiny Committees)

- **The NHS Act 2012, Section 14Z2** updated for Clinical Commissioning Groups places a duty on CCGs to make arrangements to ensure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

        - in the planning of the commissioning arrangements by the group

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

We need to make sure that our consultation activities meet the requirements of The **Equality Act 2010**, which requires us to demonstrate how we are meeting our Public Sector Equality Duty and how we take account of the nine protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The Equality Impact Assessment *(in development)* will assess the impact across these 9 protected characteristics, and list the associated mitigations. It will also recognise the considerations regarding the prevalence and impact of strokes, and also how the COVID-19 may affect these groups.

1.2. Consultation principles and priorities

The BNSSG Stroke Programme recommends launching a public consultation about potential options for stroke treatment and care.

Our consultation plan will be underpinned by some fundamental principles and priorities. As well as shaping the content and activity of our consultation, these principles and priorities will form the basis of our evaluation of the plan.

Our legal duties:

- **Consultation proposals must still be at a formative stage:** Public bodies need to have an open mind during a consultation and decisions cannot already be made. People need to be clear on what can and cannot be influenced by public input and opinion.

- **There must be sufficient information around proposals to permit informed consideration:** People involved in the consultation need to have enough information to provide an informed input into the process. This might include an impact assessment of the costs and benefits of the options being considered.

- **Consultations should last for a proportionate amount of time:** Sufficient time should be given to enable people to make an informed response and there must be enough time to analyse the feedback. The proposed consultation period is 12 weeks.

- **Consultation feedback must be conscientiously taken into account:** Decision-makers should be able to evidence how they have taken consultation responses into account. At least one month has been allocated for compiling consultation feedback after the end of the consultation period. The feedback will be taken into account when creating a Decision Making Business Case and considered in detail by the BNSSG CCG Governing Body before they make a final decision on which solution to implement to meet the challenges set out in our case for change.

Consultation principles:

Consulting with people who may be impacted by our proposals

- We will reach out to people where they are, in their local neighbourhoods and in local networks.
- We will make sure that there are 'no surprises' for staff whose jobs may be affected by the review and that they will hear from us first about the proposals and have an opportunity to respond. We will ensure that they are aware of the process, understand how their roles may be impacted and will ensure they understand how they can give their views on the consultation.
- We will cover the geography, demography and diversity of Bristol, North Somerset and South Gloucestershire.
- We will identify groups more affected by stroke and in particular, what it is about these groups that may make it more likely that they will have a stroke. Particular reference will be given to protected characteristics and consideration of health inequalities across BNSSG, also in line with the Public Sector Equality Duty (PSED).

Consulting in an accessible way

- We will provide detailed information on websites to ensure transparency. We will also produce targeted public-facing documents (some printed as we know not everybody wants to access information digitally), summaries, case studies and social media content.
- We will make sure our public information is consistent and clear; written and spoken in 'plain English' avoiding jargon and technical information; accessible to everyone and available on request in a range of languages and formats.
- We will make clinical information and agreements available to the public.
- We will provide a range of opportunities for involvement and engagement with our consultation; reaching out to people where they are, in their local neighbourhoods and in local networks, physically and digitally.

Consulting through a robust process

- We will make sure that local people and the staff working in organisations affected by the proposals across Bristol, North Somerset and South Gloucestershire have confidence in our consultation process, ensuring it is open, transparent and accessible.
- We will be clear and up front about how all views can influence decision-making, explaining it will not be possible to do everything everyone wants and why difficult decisions have to be made.
- We will widely advertise and do our best to make sure people are aware of our consultation even if they choose not to participate.
- The consultation will run for twelve weeks to allow people to give their views and we will provide regular reminders about progress and the closing date.
- We will strive to ensure we are acknowledged locally and nationally to have undertaken a meaningful and effective consultation process and will seek support for our consultation plan and process from the Health Overview and Scrutiny Panel in our ongoing engagement with them.

Consulting collaboratively

- We will work collaboratively with individuals, stakeholders and partner organisations to deliver to our legal duty and to maintain our agreed consultation principles. We will also make the most of the opportunities of partnership working to reach out to as many people as we can in a meaningful way across Bristol, North Somerset and South Gloucestershire.
- Our information will be relevant to local groups, being clear about what the proposals mean for each geographical area and for each group of people taking account of their interests, diverse needs and preferences.

Consulting cost-effectively

- We will strive to ensure our consultation budget is spent wisely and used effectively in terms of reach and response, delivering good value for money.

Consulting for feedback

- We will monitor and evaluate our consultation process consistently and in a systematic way, including capturing feedback and comments from events, meetings, surveys, discussions and individual responses
- We will commission several interim reports in terms of consultation response analysis, to assess progress on where, how and from whom we are receiving feedback and responses, so we can target our activity to address gaps in feedback geographically or demographically
- The analysis of feedback will be done independently, and the independent report shared publicly
- The results of our consultation and the feedback received will be thoroughly and conscientiously considered and used to inform decision-making.

1.3. Planned consultation approach and methods

Our current approach will include a variety of consultation methods to reach a wide range of people, in particular higher risk and harder to access groups and those communities who may be disproportionately impacted by the proposed changes.

Table 1 outlines the planned consultation methods.

Our consultation plan and consultation document will:

- Offer the same level of information to people attending events and/or who ask to be given updates
- Be clear how proposals have been developed including why some have been discounted and others preferred
- Put as much information as possible in the public domain including showing the clinical, operational and population health evidence behind the need for change and for our proposals
- Provide regular updates to everyone in the local health and care system about progress and next steps in the programme and enable clinicians and other key programme decision-makers to have wide-ranging discussions which enable challenge and debate.

The consultation plan and the consultation document will be reviewed with our Patient and Public Involvement Forum, Stroke HIT Service User Group and the programme's Communications and Engagement Group to take on board any additional comment or ideas and to ensure that they are clear and well-understood.

In addition, we will seek advice from an independent research and evaluation organisation to help us design non-leading questions that meet the highest standards of research design for this sort of exercise and undertake cognitive testing on the consultation questionnaire to ensure that our target audiences find it easy to understand and respond to.

We will also present interim results half way through the consultation which will be shared with BNSSG CCG Patient and Public Involvement Forum (PPIF) for reflections on initial findings. This will allow the opportunity for discussion and analysis on themes to date, as well as helping to identify any groups or areas which may need further engagement.

It is also recognised that the COVID-19 outbreak has affected, and continues to affect, people and their communities differently. It is important that the planned consultation methods and approaches consider how specific groups may be disproportionately affected by COVID-19, and the impact this may have on their ability to engage effectively.

Table 1 – Overview of planned consultation methods

Consultation method	Approach overview / description	Target responses/reach
General publicity & information sharing	Public information promoted via a diverse mix of physical and digital channels (with use of physical channels adapted to reflect changes in response to Covid-19) e.g. advertising in local media, posters and postcards, support on social media, as well as via NHS organisations and established stakeholder channels. This will include proactive and tailored information to be communicated or shared with specific communities or groups	n/a
Website / online media	Designated webpage with comprehensive guide to consultation, events and activities, regularly updated Including information to help the public to understand the impact of the proposed changes on them individually	n/a
Telephone and freepost	To support open and accessible communications between the programme and interested parties, the consultation team will be directly accessible via telephone and post mechanisms in addition to online contact information. This will ensure the opportunity to give feedback is available to those who may be digitally excluded or less digitally experienced. There is a need to offer a range of methods of engagement to ensure certain groups are not excluded.	n/a
Representative survey	Random sampling led by an independent provider to gain the views of a representative sample that is reflective of the geography and demography of the region. Within this approach we have the ability to boost specific sub-groups e.g. specific geographical areas or demographic groups who are disproportionately impacted by proposals.	**N=1000**

	Although the gold-standard method for this approach is face-to-face, we currently recommend using a computer assisted telephone or CATI approach instead to reduce the risk and safety concerns about face to face interviewing due to Covid-19. This may be reviewed in the future should the current situation change.	
Online quantitative survey	This work would supplement the representative sample outlined above and would be comprised of a self-selecting sample, who respond to the survey in response to general publicity or specific outreach. We would be able to compare the two samples and identify any key differences or similarities between them, both in terms of response and demographic monitoring. Independent free text coding of survey responses would also be conducted to develop a deeper understanding of any insights gathered, including areas of concern and potential mitigations.	**N=1000**
Listening events & community workshops	These will be public meetings and drop-in sessions to provide an opportunity for detailed conversations with the public, local commissioners and providers. The exact details of these events are still to be finalised, however we would be likely to arrange multiple events which would give us sufficient coverage in terms of geography. Whether these events are remote or in-person is entirely dependent on our ability to hold face-to-face meetings in the summer of 2021 because of the covid-19 pandemic; which we will assess nearer the time. As it stands, it is expected that any large scale events would be held remotely using video conferencing with the option	**N=100**

	of ‘dialling in’ to the meeting. Smaller meetings with specific groups or communities may take place in person if it is safe and appropriate to do so. These sessions would take a lead from voluntary sector organisations already very active in the community (Bristol After Stroke and the Stroke Association) with supported face-to-face and virtual groups already occurring. Each meeting or event, where possible, will have a feedback loop built in to inform those involved of how comments have or will be used in the development of the proposals.	
Qualitative focus groups and interviews	Particular groups or individuals are likely to be disproportionately impacted by our proposals and we will need to make extra effort in order to ensure the views of these groups are captured effectively. We are likely, therefore, to hold a number of targeted focus groups and interviews in order to develop insights which may be specific to these groups. These additional engagement activities are likely to be distributed appropriately on a geographical basis as well, to ensure that our feedback reflects the population as much as possible. Whether these focus groups and interviews are remote or in-person is entirely dependent on our ability to hold face-to-face meetings in the summer of 2021 because of the covid-19 pandemic; which we will assess nearer the time	**N=15 - 30**
Staff engagement	There is already representation of each clinical area and staff group on the clinical design group for the proposed reconfiguration. Through cascade via clinical leads in each provider and clinical area, MDT colleagues have been involved in co-design of the proposals and comments have been shared, collated and used to guide and refine the development of the pre-	**Representation from each discipline, where possible, and each clinical team across each of the 3 providers and community service**

	consultation business case. Before and during the public consultation there will be deliberate, focused staff engagement events organised in each of the different clinical areas in the current stroke pathway to allow staff to provide formal feedback or comments on the proposals. This will include all members of the multi-disciplinary team, in both acute and community settings and also carers and other community staff employed by local authorities. The format will likely be a blend of in-person (where Covid-19 restrictions permit), telephone and digital engagement methods. Each meeting or event will have a feedback loop built in to inform those involved of how comments have or will be used in the development of the proposals. It is expected that further staff engagement will take place up to and once the Decision Making Business Case is approved. Any employer-led formal consultation with employees, on potential changes to individual job roles to support the implementation of proposed changes, would happen at this stage. As the staffing models are developing it is becoming clear that there are sufficient roles in the proposed reconfigured services for all staff currently employed in stroke care services across BNSSG.	**providers impacted by these proposals**

Ensuring Engagement Methods are Accessible

The Equality Impact Assessment (EIA) *(in development)* will give consideration to the delivery of specific activities within the consultation need to be made to ensure the opportunity to be involved is fully accessible and meets the diverse needs of the population. It is also important that those who are the most affected by stroke have equitable access to any engagement activities that are planned.

A range of both physical and digital channels will be used when sharing and promoting information about the consultation and the associated activities. This will ensure that those who are digitally excluded or less digitally experienced, for example those who are older or from areas of higher deprivation, still have the opportunity to be engaged and feedback. The EIA will describe how in general, people from more deprived areas have an increased risk of stroke. We also know that those from deprived areas are more likely to be disproportionally affected by COVID-19. By offering a range of channels and methods for engagement it means that these individuals will still have the opportunity to be involved in the consultation process.

Considerations around the format of any engagement activities and their promotion will also be taken. For example, there may be a need for disabled people to have information in a specific format, for example braille, larger font or audible. There are also considerations around ethnicity and language. Across BNSSG 10% are from black or minority ethnic (BME) backgrounds, and how individuals from BME backgrounds are almost twice as likely to have a stroke as white people. Within our consultation principles we have emphasized the importance of consulting with those who may be impacted by the changes, and making sure we consult in a way that is accessible. To address this we will offer and deliver translations and interpreter services for any engagement activity and materials.

Another factor which will be addressed is making sure that there are a range of dates and times for any activities. This will avoid exclusion of groups, for example those who may be of a younger working age, or individuals who are parents or carers with commitments during certain times or days.

Currently it is still unclear whether face to face events and meetings will be allowed to take place due to COVID-19 restrictions. As it stands, it is expected that any large scale events would be held remotely using video conferencing with the option of ‘dialling in’ to the meeting. Smaller meetings with specific groups or communities may take place in person if it is safe and appropriate to do so. This approach will continue to be reviewed as clarity becomes available on the restrictions in place. Again, the benefits of being able to offer both online and face to face activities means that there are a wider range of options for people to engage from different groups. Any accessibility requirements for both options will be considered, for example if organising a physical meeting making sure that the location is accessible and has the correct facilities for specific needs of a group or individual, or making sure that online meetings consider that some participants may be using screen readers and the delivery of the session needs to be suitable.

As we move closer to the consultation we will continue to define and develop the details of the engagement activities. We will continue to refer to the EIA (*in development*) for reference to ensure that the engagement activities delivered meets the broad range of requirements of the population of BNSSG.

1.4. Consultation materials

At the core of our consultation will be a consultation document and summary which clearly lay out the basis on which we are consulting, the background to the consultation, a summary of the data upon which options have been developed and what the proposals/options are, and signposting for more detailed technical information if needed. This document will be presented in language which easy to understand by the public, will also seek feedback and will also promote the various other methods by which people can engage in the consultation.

The consultation document and associated materials will be published on a dedicated section of the *Healthier Together* website under the *BNSSG Stroke Programme* section. This will be clearly signposted from the CCG website and system partner websites. It will host general information about the programme and consultation, including the case for change, structure charts and maps; meeting papers and other key decision documents; clinical evidence and data used to inform the design of proposals and decisions; documents and data relating to the *BNSSG Stroke Programme;* and the consultation questionnaire.

It is essential to ensure that we target, and cater for, groups and individuals with additional requirements, those responding on behalf of another individual and those who are less familiar with the subject matter. To best meet the needs of people with additional requirements we will:

- Produce documents in plain English
- Produce our summary consultation document and response form in an aphasia friendly version
- Produce our summary consultation document and response form in accessible formats, such as 'Easy Read' and audio formats
- Produce materials in different print formats on request e.g. Large Print, Translation Service, Braille

Throughout the consultation period we will receive regular response monitoring reports from the independent consultation analysis agency (who we will use to analyse the responses). We will monitor this information closely to identify any demographic trends which may indicate a need to adapt our approach regarding consultation activity. An example would be under representation from a particular demographic group or geographic area, particularly where there is a demonstrable disproportionate impact upon individuals within that group.

1.5. Public relations, stakeholder management, news and media

We will work with the media on a proactive and reactive basis – updating them proactively with key updates and milestones and responding quickly to any of their enquiries as they arise. To support us to do this we will create a rolling set of questions and answers and briefing documents on key elements of the programme. These will be updated regularly as the consultation progresses.

We will actively promote consultation events and opportunities through the local news media and social media, and will also consider, where required, advertising in local press and on social media to further amplify the messages and encourage involvement.

Specific media handling plans will be created for significant milestones throughout the consultation, including in each case, key messages, detailed questions and answers, targeted media, arrangements to offer broadcast interviews and photograph/filming opportunities, a record of who has been approached and briefings offered.

Detailed communications and consultation plans will be put in place to cover the launch, proactive public relations activity with all our stakeholders and reactive communications. A bank of stories and case studies that illustrate the case for change and the expected benefits of the proposals will be developed. An efficient and effective approvals process will also be important in terms of reacting quickly to negative or inaccurate articles and signing of the development of any new materials to respond to issues and themes as they come through the consultation.

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