



The path to
excellence

Communications and engagement strategy

Phase two – Path to Excellence programme

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Author: Caroline Latta

Strategic public engagement and communications lead – North East

NHS North of England Commissioning Support (NECS)

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Authors:	Caroline Latta - NECS Emma Taylor - NECS Liz Davies – ST&S FT's
Owner:	Caroline Latta
NHS organisations	South Tyneside and Sunderland NHS Partnership (two CCGs and two FTs)
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1. Background to strategy development

This strategy builds upon the outline public engagement and communications strategy developed in winter 2017 for the next phase of the Path to Excellence Programme (P2E) – which focuses on the programme of acute care collaboration between South Tyneside NHS Foundation Trust and City Hospitals Sunderland NHS Foundation Trust.

It has been developed further after endorsement and input from P2E NHS South Tyneside and Sunderland partners from both trusts and clinical commissioning groups, stakeholder advisory panel and Health Watch organisations

Clear tactical action plans underpin key elements of this strategy which is a live working document, tracking key deliverables for the programme of public engagement.

It takes into account the legal and policy context for NHS service change, best practice communications and engagement advice to support staff, public and stakeholder understanding, gain support to develop the best solutions for change to ensure NHS service sustainability, and minimise opposition.

For the purposes of this strategy the term ‘public’ incorporates all stakeholders, public, patients, staff, elected members, other NHS bodies, the community and voluntary sector, and other individuals and groups as identified by the stakeholder analysis. (See section 8)

This strategy incorporates learning from phase one of the Path to Excellence pre-engagement and consultation programme as reported to both NHS South Tyneside Clinical Commissioning Group (CCG) and NHS Sunderland CCG at their joint decision making meeting in February 2018. Clear adaptations in the phase one strategy were identified along with recommendations for phase two strategy which are included in this updated paper.

[Read the P2E phase 1 consultation process assurance paper here](#)

It also takes account of the North of England Commissioning Support communications and engagement staffing resource available via the P2E programme which will deliver best practice strategic advice and guidance, and deliver agreed operational activity working closely with the trust’s head of communications, P2E programme manager and associated in-house NHS teams.

It demonstrates how enhanced staff engagement and broader participation in the pre-engagement phase will take place in response to feedback from key partners and stakeholders around their desire to be involved.

In particular, it incorporates equality delivery as integrated to this strategy and not as a standalone.

To date, the Path to Excellence programme has drawn upon robust methods of social research as consultation and engagement methodologies where appropriate to provide a best practice approaches.

However, engagement and consultation around significant NHS service change is not an academic research project but more a targeted continuous dialogue with staff and communities who are most affected by potential changes. The process aims to ensure that they have the information, time for consideration and clear ways to give their views, with a particular focus on collecting depth qualitative feedback to give the richness of insight to inform robust solutions to the problems the NHS is facing and to support decision makers in performing their statutory duties and inform their final decisions.

The Path to Excellence partners recognise that a programme of pre-engagement and subsequent formal public consultation for significant NHS service change is a continuous (on-going) dynamic (adaptable/open to change) dialogue (a two way conversation) and as a result this strategy will adapt as work progresses.

In the light of this, this strategy sets out a sound basis to progress work, with clear rationales for activities within NHS policy (Including the NHS Five Year Forward View), best practice communications and where relevant statutory duties and case law.

It should be noted that this version (March 2018) sets out the pre-engagement strategy, this paper will be updated to incorporate the formal public consultation phase, to take place in spring/summer 2019.

It should also be noted that while this strategy makes reference to the need for a wider communications and engagement strategy about creating a vision for health and care across South Tyneside and Sunderland (see section 16), this strategy specifically focuses on the acute / hospital services aspects. This in line with the NHS Five Year Forward View vision and, in particular, to help close the gaps in quality and the variations in patient outcomes and experience which currently exist by reshaping how acute hospital care is delivered.

As work progresses on a wider vision for health and care across South Tyneside and Sunderland, this will focus on other important aspects of the NHS Five Year Forward View. For example how we support people to take responsibility for their own health and wellbeing so that they do not become unwell with wholly avoidable illnesses, and how we can continue to improve efficiency across our health and care system.

2. Introduction

This strategy sets out the NHS legal and policy context for significant service change in relation to public consultation and engagement, and the strategies, governance and subsequent activities that will need to be undertaken in order to ensure a robust process for the Path to Excellence phase two pre-engagement and consultation in line with this context.

The NHS legal and policy context is set out in appendix 1.

The main services being reviewed are those delivered by South Tyneside General Hospital and Sunderland Royal Hospital. These are:

- **Acute medicine and emergency care**
- **Emergency surgery**
- **Planned care and outpatients**

The challenge is to make what are very complex, interdependent 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 view. This in turn allows decision makers to understand public feedback in a systematic way, incorporate the feedback into planning and options development, and ensure compliance in regard to legal duties around major service changes and NHS future public consultation.

This strategy provides the framework for:

- clear rationales for activities to be undertaken
- how specialised communications and engagement expertise will be deployed
- how that expertise will support clinical leaders and other NHS staff to lead public and stakeholder engagement
- how the governance and partnership arrangements provide oversight on the end to end programme of pre-engagement and subsequent public consultation.

The strategy outlines that two distinct phases of pre-engagement and subsequent formal public consultation will be developed and mobilised.

It sets out how insights gained from patient experience and public/staff engagement will influence the development of credible options for service change during the formative stage and prior to formal public consultation.

These future options will be presented and open to influence during a public consultation planned for spring/summer 2019 with decision making likely to be early 2020.

There is a clear stakeholder, staff and public expectation to be involved earlier in phase two and as a result pre-engagement phase involvement with key groups will be enhanced.

Updated programme governance includes establishment of P2E consultation stakeholder reference group (provide advice, views, suggestions or opinions on communications and engagement activity). The terms of reference for this group is included as appendix 2

2.1 Wider learning from NHS system reform

A range of issues and themes have emerged over recent years which are helpful to consider in strategy planning for major service change. The themes below have been developed from IRP learning, The Consultation Institute learning and reviews of major service change learning in Cumbria, Manchester and the North East.

Programme management resources

Consideration of the range of experience, professional expertise and resources needed within programme teams. This should include staffing as well as operational budgets to deliver a programme of public engagement and consultation.

Clinical leadership

Visible senior clinical leadership to lead the stakeholder and public conversations.

Early engagement

Ensuring early engagement with stakeholders on the issues and their involvement in options/scenarios development prior to formal consultation. This is an increasing area for judicial review, with recent successful legal challenges focusing on the pre-consultation option development phase.

Clear vision

A clear vision for the future, supported by all partners in the reform programme, and articulated clearly in case for change and communications messages supporting a transparent process throughout, openness and authenticity.

Consideration of money, transport and equality delivery

Ensuring clear articulation of finances, transport analysis and equality impact reviews. This should also include relevancy testing and incorporated into engagement and consultation strategy. In recent years a number of legal challenges have been won on equality grounds where equality delivery duties of due regard have not been met.

Credible case for change

Clear and credible published document which sets out the issues, challenges and objectives for the reform. Supported by facts and data sources.

Benefits clearly articulated

The benefits of change need to be clearly shown and aligned to evidence. This should include expectations around improvements in clinical outcomes and patient experience.

Sufficient, credible implementation planning

Ensuring a robust plan for implementation to include capital considerations and staffing/workforce.

2.2 Service change solutions development and selection

In order to support a logical process of developing solutions for change, a staged approach works best. The process below has been adapted from The Consultation Institutes recommended best practice.

Step 1 - identify all the wide range of possible solutions that should be considered in the process. This is an ideal opportunity to involve stakeholders including staff to ask them what solutions do they think will work?

Step 2 – Check which of the possible solutions is viable. A proposal is only viable if it meets agreed essential criteria. Essential criteria are ‘must have’ attributes that can include safety requirements, regulatory requirements and the total amount of money available. Step 2 assessments are normally completed by experts. Good record keeping and transparent communications are essential.

The output of Step 2 is a long list of viable proposals.

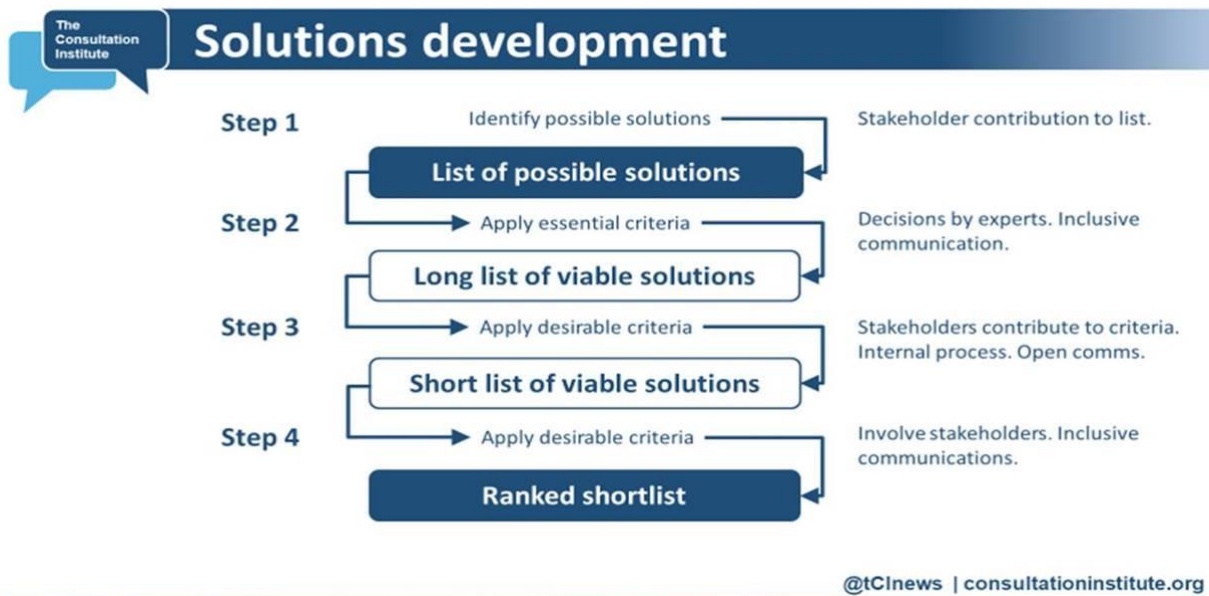
Step 3 – narrow its list of viable proposals to those that best meet the stated objectives of the Path to Excellence programme. This can be achieved by assessing each of the viable proposals against desirable criteria. Desirable criteria are those elements of the proposals over which the consultant has influence: the choice elements of a decision. Developing desirable criteria to apply is another ideal opportunity to involve a range of different stakeholder perspectives where the local NHS can ask what matters to stakeholders and use that information to inform the desirable criteria.

The output of Step 3 is a longlist of viable proposals ranked in order of those that best meet the stated objectives of the programme.

Step 4 – The consultant needs to consider which proposals to offer as credible options in a public consultation. The consultant needs more detailed information about the relative merits of each of the viable proposals on its shortlist. This is another ideal opportunity to involve a range of different stakeholder perspectives.

The output of Step 4 is detailed information on the relative merits of each of the remaining proposals for decision makers to take into account when they decide which options to present in a public consultation. The output of the process is information to present to the CCGs that informs and influences their decision on which proposals to include as options in a public consultation. It provides detailed information on the reasons for discarding each of the possible solutions that don't make it into the consultation document.

In graphic form, the basic building blocks of the process are:



3. Pre-engagement phase (December 2017– Autumn-Winter 2018)

3.1 Communications and engagement strategic objectives

During the pre-engagement phase, the key objective is to ensure all activity is to ensure the successful preparation of full pre-consultation business case and relevant assurance assessments for formal consultation in 2019.

The objectives are:

- Ensure compliance with key NHS legal and policy requirements for significant service change in relation to public engagement and future consultation
- Benchmark patient experience across the pathways to inform clinical service review case for change and option development

- Ensure staff engagement and involvement in order to provide opportunities for input, feedback, influence and sense checking on emerging future options
- Development of updated issues document /case for change to include the draft working list of future potential options be shared initially in draft form to allow for staff, public and stakeholder feedback in order to influence option development at the formative stage
- Carry out detailed stakeholder mapping and data analysis in order to identify civic society groups and organisations with interest
- Provide wider opportunities for participation by key groups with interest and experience in the specific issues as identified by the stakeholder mapping
- Deliver a highly visible public engagement programme throughout summer 2018 to socialise the issues, explain the current gaps in quality, share the early thinking from staff on potential solutions and allow an opportunity for the public to influence potential solutions at the formative stage.
- To explain how the problems are being identified, how ideas for change will be assessed using transparent assessment criteria, how 'clinical due diligence' will take place in order to ensure feasible options for the future are developed
- To test improved communications and engagement mechanisms to ensure they are robust and support continuous dynamic dialogue required for best practice consultation utilising digital and social media as required

4 Ensure compliance with key NHS legal and policy requirements

As highlighted, appendix 1 contains information on the NHS legal and policy context for service change – and it is summarised below.

NHS policy requires two distinct phases to deliver significant service change:

- Pre-engagement phase – socialising issues and case for change, staff and stakeholder involvement in option development (the focus of this strategy as of March 2018)
- Formal consultation phase – formal consultation on options devised in the pre-engagement phase (this strategy will be updated later in 2018 to plan for formal public consultation)

Compliance required with statutory legal duties for consultation, including consultation with Joint Overview and Scrutiny Committees (JHOSC), plus case law such as the Gunning Principles and the Equality Act.

Compliance required with five NHS assurance test for service change:

- Clinical engagement and support from clinical commissioners

- Strong patient, public and stakeholder engagement
- Clear clinical evidence base
- Consistent with current and prospective need for patient choice
- Bed test (added in April 2017)

Other key NHS policy areas to ensure alignment:

- Empowering community model for patient centred care
- NHS constitution standards around patient involvement and patient choice
- Clinical standards
- Five Year Forward View

In order to gain third party independent quality assurance of the process, the programme will work with the Consultation Institute.

This strategy and associated action plans acts as assurance on meeting NHS legal and policy obligations in relations to the public engagement and communications elements of significant service changes for the NHS.

5 Benchmarking patient experience

Ensuring robust insight around current experiences of services is critical intelligence required to help the clinical design teams understand what is important to patients, what is working well and what areas there are for improvement.

This will be conducted in a three phase approach, with each phase feeding into the next:



5.1 Desk review

In line with best practice, and to assist discussions taking place amongst staff from both South Tyneside and City Hospitals Sunderland NHS Foundation Trusts, a desk review was undertaken of any national benchmarking patient experience surveys to allow comparison of the performance of both Trusts against national standards.

The review also reviewed existing local, regional and nationally available insight and patient experience work for each clinical speciality.

Again in line with best practice, this is carried out in order to frame the local engagement research methodology and ensure previous work is not reinvented to continue to build a robust insight knowledge base.

5.2 Qualitative patient interviews and surveys

In addition, targeted engagement was also undertaken with patients from both Trusts to further understand patient experience and perception in relation to the above clinical review service areas.

Planning started with the communications and engagement task and finish group in November 2017 to develop surveys and discussion guides.

Patients and carers in hospital settings were targeted to share their recent experience of using these three clinical service areas and how they feel they could be improved.

A small segment of the patient population with an overall sample size of 126 people responded by taking part in a facilitated one to one surveys in Trust sites.

These face to face surveys were carried out in order to give a flavour of the real-time views and opinions of patients who have recently used services at both Trusts (during February 2018) in order to inform staff engagement workshops planned for March 2018 and clinical service review discussions at the earliest possible stage.

Field work in the Trusts took place during the month of February 2018 at a time of heightened demand for NHS services.

A draft analytics benchmarking patient experience report is included at Appendix 3 and will be updated with wider field work findings when completed.

5.3 Wider patient experience field work and quantitative research

The qualitative face to face survey work described above will be supplemented by broader quantitative field research over Spring 2018 which again will be shared with the teams involved in the clinical services review work streams to inform discussions.

The tactical engagement delivery of the qualitative research will be decided after the key demographic data for the target groups of patients is analysed in order to ascertain the most appropriate engagement method.

This will be used to inform the further development of the engagement and communications plan for each specialty included in Phase 2 and will include publicity and promotional activity relevant to each target group (in line with the MOSAIC segmentation tool) to raise awareness of the opportunity for those with experiences of the local services to give their views.

For example, targeting of people who've recently used Emergency Departments via social media for an online survey (younger groups more likely to use smart phones and social media); and the direct mailing of a paper survey to acute medical patients

with long-term conditions and their carers (older groups with a preference for paper formats).

The two main methods for this engagement research phase includes quantitative surveys, either by direct mailing with a free post return or online targeted via digital advertising and social media, and as noted above by face to face qualitative surveys carried out on hospital wards and out-patient clinics in the hospitals by trust patient experience staff and volunteers.

In order to ensure quality assurance, surveys and questions will be benchmarked against national NHS or special interest group surveys, in order to ensure relevancy and good practice. All final versions are to be agreed by the communications and engagement task and finish group and signed off by the lead medical director for the programme.

During this engagement activity, a dedicated event with local community and voluntary sector organisations to brief them on the issues, explain the engagement process and gain support and involvement to engage with service users to provide the opportunity to give their views. In summary, with the focus particularly in relation to equality impact and ensuring the process can capture the views of people with protected characteristics.

6. Staff engagement and involvement

As key improvements from phase 1, enhanced staff engagement and involvement has been supported and as highlighted in the outline strategy, is underway.

Across both Trusts there has been improved staff communications for all staff – and specific targeted with staff working across the three key clinical service areas under review. This has included very clear visibility on who is involved in each of the work streams and regular proactive briefings across both Trusts in relation to Phase Two.

Targeted staff communications and involvement was identified as needed with teams in the three service areas:

- Acute medicine and emergency care
- Emergency surgery (including theatres and critical care)
- Planned and ongoing care and specialist services

The objective was to capture views from frontline staff on the challenges and difficulties they currently face in service delivery, what ideas they had for improvements for service delivery and also their feedback on how staff should be involved.

6.1 Staff survey

A survey was designed to capture views from frontline staff in South Tyneside and Sunderland on the challenges and difficulties they currently face in everyday service delivery and to seek their ideas on how to further improve the quality of patient care.

The survey included quantitative and qualitative methods, the findings reported back to staff and used to inform the development of phase 2 case for change as well as improved staff communications and involvement.

In total, 710 people members of staff responded to the questionnaire from a total of 4246 staff who were invited to take part who work in the areas impacted by Phase two. This represents an overall response rate of 16.7%. Of these 710 responses 580 members of staff responded to most of the questionnaire.

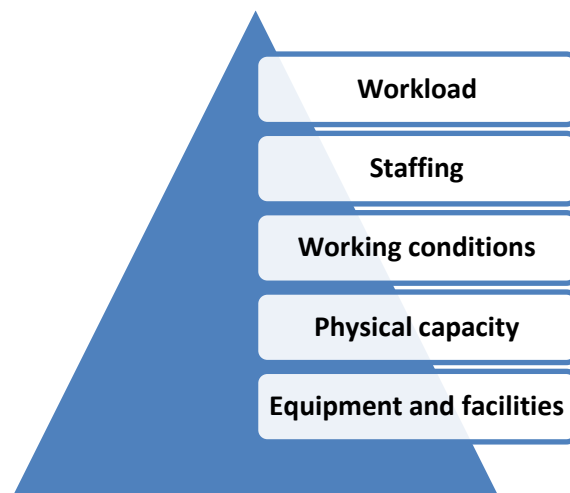
Almost a fifth (17.8%) of staff invited to complete the survey at South Tyneside NHS Foundation Trust did so (n = 215 from a sample size of 1207). This equalled six per cent of the total Trust workforce. For City Hospitals Sunderland NHS Foundation Trust, sixteen per cent (16.3%) of staff invited to complete the survey did so (n = 494 from a sample size of 3039). This equalled ten percent of the total Trust workforce.

Summary quantitative feedback from staff survey

- A third of staff told us that their ward or department often saw patients who should be admitted or seen by another speciality. Nearly all (93%) of respondents felt they had the right skills to deal with patients in their ward or department.
- Almost four out of ten staff felt there was enough staff and capacity on their ward or department to treat patients safely and effectively most of the time (38%) or some of the time (37%).
- Only 24% of staff reported having easy and quick access to specialist advice about their patients care and treatment all of the time, with 53% stating this was available most of the time.
- Only 17% of staff reported having easy and quick access to diagnostic tests, scans, and results all of the time, with 52% stating this was available most of the time

Summary qualitative feedback from staff survey

The top five qualitative themes from the staff survey are detailed below, with most people commenting on issues to do with workload, staffing, working conditions, physical capacity and equipment and facilities:



Workload

This theme includes comments made about an increased or large workload for staff. This includes staff having to work across multiple sites. Staff mentioned having a lack of capacity to carry out their role, with competing timescales. Staff commented on high-dependency patients and balancing complex case-loads.

Staffing

A number of comments were made in relation to a shortage of staff, and a shortage of appropriately trained staff or specialist staff. Some staff commented that there was inadequate staff employed. Training was identified as an issue – either through people having training needs which are not being addressed, or not being able to find the time to attend training. Some staff were asked to work-up beyond their skills or role, and some staff felt they were asked to do jobs below their current role. There was also comments made about the use of agency staff and locums, particularly in the final question (any other thoughts or comments). For example, one member of staff commented how they needed a consistent consultant instead of locums to help support the team and ease pressure. Another member of staff commented on the expenditure of outsourcing staff (locums) in Radiology.

Working conditions

This theme identified issues such as overtime, flexi-time, sickness, low pay, and lone-worker policy. Some people identified bullying and harassment, unfair dismissal, or working with obstructive staff. This theme also covers comments made about management, decision making and financial issues. A number of staff mentioned low morale, and feeling undervalued. This includes low job satisfaction and people looking for other jobs. People commented how they are unable to find a work-life balance, and were asked to work beyond their hours without pay. Staff commented on feeling mentally exhausted. Alongside job insecurity, staff felt there was no career pathway or progression for them. They also felt their roles had too many admin tasks associated with them. A lack of communication was also

mentioned, both internally with staff, perhaps through bulletins, and externally to the public.

Physical capacity

Staff frequently mentioned a shortage or limitation of bed space for patients. Comments were received in relation to not having capacity to accommodate referrals from other services. Staff felt pressured to discharge patients to free up bed space and capacity. Comments about waiting lists also fell into this theme. In addition, comments about a lack of storage space fell into this theme.

Equipment and facilities

A number of comments were made in relation to out of date equipment. This included IT equipment, but also medical facilities. Staff identified a high demand for certain rooms and facilities (such as theatre space and x-ray equipment) as a challenge. They also identified improved IT systems and electronic access to medical records as an area for improvement. Staff also commented on inappropriate facilities for patients (for example – a ward not being suitable for neuro or stroke rehabilitation). Finally, this theme covered a lack of stock (staff predominantly did not elaborate further than ‘not enough equipment’ or ‘low stock’, however one member of staff identified low film for x-ray rooms).

The full staff survey report is included as appendix 4

6.2 Staff engagement events

Three half-day discussion workshops were held in March 2018 for each of the clinical review service areas:

- Emergency care and acute medicine
- Emergency surgery
- Planned and ongoing care and specialist services

As well as the core design team, key representation from the wider workforce was invited **from both Trusts** and included:

- Ward managers and senior nursing staff
- Junior doctors and middle grades
- Clinical support (radiology, pathology, therapies, pharmacy as appropriate)
- Therapy teams

In order to allow some clear thinking space and signal unity between the two FTs, these sessions were held off site at a venue in between South Shields and Sunderland (Boldon) and bring together staff from both Trusts.

The format included an introductory presentation from the core design team, feedback from the staff survey work (see section 6.1) and feedback from the patient experience benchmarking to date (see section 5)

The purpose was to explain the issues each core design team had identified to date, asking staff about what issues they identify and what ideas and potential solutions for these challenges they had. Their comments and feedback would be captured in-order to feed into case for change development.

In order to provide the best conditions for open and honest conversations, the workshops required facilitated round table discussions, allowing people to input their views. Independent facilitation of these events supported by NECS ensured smooth running and that no-one side of the alliance were perceived to dominate the conversation.

A draft feedback report from the staff events covering issues and ideas is contained as appendix 5.

A further round of similar staff engagement events is being planned for June 2018 and will include a discussion on:

- Brief feedback from March events (You said, we did)
- Progress update from work stream
- The draft case for change and working list of potential future scenarios
- Risks and opportunities / links to other work streams

Organisational support for staff during change.

Feedback from these June staff engagement events will be fed into the first clinical due diligence event in July 2018 (see section 6.5).

6.3 Key insights gained from staff in relation to communications and engagement up until April 2018

During the staff survey work and staff workshops, there was a re-occurring theme of the desire for more opportunities for engagement and enhanced staff communications.

Staff emphasised the importance of being engaged and empowered at an earlier stage. They wished to have further advanced notice of staff engagement events and more opportunities to get involved as well as references to staff needing time to respond to engagement opportunities – either face to face or survey work.

Feedback also contained references to how staff on the ground wanted to influence the shape of how services might change. There was also mention of the culture of the organisations making sure people felt able to contribute ideas without concerns of criticism for doing so.

One particular area of interest surrounded the use and importance of patient feedback and how this could be used much more practically and visually across both organisations as well as with patients and the public.

It was requested that after each clinical services review session, sub groups of the clinical service review group should feedback progress. There was emphasis about wishing to have open and honest communication, with 'clarity' and being 'consistent' the key words used by staff in feedback.

Feedback from the event evaluation forms showed that there were some very positive responses to the three events. Staff felt that the events were a good opportunity to discuss their opinions, concerns or themes, especially away from their departments and interruptions. They enjoyed being in a different atmosphere and being able to speak their minds among staff from both Trusts. In particular, staff at all three workshops mentioned that the events made them feel valued and being able to give their opinions made them feel appreciated, it also provided staff with the opportunity to begin creating personal links with colleagues from both sites.

There was some concern about the lack of representation from other organisations and services, therefore more work needs to be done to understand how staff are invited to events. There was very much an appetite for more sessions to take place - which is a good starting point - and they liked the way the events were structured and organised.

The table discussions stood out as a positive along with the opportunity to hear the opinions and views of other people. Facilitators were mentioned specifically and were seen as very supportive, with staff praising the idea of having a facilitator at each table and they liked having their comments recorded by a scribe.

Some even indicated that they liked the table facilitation process the most, therefore consideration needs to be given in regards to how facilitation training could be broadened to staff across the Trusts and wider health economy in order to support staff engagement, recording their feedback in order to influence plans and respond to issues raised.

In regards to improvements while it was commented that the events were well organised, there were some suggestions for improvements to timing and length, however as mentioned earlier, as much notice as possible should be given to ensure a wider representation of staff groups. Concerns about how people who cannot attend events in person could be part of the process were also raised, this could be resolved through video, apps such as sli.do and post event communications allowing people to contribute in different virtual ways.

In terms of what happens next, staff wanted to see action plan which includes the impact of their contribution and how the information that they have provided will be useful in the case for change.

Some early themed questions have emerged around jobs and organisational culture, these included:

- There were many questions surrounding the future of South Tyneside District Hospital, will it change into a “cottage hospital”?
- There were many questions about what any changes might mean to people’s individual jobs, for example:
 - If there will be job losses
 - In relation to seven day working, would people be moved from shift work (especially those who don’t current work shifts)
 - Will people need to move and work on different sites
- Have the larger decisions already been made?
- Will there be equal influence and voice across both trusts? (perceptions of bias)

These questions were addressed during the events and will continue to be incorporated into wider staff communications.

6.4 Staff communications from clinical design teams

It is recognised that there is a strong appetite for more communications and engagement activity as set out above to ensure the workforce across both Trusts is kept up-to-date as work progresses and make sure staff have an opportunity to become involved at appropriate times.

- A revised programme of regular internal communications and engagement activity for both Trusts is significantly helping this process as follows: Regular proactive updates for all staff are shared across both organisations about Phase Two via a number of mechanisms
- Updated intranet pages across both Trusts now include:
 - Details of work stream leaders and membership
 - Overarching timeline for Phase Two
 - Monthly e-bulletin updates from each work stream meeting which have been held since December 2017 are now available to all staff
 - Facility to ‘Ask a question’ / get involved and give views Copies of all materials shared at March 2018 staff engagement events
 - Staff survey report
 - Staff engagement events report

In addition to the above, there is a need to support the clinical leaders involved in the core design teams for each area undergo some strategic leadership / core interpersonal communications skills training in preparation for helping to deliver staff, stakeholder and public engagement activities in front of large audiences. Work is also underway with organisational development and HR colleagues in both Trusts to develop a suite of support to be made available to help staff cope and deal with what is going to be a challenging agenda at the same time as managing business as usual.

6.5 Clinical 'sense check' due diligence workshops

Two clinical 'sense check' due diligence workshops are recommended for summer 2018 and autumn 2018. These will be day-long events and will bring together the core design teams only, across the three service areas from both Trusts. These events will allow for strategic discussion and sense checking on the working list of potential future scenarios which have been put forward by each work stream.

Again, it is recommended that these are held off site and independently facilitated. The purpose will be to look at the working list of emerging models from each work stream and sense check on the clinical interdependencies and any other areas for consideration as part of option development. These events will also play a key role in building upon the work started in the March staff engagement workshops by bringing together working cultures from both organisations.

Elements of these events will be captured on video, with vox pops from clinical leaders which can be shared with the wider workforce and demonstrates transparency – linking back to staff requests for more information to be shared (see section 4.4.3)

There should also be simultaneous updates for stakeholders and the public on the work underway as part of the clinical service reviews.

To coincide with these clinical due diligence events, simultaneous staff and stakeholder updates will be shared widely to ensure there is a consistent message about:

- Context / case for change / current situation
- Why change is needed and will be better for patient care
- Feedback gained from discussion workshops with staff / staff involvement
- The emerging direction of travel / potential future options
- What needs to be considered as part of option development
- Timeline, process and next steps for public engagement and consultation

7. Updated issues document – the narrative for the case for change

In order to articulate to the public the issues the local NHS is facing, an updated issues document will be developed which will act as the underpinning narrative and key messages for phase two.

This will take into account the feedback to date from staff, patient experience benchmarking and the work carried out to date by the clinical design teams.

It should be shared initially in draft form for staff, public and stakeholder feedback and updated as necessary as work moves towards formal public consultation in summer 2019. .

The updates 'case for change' should include:

- Reminder about why phase one vulnerable services were chosen
- Learning lessons from phase one to improve wider staff and stakeholder involvement at earlier stages
- The strong and vibrant future for South Tyneside hospital
- Changes are clinically led to make best use of staff resource, expertise and to improve clinical care and therefore outcomes for local people
- Feedback to date from staff engagement regarding the challenges they observe
- Feedback to date from patient experience

In addition to this, a high level clinical narrative is developed which clearly articulates the clinical vision and the areas being discussed and likely to be consulted upon:

- Emergency care and acute medicine
- Emergency surgery
- Planned and ongoing care and specialist services

This will underpin all communications and engagement activity during the pre-engagement and formal consultation phases and ensure there is a consistent message from the outset of phase two.

For each of the clinical service review areas, a specific narrative will need to be developed and approved which covers the following points:

- What is the current situation? (Data, facts and figures)
- Why is change needed?
- Why would change be better for patients and what is important to them?
- What do we need to consider?

8. Stakeholder mapping

In order to ensure the programme effectively targets patients, key groups and organisations, detailed stakeholder mapping and data analysis of demographics will be carried out in order to inform who has influence and/or interest in the issues within the Path to Excellence programme.

It must be emphasised that this is best public relations practice, and it is carried out in order to make the best use of programme resources to target key interest groups, in order to ensure they have the opportunity to hear about the issues, get involved as they wish, ask questions and feedback views.

9. Democratic engagement

9.1 South Tyneside and Sunderland joint health overview and scrutiny (JHOSC)

NHS partners are mindful of their statutory duties to engage with health overview and scrutiny committees and elected members and respect this is how NHS organisations are locally democratically accountable. Section 244 sets out the duty to consult with local scrutiny committees on matters of NHS significant variation of services and NHS consultation (see appendix 1).

From April 2016, South Tyneside and Sunderland hospital trusts began a formal discussion with the two separate health overview and scrutiny committees around the formation of the partnership and subsequent Path to Excellence phase one programme.

The partnership made a formal request to the local authorities that the formation of a joint overview committee should be considered under section 30 [of the local authority health scrutiny guidance](#).

NHS leaders subsequently attended 11 JHOSC meetings since April 2016 to January 2018, in addition to a large commitment of the programme management resource to support requests for information, involvement of elected members in procurement etc.

This also included:

- Programme support to fund The Consultation Institute for members training
- Support provided for lead specialist and senior clinicians from NHS clinical networks to attend JHOSC to provide independent clinical views on the options
- Dedicated briefing session for members on the safety of freestanding midwife led units by the regional maternity system lead consultant took place and a visit to a successful FMLU is being organised. This was in direct response to a request from JHOSC members to obtain better information about the safety of midwifery-led care

The JHOSC interim response to the P2E phase 1 consultation praised the NHS involvement with the committee, however its final response criticised the NHS for use of jargon and not understanding the scrutiny process.

In March 2018, the JHOSC and subsequent the two single local authority health overview committees decided on a unanimous basis to refer the Path to Excellence phase 1 consultation to the Secretary for State for Health and Social Care, citing inadequacy of consultation with them (JHOSC), and that decisions were not in the best interest of local health services.

In the light of this, consideration should be given to how programme management resources should be aligned on a proportionate basis in order to make best use of the limited resources (people and time) and also ensure statutory duties to consult with the committee are met.

9.2 Co Durham Health overview and scrutiny

The programme will continue to engage with County Durham Health Overview and Scrutiny committee to assess their requirements for consultation with them as a single HOSC.

9.3 Members of Parliament

Each of the NHS organisations continue to engage with local members of parliament, usually via chief officers. NHS Chief Officers will continue to co-ordinate this via their regular CEO meetings.

9.4 Attendance at local area ward committees

As part of developing the updated issues document, attendance at local area committees is recommended to reach local communities and civic society.

10. Engagement with NHS partners

10.1 Health Watch organisations

Both South Tyneside and Sunderland Health Watch organisations are members of the communications and engagement task and finish group and stakeholder advisory panel. They continue to provide robust positive challenge, suggestions and ideas to contribute to the development of the overall engagement and consultation processes. This is in line with their statutory role as a consumer voice for health and social care.

The Path to Excellence partners welcome and value the ongoing involvement of the Health Watch organisations. They recognise that as small organisations, their contribution of time and knowledge is extremely precious – therefore even more valuable as a result.

10.2 Primary care – GP community

The CCGs are membership organisation of GP practices, and therefore are ideally placed to support enhanced GP engagement for phase 2.

A programme of engagement with the GP community will be developed in parallel with the public and trust staff engagement. This is likely to take the form of updates at training events, council of practices, via GP federations and via The British Medical Association and Local Medical Committees.

10.3 North East Ambulance Service (NEAS)

During phase one, there was a public perception that NEAS were not involved in P2E discussions, despite the organisation being involved at appropriate times.

In order to allay public fears, work will take place with NEAS to provide joint updates and specific references to their involvement in work as it progresses.

This also accounts for NEAS being a regional organisation and will assist in helping make best use of resources.

10.4 Clinical senate and clinical networks

As a continuation of phase 1, work will continue with the Northern region clinical senate and networks.

They provide targeted system support to improve health outcomes and reduce unwarranted variation, and support the development of lasting local solutions to address national priorities.

Combining the experience of clinicians, the input of patients, and the organisational vision of NHS staff, the Northern England Clinical Networks work in partnership with those who use, provide and commission health services to make improvements in outcomes and reduce variation across the region.

11. Public participation and involvement

There is a clear mandate from NHS England, for the enhancement of participation and 'co-production' with stakeholders and communities in order to deliver the NHS Five Year Forward View, and the development of integrated care partnerships (formally known as sustainability and transformation partnerships).

Participation means giving people the meaningful opportunity to shape and take part in activities that will have a clear influence in the end results.

A key element of the pre-engagement strategy is to provide wider opportunities for participation by key groups with interest and experience in the specific issues under review as identified by the stakeholder mapping (see section 8).

Given the complex nature of the interrelated service reviews, consideration should be given to how participatory techniques can be deployed in a realistic and meaningful manner.

There are different participatory techniques that can be deployed, and there is no one size fits all, so different approaches will need to be adopted depending in the emerging issues. Approaches may include face to face events or digital participation.

It may be that wider participation can be deployed (beyond clinical staff in clinical due diligence workshops see section 6.5) to support options development and/or options appraisal as well as participation in setting the evaluation criteria which is

used to assess options as being robust for consideration and testing via formal public consultation period in 2019.

In the pre-engagement phase, each area of clinical service review requires close consideration between the clinical design teams and communications and engagement staff in order to ascertain the most meaningful participation techniques relevant to develop and deploy.

12. Wider communications plans to explain the case for change and clinical assurance (pre-engagement phase)

Whilst the pre-engagement phase should not feel like it is a public consultation, it is important that public engagement activity is highly visible in order to socialise the issues, explain the current gaps in quality, share the early thinking from staff on potential solutions and allow an opportunity for the public to influence potential solutions at the 'formative' stage.

In addition to this wider public engagement, activity will also be carefully targeted in order to support engagement with key groups as identified via the stakeholder analysis (See section 8).

It is important to note that this does not exclude anyone who wishes to take part, stakeholder analysis is a tool to assess those with interest and influence in issues in order target their involvement and make best use of programme resources in order to gain meaningful and informed feedback on the issues.

The main purpose of communications and publicity in the pre-engagement phase is to explain how the problems are being identified, how ideas for change will be assessed, how 'clinical due diligence' will take place in order to ensure feasible options for the future are developed and how people can be involved.

All public materials will use plain language, be honest and transparent for example – instead of saying clinical risks – say the harm that can happen to patients that could result in their condition becoming worse, or in some cases long term disability or even death.

This is recognition that in phase 1, despite best efforts, it was clear in public events and other public feedback received that some people did not make the connection between quality of services meaning that having qualified and trained staff to work in those services with access to the right support/supervision and diagnostics had a direct link to the care delivered to patients – and the subsequent effect this had on the patient's health outcomes.

Wider communications plans include:

- Promotion of wider patient experience field work (see section x) defined by data analysis for most relevant tach
- Updated and refreshed Path to Excellence website (Phase 1 archived so will be available)
- Publication of key documents, print and digital – including updated issued document (see section 7)
- Stakeholder bulletin updates
- Enhanced social media presence, with video, graphics as required
- Use of existing communications channels, NHS websites, staff communications
- Regular media releases and special features in the Echo and Gazette – in particular pre and post key milestones (eg staff or stakeholder participation events)
- Continuation of promotion and use of My NHS (CCG membership scheme with c1500 members)
- Public engagement roadshows across South Tyneside and Sunderland during summer 2018 and quantitative feedback via an online survey

13. Monitoring improved communications and engagement plans

As previously stated, this strategy is about developing a continuous dynamic dialogue, with every aspect of strategy delivery open for review and continuous improvement and therefore adaptation as phase 2 progresses into formal public consultation.

Consideration should be given to evaluation measures that can be tracked and reported to give insight into the strategy's effectiveness. This is a continuation of phase one metrics and examples are included below and more should be developed as time progresses.

13.1 Evaluation and measures

In order to assess what communications and engagement mechanisms are working and what could be improved it is important to build in continuous review in order to ensure tactics are robust and support continuous dynamic dialogue required for best practice consultation.

It is recommended that:

- Every event to have post event evaluation forms, analysed and reviewed for lessons and improvements, shared with relevant groups and published.
- Every event to have pre-meet and post event debrief with event staff in order to bring lessons or improvements into the next event.

- For every key tactic being planned, active evaluation measures are considered and should be a key part of each specific plan.

Outputs

- Feedback forms from staff and public at events (including demographic analysis and sentiment)
- Numbers of staff attendance at events
- Number of stakeholder/public at events
- Attendance at public engagement roadshows
- Online survey responses
- Number of questions asked by staff via intranet page
- Social media engagement, sentiment and tracking
- Media coverage sentiment and tracking

Outcomes

- Improvement in 2017 NHS staff survey for Trust staff
- Best practice met in line with Consultation Institute independent quality assurance
- Improvement in CCG stakeholder 360 survey results in relation to key stakeholders

14. Equality delivery

The Path to Excellence plans are subject to a rigorous NHS assurance process which aims to eliminate discrimination, promote equality of opportunity and ensure that, wherever possible, services are provided in ways which might reduce health inequalities.

The general and specific equality duties (detailed in appendix 1) and set out in section 149 of the Equality Act at:

<http://www.legislation.gov.uk/ukpga/2010/15/contents>.

In exercising its functions, the NHS must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act, and actively promote equality
- 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

As part of the pre-consultation business case, a fully integrated equality, quality and health impact assessment will be carried out.

In addition to this, a health equalities analysis will be conducted on the pre-engagement and consultation processes. The health inequalities impact assessment (HIIA) is a tool used during NHS service reform planning to assess the potential of any policy, plan, proposal or decision to reduce or increase health inequalities. Many policies have the potential to impact on health inequalities and this is critical information that the NHS will need to consider in making their final decision.

It is very important that key data monitoring information is requested at all opportunities consistently across all engagement methods. However whilst it is a public sector equality duty to ask for data monitoring information, it is an individuals' choice whether to decide to provide it.

The assurance process requires appropriate engagement with the identified groups who work with people who may face barriers to taking part in engagement activity providing a meaningful opportunity for people who may be more impacted by any potential change to consider and feedback on the various issues.

The programme will build upon the robust work carried out in phase one, which took an asset based approach to work with local third sector voluntary and community groups or organisations to hold focus groups or an event in South Tyneside and Sunderland to support phase 1 consultation with different vulnerable groups in relation to specific or different issues.

14.1 Standards and formats of information

As a result of learning from phase 1 – the following aspects have been incorporated into phase 2 planning.

- Support from Sunderland People First (learning disability) to develop a protocol for easy read documentation
 - This includes ensuring key programme public documents have sufficient lead in time so that easy read versions can be developed and published alongside other public document in order to ensure equity of access
- Inclusion of HealthNet (CVS umbrella organisations) in a new Stakeholder Advisory Panel – earlier engagement with CVS organisations to support equality delivery

All public information produced as part of the programme 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:

- Easy read

- Large print
- Audio
- Braille
- Different languages
- Video
- Interpreters at public events

All tactical delivery plans will include equality delivery as standing items to ensure active consideration of equality as part of each key planning document.

15. Travel and transport

In phase 1 pre-engagement period, from November 2016 to March 2017, a number of activities were carried out to develop how the issues relating to travel and transport could be understood.

At an early stage travel and transport was identified as a key issue. As a result, dedicated travel and transport events were planned – one for the public that allowed the feedback to be considered at a second event for stakeholders. The feedback helped to identify the risks in relation to travel and transport and what might be needed to mitigate some of these.

The stakeholder event was attended by travel and transport organisations, bus providers, councils and third sector organisations. All issues and concerns, as well as comments and ideas for solutions, were collected and were extremely helpful in enabling wider discussion with those organisations directly involved in travel and transport.

A working group has been established to take these issues forward – and will continue to work together and two key task and finish groups have been agreed as part of this.

As part of the North East and North Cumbria strategic work around developing integrated care systems, a regional transport group has been identified as being required. The P2E programme will make links with this group as it is established.

16. Developing a wider vision for health and care for South Tyneside and Sunderland

It has been recognised that in order to solve the issues being faced by acute hospital services, a considerable element of ways to help solve these problems sits outside of hospital settings within primary care, community services, public health

prevention, social care and services provided by the community and voluntary sector.

The strategy for the overarching health and wellbeing of the residents of Sunderland and South Tyneside sits with each local authority Health and Wellbeing Board.

The current policy direction of the NHS in England (NHS England, NHS Improvement and Public Health England) is developing on from Sustainability and Transformation Partnerships (bringing all local plans together into one overarching plan) to the development of integrated care partnerships in order to secure the future of local NHS services and maintain and improve the quality of services.

The two clinical commissioning groups have indicated that they wish to explore how a joint vision and joint working may be developed across the health and care system, drawing upon existing health and wellbeing strategies.

This section will be developed as this work progresses, and can be incorporated into the work programme as it develops.

17. Timeline for engagement and communications

A detailed timeline is required in order to plan key activities – this is underway as at April 2018, however at a high level the timings are:

May to July 2018

May 2018 - Wider qualitative patient experience research starts (see section 5.3)

June 2018 – Staff engagement events

July 2018 – First clinical due diligence ‘sense check’

Public / stakeholder briefings to update on workshops taking place with staff and ensure consistent messaging about the case for change, areas under discussion with staff and robust process being followed.

Wider communications and publicity takes place (see section 12)

Summer 2018

July 2018 – publication of the case for change document and emerging ideas for the future (widespread staff, public and stakeholder engagement activity to capture views and opinions at the formative stage)

Two targeted stakeholder events (one in each area) following the first clinical ‘sense check’ due diligence workshop to share feedback gained from staff, emerging

models/direction of travel, sense check hurdle criteria and process for option development.

September 2018

Update for staff, public and stakeholders following second clinical due diligence event and direction of travel, timeline and next steps for engagement and consultation.

October to December 2018

Further public engagement events as required to test aspects of the process for example hurdle criteria.

January 2019 to March 2019

Further round of staff, public and targeted stakeholder engagement activity to provide final opportunity to influence prior to formal public consultation in summer 2019

Appendix 1 – NHS legal duties and requirements

There are several areas of statute, 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.

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.

S.244 NHS Act 2006 (as amended)

The Act also updates s244 of the consolidated NHS Act 2006, which requires NHS organisations to consult relevant local authority overview and scrutiny committees on any proposals for a substantial development of the health service in the area of the local authority or a substantial variation in the provision of services.

S.3a NHS Constitution

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

Right: You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

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

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

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

The Gunning Principles

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

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

The principles are as follows:

1. When proposals are still at a formative stage
Public bodies need to have an open mind during a consultation and not already made the decision, but have some ideas about the proposals.
2. Sufficient reasons for proposals to permit 'intelligent consideration'
People involved in the consultation need to have enough information to make an intelligent choice and input into the process. Equality assessments should take place at the beginning of the consultation and be published alongside the document.
3. Adequate time for consideration and response
Timing is crucial – is it an appropriate time and environment, was enough time given for people to make an informed decision and then provide that feedback, and is there enough time to analyse those results and make the final decision?
4. Must be conscientiously taken into account
Decision-makers must take consultation responses into account to inform decision-making. The way in which this is done should also be recorded to evidence that conscientious consideration has taken place.

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

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

The four tests are:

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

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

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.”

Appendix 2 – Stakeholder Advisory Panel terms of reference

To be added

Appendix 3 - Benchmarking patient experience – report as of March 2018

To be added

Appendix 4 – Staff feedback report – staff survey

To be added

Appendix 5 – Staff feedback report - staff workshops