



Fit for the Future – Lessons Learned

1 Introduction

Fit for the Future (FFF) was a major strategic exercise, designed to review and potentially reconfigure services across the south east and in doing this to engage and consult a variety of stakeholders. FFF encompassed a number of commissioning organisations and service providers. Like other strategic change projects, FFF presented a significant challenge to manage and to bring to a conclusion. In particular, FFF in West Sussex proved to be a major undertaking.

At the conclusion of FFF, NHS West Sussex convened a review meeting to look back and reflect on learning from the process undertaken. Two key questions were posed:

- *What did we do well?*
- *What did we do not so well?*

This paper presents the proceedings of that meeting and some follow-up discussions. It begins with a narrative describing the background to FFF and the process itself. The paper then summarises the discussion at the review meeting, addressing:

- Project planning and management;
- Gathering, presenting and weighing the evidence;
- Engagement and communication.

Some overall conclusions are then presented.

Verbatim comments captured on notes at the review meeting are given as Annex 1. It should be noted that the comments do not neatly fall into categories and so there may be repetition or cross-over between the various aspects of FFF that were discussed. Meeting attendees are listed at Annex 2. Other key stakeholders, to whom this paper will be distributed, are listed at Annex 3.

2 Narrative

One of the defining characteristics of the West Sussex FFF project was the scale of the undertaking. The consultation exercise was one of the biggest undertaken by the NHS (see exhibit in section 3.3.3 below). It also took place at a time of great change in the NHS and in particular during a time of significant new investment.

The origins of FFF lay in the historical position of health economies in the old Surrey and Sussex Strategic Health Authority and its predecessor organisations. The local NHS had a reputation for poor performance and an inability to make strategic decisions. The new South East Coast Strategic Health Authority (SHA) had a brief to quickly change this.



In Brighton and Hove and Mid Sussex, the *Best Care Best Place* strategy had been developed. This encompassed some of the access and clinical sustainability issues that would need to be addressed in West Sussex.

A key report prepared by McKinsey as part of the regional “S4” strategy stated that £100M in savings was required and that service closures would be needed to achieve this. The report has since been questioned, but an apparent emphasis on finding financial savings remained in the public mind and for a while, the “centralise and close” route was followed, at least intellectually, by local managers.

PCTs worked collaboratively with providers on local versions of the strategy. When *Commissioning a Patient Led NHS* was implemented, new, larger primary care trusts came into being. As the new management teams were appointed, transitional arrangements for strategic planning continued, led by the SHA. A range of discussions and modelling and planning activities took place, with various personalities involved. It was difficult for those involved to criticise S4 or to pause the process.

There was an ambition to proceed to consultation on proposals for change – *Fit for the Future* - early in 2007. In common with other new PCTs, West Sussex wished to get its own local “grip” on strategic matters before making and consulting on proposals for change. The PCT decided not to proceed (despite public demands) on service change proposals until it was ready. Deadlines were therefore pushed back. Consultation eventually began in the summer of 2007 and ran to November.

FFF in West Sussex had some clearly stated objectives. They were that services should be:

- *Clinically sustainable – will deliver the high quality services outlined in our vision or care in West Sussex and will be as safe as possible for patients;*
- *Deliverable – to make sure new services are delivered by appropriately trained, high quality staff and that alternatives are in place before changes are made;*
- *Financially sustainable.*¹

Over time, it became clear that there was a fourth objective – maintaining local access to services. Access came to dominate discussions. Meanwhile the financial objective – important in the origins of FFF but increasingly *not* the main driver for reconfiguration as time went on – was continually viewed by the public and others as the “real reason” for change.

¹ [Creating an NHS Fit for the Future – Have Your Say](http://www.westsussex.nhs.uk/about-us/fff-nextsteps/fit-for-the-future/public-consultation/consultation-document/), <http://www.westsussex.nhs.uk/about-us/fff-nextsteps/fit-for-the-future/public-consultation/consultation-document/>



Though the consultation was a joint one with Brighton and Hove, The FFF debate in West Sussex became more specific to local circumstances, and varied from other health economies. From the perspective of the NHS in the north east of West Sussex, the focus of FFF appeared to be on the coastal areas. Only later did the PCT's North East Review balance this.

The *appearance* of rapid progress towards service closures – fed by active political campaigning from an early stage – caused alarm amongst the public. From the perspective of NHS managers, campaigning against change had begun *before* any proposals had been made. When consultation eventually took place, statements made by the local NHS were not trusted.

Clinical working groups were established in late 2006. A perceived lack of clinical engagement up to this time had been of great concern. A meeting of local clinicians with Sir George Alberti presented an opportunity for strong expressions of anger over the strategic planning process that had been undertaken so far. The McKinsey model was widely rejected, including by primary care clinicians. The strategy was viewed as “acute-centric”.

In the working groups, clinicians began to review and collect evidence and develop local thinking on service models. They began to challenge the McKinsey model. With the support of Sir Graham Catto, the process of clinical engagement (though mostly at senior medical level) and the development of local models of care began to generate options. Sub-groups formed around some of the key areas such as A&E and maternity. There was support for the development of a “big” hospital for West Sussex; though little appetite for the flip side of this – that another hospital would become “small”. The debate remained hospital-focused and by the summer of 2007 it was clear that acute issues needed to be prioritised – to do more than this appeared to be unmanageable.

A well-organised public campaign against FFF continued to generate negative coverage and West Sussex PCT found itself in a position of “crisis management” rather than being able to make a case for change. Corporate urgency on the FFF agenda came relatively late in the process, after much of the media had started to produce stories about A&E departments being closed. Therefore the PCT was placed on the defensive. There was a constant need to rebut inaccuracies and this contributed to a public debate that was negative and focused on loss of service rather than improvements. As a result much effort was expended in trying to explain terminology (“LGH plus”) and clarifying the stated options rather than engaging people in a debate on the principles of high quality, safe and sustainable health care.

Over time, the evidence that was gathered and used for decision-making improved in quality. The inequalities debate started to impact on thinking. Issues such as the impact of the Working Time Directive were addressed. However, much of this came late – after the debate had begun and after public campaigning had focused on finances and cuts. The proper linkage of travel, population and transport evidence as part of the access debate was probably not made early enough. The development of options may have resulted in too prescriptive a debate.



3 Summary of the review meeting discussions

3.1 Project planning and management

Project management of FFF was generally held to be effective, but given the circumstances described above, can be summarised by the phrase “it made the best of a bad job”. The project successfully delivered its objectives while it was under constant time pressure, while circumstances (the drivers for change) shifted and while significant external pressure was brought to bear.

The key lessons learned were:

- Local project leaders must be able to resist external pressure and remain in control of the process.
- More time is needed at the earliest stages, to gather evidence and talk through the issues and to get a real consensus around a case for change *before* potential solutions are discussed.
- GPs must be involved at the earliest stages.
- “Being right is not enough” – public trust must be gained.
- The debate must focus on gains, not losses.
- Take guidance from similar projects elsewhere – such as *Best Care Best Place*.
- PCT staff should be trained alongside management consultants to learn from them to build up local capacity and reduce cost.
- Questions to management consultants must be well-formulated in order to ensure that the answers address the real issues.
- A commonly agreed “burning platform” is needed to ensure that all key decision-makers and stakeholders understand the need to change and have a shared view of *why*.

Effective project management is therefore not enough to overcome the challenges of strategic change.

3.2 Gathering, presenting and weighing the evidence

In general, the evidence used for FFF was felt to be a strong point, though it came too late in the process to change many widespread public fears and perceptions. All analytical work was quality assured by an independent analyst so that no data was published unless it had been double checked for accuracy. In general, evidence improved after significant unrest among local clinicians led to a clinical commitment to getting the process right.

The key learning points were:

- CRAG groups were a success, especially when informed by external views.



- Evidence will evolve throughout the process, reflecting changing circumstances; for example, the need for stronger finances to achieve foundation trust status.
- Clinical leadership and examination of evidence led to new solutions – such as trust merger as a means of strengthening local services.
- A shared cross organisation data modelling group (chaired by the PCT or an independent expert) could have been set up from the beginning to help to define the model, assess the baseline information and assess the outputs - it would have helped to have a widely agreed evidence base before going public.
- External factors such as Independent Reconfiguration Panel rulings in other parts of the NHS can weaken local evidence – for example ruling against changes to small maternity units.
- Independence is important in presenting evidence for change.

The need for timely, relevant, robust and trusted information is a prerequisite for success. The appearance during FFF of new and contradictory evidence, such as the Independent Review Panel decisions on the Banbury and East Sussex maternity reconfigurations, made it difficult to hold a consistent line.

3.3 Engagement and communication

3.3.1 Engagement of local NHS Boards

In general, there was a sense that while local boards were engaged, there was inevitably a divergence of interests once the specific interests of provider trusts came into play. Engagement with boards outside of West Sussex was less effective. Important cross-border issues were perhaps not addressed as well as they should have been.

A major and recurring theme is the difficulty of managing service change while undergoing organisational change. For the West Sussex PCT board, FFF dominated proceedings to the exclusion of other important topics.

3.3.2 Engagement of NHS staff, particularly clinical staff

Views on engagement of staff closely match views on evidence. While engagement was seen as a strength (eventually) this was less evident among primary care doctors.

Key learning points were:

- Strong and visible clinical leadership from all organisations is needed – “on the platform”.
- The ambulance contribution was very valuable.
- GP engagement was less effective, despite very effective leadership through the PEC chair, and this must be addressed.
- Clinical leadership is not just about senior doctors – nurses, midwives and others could have been engaged more closely.



Once in place and properly operational, the CRAG meetings and outputs were helpful and it may have been useful to keep them in operation for longer.

3.3.3 Engagement of patients, the public and their representatives

Inevitably, public consultation and patient and public engagement were major and time-consuming exercises. Some isolated problems with venue size – resulting in members of the public being excluded from meetings – generated very negative feelings. Public meetings organised by the County Councils were particularly difficult to address in a pro-active way.

A huge amount of energy and effort was expended on managing public concerns – particularly in reacting to negative or misleading comment and news media coverage. While some members of the public did express support for aspects of FFF, it was difficult for them to do so in mass meetings. It was found that eloquent orators or powerful individuals could sway a pattern of thinking which could be both helpful and unhelpful.

The size of the consultation process can be usefully compared with the Healthcare for London exercise:

| | Healthcare for London | West Sussex FFF |
|--------------------------------------|--------------------------|--------------------|
| Duration (months) | 3 | >4 |
| Meetings held | 35 | 136 |
| Attendees at meetings | 4,000 | >5,000 |
| Responses to consultation | 3,500 | >38,900 |
| Hits on consultation web site | >20,000 | >40,000 |
| Population covered | 7,200,000 | 776,300 |

For a much smaller population, FFF was a far greater undertaking. However, while it was resource intensive, FFF seems to have cost lot less than similar exercises in north east London and elsewhere.

The key learning points were:

- Once a negative view of change has been presented (finances, closures) it is extremely difficult to regain the initiative and focus on benefits.
- To mitigate the impact of powerful individuals, effective process, minimum standards of evidence for decision-making and success criteria are explicitly required from the outset.
- Evidence and proposals must be presented in a way that can be understood by the public.
- Engagement is needed on the fundamental issues first, before any potential solutions are offered.
- Engage early.



3.3.4 Communication of decisions

Views on communications closely mirror previous sections.

Communications need to spell out the drivers for change, the evidence and the benefits that are being sought. A more imaginative approach might be needed to reconcile on the one hand the need for formal evidenced papers used in decision-making and providing on the other hand understandable messages to the wider public.

4 Conclusions

FFF was a difficult process that presented many challenges for the local NHS. The origins of the process and early planning work did not provide a strong platform – particularly given time pressures. A new PCT board struggled to catch up with the process and take control. They found themselves in the position of being system managers, setting out provider options, rather than commissioners clearly setting out health and health care needs for providers to meet.

Other important developments such as the primary and community proposals set out in *A Breath of Fresh Air* may not have been given the equal and early attention that they warranted. The exercise was particularly demanding of the West Sussex PCT chief executive, even with a good project manager in post and with the successful appointments of a deputy CEO and a communications director.

However, FFF did bring about positive change –

- The Western Sussex Hospitals merger was implemented on the basis of providing safe, sustainable and high-quality services.
- The North East Review came about and addressed a number of important issues.
- Strong relationships with the Health Overview and Scrutiny Committee and County Council colleagues were developed.
- The PCT board became more cohesive.
- Patient and public engagement is now much more effective.

It was agreed that this paper would be disseminated to interested parties. It was also suggested that the paper could form the basis for a published article, for sharing the learning more widely.

David Brodin

Director of Consulting, Finnamore Limited

July 2010



Annex 1

These are verbatim comments captured from a Post-It exercise. Some comments may have been slightly edited for clarity, but without changing the meaning.

Project planning and management

What did we do well?

- *The process evolved – got better more inclusive of shareholders as time went by.*
 - *Programme governance was good.*
 - *Use of CRAGs.*
 - *Honesty.*
 - *Made the 'best of a bad job'.*
 - *Recognised inherent flaws.*
 - *Moved timescale back.*
 - *Did as much pre-engagement as possible.*
 - *Extending FFF to incorporate a review of North Eastern was welcomed.*
 - *Good communications and links between project management and provider organisations.*
 - *Chief executive 'read ups' project and hand over day to day business to deputy.*
 - *Got everyone through to a decision.*
 - *Good project/programme management overall - worked well with SHA programme director (Lynne Whitehead).*
 - *Great debates.*
 - *Appeared to be good project management.*
 - *Good team working when task was set clearer and agreed.*
 - *CRAG structure.*
 - *CRAG work and co-design events excellent.*
 - *Late but critical involvement of independent clinical oversight.*
 - *Process well managed – (eventually) but at the start was in “catch up made” and PCT (probably) underestimate time commitment.*
 - *Documentation was good. Evidence base developed and evolved (but evidence was sketchy during 2006 – 2007).*
-

What did we do not so well?

- *Lack of clinical engagement prior to public consultation.*
 - *FFF appeared very focused on the coast not the entire patch of West Sussex.*
-



What did we do not so well?

- *Needed to have a more defined clinical model on which to base the planning assumptions. Also better sync between CRAG sub groups.*
- *Lack of modelling of services prior to public consultation i.e. which service needed centralisation and which didn't.*
- *'Story' that consultation tried to tell was not accepted by the public as credible because of pre-consultation work by SHA. Public trust lost before consultation started.*
- *Not enough preparation and pre consultation of the process.*
- *Involve wider audience (community/key interest groups) in developing plans at onset. (Could've helped to improve planning and understanding/ownership of direction of travel.*
- *More (structured) pre-consultation, and use this to help design formal public consultation.*
- *Programme most difficult against constantly moving deadlines.*
- *Give more time for organisational restructuring to bed in before launching FFF.*
- *SHA pressure to consult before PCT was ready.*
- *What ever leads to the review you need to plan to have the public and clinicians on 'your side' from day 1.*
- *Need to address evidence, access, and in equalities/deprivation from the start even if review is driven by other things.*
- *No evidence of implementation of Breath of Fresh Air.*
- *'Politically' no one wants to lose their local hospital therefore project needs to address now this is to be handled from the start even if services will remain local whatever the review finds.*
- *Large change agenda imposed on new and therefore immature organisation coping within its own internal changes.*
- *Could not set our own timeframe for 'going public'.*
- *Lack of advice /input from a dedicated Communications Director in the early stages [things improved a lot when we got one – Stephen Pollock].*
- *Going out to consultation when we still weren't ready – having delayed at least once we didn't feel we could choose to delay again.*
- *Lack of ownership by those who had to run the project of -*
- *what was really driving things*
- *Timings.*
- *Project should have been framed in terms of commissioning services not expanding/contracting hospitals.*
- *The process felt hurried as though the PCT had started before they were ready to start.*
- *Not enough involvement of key stakeholders at the beginning e.g. councillors, GPs.*
- *Drivers for change mixed, unclear and variable – should have been more clinically*



What did we do not so well?

- focussed.*
 - *Proposals outlined in document changed halfway through consultation.*
 - *Difficult for a newly formed PCT with financial problems to mount a controversial public consultation in the time required.*
 - *Insufficient focus on messages delivered to public.*
 - *Some of the planning of clinician engagement events e.g. GP meetings @ 6pm.*
 - *Health economy Gateway review when realised it was no longer just financial - could not stop train. Surrey was able to step back?*
 - *Don't start from here!*
 - *Test the hypotheses to the limit before opening Pandora's box*
 - *Pre – consultation phase is the most time consuming.*
 - *Managing Department expectations (rushes) (models).*
 - *Effective communication between programme and staff – esp more junior clinical staff.*
 - *Clarity about the rationale/case for change.*
 - *Lack of consistency in project team from start to finish.*
 - *When the pressure was really on the jointness of the process with B&H suffered.*
 - *Absence of Director of Comms in the early days.*
 - *Opportunities to 'pause' and 'reflect' not taken.*
 - *Clinicians not engaged early enough in the process.*
 - *Relationships with key players were not always well managed.*
 - *Lack of ownership of the totality of the task.*
-

Gathering, presenting and weighing the evidence

What did we do well?

- *Transparent decision making.*
 - *High quality evidence collection.*
 - *Strong evidence in support of changes.*
 - *A wealth of evidence throughout that was worked through. Clinical consensus reacted.*
 - *Very thorough process, particularly ambulance times which became important for public.*
 - *Evidence improvement throughout the process.*
 - *Willingness to incorporate new evidence.*
 - *Financial evidence was strong with some good work from 20:20.*
 - *Evidence for change. Evidence based [?] up to date, well done. Decisions were based*
-



What did we do well?

- on evidence.*
- Stepped and fair final decision making process was excellent.*
- Having public health clinicians chairing the groups reviewing the evidence.*
- We didn't take the 'group-think' view at face value, we tested the evidence hard and listened to contrary views.*
- Clinical evidence disputed initially but via CRAG was excellent.*
- Pace of decision making varied to allow fullest review of evidence.*
- At the end evidence base became very robust.*
- Process used allowed 'view' and emerging evidence to be introduced. Clinicians generated evidence and appraised it through CRAGS.*
- CRAG groups.*
- Weighing – objective weighing and score mechanism.*
- CRAG influenced "new" model – based on evidence that had emerged.*
- Real attempt to identify clinical drivers and involve clinicians.*
- A lot of very good evidence was obtained to inform decision making.*
- Got lots of non-clinicians to understand the evidence (and clinicians).*
- Bringing in an external 'heavy' – Sir Graham to chair clinical discussions.*
- Good clinical consensus on model of care.*
- Evidence rigorously reviewed.*
- Evidence from the CRAGs valuable and respected.*
- There was a lot of very detailed evidence which was provided.*
- A lot of evidence was gathered – we learned a lot e.g. about the population and their needs.*

What did we do not so well?

- Could have done more to understand clinical models.*
 - Population growth appeared to differ between the PCT and local councils which was a barrier.*
 - The "story" the evidence was telling was not very clear in spite of a lot of resources going into gathering and presenting it.*
 - Traffic model came in late/changed. Access therefore became a driver.*
 - The evidence base is equivocal in some key areas – need to make judgements not just follow and equation. National 'evidence' (IRPs, Royal Colleges etc.) follows fashion.*
 - Opening clinical evidence base was weak/non-existent/contested.*
-



What did we do not so well?

- *Never compiled a body of evidence to be the bedrock of clinical work.*
 - *Evidence base change e.g. colleges, ETTD, Finances and Access (Sheffield Paper).*
 - *Dealing with conflicting evidence.*
 - *Comms was always in catch up until 2008.*
 - *Relationship between W Sussex and Brighton sometimes fell down – weren't saying the same things.*
 - *Rushed slant to consultation did not allow clinical evidence to be fully gathered in support of the consultation.*
 - *Disputed evidence damaged PCT credibility.*
 - *Basic trust with community not in place.*
 - *Evidence needs to be timely and well founded.*
 - *Changing "Clinical Consensus".*
 - *Emerging evidence can change thinking and in turn can change the model developed.*
 - *CRAG groups too late.*
 - *IRP process where outcome related to chair and therefore SOS.*
 - *"Opponents" seemed to present evidence more convincingly.*
 - *Some evidence presented POST public meetings.*
 - *A wealth of evidence that on occasion took us by surprise.*
 - *Presentation of the evidence at the beginning could have been better – strong evidence essential but was not, at that stage.*
 - *Evidence is no good if you have no advocates in key communities you need to support e.g. clinicians and so many people don't trust you.*
 - *Deliverability was not sufficiently taken into account.*
 - *Lack of evidence based policy – had to rely on local clinicians to interpret the evidence.*
 - *The evidence seemed to evolve and change. This made it difficult to pin down the pros and cons of proposed models (particularly for lay-people).*
 - *Decision making process was divisive – Trust against Trust.*
 - *Most of the evidence 'gathering' seemed to centre on what will be taken away not what new services will be available e.g. close to home.*
 - *Issues over social deprivation – evidence at ownership.*
 - *Evidence often difficult to translate into understandable messages.*
 - *Difficult to translate the message into something simple. Evidence base was complex. Clinicians may have understood. Public didn't.*
 - *When we did our scoring against the list of criteria, issues arose that some of the criteria were not mutually exclusive – so the weighing up of the evidence felt flawed.*
-



What did we do not so well?

- *National clinical guidance unclear.*
- *Some of the evidence was not strong – ambiguous e.g. travel times/access to specialist services. Cannot use this to make a strong case for radical change.*
- *Initial evidence for change poor from a clinical perspective.*

Engagement of local NHS boards

What did we do well?

- *NHS Boards initially involved as process progressed been more WSx focussed.*
- *NHS organisations were heavily engaged and presented a remarkably consistent picture after sufficient debate.*
- *Local NHS Boards well engaged but PCT could have better engaged bordering Trusts.*
- *The local NHS organisations held a line together externally throughout the consultation.*
- *Good engagement local boards.*
- *W Sussex went well with good effort to get right.*
- *Robust systems and processes to manage public response.*
- *Area of strength good links here.*

What did we do not so well?

- *Boards fell back to supporting their institution as he felt it was a win – lose option.*
- *Should have engaged across wider health economy much more.*
- *NHS Boards must have sufficient time to absorb the detail and the consequences before consultation – don't launch major change during an organisational reconfiguration.*
- *Out of county Board 2 Board engagement.*

Engagement of NHS staff, particularly clinical staff

What did we do well?

- *Clinically unpopular model united staff and galvanised alternative proposal.*
- *Eventually good clinical engagement with CRAGS etc. Almost consensus i.e. model.*
- *The most senior clinicians (MDs/PEC chairs) were on board and the consensus held.*
- *Clinical (consultant) engagement good – use of independent support important.*
- *Genuine attempts to engage with clinicians were made – but not effective until much later on.*



What did we do not so well?

- *Need all our staff to be happy to give 'this weeks 3 key messages' for our case if asked by the public in their 'life outside work'.*
- *Lack of involvement of clinicians from other surrounding Trusts e.g. Portsmouth.*
- *Needed to engage beyond consultants but no time/resource to do this.*
- *Difficult to engage all clinicians across all disciplines.*
- *The story was too convoluted even for staff/clinicians.*
- *Too much importance given to Brighton and too little to Portsmouth (clinical engagement).*
- *Engage widest possible range of clinical staff, not just doctors, not just secondary care from day one.*
- *Staff although they recognise need for change – felt it was win lose and therefore felt threatened.*
- *GPs not within the tent.*
- *GPs should have been engaged earlier in the process – in fact at the beginning.*
- *Very destructive to local relationships – but much not within our control.*
- *Engagement with clinicians especially GPs was not effective enough e.g. many GPs believed what the paper said re hospitals closing.*
- *Clinical engagement. Primary Care had to mobilise.*
- *Clinical engagement should have been fundamental to the process from much earlier on.*
- *Breaking the senior consultant "barrier". How to engage with more junior staff?*
- *Clinical engagement could have been better.*
- *Clinical involvement/engagement assumed but often not realised.*
- *Lack of clinical engagement at the start.*
- *'Competition' between clinicians from the two W Sussex trusts muddled the water.*
- *GP engagement too late.*
- *Some acute clinical engagement was partisan.*
- *Visible clinical leadership and support especially primary care. Folk talk to their GP – what they say is influential.*
- *Could not get adequate level of GP engagement – many were negative.*
- *Need staff and public engagement before you start.*

Engagement of patients, the public and their representatives

What did we do well?

-
- *We now know how absolutely important access is to patients/public.*
-



What did we do well?

- *The public consultation was a genuine attempt to listen and learn – the decision had not already been made.*
 - *Public involvement at co-design events very positive.*
 - *Good working/behind the scenes relationships built between HOSC/JHOSC and West Sussex PCT.*
 - *Effective engagement led to opening up of access issues as a key element of decision making criteria.*
 - *Very good engagement of the public – extensive, but was refined and improved during the “process” e.g. co-design.*
 - *The introduction of Sir Graham Catto (and then the NE Review) turned the consultation into something constructive and not confrontational.*
 - *Engagement of the public, patients and relatives was good via the stakeholder group for the NE Review of FFF.*
 - *Great deal of trouble/time was spent trying to engage public but argument already lost.*
 - *NE Review came out of public perception of FFF being about the “coastal strip”.*
 - *Co-design events good.*
-

What did we do not so well?

- *Need to tailor information to suit audience: JHOSC had a lot of papers from PCT that were too detailed/technical (often designed for Board). Needed summaries/overviews and explanation of technical terms.*
 - *PCT tried hard to engage with MPs some of whom had aligned themselves strongly with the protest groups.*
 - *Very focussed pre-consultation. The chance to have a proper debate/dialogue with public and clinicians.*
 - *The “Audience”/Stakeholders – grew as process developed and therefore a perception of “done to” was further compounded.*
 - *Patients only perceived process about closure.*
 - *More engagement with local councils.*
 - *Failure to get across message of best hospital not the nearest.*
 - *Very difficult changing public opinion re campaign groups, MPs and ‘hostile’ media.*
 - *Public/patients trusted the newspapers and campaign leaders – who did not mind that people believed whole hospitals might close.*
 - *Access needs to be seen as access to appropriate care/services not access to hospitals.*
 - *Engagement of patient representatives in the stakeholder group good but could have been set up earlier.*
-



What did we do not so well?

- *Seen to be about services in the South of the county.*
 - *Visiting relatives in hospital – only appreciated patient perspective.*
 - *The way the issues were set out for the public consultation was convoluted – hard for public to engage in meaningful way.*
 - *Difficult to counter single interest campaigners.*
 - *Engage the public with open questions first, then on an emerging hypothesis, then on formal consultation/options. Not the other way round.*
 - *Major meetings necessary but not the best medium for delivering the message.*
 - *Did not gain the ‘hearts’ of politicians.*
 - *Provider organisation non-medical staff could have been better engaged in developing the model.*
 - *We allowed MPs to use it for their own agenda. Earlier engagement may have helped.*
-

Communication of decisions

What did we do well?

- *Regular communications through a range of channels.*
 - *As good as they could be given the speed at which some of the ‘external’ influences happen.*
 - *Decisions made in public.*
-

What did we do not so well?

- *Need many reminders about the “Joint” nature of the consultation.*
 - *Tougher rebuttal. Hit inaccuracies hard in public – manage the relationship in private.*
 - *PCT decision on Worthing/StR was not handled well with their senior leaders. One to one conversations in private should have happened before direction of travel emerged in meetings.*
 - *Locked into a website that was little more than a system for document storage. Needed improved functionality.*
-



Annex 2 – Meeting Participants

The following attended the workshop on 26 February 2010:

Jean Barclay, NHS West Sussex

Andy Cashman, South East Coast Ambulance Service

Amanda Fadero, NHS Brighton and Hove

Andrew Foulkes, NHS West Sussex

Nick Fox, Western Sussex Hospitals NHS Trust

Darren Grayson, NHS Brighton and Hove

Catherine Greenaway, Surrey and Sussex NHS Trust

Mike Harris, NHS West Sussex

Peter Hayward, NHS West Sussex

Simon Holmes, Portsmouth Hospitals NHS Trust

Brian Hughes, NHS West Sussex

Helen Kenny, West Sussex County Council Health Overview and Scrutiny Committee

David King, NHS West Sussex

Liz Knight (nee Tatlow), NHS London (previously FF Lead for West Sussex)

Susan Onslow, NHS West Sussex

Steven Pollock, NHS West Sussex

Norman Robson, NHS West Sussex

Betty Smith, Interim Patients Council, West Sussex

Gail Wannell, Surrey and Sussex NHS Trust

John Wilderspin, NHS West Sussex

Barbara Wilkins, NHS West Sussex

Michael Wilson, Brighton and Hove University Hospitals NHS Trust

David Brodin, Finnamore (facilitator)



Annex 3 – Other Recipients

This paper is also distributed to the following:

Margaret Bamford, ex-NHS West Sussex

Philip Britten, Western Sussex Hospitals NHS Trust

Brian Courtney, Portsmouth Hospitals NHS Trust

Cllr Peter Griffiths, West Sussex County Council

Andrew Liles, Ashford and St Peters NHS Trust (previously Royal West Sussex NHS Trust)

Malcolm Liles, ex-NHS West Sussex

Christine McDermott, ex-FFF Team now NHS III)

David Mallett, NHS London (previously NHS South East Coast)

Amanda Philpott, ex-BSUH

Julie van Ruyckevelt, ex-FFF Team – now West Kent)

Mike Rymer, Western Sussex Hospitals NHS Trust

Mandy Shipley, JHOSC