South Tyneside & Sunderland Healthcare Group
South Tyneside Clinical Commissioning Group
Sunderland Clinical Commissioning Group

Path to excellence:
Ensuring a safe reconfiguration of service – best practice recommendations for communications and engagement

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Partners in improving local health

North of England Commissioning Support

Contents

1. Background

South Tyneside and Sunderland have been developing a Sustainability and Transformation (STP) plan in line with NHS requirements, to deliver the national Five Year Forward View (5YFV) and to ensure services for the combined areas will be sustainably safe and fit for purpose for the foreseeable future and tackle identified issues within the existing configurations and service inequalities.

Drivers for change include financial sustainability, limited workforce availability and the three gaps highlighted in the 5YFV

- the health and wellbeing of the population
- the quality of care that is provided
- and finance and efficiency of NHS services.

The programme is also being developed to ensure alignment with the adjacent STP across Durham, Darlington and Teesside. However it is important to note that the STP also includes out of hospital care and pathways across both hospital and community services.

The acute care programme is looking to achieve its objectives via three phases:

- Stroke, Trauma & Orthopaedics, General Surgery, Obstetrics and Gynaecology, Paediatrics, Increasing Elective work at STFT
- Pharmacy, Anaesthetics and Theatres, Cardiology, Gastro, Respiratory, Diabetes, Care of the Elderly, Specialist Rehabilitation
- ED, Critical Care, AMU, Diagnostics and Therapy Services

Whilst the primary focus of the Clinical Service Reviews will be services across Sunderland and South Tyneside, the on-going discussions around the STP footprint across Northumberland, Tyne and Wear, may provide further opportunities to explore wider economies of scale, particularly across Durham where City Hospitals Sunderland currently provides some specialist acute services.

Currently the plan is to have a programme of pre-consultation engagement and consultation for each phase, running with each phase initiated when the preceding one reaches the end of pre-consultation. This may be subject to change in timings dependant on how work progresses.

Communications and engagement requirements and resources have been scoped and agreed by the organisations involved. The proposal has been benchmarked against the resources and budget made available in Manchester for Health Devo, the Cumbria Success Regime and the Durham and Tees Better Health Programme and includes the communications and engagement experience and skill mix required and budget recommendations to deliver a safe engagement and consultation process. Safe refers to there being no successful legal challenge, no successful referral to the Secretary of State for Health and subsequent intervention by the Independent Reconfiguration Panel and therefore damage to the reputation to the NHS organisations involved.

This document provides the strategic context and parameters for the listening activity, and set the scene for the detailed case for change. A detailed case for change will set out the background and key partners driving the change. It would also explain the main challenges for the programme such as changing health needs, quality standards, availability and sustainability of workforce, and financial constraints. It will be important to outline here any discussions that have taken place with clinical staff, independent experts and national reviews

2. The Case for Change – communications positioning

A draft Case for Change document is being developed and in the main this considers the clinical case for change for each area of care service review. The rationale is so that clinical specialities can consider the challenges around each area of care and propose possible solutions.

There are a number of complex areas that are interwoven and it is important that there is no pre-determination of any final solutions that would be subject to formal public consultation. It is strongly recommended that all plans are marked and considered to be draft as

organisations and proposals are required to be open to influence through public engagement and subsequent formal public consultation insights.

Currently the case for change focuses naturally upon acute care. However there is a need to ensure there is a strong local narrative that gives a compelling vision of the challenges facing the sustainability of the local NHS and why it needs to be significantly transformed in order to be fit for the future.

This needs to be aligned to narrative development for the North East as a whole, Northumberland, Tyne and Wear sustainability and transformation, and to managing the three gaps in the Five Year Forward View.

These narratives must contain the full system health and social care perspective which is co-dependent on the acute care situation – and how more care must be moved out of hospital, and the role that empowering communities has to play in order to ensure a sustainable NHS in the future.

Given the complexity of the many different areas of service review, there is a significant risk of confusing the public as they are unable to relate the different changes needed to a bigger picture, making the communications and public relations challenges more difficult to manage therefore increasing the risk of fragmentation, stakeholder opposition, challenge to the process and damage to reputation and safe reconfiguration.

It is recommended that a strong overarching vision for health care fit for the future for South Tyneside and Sunderland is developed rapidly which is supported by all partners. This should explain the challenges and problems and that clinical leaders working with local community clinicians can develop some solutions. It should also link to any vision being developed for the STPs both regionally and nationally (this is still being determined.)

The vision should set out the gaps as highlighted in the Five Year Forward view and how they are relevant for local NHS and care services in South Tyneside and Sunderland.

Using this strong vision a high profile listening exercise should be planned and launched as the pre-consultation phase as statutorily required.

This would also need to contain the key threads of pre-engagement listening around the service reviews. By simplifying the approach it would help the public see the bigger picture and gain their input into what they feel is important to them.
The challenge is to make what are very complex issues as simple as possible for the public to understand, while ensuring underpinning good communications and engagement processes providing the right information for people to make an informed opinion. This in turn allows decision makers to understand public feedback in a systematic way, therefore fulfilling legal duties around major service changes and consultation.

Once a collective vision and case for change is agreed by local health leaders, a summary 'issues' document intended as a discussion document should be developed, along with a full programme of pre-engagement listening activity.

3. Consultation Governance and Quality Assurance

An Engagement and Consultation Governance Group should be established to manage and oversee the development and implementation of the consultation process and related consultation dialogue activity with the public. The senior strategic communications and engagement lead will chair the group:
Terms of reference will be developed for the Group, defining it's:

- Membership – including key clinicians, provider & commissioner representation and programme manager
- Purpose, scope and frequency of meetings

The scope of the Group will include, but will not be limited to, areas such as:

- Identification and mitigation of risks
- Co-ordinate key partner and stakeholder management (Eg councils, OSC, MPs)
- Budget oversight and management
- Compliance to legal duties, local and national policy, guidance and mandated requirements
- Ensure strategic links to wider STP development, NHS England assurance
- Mid-point review in line with best practice

The group will seek delegated authority to act and will help to ensure clear roles and responsibilities during the listening and consultation development and implementation processes, as well as avoiding unnecessary delay to activity that may otherwise be incurred whilst seeking permission to act on day to day matters.
The group will also develop links with NHS England and the Consultation Institute as part of its assurance and quality function.

Terms of reference are being developed for this group.
Appendix 2 shows the accountability and governance structure for this group.

4. Communications and engagement task and finish group

The main tasks of operational delivery of the communications and engagement programmes will be developed by a communications and engagement task and finish group. The membership of the group will be communications, engagement, patient experience professionals from all health and care organisations across the two areas.
Chaired by the senior communications and engagement lead, it will have strategic input from the health group programme manager and CCG commissioning managers.
The group will include HealthWatch organisations to ensure objectivity.
The group will act as the engagement and consultations issues management hub in order ensure horizon scanning and response to issues as they arise.
This group will advise, devise and develop best practice communications and engagement plans and operational activity to drive service review activity forward.
The scope of the Group will include, but will not be limited to, areas such as:

- Dialogue communications and engagement activity
- Developing narrative, questions and answers
- Ensure supporting communications, publicity and marketing as appropriate
- Development of surveys, discussion guides and other engagement activity
- On-going equality analysis and assurance throughout the consultation. Targeted engagement where necessary to ensure that people from groups with protected characteristics are fully engaged in a way that is accessible to them
- On-going analysis and identification of under-represented stake-holder groups and targeted engagement to ensure they have the opportunity to participate

- Advise the Consultation Governance and Quality Assurance on resources required and highlight risks and suggest mitigations

Appendix 2 shows the accountability and governance structure for this group.

5. Listening (Pre-engagement) and scenario (Options) development

One phase of pre-engagement will be known as the **listening phase** should be planned, developed and implemented to inform and underpin the:

- Draft vision for health and care in Sunderland and South Tyneside
- Development of proposed new models of acute care across:
    - Stroke , Trauma & Orthopaedics, General Surgery, Obstetrics and Gynaecology, Paediatrics, Increasing Elective work at STFT
    - Anaesthetics, Pharmacy Cardiology, Gastro, Respiratory, Diabetes, care of the elderly, Specialist Rehab
    - ED, Critical Care, AMU Diagnostics and remaining therapy
- Business case relating to the proposals and
- Development of a full public consultation on the proposals.

A listening phase should successfully achieve the following objectives:

Phase 1 listening exercise – to understand from listening (pre-engagement) phase

- The public and stakeholder understanding of the drivers and context for change
- The public and stakeholder response to the vision for health and care in South Tyneside and Sunderland
- The public and stakeholder response to the significant issues facing the health economy
- The experience of people using current services under review
- The ways in which those people, and the wider general public, think hospital services could be improved in South Tyneside and Sunderland

Phase 2 formal public consultation programme

- Build on any gaps in the engagement conducted in phase 1

- Provide the public with the opportunity to comment on the scenarios that are taken forward from an appraisal and scoring process
- Ensure a balance between clinical and public perspectives within the models going forward as potential options/scenarios for consultation
- Engage around, and validate, the equality analysis

6. Legal Duties and Requirements

There are several areas of interrelated statue, case law and national policy in relation to NHS reconfiguration and consultation. This section shows where this work would need to be compliant and planning audit trails would need to demonstrate the activity undertaken. This would also ensure best practice engagement and consultation as part of a quality assurance process with the Consultation Institute. NECS have a partnership agreement with the Consultation Institute and quality assurance is included as part of consultation activity NECS will deliver.

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

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

- Duty to promote the NHS Constitution (13C and 14P)
- Quality (13E and 14R)
- Inequality (13G and 14T)
- Promotion of patient choice (13I and 14V)
- Promotion of integration ((13K and 14Z1)
- Public involvement (13Q and 14Z2)
    a. Under S14Z2 NHS Act 2006 (as amended by the Health and Social Care Act 2012) the CCG has a duty, for health services that it commissions, to make arrangements to ensure that users of these health services are involved at the different stages of the commissioning process including:
        i. In planning commissioning arrangements

ii. In the development and consideration of proposals for changes to services
iii. In decisions which would have an impact on the way in which services are delivered or the range of services available; and
iv. In decisions affecting the operation of commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

6.2. S.244 NHS Act 2006 (as amended)

The Act also updates s244 of the consolidated NHS Act 2006, which requires NHS organisations to consult relevant Local Authority Health Overview and Scrutiny Committees (HOSC) on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services. They have powers to refer to the Secretary of State and/or ask the council to support a legal challenge if they feel listening and consultation processes are not robust.
Because the potential changes cover two local authority areas, the local NHS will need to formally request that the two HOSCs form a single joint HOSC to consider the issues, however they will retain their right to an individual HOSC view.

6.3. S.149 Equality Act 2010

1. A public authority must, in the exercise of its functions, have due regard to the need to:
    a. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
    b. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
    c. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
2. A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).
3. Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

a. Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
b. Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
c. Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

4. The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.
5. Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:
    a. Tackle prejudice, and
    b. Promote understanding.
6. Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.
7. The relevant protected characteristics are:
    - Age
    - Disability
    - Gender reassignment
    - Pregnancy and maternity
    - Race
    - Religion or belief
    - Sex
    - Sexual orientation

6.4. S.3a NHS Constitution

The NHS Constitution sets out a number of rights and pledges to patients. In the context of this project, the following are particularly relevant:

Right: You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of

proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

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

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

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

6.6. Mental Capacity Act 2005

The MCA says:

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

The principles

1. The following principles apply for the purposes of this Act.
2. A person must be assumed to have capacity unless it is established that he lacks capacity.
3. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

4. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
5. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
6. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

6.7. Human Rights Act 1998

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

6.8. The Gunning Principles

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

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

The principles are as follows:

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

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

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

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

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

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

The four tests are:

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

As a proposal is developed and refined commissioners should ensure it undergoes a rigorous self-assessment against the four tests

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

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

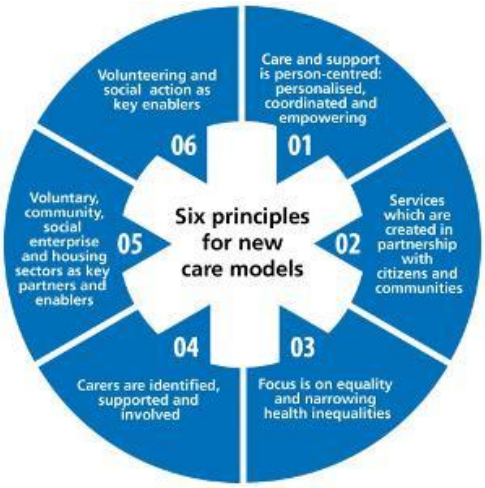
Section 4.4 of the guidance refers to involvement of patients and the public, stating that “it is critical that patients and the public are involved throughout the development, planning and decision making of proposals for service reconfiguration. Early involvement with the diverse communities, local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

6.11. Transforming Participation in Health and Care – NHS England Guidance

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

6.12. Empowering communities – six principles for new models of care

NHS England has published six principles for changing the way that health and care relate to people and communities. These ‘six principles’ set out the basis of good person centred, community focused health and care in the model here.



7. Equality analysis

The NHS has a duty to meet its public sector equality duty, as defined by S.149 of the Equality Act 2010.

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

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

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

Targeted engagement has ensured that people from all groups with protected characteristics, defined within the Equalities Act have had the opportunity to participate in the three phases of pre-engagement and the development of potential new care models.

To ensure that the CCG is fully meeting this duty, an equalities analysis will need to be undertaken, validated and then further informed through continuing engagement.

An equality analysis will consider potential impacts that any change to care services may have on people from groups with protected characteristics.

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

The equalities analysis will need to be reviewed throughout the consultation process, and additional engagement will be conducted around this as required. It is worth noting that around 80 per cent of legal challenges are won on equality grounds where it has been shown that not enough attention has been paid to equalities analysis and subsequent mitigation.

8. Stakeholder mapping and issues management

NHS organisations need the right information to inform decisions for its community. It continually strives to maintain and strengthen its its strong working relationships with its stakeholders.

A detailed stakeholder map will be developed to ensure that relevant stakeholders are aware of, and have the opportunity to participate in engagement and consultation. These will be mapped against interest and attuitudes.

- General public (includes Patient Reference Groups)
- Voluntary development agencies

- Charity and community groups
- Statutory authorities and regulatory bodies such as health overview and scrutiny committees HOSC and a formal request to establish a joint overview and scrutiny committee JHOSC across the two geographies
- Internal (such as other CCGs and providers)
- Media (such as local and national radio and TV)
- Government (such as MPs)
- Regulatory bodies (such as NHS England and NHS Improvement)
- Public sector partners (such as Local Authorities)

Stakeholder mapping will also include a focus on disadvantaged, marginalised and minority groups and communities, who may not always have the opportunity to have their say in decisions that affect them. This is particularly important in South Tyneside and Sunderland area due to high levels of deprivation and health inequalities, as well as the diverse make-up of the local population.

It is very important to take a managed approach to liasing with MPs, JHOSCs and other stakeholders to ensure a consistent message and any issues are identifed at an early stage and minimised.
It is therefore best practice and strongly recommended that an issues hub is established to identify and manage stakeholder relationships and issues to ensure co-ordination and consistency of message. This will also allow best use of resources and field the most appropriate clinican, executive or senior staff as appropriate.

9. Narrative development

A listening exercise and subsequent formal consultation narratives will be developed, that will detail:

- The background to the listening phase and how that progresses as a thread into the consultation phase
- The case for change (builds from listening into formal consultation)
- The options/scenarios for change
- The rationale for the options/scenarios and why some options were not included, or developed, as part of the consultation

- How people can participate in both the listening and consultation phases and give their views

The narrative content will ensure integrity, accessibility and transparency of information. It will clearly inform those participating in the consultation of the rationale and case for change, the options for change and any potential impact that change might have on those using, or likely to use, hospital services under consideration.

10. Dialogue development

A variety of communications and engagement activity will be used to ensure that the listening and consultation dialogue activities are fully accessible to the diverse and varied population.

To deliver this engagement activity effectively, across the consultation dialogue period, a substantial amount of development work will be required.

Development activity around areas such as:

- Identification of resources and suppliers
- Stakeholder mapping
- Consultation narrative and questionnaire/survey work
- PR, marketing and advertising
- Use of digital technologies, dedicated web pages, on-line survey, social media
- Public events, drop-ins, information sessions etc.
- Production and distribution of consultation materials
- Ensuring mechanisms are in place for analysis and reporting of data streams from both phases of dialogue activity

11. Standards and formats of information

All information produced as part of the consultation will be written in language that can be understood by members of the public. Technical phrases and acronyms will be avoided, and information will be produced in other formats as required, to reflect the needs of the population.

This may include, but is not limited to:

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

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

12. Documentation and resources

Development work will include consideration of required documentation and resources.

This will include, but is not limited to:

- Consultation narrative documents and questionnaires
- Posters, leaflets and flyers – print and digital
- Video and audio for on-line and social media
- Stand-up banners
- Venues for public events
- Catering

13. Communications and engagement objectives

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

The communications and engagement objectives are to:

- Effectively engage the local population, partners and other stakeholders
- Give the local population, partners and stakeholders the opportunity to consider and comment on the scenarios for new models of acute care services

- Use the comments and feedback from the local population, partners and stakeholders to inform consideration by the CCGs and providers as to how it should provide services to best meet the needs of the population
- Inform CCG commissioning responsibilities in relation to the services under review and inform providers in the delivery of those services
- Ensure that the listening and consultation is accessible to local people, patients, partners and key stakeholders, that they are aware of the phases and have the opportunity to participate fully, should the wish to do so

14. Communications and engagement activity

A comprehensive programme of communications and engagement activity will be planned for the consultation. This will include:

- Media releases
- Public relations activity e.g. consultation launch
- Briefings with local media outlets e.g. BBC Newcastle, the Gazette, the Echo
- Social media and digital activity and paid for advertising – Facebook, YouTube and Twitter
- Videos/Podcasts/Blogs
- Syndicated Information for internal newsletters, e-bulletins and paid for media supplements
- Attendance at local area committee/People boards
- Articles and/or advertising in local authority publications
- Paid for advertising in local media outlets
- Posters, leaflets, brochures inc. distribution/mail drop
- Public events in different styles
- Surveys – subject specific both paper and on-line
- Face to face interviews
- Focus groups

15. Budget and expenditure

The budget will be overseen and managed by the project team. The project team will also oversee and manage expenditure relating to listening phase and consultation phase development and dialogue implementation activity. Bench marked against similar

programmes Manchester Health Devo non-pay programme budget £500k, Cumbria success regime £200k- it is recommended that around £90k should be budgeted to deliver the two phases until March 2017.

A full detailed budget will be produced to illustrate the main costs and overseen by the Consultation Governance Group.

16. Risk and mitigation

Risk and risk mitigation will be managed by the Risk will be identified and regularly reviewed and assessed throughout the consultation development and implementation.

Current identified risk includes:

Failure to engage with relevant stakeholders and meet statutory duties / stakeholders feel that they have not been fully involved

- Plan developed identifying relevant stakeholders and partners
- Ensure all stakeholders receive appropriate updates and feedback
- Ensure appropriate stakeholders are invited to participate in a way that is accessible to them
- Ensure clear communication of messages through robust communications plan, including updates on CCG and trust website, newsletters, bulletins and through My NHS

CCG does not engage with marginalised, disadvantaged and protected groups

- Plan identifies relevant groups and organisations. Also work with local voluntary sector groups, community organisations and partners to access these groups and communities

Lack of response / “buy in”

- Ensure adequate publicity and support

Accessibility of activities and appropriate feedback mechanisms to those taking part

- Ensure clear contact for translations or alternative format
- Include appropriate feedback mechanisms in plan that are accessible to people with varying needs and abilities

Managing expectations of members of the public

- Ensure adherence to communications plan and advise of any issues that arise

The consultation and proposals for change may be seen as a cost-cutting exercise by members of the public

- Ensure clear case and rational for change is communicated within the consultation narrative
- Ensure adherence to communications plan and advise CCG of any issues that arise

The consultation may be subject to challenge

- Appropriate governance policies / standards will be put into place to ensure correct procedure and equality analysis are maintained throughout the consultation

The public may become confused due to the number of change projects, and related engagement, taking place at the same time

- The following projects will be conducting engagement activity at the same time:
    - New Care Models Programme MCP and U&EC (Vanguards)
    - Better Health Programme (Durham)
    - Urgent care in Sunderland.
- The overlap of these programmes, with simultaneous engagement activity, may confuse members of the public and cause engagement “burn out.”
- Communications channels will be established between the different projects to co-ordinate engagement activity and to minimise potential confusion

- Clear messages will be communicated to the public to ensure they understand what each project relates to, and to enable them to decide whether or not they wish to engage with each project

17. Data analysis

The listening and consultation activity will result in a number of streams of quantitative and a very large amount of qualitative data. Due to the size and nature of the consultation, it is anticipated that the amount of data will be significant and the time and expertise to analysis should not be underestimated.

As the data and feedback from the public will inform the decision-making in relation to potential changes and developments to care services, it is essential that the data and feedback is subject to robust, in-depth analysis. The final reports will be subject to a great deal of scrutiny by the public and by other stakeholders such as HOSC, Health Watch and the media, therefore it is critical that it is robust and well presented.
Given the size and complexity of the data, along with the timescale available for analysis, an external supplier, with expertise in this area, will be commissioned to conduct the data analysis. This also provides independence from the NHS and helps reassure stakeholders and the public that it is robust, trustworthy and transparent.

This supplier will be identified as part of the listening and consultation development process, and will be in place to begin the analysis before the end of the listening and consultation dialogue activity.

18. Reporting and feedback

Full communications and engagement reports will be produced for each phase.

This will contain an overview of the listening and consultation, along with the data analysis, feedback on options from the public perspective and conclusions and recommendations for consideration by the CCG as part of its decision-making process.

The reports will be published and widely distributed, to enable all stakeholders to see the results and recommendations from the listening phase and them also from the consultation.

Formal feedback periods will be planned to allow anyone to challenge the content of the reports, therefore allowing time to adjust if needed, therefore minimizing risk of any challenge.

Following a period of consideration post consultation, the CCG will then make a decision on any changes to health and care services. This decision will also then be published and communicated to stakeholders, along with the rationale for making that decision and the reason that other options were not taken forward.
This will be subject to a communications plan in order to close the loop as the final decision on the changes that will take place and how stakeholders will be involved / informed of progress in delivering those changes.

19. Evaluation

Evaluation will be on-going throughout the consultation period, led and overseen by the Consultation Governance Group.

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

The results of the evaluation will be shared and lessons learned will be taken forward to inform future projects

20. Recommendations

The hospital group and CCGs are recommended to endorse the best practice communications and engagement approaches outlined in this paper and:

- Recognise the risks of not ensuring good process and communications/engagement best practice presents around significant variation of services
- Mandate a governance group to be established to undertake the engagement and consultation

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21. Appendix 1 – references to other engagement and consultation programmes

Deciding together

NHS Newcastle and Gateshead – reconfiguration of specialist mental health services. Full details of the two listening phases and subsequent formal public consultation period can be found on the link below. This two year process culminated in June 2016.
http://www.newcastlegatesheadccg.nhs.uk/get-involved/mental-health/deciding-together-2/

Better Health Programme

The Better Health programme has been created to bring together local NHS organisations to create area wide solutions which address challenges that, until now, individual organisations have been trying to tackle on their own.
https://nhsbetterhealth.org.uk/

Manchester Health Devo

Wide ranging public consultation around rearranging acute services as part of the devolution.
http://www.gmhsc.org.uk/

Cumbria Success Regime

The West, North and East Cumbria Success Regime has been established to help create the right conditions for high quality health and social care to develop in this area. Its aim is to secure improvement by introducing new care models where appropriate, developing leadership capacity and capability across the health system and ensuring collaborative working.
http://www.successregimecumbria.nhs.uk/

22. Appendix 2 – governance group accountability chart