Taunton and Somerset NHS Foundation Trust

Somerset Partnership NHS Foundation Trust

STAKEHOLDER ENGAGEMENT STRATEGY

2018-21

Version:	2
Date of Issue:	September 2018
Review Date:	September 2021
Applies to:	All staff groups

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DOCUMENT CONTROL

Reference	**Version**	**Status**	**Author**
S/CG/001	2	FINAL	Patient and Public Involvement Manager/Head of Communications
Amendments revised to replace v1 of the Communications and PPI Strategy.			
Approving body	Trust Board		Date: September 2018
Equality Impact Assessment	Impact Part 1		Date: September 2018
Ratification Body	Trust Board		Date: September 2018
Date of issue	September 2018		
Review date	September 2021		
Contact for Review	Head of Communications		
Lead Director	Director of Governance and Corporate Development		

CONTRIBUTION LIST Key individuals involved in developing the document

Contributor – Designation or Group
Director of Governance and Corporate Development
Head of Communications
Associate Director of Patient Centred Care
Patient & Public Involvement Manager
Patient and Public Involvement Group
Communications and Engagement Group
Carers' Vision & Action Group
Executive Team

CONTENTS

1. EXECUTIVE STATEMENT

Effective stakeholder engagement is vital to ensure that we are providing patient and family centred care for the people of Somerset, and upholding the underpinning principle of the NHS Constitution that the NHS belongs to us all.

2. INTRODUCTION

Somerset Partnership NHS Foundation Trust and Taunton & Somerset NHS Foundation Trust provide hospital, community, mental health and learning disability services, and together employ more than 8,000 staff.

The Trusts provide services in Musgrove Park hospital, community hospitals, mental health wards, GP surgeries, dedicated clinics and in patients' homes across Somerset.

As providers of NHS services to Somerset, the Trusts and their day-to-day work are of interest to and impact upon a wide range of individuals, groups and organisations. These people are our stakeholders.

This strategy sets out our approach to engaging and communicating with those stakeholders.

The strategy underpins the Trusts' communication plans, patient and public engagement and patient and family centred care. It also supports the wider Business Strategy and Action Plan and the Alliance People Strategy.

3. WHAT IS STAKEHOLDER ENGAGEMENT?

Stakeholders can be defined as any person or group of people who have an interest in services provided, or who receive or may be affected by our services.

Engagement is the way we listen, communicate with and involve people and organisations.

Stakeholder Engagement is the process by which we build relationships with our stakeholders through communication, listening to their views and experiences and involving them in the life of our services.

4. WHAT IS THE PURPOSE OF THIS STRATEGY?

The purpose of this strategy is to provide a clear framework for stakeholder engagement and to clarify the key stakeholder relationships in the life of the Trusts.

The strategy explains the structures and processes that are in place to ensure that stakeholder engagement is clear, honest and supports the objectives of the Trusts. This strategy aims to ensure good relationships with stakeholders by clarifying key audiences and lines of communication through responsible staff.

This strategy applies to all staff, in particular operational management, the Trust Board, and the communications and patient experience teams.

This strategy is relevant to all our stakeholders, including our patients, their families, our staff and the wider public.

5. WHO ARE OUR STAKEHOLDERS?

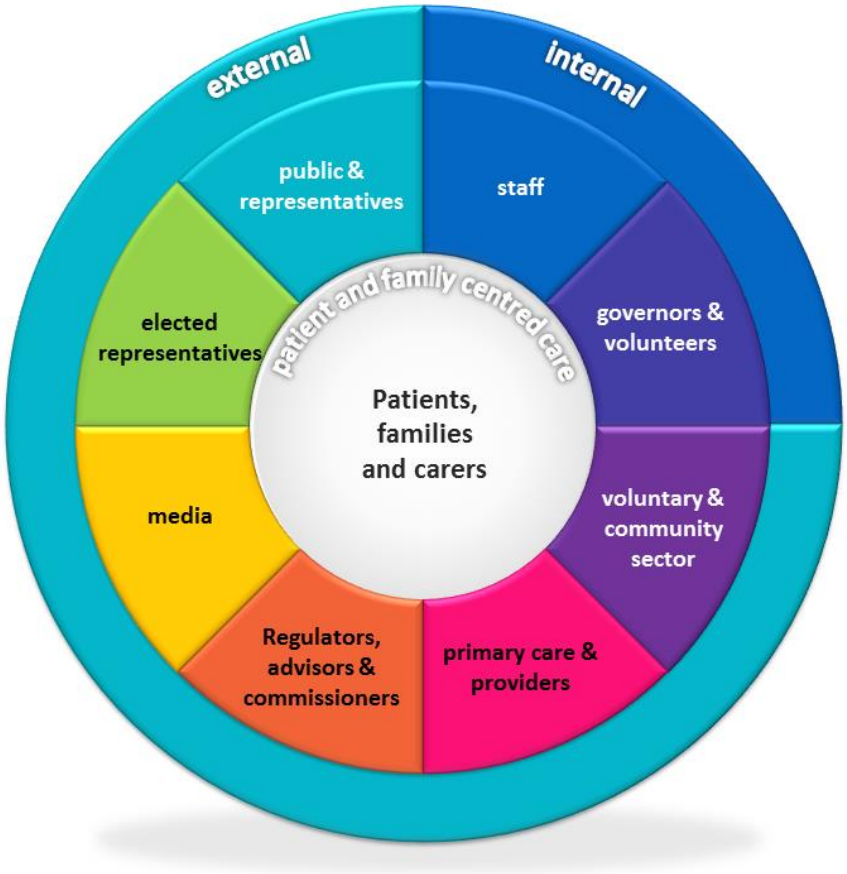
Stakeholders are grouped into internal or external stakeholders.

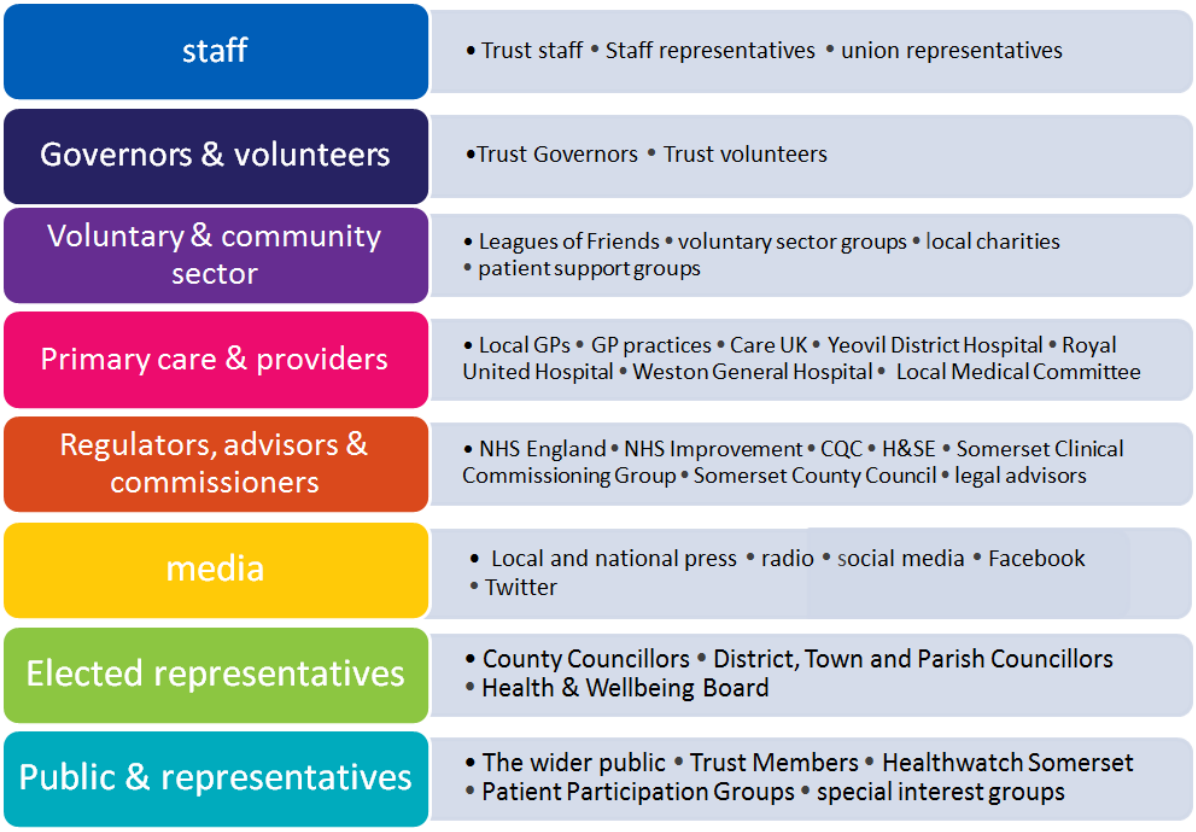
Internal stakeholders are people and groups who are part of the Trust.

External stakeholders are people and organisations outside of the Trust.

Patients and their carers are external stakeholders. We strive to provide patient-and-family centred care. Patients and their families are at the heart of all we do.

Our Trust stakeholders can be described as follows:





6. WHAT IS OUR APPROACH TO STAKEHOLDER ENGAGEMENT?

This Strategy represents our commitment to the principle that the NHS belongs to us all and to the following aims:

1. **TO ENGAGE:** To engage and build relationships with our local community.

2. **TO COMMUNICATE:** To ensure that our stakeholders are regularly updated about everything significant we do and we listen to what they tell us.

3. **TO INVOLVE:** To involve stakeholders at all levels of the Trust, and to listen and learn from what local people have to say about our services before change is made or decisions are taken.

We will do this through the following Stakeholder Objectives, which will help us to meet our overall Trust strategic objectives:

Theme	Strategic Objectives	Stakeholder objectives
Safe and high quality care	Deliver person-centred care in the most appropriate setting, delivering improved outcomes and satisfaction for patients. Deliver and maintain the highest quality care standards, 7 days per week.	1. To ensure stakeholders are aware of the full range of services provided by the Trust and how to access them. 2. To ensure staff are supported with the information they need to provide safe, high quality care.
Transforming and improving services	Promote good practice, transform and innovate, including through digital working to improve safety, outcomes and efficiency Deliver levels of performance that are in line with plans and national standards	3. To take stakeholders' voices and experiences into account when reviewing, improving and planning changes to services. 4. To enable stakeholders to design and produce solutions with us wherever possible. 5. To promote best practice and celebrate success
Colleagues and Culture	Resource, Engage and Develop the existing workforce across the whole alliance whilst aligning and developing a positive and progressive culture to deliver high quality, cost effective care whilst ensuring the alliance is a great place to work..	6. To build strong and trusting relationships with stakeholders so that they know their contribution is necessary, valued and important. 7. To provide accessible information and engagement opportunities for all stakeholders, using communication that meets their needs. 8. To communicate openly and honestly and learn from mistakes
Sustaining a healthy community	Work well together as an alliance of two organisations, and work with primary care, social care, public health and voluntary sector partners to deliver integrated, high quality services. Work with STP partners to deliver the joint objectives in the Fit for My future programme which will lead to a sustainable county health economy.	9. To work towards a culture of 'no surprises', where stakeholders hear our news from us first, planning change at a pace that is appropriate for both staff and the wider community. 10. To work together across the county to communicate and engage on the vision for Somerset's health and social care.

7. HOW WILL WE ENGAGE WITH STAKEHOLDERS?

We are mindful that some stakeholders will have communication needs that we will need to consider if we are to engage effectively with them. This may include people with protected characteristics such as disabilities (visual, auditory or other physical needs) and people who require translators or interpreters, or

information in different ways. We are also mindful that not all stakeholders have access to computers or want to engage online.

Our communication methods need to consider a broad spectrum of ways of engaging and communicating with all groups in our communities.

AIM 1: TO ENGAGE: To engage and build relationships with our local community.

The following Stakeholder Objectives reflect our engagement commitment to our stakeholders. We will:

Objective 3. take stakeholders' voices and experiences into account when reviewing, improving and planning changes to services.
Objective 4. enable stakeholders to design and produce solutions with us wherever possible.
Objective 6. build strong and trusting relationships with stakeholders so that they know their contribution is necessary, valued and important.
Objective 9. work towards a culture of 'no surprises', where stakeholders hear our news from us first, planning change at a pace that is appropriate for both staff and the wider community.

Effective engagement requires strong, honest relationships between the Trust and the communities it serves. We strive to be accountable, transparent and open and to reflect this in strong relationships with our local community.

We strive to understand the views, perspectives and experiences of our stakeholders so that we can form trusting relationships based on shared values.

To build trust with others, we will demonstrate the following actions and behaviours:

- have empathy;
- be straightforward;
- admit mistakes;
- keep promises;
- avoid surprises and to share information as early as possible;
- be consistent in thought and action[1].

This strategy underpins our Alliance People Strategy. The Trusts' Director of People and Organisational Development is responsible for the Trust's Alliance People Strategy and the associated plans. The People Strategy is based on a framework of Resource, Engage and Develop.

[1] Adapted from Keegan (2015)

Support is available from the People and Organisational Development team for staff to help plan communication with their internal stakeholders for specific pieces of work.

AIM 2: TO COMMUNICATE: To ensure that our stakeholders are regularly updated about everything significant we do and we listen to what they tell us.

The following Stakeholder Objectives reflect our communications commitment to our stakeholders. We will:

Objective 1.	ensure stakeholders are aware of the full range of services provided by the Trust and how to access them.
Objective 2.	ensure staff are supported with the information they need to provide safe, high quality care.
Objective 5.	promote best practice and celebrate success.
Objective 7.	provide accessible information and engagement opportunities for all stakeholders, using communication that meets their needs.
Objective 8.	To communicate openly and honestly and learn from mistakes.
Objective 9.	work towards a culture of 'no surprises', where stakeholders hear our news from us first, planning change at a pace that is appropriate for both staff and the wider community.
Objective 10.	work together across the county to communicate and engage on the vision for Somerset's health and social care.

This strategy underpins our Communications Plan. The Trust Head of Communications is responsible for the Trust's Communications Plan. Tools - including a Communications Checklist - and support are available for staff to help plan communication with their stakeholders for specific pieces of work.

AIM 3: TO INVOLVE: To involve stakeholders at all levels of the Trust, and to listen and learn from what local people have to say about our services before change is made or decisions are taken.

The following Stakeholder Objectives reflect our communications commitment to our stakeholders. We will:

Objective 3.	take stakeholders' voices and experiences into account when reviewing, improving and planning changes to services.
Objective 4.	enable stakeholders to design and produce solutions with us wherever possible.
Objective 6.	build strong and trusting relationships with stakeholders so that they know their contribution is necessary, valued and important.
Objective 7.	provide accessible information and engagement opportunities for all stakeholders, using communication that meets their needs.

We are committed to involving stakeholders as much as possible, with particular regard for involving patients, carers and the wider public in service change and

development. In doing so, we are committed to involvement at all levels of the Trust, in a 'ladder of involvement' model that is described in Appendix 4.

In order to ensure that stakeholders design and produce solutions with us wherever possible, we will uphold the principles of coproduction, as described in the Somerset Guidelines for Co-production in Appendix 6.

This strategy underpins our Patient and Public Involvement Plan, which describes how we will involve our stakeholders in the work of the Trusts. Tools such as bespoke online surveys, 'how-to' guides and support are available for staff to help plan engagement and involvement with their stakeholders for specific pieces of work.

This 'Ladder of Involvement' represents differing levels of involvement, which will vary depending on the project at hand and the stakeholder group. The levels of involvement move from 'doing to' through 'doing for' to 'doing with.' We will strive to involve stakeholders as much as possible, with the aim of 'doing with' (or 'coproduction') through our service and Trusts' development.

Our principles and framework for Patient and Public Involvement is shown in Appendix 5.

8. WHO IS RESPONSIBLE FOR STAKEHOLDER ENGAGEMENT?

Stakeholder mapping and engagement will be a necessary part of Trust projects and the responsibility for this lies with the Project Manager or lead.

Responsible managers and key contacts are assigned to each Stakeholder Group. This is detailed in Appendix 3.

The Director of Governance and Corporate Development is responsible for the Stakeholder Engagement Strategy.

9. TRAINING SUPPORT

If staff need support for stakeholder engagement, this is available through the Communications team, the Patient and Public Involvement Team, the Equalities Lead and the HR Team, depending on which is appropriate for the stakeholder group that they are working with.

10. MONITORING COMPLIANCE AND EFFECTIVENESS

Stakeholder Engagement is measured through the views of our stakeholders, and how these are reflected in our relationships with those stakeholders, through conversations, meetings, public engagement events and wider media commentary.

We will seek ongoing direct feedback from our Governors and our Patient and Public Involvement and Patient and Carer Engagement Groups about our engagement with our stakeholders groups, and this will be fed back to the responsible manager for the relevant group.

Staff engagement monitoring and measurement is described in the Staff Engagement Plan.

A formal Stakeholder Audit will occur every three years.

11. APPENDICES

APPENDIX 1: Our legal duty to involve (National and Statutory context)

APPENDIX 2: Our stakeholders mapped to the 9Cs model.

APPENDIX 3: Stakeholders and key contacts

APPENDIX 4: Our ladder of involvement

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APPENDIX 1: OUR LEGAL DUTY TO INVOLVE (NATIONAL AND STATUTORY CONTEXT):

This Strategy reflects the duties, responsibilities and guidance outlined below.

In recent years government policy has stressed the importance of involving the public and other stakeholders in the day to day planning of health services. The NHS belongs to us all.

Major government policies designed to improve and transform the NHS reinforce this commitment to involve stakeholders.

Section 242 of the NHS Act 2006

The legal duty to involve service users is set out under Section 242 of the NHS Act 2006 (HMGov.2006). This places a duty of care on those providing health services to make arrangements to involve users of services - whether directly or through representatives:

- From the beginning in the planning and the provision of services
- In the development and consideration of proposals for change in the way the services are provided
- In decisions to be made by the body affecting the operation of services

The NHS Act also identified a requirement to consult Health, Community and Care Overview and Scrutiny Committees (HCCOSC) where there is any proposal for substantial change or development of the health services or for substantial variation in how that service is provided.

The NHS Constitution (DOH 2009)

The NHS Constitution lays out the right of patients: “to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided and in the decisions to be made affecting the operation of these services.”

Further guidance and good practice is set out in a range of national documents including:

- Real Involvement: Working with people to improve health service (DOH 2008);
- Guidance when undertaking major changes to NHS services (DOH 2007).
- Involving people in their own health and care: statutory guidance for clinical commissioning groups and NHS England (DOH 2017)

Additional legislation that this strategy also reflects is the Equality Act (2010) and the Mental Health Act.

APPENDIX 2: OUR STAKEHOLDERS ACCORDING TO THE 9Cs MODEL

The “9 Cs” are a way of categorising and considering an organisation’s stakeholders. It is a tool to help start consideration of mapping, which will need to be done for individual projects. We have used this model below to illustrate how this maps to our Trust Stakeholder Groups.

	Stakeholder group:	Internal:	external:	Maps to our Trust Stakeholder Group:
1.	**commissioners:** those who pay the organisations to do things	-	Somerset Clinical Commissioning Group (CCG) NHS England Somerset County Council	**6. Regulators, advisors and commissioners**
2.	**customers:** those who acquire and use the organisations’ products	Our staff may also be our patients and carers	Patients Carers Their families	**1. Patients, families and carers**
3.	**collaborators:** those with whom the organisation works to develop and deliver products	Patients Staff Foundation Trust members	Patients and carers Somerset CCG Somerset County Council Other local NHS Trusts	**1. Patients, families and carers 2. Staff 9. Public and representatives**
4.	**contributors:** those from whom the organisations acquire content for products	Staff volunteers Foundation Trust members governors	Suppliers	**3. Governors and Volunteers 9. Public and representatives**
5.	**channels:** those who provide the organisations with a route to a market or customer	Staff referring patients to our other services	Voluntary sector Families GPs Other Trusts/consortiums (for new business)	**5. Primary Care and Providers**
6.	**commentators:** those whose opinions of the organisations are heard by customers and others	Chief Executive Staff	CQC Healthwatch elected representatives (e.g. Members of Parliament, local councillors) patients and families voluntary sector Leagues of Friends press/media	**7. Media 8. Elected representatives 9. Public and representatives**
7.	**consumers:** those who are served by our customers: ie patients, families, users	Staff who are patients or carers	Patients carers Families	**1. Patients, families and carers**
8.	**champions:**	Staff	Patients	**1. Patients, families and**

Stakeholder group:		Internal:	external:	Maps to our Trust Stakeholder Group:
	those who believe in and will actively promote the project	Communications teams Governors Members	Families Volunteers Leagues of Friends Voluntary sector	**carers 2. Staff** **3. Governors and Volunteers** **4. Voluntary and Community Sector**
9.	**competitors:** those working in the same area who offer similar or alternative services.	-	Other Trusts Private providers	**5. Primary Care and Providers**

APPENDIX 3: Stakeholders and key contacts

This table lists our key stakeholders and their key contacts within the Trusts ("responsible manager"). This list may change over time and we would welcome the views of stakeholders, including staff. This list is not intended to be exhaustive.

Stakeholders:	Key contact/responsible manager:	May be delegated to:
1. Patients, Families and Carers		
Patients	Chief Nurse	Front line staff Communications team PALS and complaints team Public and patient involvement team
Carers and families	Chief Nurse	Carers' Service Communications team PALS and complaints team Public and patient involvement team
2. Staff		
Staff	Director of People and OD	Line managers Team managers Directorate leads
Union Representatives	Director of People and OD	
3. Governors and Volunteers		
Governors	Trust Secretary	
Trust volunteers	Director of People and OD	Individual managers
Musgrove Partners	Director of People and OD	Associate Director of Patient Centred Care

Stakeholders:	Key contact/responsible manager:	May be delegated to:
4. Voluntary and Community sector		
VCSE Groups	Chief Nurse	Associate Director of Patient Centred Care
VCSE Groups (particularly those with whom we sub-contract or work with in partnership)	Director of Integration – Strategy and Partnerships	
5. Primary Care and Providers		
GPs	Chief Medical Officer	
Local Medical Council (LMC)	Chief Medical Officer	
Care UK and other private sector providers	Director of Integration – Strategy and Partnerships	
Opticians	Chief Medical Officer	
Pharmacists	Chief Medical Officer	
NHS Litigation Authority	Director of Governance and Corporate Development	
6. Regulators, advisors and commissioners		
Care Quality Commission	Chief Executive	Director of Governance and Corporate Development
NHS Improvement	Chief Executive	
Health and Safety Executive	Chief Executive	Director of Governance and Corporate Development

Stakeholders:	Key contact/responsible manager:	May be delegated to:
Health Research Authority	Chief Executive	Chief Medical Officer
Medicines and Healthcare Products Regulatory Authority	Chief Executive	Director of Governance and Corporate Development
National Institute Clinical Excellence (NICE)	Chief Executive	Director of Governance and Corporate Development
Public Health England	Chief Executive	Director of Governance and Corporate Development
NHS England	Chief Executive	Director of Finance
Trust Solicitors	Director of Governance and Corporate Development	
7. Media		
Local and national media	Director of Communications	Staff members
8. Elected Representatives		
County, District and Parish Councillors	Chief Executive	Chief Operating Officers Associate Director of Patient Centred Care
Health and Wellbeing Board	Chief Executive	Chief Operating Officers Associate Director of Patient Centred Care
Health Scrutiny	Director of Governance and Corporate Development	Associate Director of Patient Centred Care
Members of Parliament	Chief Executive	Director of Communications
9. Public and Representatives:		

Stakeholders:	Key contact/responsible manager:	May be delegated to:
Patient and Public Involvement Group	Chief Nurse	Associate Director of Patient Centred Care
Healthwatch Somerset	Chief Nurse	Associate Director of Patient Centred Care

APPENDIX 4: LADDER OF INVOLVEMENT

		Examples:	When we will do this:	Some ways of doing this:
Doing 'with'	**Acting together**	• Representatives on our working groups and boards • Patients and carers involved in monitoring and running services	• Significant service change • For new services involving local people	• Community development • Non-Executive Directors • Governors • Patient/carer representatives • PLACE Assessments
	Deciding together	• Patient and carer representatives on our boards • Public consultations	• Significant service change • Moving services from hospital to home	• Health Panels • Programme Boards • Participation Groups • Involvement in service development • Formal consultations
Doing 'for'	**Discussing**	• Workshops • Engagement events	• Changing services • Changing location of services	• Workshops and Focus Groups • Carers' support groups • Peer support groups • Public meetings
	Listening	• Workshops • Patient and carer meetings • Public meetings	• Developing ideas and plans • Changing service access criteria	• Open days • Meetings • Questionnaires and surveys • Friends & Family Test • Compliments and complaints • Social media and local media • Patient stories
Doing 'to'	**Informing**	• Newsletters • Talks at patient groups	• All the time	• Posters • Leaflets • Newsletters • Videos • Website • Social Media • Local media

Our principles for public involvement:

Patient and Public Involvement is based on the principles of patient and family centred care, which are[2]:

1. **Dignity and Respect** where health care staff listen to and respect patient and family perspectives and choices.

2. **Information Sharing** where health care staff communicate and share complete and unbiased information with patients and families to enable effective participation in care and decision-making.

3. **Participation** where patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

4. **Collaboration** where patients and families are enabled to contribute to policy and strategy development, implementation and evaluation. This would include the design and development of the facilities/estate and training programs.

Our framework for public involvement:

Public involvement occurs at all levels within the life of the Trusts, from individual level (patients involved in their own care) through to Trust level (patients involved as Governors or on Boards). This is shown below:

Trust level

- ✓ We will identify Board members who are champions for patient and public Involvement.
- ✓ We will listen to and learn from complaints.
- ✓ We will ensure that patients, families and carers have a voice on appropriate groups in the Trust
- ✓ We will involve patients and carers in training and education of staff and volunteers.

Service Level

- ✓ We will give all patients ways to tell us about their experiences of our services.
- ✓ We will listen to all feedback from patients and carers and report what they say about our services.
- ✓ We will make changes to our services based on feedback from patients and carers.

Individual Level

- ✓ We will involve patients in decisions about their own care.
- ✓ We will listen to carers and involve them in the care of their loved ones as much as we can.
- ✓ We will make sure people receive information about their treatment and care.

[2] The Institute for Patient and Family-Centered Care

Co-production: Somerset Summary Guidance

What is co-production?

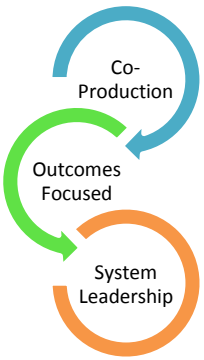
Co-production is about breaking down the barriers between people who use services, people who provide services, and people who design services. It allows people to work together rather than doing things for people. It is built on the idea that everybody has something equally valuable to offer (for example their skills, knowledge or experience) and that we need to work together and use all of these strengths.

Co *(Coming together)* + **Production** *(Making something)* = **Co-production** *(Making something together)*

This means: *"A way of working whereby decision makers, customers, families, carers and services providers collaborate to create solutions which work for them all."*

Why is co-production important?

It is very hard to design a service that works if we do not fully involve those that will actually provide it or use it. It is a particularly important idea now because the pressures on the public sector mean that we having to make major changes to how we do things. Fresh thinking and new ways of working can come from a more collaborative and equal relationship between people and professionals.



Laws, such as the 2014 Care Act in relation to social care, tell us this is what we should do. We expect co-production to be how we work in all parts of health and social care, alongside thinking about the impact of what we do (*outcome focus*) and how all services fit together (*system leadership*) rather than looking at individual services in isolation.

How should co-production be done?

How to co-produce something will depend on what it is you are trying to produce:

- A social worker should talk to an individual person to help them bring out their strengths, the outcomes that matter to them, and agree a plan to achieve these in a way that builds on their strengths;

- A commissioner considering a change to a service affecting children or vulnerable adults should involve children / vulnerable adults and their families in reviewing the existing service, designing and procuring any new service.

Whilst very different, each of the examples above has the following things in common:

1) Actively involving people equally

People need to have an equal chance of being able to fully participate in the process in a way that best suits their needs. This will ensure that those who are seldom heard are included and this will enrich the outcome.

2) Building on people's strengths

Co-production relies on the principle that everyone has skills, abilities and experience to contribute to the process, and no one person or group is more important than others are. Everyone involved should feel that they have made a difference and see the impact of their efforts – though this does not mean getting everything they originally thought they wanted.

3) Being open and inclusive throughout

This involves starting the conversation before we have a fixed idea in mind – working together with people when understanding the issue, planning how to address it, in any procurement, and when delivering and reviewing a service.

What can help you do it well/top tips?

Be prepared: Co-production can take a long time, be messy and may take you in a direction you never expected or wanted, so you will need to be prepared for this. You will need to build trust, may need to learn to share power and take more risks, but in return you may achieve beneficial changes that you might not have thought possible. Ensure that you have the resources needed to support this (including the time, flexibility, and support of participants).

Be honest: Ensure that individuals, carers and families will be involved in every aspect of planning, design/development and delivery of a change at every level. Set out any constraints at the outset, this helps to manage expectations as the work progresses. Welcome new ideas and encourage people to define the issue themselves, for example by asking '*How might we*…'.

Be human: Acknowledge and respect what individuals, carers and families say. Do not use jargon and acronyms – plain English helps everyone understand what you mean.
Be open: Ensure that someone in the group has good facilitation and listening skills, to reflect and act upon what is heard.

Somerset County Council, 2017
Vikki Hearn, Strategic Manager Commissioning Development
VHearn@somerset.gov.uk

APPENDIX 7 Communications Checklist

Template communications checklist: Audiences and tools

This is a checklist to make sure that any communications activity – either proactive or reactive – is planned and timed to get to key stakeholders so that they hear all Trust news from the Trust before they hear or read about it from any other source.

Audience	Timing	Possible channels of communication
Patients, Families and carers: • Patients and families affected	Patient engagement should be evidenced during decision-making process	• Focus groups • Leaflets • Posters • surveys
Trust staff: • directly affected • indirectly affected • affected staff on leave or off shift at the time of the announcement, including staff on sick leave and maternity leave • Integration Champions • Union representatives • all other Trust staff	What time/date is this planned? How many days' notice can you give? How sensitive is the announcement? .	• Face to face briefing • Email • Letter • Staff newsletter • Intranet • Phone calls where appropriate
Governors and volunteers: • FT members • Council of Governors • Board members • Non-executive Directors • Chief Executive and Executive Directors.	Wherever possible, this should closely follow communications to staff.	• Regular meetings • Briefings • Email • Letter • Staff newsletter • Intranet
Voluntary and community sector: • Hospital Leagues of Friends • Other charity organisations		• Briefings • Email or letter
Primary care and providers		• Phone calls • Letters and emails

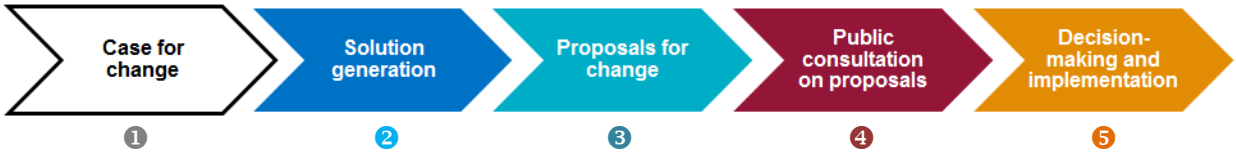
Audience	Timing	Possible channels of communication
Regulators, advisors and commissioners: • Public Health • Department of Health • NHS England • NHS Improvement • Care Quality Commission	It is expected that the CCG is involved in discussions about announcements relating to service change. As such communication plans and products should be shared as early as possible.	• Face to face briefing/meeting • Phone calls • Letters and emails • Text for CCG newsletter and GP bulletin
Media: • local, regional and national broadcast and print media • national media health specialists • trade press including medical, nursing, scientific and management publications	Timing should be planned so that our other audiences have as much notice of our announcement/decision as possible.	• Sharing press notices • Emails/phone calls
Elected representatives: • Somerset County Council • Parish/town councils • District councils • Health and Well Being board • Somerset **County Council's** Overview and Scrutiny Committee • Local MPs		• Phone calls • Letters • Attendance at public meetings • Emails, phone calls to constituency offices. Sharing press notices
Public and representatives: • Patient representative/advocacy groups • Healthwatch • Patient Participation Groups • Wider public		• Sharing press notices • Emails/letters • Briefing for newsletters

APPENDIX 8: Communications and Engagement Project Plan Template

COMMUNICATIONS AND ENGAGEMENT PLANNING TEMPLATE

1. THE PROJECT

Project:	
Project lead:	
Comms and engagement leads:	
Context: What are the problems we are facing:	
What we need to achieve:	
What the outcome may be:	
How far has the project progressed against the timeline below?	



2. PEST & SWOT ANALYSIS

External Factors:

Political	**Economic**
• •	• •
Social	**Technological**
• •	• •

Organisational factors:

Strengths	**Weaknesses**
• •	• •
Opportunities	**Threats**
•	•

•	•

3. DEMOGRAPHICS (WHO WILL BE AFFECTED?)

What staff, patient or carer groups will this affect?	
What do we already know about the relevant groups' understanding, opinion or behaviour?	
What communication have we already had with different groups?	
What further analysis is needed?	
What impact can patient involvement have?	

4. STAFF, PUBLIC AND PATIENT PARTICIPATION SO FAR

Stage:	What evidence of involvement do we have?
Case for Change	
Solution Generation	
Proposals for Change	
Public Consultation on Proposals	
Decision-making and implementation	

5. STAKEHOLDER RELEVANCE

	Low interest	High interest
Low relevance (i.e. won't be affected)	• • •	• • •

High influence (will be affected)	• • •	• • •

7. COMMUNICATIONS OBJECTIVES

How do we strategically want to change understanding, opinion or behaviour, to help achieve the business objectives? (Not focused on tactical activities - this comes later).	

8. KEY COMMUNICATIONS MESSAGES

Segmented by audience, what are our very top-line propositions/messages?	
Audience:	**Key messages:**

9. ENGAGEMENT & CONSULTATION

Should a formal consultation be considered?	
Project contact for NHS England:	
Project contact for CCG:	
Date to be presented to Scrutiny:	

10. TACTICS

What are the communication	

channels/activities/methods we will use and in what order?	
What key engagement approaches will we use to gather feedback from our key patient, carer, public and voluntary sector groups?	

11. RESOURCES

How much resource will we need (including comms and engagement)?	

12. EVALUATION

How will we monitor the success of activities to ensure the campaign is on track?	
At the end of the campaign, who will produce an evaluation report on the outcomes?	

TO-DO LIST (Additional documents):
☐ **Equality Impact Assessment:** A live document for updating as our understanding develops. ☐ **Engagement Record:** Recording information obtained from desktop research and engagement and involvement activities, by the stages defined above. ☐ **Project Plan (for large projects):** with key milestones for Communication and Engagement.