

Improving mental health services in Sussex

Communications and engagement review

Produced for NHS East Sussex Downs & Weald, NHS Hastings & Rother, Sussex Partnership NHS Foundation Trust and NHS West Sussex

August 2010

Introduction

This paper provides a summary and review of the communications and engagement work undertaken to support the Improving Mental Health Services in Sussex public consultations. It has been written following interviews with communications and engagement leads from each organisation.

At the time of writing (August), the recommendations resulting from the consultations have been approved by the PCT boards but still require final approval by HOSCs. They are meeting as a joint taskforce on 16 September.

This paper sets out how the consultation was approached and delivered and reviews lessons learned at the end of each section. A summary of lessons learned and recommendations is at Annex A.

Background

The programme, which aimed to increase and improve mental health provision in the community and reduce the number of inpatient mental health beds, involved the following organisations:

- NHS East Sussex Downs & Weald
- NHS Hastings and Rother
- NHS West Sussex
- Sussex Partnership NHS Foundation Trust (SPT)

The programme was governed by a programme board chaired jointly by the chief executives of SPT and one of the PCTs.

The programme led to two public consultations, one in East Sussex and one in West Sussex.

NHS Brighton and Hove were involved in the programme. However, because they did not need to go to public consultation at the same time as the other PCTs, they have not been involved in all of the communications and engagement work.

Communications and engagement review

Joint working approach

A 'virtual team' was established, comprising communications and engagement leads from the PCTs and SPT. It was led by an external project manager with senior-level local NHS communications experience. A list of virtual team members is at Annex B.

The team met face to face in the early stages and then began regular weekly teleconferences, chaired by the project manager. Teleconferences became fortnightly in the later stages as appropriate. Occasional face to face meetings were held when there were significant items for discussion, such as managing the close of the consultation and the handling of the subsequent recommendations to the boards.

The virtual team was closely linked to the programme board, with the project manager attending all meetings, along with the communications lead from SPT. In parallel, virtual team members maintained close links with their commissioners and service managers who also attended the board.

The joint working approach was felt to have worked very well. It was seen by some as one of the more successful joint working relationships in their experience. The virtual team was felt to have contained the right mix of people.

The balance of meetings and teleconferences was seen to have worked well, particularly as their frequency and duration could be flexed up and down as appropriate.

The role of the external project manager was seen as very valuable. Particular advantages of an external project manager were:

- *Ability to act as an independent facilitator, with no organisational agenda.*
- *Ability to maintain momentum and bring focus to the project – particularly at the very outset when this was very time intensive.*
- *Ability to keep things moving on a day-to-day basis and to act quickly to trouble shoot.*

It was felt that the external project manager's NHS experience and familiarity had proved valuable.

The relationship between the virtual team and the programme board was also seen as valuable. Having a seat on the board meant that communications and engagement was at the heart of the project and able to quickly escalate issues if necessary. However, the project manager could have ensured the virtual team had more structured input and feedback from programme board.

Strategy and plan

One of the first tasks of the virtual team was to develop a strategy and action plan (see Annex C). This was produced by the project manager in discussion with the virtual team. It set out strategic

principles to underpin all communications and engagement activity. These included that activity should be clinically led where possible, with clinicians presenting and explain the proposals to the public.

The strategy and action plan set out agreed activities for the preparation and delivery of the consultation and supporting communications and engagement, with clear responsibilities. It also included a media handling protocol, setting out how organisations would work together to handle any enquiries and interview requests.

Further action plans were developed in a similar way later in the process to set out the communications and engagement activity around the close of the consultation and the board decisions on the resulting recommendations.

Developing the strategy collectively at the start of the process was seen to help get the team working well together. It ensured the team all understood how they would be working together and got everyone on the same page.

It was seen as very positive to have clinical voices fronting much of the communications and engagement, particularly in media work and at the public meetings. However, it was recognised that it had been difficult to get to the position where the team were confident of clinical support. SPT reflected that the whole programme needed significant internal engagement and that, with the programme progressing at pace, it was not always easy to keep the internal timing aligned with the external.

It was felt that the next step on from the clinical input to the communications and engagement activity would have been if service user advocates had been identified. This would have required a longer period of pre-engagement and a more concerted effort to engage potential user advocates.

Supporting toolkit

A core narrative was developed and agreed to form the basis of all communications materials. This fed into the development of the consultation documentation which, once produced, took over as the core narrative for the programme.

An extensive Q&A briefing document was developed, covering any question that might conceivably be asked about the programme. It was very long, stretching to 40 pages. It had dual purposes: to support communications activity and also to assure the programme board that all potential issues had been considered and addressed.

A list of spokespeople was produced to ensure there was a bank of briefed and prepared spokespeople for any public activity and to meet the strategic commitment to have the programme fronted by clinicians wherever possible.

The toolkit was seen as worthwhile and provided useful evidence to present to HOSCs and at SHA and OGC gateway reviews.

There were mixed views about the value of such a lengthy and detailed Q&A document. It was perceived by some as too long to be of use and as having taken up disproportionate time to develop. Others thought that going into such detail was valuable as it forced the broader programme team come to agreement on issues where we might otherwise have presented conflicting views in public. It did give the programme team assurance that all issues had been considered.

It was felt that in the future we could be more persuasive with programme colleagues of the need to agree short, simple answers both to enable more concise briefing and as useful preparation for public meetings and media handling.

Pre-consultation engagement

The majority of the pre-consultation engagement was carried out by the commissioners and SPT before the inception of the virtual team. Once the virtual team was established, efforts were made to collate details of all prior and ongoing engagement activity and feedback.

As a result of the pre-engagement, the proposed options for one of the consultations were modified at a late stage.

It was felt that, ideally, there would have been more time for pre-engagement and it would have been more formally developed. Patient and public engagement colleagues could have been brought in to work with commissioners sooner. Where commissioners were proactive with pre-engagement, they would not necessarily have considered what they were doing as 'engagement'.

There could have been more user involvement earlier in the process to build advocacy and to help shape the process and options.

More structured note-taking at the pre-engagement stage would have enabled more detailed analysis of that feedback to be made at the end of the process.

It was seen as really helpful to be able to change the proposed options as a result of feedback collected before the consultation.

Consultation documents

Two formal consultation documents were produced – one for each consultation.

Initial drafts were produced by the project manager, using briefing materials provided by the commissioners and provider. It was decided that they needed significant re-writing and, following further work by the commissioners they were re-written by the SPT communications lead.

The OGC gateway review, which led to the re-writing of the documents, while uncomfortable at the time, was seen to have been a useful process which highlighted the value of third party review.

Although the view was that we produced very good documents in the end, it was felt that the drafting of the documents could have been much better managed. The bulk of the content and the broad narrative needed to be set out by commissioners. Communications and engagement could then have turned this into the consultation document.

There could have been clearer roles in the production of the consultation documents, with commissioners responsible for content and different members of the communications and engagement team responsible for messaging, facts and figures and case studies, checking accuracy, readability and proofing, etc.

- **Content**

The documents set out the background and context for the proposed changes, reviewing previous changes, highlighting the key national policies and frameworks, and reflecting what service users, carers and staff had already said about how they wanted to see services develop.

The proposals and their impact were set out in detail, including information about the process and criteria that were used to reach them.

The consultation documents set out the various mechanisms that people could use to provide their feedback and included a detachable feedback form. Information was provided about the next steps in the process, how the feedback would be used and how decisions would be taken.

Annexes included a map of services, answers to frequently asked questions, information on options which were considered but did not meet the criteria, a list of stakeholders involved in developing the proposals, more information on the key policies and strategies and a glossary of terms.

It was felt that there could have been a little more supporting detail in the documents, particularly around the financial information, which would have headed off some criticisms.

- **Alternative formats and accessibility**

Short A5 summary versions of the documents were produced which highlighted the main points and signposted readers to more detailed information.

The documents included information on the cover in the most common foreign languages in each area, asking people to turn to the back page. There, more detail was given in each language and a form was provided for alternative language requests to be made.

The documents were also offered in large print, Braille and audio. An easy-read version was also produced for people with learning difficulties.

The approach to translations was seen as providing a really good example of how this should be done. Although, in the case of one Mandarin translation requested in East Sussex, it was later realised that offering the services of an interpreter would have been a much more cost effective way of responding to the request than translating the whole document.

It was felt that an easy-read version of the document should have been produced at the outset.

- **Production**

The documents were designed in two-colour, striking a balance between a professional and inviting look and feel and value for money. The print run was 3,000 for West Sussex and 2,500 for East Sussex with 7,500 summaries in West Sussex and 5,500 in East Sussex.

It was felt that the document was well designed and achieved the right look and feel.

- **Distribution**

In addition to sending them to stakeholders and using them at meetings, hard copies of the consultation documents were distributed to a wide variety of locations, including SPT premises, GP surgeries and local libraries.

The distribution of the document was felt to have been fine.

Websites

A dedicated section was created on each PCT's website, offering visitors the latest information on the consultation, copies of the documents, links to key national and local policy documents, details of public meetings and a range of ways to give feedback, including an online form. Information was also provided on SPT's website, with links to the sections on the PCT websites.

The material provided on the websites was seen to have successfully achieved its aims.

Stakeholder communications

Each PCT developed its own list of stakeholders. These included MPs, local authorities, GPs, patient, carer and voluntary groups, community groups, etc.

Update letters from the PCT chief executives were emailed to these groups at key points during the process, including:

- When we knew we would be going to formal consultation
- At the launch of the consultation
- As we approached the close of the consultation
- At the close of the consultation
- When board papers detailing the subsequent recommendations were published
- After the boards had made their decisions.

Stakeholders were offered meetings or presentations on the proposals. These were normally delivered jointly by the relevant commissioners and SPT, with notes made of the feedback received.

MPs were informed by letter and also updated by chief executives at routine meetings.

There was very close working with the HOSCs, with frequent joint presentations from each PCT and SPT and regular communications between the commissioners and HOSC business leads.

The regular flow of letters was felt to have worked well. They maintained momentum and prompted responses and people said they appreciated the updates. There were no complaints that people weren't aware of the consultation. It was seen as a good sign that there was no negative reaction from MPs.

The various stakeholder presentations and meetings were regarded as one of the most valuable and successful elements of the consultation, certainly from the West Sussex perspective. It helped to have proactive commissioners – they were happy to go out and talk to people and responded to the comments made. However, East Sussex found it difficult to get engagement beyond those groups and individuals it engages with most frequently. It was felt across both PCTs that there could have been more meetings with service user groups.

It was not seen as a problem that the virtual team were not normally involved in the meetings so long as there was assurance that they were happening and any issues raised were fed back.

The strong relationships with the HOSCs, led jointly by the commissioners and provider leads, were felt to have been very valuable and important to the progress of the programme. However, there was one unexpectedly difficult HOSC meeting in West Sussex and this highlighted the importance of not becoming complacent and continually engaging and checking expectations.

Public meetings

Public meetings were arranged at the start of the consultation and held in a range of locations and at different times of the day. They were held in a wide variety of venues including hotels, theatres and town halls. Six were held in West Sussex and three in East Sussex

Each meeting included a presentation from a PCT executive director and an executive director and senior clinician from SPT, followed by a 90-minute question and answer session.

Each meeting was chaired by a fully briefed independent figure (an ex-councillor in West Sussex and the LINK chair in East Sussex).

One AV technician was hired to cover all the meetings and was responsible for ensuring they were recorded and transcribed.

Because of the potential for public meetings to become unruly, the security provider from one of the PCTs was asked to provide advice and have staff on hand should it be decided they might be needed at any of the meetings.

The format of the meetings was felt to have worked well, and it was good to have independent chairs, although it is important they have the appropriate expertise to manage a meeting.

Having clinicians on stage was seen as very positive. They won the confidence of the audience although some of them could sometimes have been clearer about the points they

were trying to make. A balance needs to be struck between ensuring they are well briefed and prepared, while allowing them to say what they want in their own words.

It was felt that there were the right number and location of meetings. However, the venues were mixed. The best venues were found, given the short lead-in time and limited availability of key speakers, but it is essential that venues are visited before they are booked. Venues need to be large enough to allow a large audience, but if it becomes clear that interest in a particular location is low an ideal venue would allow the physical size of the meeting to be scaled down nearer the time.

The PA system, recording and production of transcripts worked really well.

Implications of the election

When it became clear that there was likely to be a general election during the planned period of consultation, it was decided to continue, but to sequence the consultation so that it could fit around the election. This meant four weeks of public activity, four weeks of private meetings with stakeholders during the likely period of purdah, and then a further four weeks of public activity after the election.

This approach was agreed with the HOSCs who confirmed that they were content for the consultation to continue during the election so long as there were no public meetings or proactive publicity during the purdah period.

The timing of the election matched what had been expected. However, purdah continued after the election because of the period of negotiations before the new government was formed. This led to the postponement of one public meeting. Although this was rescheduled for the final day of the consultation, the consultation was extended by one week to take account of this.

Although HOSCs were supportive of the plans and approach around the election, the greatest difficulty was in providing sufficient assurance to the SHA. It was felt that, with hindsight, more could have been done to keep the SHA informed and abreast of communications and engagement plans as they developed, separately to the formal SHA gateway process. Additionally, there could have been greater comms and engagement input to and involvement in the SHA gateway process.

With hindsight, the potential implications of the election result could have been realised earlier and the decision to extend taken sooner, enabling alternative arrangements to have been made and communicated earlier, better protecting the reputation of the process. The virtual team could possibly have escalated this sooner and been more persuasive on this point with the programme board.

Media handling

Proactive media was carried out by the PCTs at key stages in the consultation and there was good information sharing and advance notice given between all the organisations of any media issues.

All organisations worked closely together, as described in the media handling protocol, to manage any reactive issues, with joint statements provided. Incorrect articles or letters in the media were rebutted with joint letters from clinical leads at the relevant PCT and SPT. SPT also made clinicians available for the PCTs to put up for interviews.

Media handling was felt to have worked really well – the protocol established at the start built a strong foundation. It was felt that there was a high level of respect between the press teams in each organisation which meant that collective decisions could be made and effective responses implemented very quickly. PCTs also really valued being able to call on SPT for spokespeople.

Internal communications

Internal communications in the PCTs was carried out through routine channels.

Within SPT, communications about the programme formed part of a major internal engagement project around the trust's vision and strategy, with a series of staff meetings and events held.

The internal communications and engagement at SPT were seen as having been very effective, although the pace of the programme meant that it was challenging to always keep on top of the internal impact of external communications. This alignment was essential. SPT felt that it was important to get the right balance between top-down direction and bottom-up engagement. Embedded programme leads were very helpful in supporting this and it was seen as important to have involved union representatives from the start.

Response handling and analysis

A range of feedback mechanisms were made available including by post, telephone, and e-mail, in addition to the feedback forms in the consultation documents and online. Any responses received by SPT, or captured through their internal engagement, were sent to the PCTs to be collated for analysis.

Independent analysts, the Evidence Centre, were procured to analyse the responses. They provided each PCT with a template for logging all responses.

The analysts provided an early summary of the responses, to enable work to begin on developing recommendations. More detail was sent through before the final reports, which were presented to the programme board.

Response handling mechanisms worked well. Handling the responses was fine given the low level of responses, but more resource would have been required had there been a greater response.

The Evidence Centre were seen to have been responsive and to have carried out a very high standard of work. There were questions about whether an external company was required to analyse the feedback given the low level of responses, but their independence was certainly seen as adding value to the final analysis.

There was a problem with one of the e-mail addresses for feedback and in future all e-mail addresses, phone lines, etc, should be checked externally, not just internally.

Equality impact assessments

Equality impact assessments (EIAs) were carried out on the proposals, the consultation process and the consultation materials.

As with the OGC gateway process, third party review was seen as valuable and as providing good evidence. However, there was a lack of clarity about who should conduct the EIAs and how they should be carried out. Organisations could establish EIA processes for consultations so that they are on the shelf and ready to use when needed in the future.

Resources

Each organisation met its own communications and engagement costs where these were obvious. Where costs were shared, for example the external project manager, the design and production of the documents, translations, etc, these were met by one organisation and re-charged on a pre-agreed basis to the others.

Recharging has worked well. It needs one person to manage and co-ordinate it.

Annex A:

Summary of learning and recommendations

Joint working approach

1. Similar programmes involving more than one organisation should consider a similar approach of a virtual team with an external project manager.
2. It is essential that communications and engagement is fully involved at the heart of any programme governance structure. Clear processes should be established for ensuring a good flow of information between programme boards and broader communications and engagement teams.

Strategy and plan

3. For joint projects, strategies and action plans should be actively developed in collaboration to help build cohesion.
4. Clinical voices are very powerful in public and patient communications. Considerable and early internal engagement is necessary to secure this.

Supporting toolkit

5. Developing a detailed Q&A can be very valuable as a way to bring an external perspective and build agreement on tricky issues. However, care should be taken to ensure the resulting document is concise and not overly time-consuming to produce.

Pre engagement

6. Public and patient involvement expertise should be brought into potential service change programmes as soon as possible to help support engagement activity and establish structures for collecting evidence.

Consultation documents

7. There should be clear roles and responsibilities for the drafting of consultation documents. Initial drafts of the bulk of the content and the broad narrative should come from commissioners and service managers. Different people should be tasked to focus on messaging, readability and comprehension, checking accuracy, proofing, etc.
8. A good model for making a document available in alternative languages is to have a line of text in the most common languages on the front inviting people to turn to the back for more information. Translated text on the back can then give more detail on what the document is about and how to request translated copies.
9. Easy-read versions of consultation materials should be produced at the start of a consultation.

Stakeholder engagement

10. Distribution lists of key stakeholders should be established at the start of the process and they should be provided with regular updates.
11. Strong working relationships should be sought with HOSCs.
12. Presentations and meetings with stakeholders groups should be prioritised. Proactively engagement should be sought beyond the 'usual suspects', particularly with patients and service users.

Public meetings

13. It is very valuable to have briefed and prepared clinicians on stage explaining and supporting proposals.
14. Meetings should be chaired by an independent figure with the appropriate expertise for managing a large meeting.
15. Venues should be visited before being booked and ideal venues have flexibility to accommodate both large and small audiences.
16. Consider using one AV supplier with responsibility for ensuring all meetings are recorded and transcribed.

SHA assurance

17. Communications and engagement should be fully involved in SHA gateway reviews. Additionally, consider regular updates with SHA communications and engagement teams.

Media handling

18. Establish a media handling protocol at the start of the process and ensure relationships are in place between different organisations' press teams.

Internal communications

19. Provider trusts should prioritise early and ongoing staff engagement.

Response handling and analysis

20. Be prepared to bring in extra resource for logging feedback if there is a high response rate.
21. Consider using independent analysts to give credibility to consultation findings.
22. Double check response mechanisms are working. Check e-mail addresses and phone lines are working externally.

Annex B:

List of virtual team members

External Communications and Engagement Programme Lead	Dan Wood
Communications Manager, NHS East Sussex Downs & Weald and NHS Hastings & Rother	Joel Hufford
Deputy Director of Communications and Engagement, NHS West Sussex	Sarah Hawke
Public Engagement Manager, NHS West Sussex	Sue Pumphrey
Communications Manager, NHS West Sussex	Nick Brooks
Head of Consultation and Stakeholder Engagement, Sussex Partnership NHS Foundation Trust	Andrew Partington

Annex C:

Original strategy and plan

Improving mental health services in Sussex Communications and engagement action plan

1) Background

The NHS is working to improve the mental health services available to people in Sussex. The East and West Sussex PCTs and Sussex Partnership NHS Foundation Trust (SPT), the main provider of secondary care mental health services across Sussex, have been working with service users, staff and stakeholders to develop proposals which will go to formal consultation early in 2010.

This communications and engagement action plan sets out a shared, co-ordinated approach between the PCTs and SPT to communications and engagement around the consultation and the consultation process itself.

2) Aims and objectives

The overarching aim of the communications and engagement activity is to deliver a successful consultation. This means that:

- all members of the public, service users and stakeholders have the opportunity to have their say
- each Health Overview and Scrutiny Committee (HOSC) and Local Involvement Network (LINK) is satisfied that the final proposals submitted for implementation have been subject to sufficient consultation.

Additionally, communications and engagement should also enhance the reputations of the PCTs and SPT, increase public confidence in the NHS in Sussex and contribute to efforts to tackling the stigma around mental health.

3) Audiences

We want to ensure that all members of the public are aware of the proposal and have an opportunity to have their say and will ensure we reach out to groups that do not traditionally engage. However, we need to be mindful that with only 6% of the population using mental health services in the last year or so, general public interest in the consultation may not be high.

We will focus particularly on service users and carers, an audience segment where we can be confident of a high level of interest and feedback. Many stakeholder groups, such as community and voluntary groups, will be an important audience, especially where they are able to act as a channel to reach service users, carers and people who do not traditionally engage.

Effective staff engagement is vitally important and essential if change is to be successful. As well as being a crucial audience in their own right, health and social care staff are also a vital channel to

reach the wider public and service users. GPs are a particularly important group within the staff audience.

Health Overview and Scrutiny Committees (HOSCs) and Local Involvement Networks (LINKs) are a critical audience. Their input is fundamental to shape the consultation process, the proposals consulted on and then to approve the plans that emerge from the process and they should be fully engaged at every stage.

MPs and councillors represent the interest of their constituents and as such are an important audience. They also have a significant impact on the media.

4) Strategic approach

There are several strategic principles which will underpin our communications and engagement activity:

- Compelling vision
Communications and engagement activity based on our compelling vision for the future of mental health services in Sussex.
- Clinically led
The proposals are based on clinical evidence and judgement and clinicians will present and explain them to the public.
- Discreet but linked consultations
There are two separate consultations but we will bring economies of scale where possible and ensure we tell a joined-up story about mental health services across Sussex.
- Targeted, effective communications
While ensuring all members of the public have opportunity to have their say, some audiences will be more interested than others and we will target our resources accordingly, working with partners where that is the most effective way to reach our audiences.
- Supporting broader communications aims
Where possible communications and engagement activities will support each organisation's broader strategic communications aims at the same time as delivering the consultation.

5) Action plan

There are a series of activities and products that will be delivered to implement this communications and engagement action plan. A project plan is at Annex A.

- Core narrative and key materials
A core narrative, set of key messages, detailed Q&A and set of core presentation materials will be produced to support each consultation and the communications around it.
- Bank of case studies and evidence
A bank of case studies, real patient stories, examples, quotes, evidence, graphs, illustrations and photographs will be built to help set out improvements so far and to bring to life the

vision for the future. We will also identify clinicians, service users, carers and stakeholders willing to advocate the proposals.

- Continual engagement

A significant amount of work has already been undertaken, and is continuing before the formal consultation begins, to engage stakeholders in the development of the proposals and the process. We will build on this, ensuring all key stakeholders are identified and engaged in advance of the formal consultation. We will also use this ongoing dialogue to identify potential advocates.

- Briefed and prepared spokespeople

We will identify a panel of key spokespeople from both commissioners and providers, managerial and clinical, who will take public platforms and speak with the media. We will ensure that they are fully prepared, briefed and media trained from the outset and that they receive regular updates of key messages, Q&A etc. A list of key spokespeople is at Annex B.

- Public meetings and events

Each PCT is arranging its own programme of public and stakeholder meetings and events to ensure they are tailored to best meet local circumstances and stakeholder expectations in terms of the number, location, format and content. There will be central co-ordination to ensure that events in different areas do not clash and they are supported by core materials, suitable spokespeople from the PCT and SPT and other advocates and that we are striking a balance between targeting audiences and demonstrating that we are giving all sections of the public a chance to have their say.

Where appropriate, events will be extensively promoted through the media, targeted distribution of leaflets and posters, and through partner stakeholder channels and followed up through proactive media relations, in staff communications and in updates to stakeholders.

We are seeking to ensure scheduling of public meetings so that none are planned for the anticipated purdah period.

- Staff communications

Template newsletter articles and team briefings will be produced regularly to support consistent and timely communication with staff across all organisations, signposting the website for further details, maximising the use of existing staff communications channels within organisations without creating further communications vehicles where they are not needed.

These briefings and materials will be provided to all NHS and social care organisations in Sussex, including acute trusts and the ambulance trust, to encourage widespread staff engagement.

- GP engagement

Each PCT is developing its own GP engagement plan to maximise the use of local channels and networks, supported by centrally produced materials and jointly coordinated approaches to LMCs.

- Stakeholder engagement

Each PCT is identifying its key stakeholder groups (see Annex C). Each stakeholder will be communicated with as soon as possible to ensure that it is aware of the process and current proposals. Once the formal consultation has begun, all stakeholders will receive regular updates on progress. Spokespeople will be provided to present the proposals and receive feedback at stakeholder events and meetings.

We are seeking to set up meetings with stakeholder groups to fall during the anticipated purdah period, when more public activity would not be possible.

- Media relations

Key media will be identified and briefed on the consultation by each PCT before it launches. Following the consultation launch we will maintain a regular flow of proactive media stories to promote and report on consultation events. We will use existing media monitoring arrangements to keep abreast of any media coverage and to ensure that any inaccurate or adverse coverage is addressed immediately.

We will not conduct any proactive media during any period of purdah.

- Consultation documentation

We will produce a full consultation document and a summary document for each PCT. There will be economies of scale in the design and drafting of the documents, with content shared between the documents where appropriate.

Documents and summaries will follow current accessibility best practice in terms of font sizes and colour schemes. They will be made available in alternative formats and will offer advice in the most common community languages on how to receive more detail in other languages.

- Websites

Detailed consultation materials (including reference material such as research documents and national and regional vision document and policy frameworks) will be hosted on the relevant PCT's website, along with updates, latest information on events and opportunities to provide feedback and get involved.

In addition, the PCT websites and SPT website will feature core information about the overarching plans, providing links to the other consultation materials and more detail on the PCT websites.

- Response handling

We will establish (or use existing, where possible) a wide range of mechanisms to capture consultation responses in each PCT, including:

- Freepost address
- E-mail address
- Online response form
- Dedicated phone line with voicemail
- Provision to transcribe comments from those unable to use other means.

We have appointed an independent analyst to collate and review all the feedback received, along with notes of public and stakeholder meetings. They will produce a report identifying the themes and issues raised which will be presented to the PCT and SPT boards.

All consultation responses will be received by the two PCTs. Any responses received by SPT will be forwarded to the most relevant PCT so that all feedback is included only once in the analysis.

6) Equality impact assessments and monitoring

Equality impact assessments will be carried out on the consultation process and the consultation documents (equality impact assessment on the proposals put out to consultation will also need to be undertaken). Equality monitoring will be carried out alongside the consultation to ensure that all sections of the population are able to have their say on the proposals.

7) Resources

The communications and engagement programme is being delivered by the communications and engagement teams at each of the PCTs and SPT. A virtual team has been convened and an external programme lead has been brought in to co-ordinate the work of the group. Overarching programme costs and the costs of the documents are being shared between organisations involved. Each PCT is meeting its own costs for public events.

8) Evaluation

This communications and engagement strategy will be formally evaluated against the SMART objectives being developed in line with section 2 above. In line with established best-practice (and budget allowing) we will also seek to conduct formal evaluation through research to assess the effectiveness of our communications and engagement activities and to ensure that any lessons can be learnt and shared with the wider health and social care community.