Public Document Pack

Wirral Place Based Partnership Board

Date:	**Thursday, 12 January 2023**
Time:	**10.00 a.m.**
Venue:	Committee Room 1 - Wallasey Town Hall

Contact Officer:	Mike Jones
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Please note that public seating is limited, therefore members of the public are encouraged to arrive in good time.

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This meeting will be webcast at
https://wirral.public-i.tv/core/portal/home

AGENDA

1. WELCOME AND INTRODUCTION

2. APOLOGIES

3. DECLARATIONS OF INTEREST

Members are asked to consider whether they have any relevant interest in connection with any item(s) on this agenda and, if so, to declare them and state the nature of the interest.

4. MINUTES (Pages 1 - 6)

To approve the accuracy on the minutes of the meeting held on 8 December 2022.

5. PUBLIC AND MEMBER QUESTIONS

Questions by Members

Questions by Members to dealt with in accordance with Standing Orders 12.3 to 12.8.

Public Questions

Notice of question to be given in writing or by email by **Monday 9 January 2023** to the Council's Monitoring Officer (via the online form here: Public Question Form) and to be dealt with in accordance with Standing Order 10.

Please telephone the Committee Services Officer if you have not received an acknowledgement of your question by the deadline for submission.

Statements and Petitions

Statements

Notice of representations to be given in writing or by email by 12 noon, **Monday 9 January 2023** to the Council's Monitoring Officer (committeeservices@wirral.gov.uk) and to be dealt with in accordance with Standing Order 11.1.

Petitions

Petitions may be presented to the Committee if provided to Democratic and Member Services no later than 10 working days before the meeting, at the discretion of the Chair. The person presenting the petition will be allowed to address the meeting briefly (not exceeding three minute) to outline the aims of the petition. The Chair will refer the matter to another appropriate body of the Council within whose terms of reference it falls without discussion, unless a relevant item appears elsewhere on the Agenda. If a petition contains more than 5,000 signatures, it will be debated at a subsequent meeting of Council for up to 15 minutes, at the discretion of the Mayor.

Please telephone the Committee Services Officer if you have not received an acknowledgement of your statement/petition by the deadline for submission.

6. PLACE DIRECTOR OBJECTIVES UPDATE (Pages 7 - 26)

7. WIRRAL DELIVERY PLAN - DELIVERY UPDATE (Pages 27 - 34)

8. PLACE PARTNERSHIP BRIEFING - NHS CHESHIRE AND MERSEYSIDE PUBLIC ENGAGEMENT FRAMEWORK (Pages 35 - 172)

9. PLACE REVIEW MEETINGS (Pages 173 - 186)

10. 2022/23 POOLED FUND FINANCE REPORT TO MONTH 7, SEPTEMBER 2022 (Pages 187 - 194)

The Appendix for this item may not be suitable to view for people with disabilities, users of assistive technology or mobile phone devices. Please contact Mike Jones (contact details above) if you would like this document in an accessible format.

11. WIRRAL PLACE BASED PARTNERSHIP WORK PROGRAMME (Pages 195 - 200)

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WIRRAL PLACE BASED PARTNERSHIP BOARD

Thursday, 8 December 2022

Present:

Simon Banks	Place Director/ Chair
Dr Abel Adegoke	Primary Care Provider
Graham Hodkinson	Wirral Council
Ali Hughes (in place of Karen Howell)	Wirral Community Health and Care NHS Foundation Trust
Carol Johnson-Eyre	VCSE
Dr David Jones	Primary Care Provider
Councillor Mary Jordan	Wirral Council
David McGovern (in place of Janelle Holmes)	Wirral University Teaching Hospital NHS Foundation Trust
Martin McDowell	NHS Cheshire and Merseyside
Justine Molyneux	VCSE
Councillor Yvonne Nolan	Wirral Council
Paul Satoor	Wirral Council
Andy Styring	Cheshire and Wirral Partnership NHS Foundation Trust
Councillor Jason Walsh	Wirral Council

28 **WELCOME AND INTRODUCTION**

The Chair welcomed the members of the Board, officers and those watching the webcast to the meeting.

29 **APOLOGIES**

Apologies for absence were received from:
David Bradburn, Director of Public Health, Wirral Council
Janelle Holmes Wirral University Teaching Hospital
Karen Howell, Wirral Community Health and Care NHS Foundation Trust
Karen Prior, Healthwatch Wirral
Simone White, Director of Children's Services, Wirral Council
Tim Welch, Cheshire and Wirral Partnership NHS Foundation Trust

30 **DECLARATIONS OF INTEREST**

The Chair asked for members to declare any interests in any items on the agenda. No interests were declared.

31 **MINUTES**

Resolved –
That the minutes of the meeting held on 10 November 2022 be approved as a correct record.

32 **PUBLIC AND MEMBER QUESTIONS**

The Chair reported no public questions, statements or petitions had been received.

The Chair proposed amending the order in which the agenda items were considered with item 8 (Key Issues Relating to Quality and Safety) being heard first at the request of the presenter. This was agreed.

33 **KEY ISSUES RELATING TO QUALITY AND SAFETY: (REPORT FROM THE QUALITY AND SAFETY GROUP)**

The Director of Quality and Safety at NHS Cheshire and Merseyside presented this report which identified key issues identified relating to Quality and Safety through the Wirral Quality and Performance Group and other relevant sources. The report included: Issues of concern, issues of a general update, and issues for assurance. The report also highlighted where appropriate the actions that have taken place and the timescale of completion.

Members highlighted the issue of the increase in mental health problems and provision of care, including an increase in patients being placed in beds out of the area due to problems in community provision locally. The issue of the spread of C Difficile was also highlighted, which was to be investigated in trials in January 2023.

Resolved – That the areas of concern contained within the report, and the actions that are being taken be noted.

34 **WIRRAL PLACE BASED PARTNERSHIP BOARD TERMS OF REFERENCE REVIEW**

The Assistant Director – Communications & Corporate from NHS Cheshire and Merseyside presented this report which summarised the action taken by the Place Governance Group to progress points raised at the first formal meeting of the Wirral Place Based Partnership Board on 13 October 2022. The report presented revised Terms of Reference.

Several points of clarification were requested including:

- A wish to see reports from all of the reporting groups
- Specified representatives or level of representation from the constituent bodies

- The specific quorums for Council officers and Members and voting rights

The Chair suggested that the recommendations be amended in the light of the discussion:

Councillor Mary Jordan moved new recommendations: That the Wirral Place Based Partnership Board
1. note the work to progress the actions detailed in the report and note that further work will be undertaken, with the terms of reference being draft;
2. ask the Place Governance Advisory Group to address the issues raised by the Place Based Partnership Board at its meeting on 8 December 2022 and
3. The Place Director remains as chair for the remainder of the Municipal Year and until a system is agreed regarding frequency and change of Chair and Vice Chair.

This was seconded by Councillor Yvonne Nolan.

Resolved – That

(1) the work to progress the actions detailed in the report be noted and further work be undertaken, with the terms of reference being draft;

(2) the Place Governance Advisory Group be asked to address the issues raised by the Place Based Partnership Board at its meeting on 8 December 2022; and

(3) the Place Director remain as chair for the remainder of the Municipal Year and until a system is agreed regarding frequency and change of Chair and Vice Chair.

35 **WIRRAL PLACE BASED PARTNERSHIP BOARD SUPPORTING GROUPS TERMS OF REFERENCE REVIEW**

The Assistant Director – Communications & Corporate from NHS Cheshire and Merseyside presented this report which set out the four key governance and assurance groups that NHS Cheshire and Merseyside had established with partners in Wirral to support the Wirral Place Based Partnership Board and prepare for additional responsibilities through delegation. The report set out progress to date and draft terms of reference. It was noted that the groups were replicated in each of the nine Places in the Cheshire and Merseyside Integrated Care System.

Members pointed out consistency errors and made wording suggestions.

The Chair suggested amended recommendations in the light of the discission. These were proposed by Carol Johnson-Eyre and seconded by Alison Hughes.

Resolved – That

(1) the work to establish the supporting governance and assurance mechanisms to support the work of NHS Cheshire and Merseyside and the WPBPB in the Borough be noted;

(2) the establishment of the four supporting groups be endorsed;

(3) amended terms of reference be brought back to the February Board meeting for approval.

36 **2022/23 POOLED FUND FINANCE REPORT TO MONTH 6 SEPTEMBER 2022**

The Chief Finance Officer of NHS Cheshire and Merseyside presented this report which provided a description of the arrangements that had been put in place to support effective integrated commissioning. It set out the key issues in respect of: a) budget and variations to the expenditure areas for agreement and inclusion within the 2022/23 shared ("pooled") fund; and b) risk and gain share arrangements. The report also provides an update on the preparation of the framework partnership agreement under section 75 of the National Health Services Act 2006 relating to the commissioning of health and social care services, which will be subject to approval and final sign off by Cheshire and Merseyside Integrated Care Board (ICB).

The pooled finances were on target for a balanced position, and there was one major risk which was around the continuation of discharge and assessed beds. There had been an overspend but a financial recovery plan was in place.

Resolved – That

(1) the forecast position for the Pool at Month 6 be noted as a £5.3m overspend position due to the Clinical Commissioning Group (CCG) / Integrated Care Board (ICB) Wirral Place pool commissioned services and that the ICB Wirral Place holds the financial risks on this overspend.

(2) it be noted that the shared risk arrangements are limited to the Better Care Fund only, which is reporting a break-even position.

37 **ELECTION OF CHAIR TO THE JOINT STRATEGIC COMMISSIONING BOARD SUB-COMMITTEE**

The Head of Legal Services introduced this item, which was to elect a Chair from amongst the three Councillors who were members of Wirral Council's Adults, Social Care and Public Health Committee who sat on the Wirral Place Based Partnership Board. This was because a decision was required on the following agenda item and the decision had to be made by the Joint Strategic Commissioning Board Sub-Committee, which was a Sub-Committee of the Adults, Social Care and Public Health Committee and which sat in common

with the Wirral Place Based Partnership Board but with only the three Councillors having voting rights.

Nominations were invited for the role of Chair.
Councillor Jason Walsh nominated Councillor Yvonne Nolan. This was seconded by Councillor Mary Jordan.

There were no other nominations so Councillor Yvonne Nolan sat as Chair.

38 **ADULT SOCIAL CARE DISCHARGE FUND**

The Place Director introduced this report which set out the purpose of the Adult Social Care Discharge Fund, how the resources have been allocated, the conditions attached to the funding and how this impacted on Wirral as a Place. The Adult Social Care Discharge Fund was a national allocation of resources to local authorities and the NHS from His Majesty's Government. The deadline for submission of the Wirral plans for the Adult Social Care Discharge Fund was 16th December 2022.

The funding was being released in two tranches in December 2022 and January 2023 and there were are some specific conditions set by the Department of Health and Social Care (DHSC). The NHS allocation was to allow movement from hospital, supporting discharge using a home first policy, with metrics to track performance. There is a share of £2.1 M with schemes funded at actual rather than planned cost so funds can be reinvested if schemes were not effective.

The Director for Care Health and Strategic Commissioning explained that the local authority allocation was £1.5 M, with the same deadline of 16 December and the same chief officers from the NHS and Council working on it, but the focus was different. The Council's allocation was focussed on the care market, sustainability and capacity and also on the domiciliary care market, looking at admissions and discharges with a proportion to support 'charge to assess', where assessment is carried out at home to avoid hospital admissions.

Members discussed the schemes and plans involved.

The three elected Members sitting as the Joint Strategic Commissioning Board Sub-Committee Resolved – That

(1) the approval of the Wirral plan for the Adult Social Care Discharge Fund be delegated to the Director of Adult Social Care and Health, Wirral Council in consultation with the Place Director, NHS Cheshire and Merseyside.

(2) a further update report on the submission be brought to the next meeting of the Joint Strategic Commissioning Board and Wirral Place Based Partnership Board.

The Place Director resumed the Chairing of the Wirral Place Based Partnership meeting.

39 **WIRRAL PLACE BASED PARTNERSHIP WORK PROGRAMME**

The Head of Legal Services introduced the report which detailed the annual work programme of items for consideration by the Wirral Place Based Partnership Board. The Board was comprised of members from multiple organisations and the report enabled all partners to contribute items for consideration at future meetings. It was noted that it had been agreed that the financial recovery plan would be reported back to the January 2023 meeting.

Changes to the work programme were made and noted by officers.

Resolved – That the work programme be noted.

WIRRAL PLACE BASED PARTNERSHIP BOARD

12th JANUARY 2023

REPORT TITLE:	**PLACE DIRECTOR OBJECTIVES UPDATE**
REPORT OF:	**PLACE DIRECTOR (WIRRAL), NHS CHESHIRE AND MERSEYSIDE**

REPORT SUMMARY

NHS Cheshire and Merseyside's Chief Executive asked each of the nine Place Directors to develop objectives with representatives from their respective places. The intention was that the objectives of the Place Director are align to, owned, and delivered by each place collaboratively.

The attached objectives were developed by the Place Director during June and July 2022 in dialogue with key system partners. The objectives reflect the ambitions of the Wirral Plan 2026 and key areas of delivery for the Wirral health and care system in 2022/23. The objectives were approved by the Chief Executive of NHS Cheshire and Merseyside in August 2022. The objectives were endorsed by the Wirral Place Based Partnership Board on 13th October 2022. This report provides an update of progress against these objectives as of 5th December 2022.

This report is for information. This matter affects all Wards within the Borough.

RECOMMENDATION/S

The Wirral Place Based Partnership Board is recommended to note the progress against these objectives and receive quarterly progress reports on their delivery.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 NHS Cheshire and Merseyside's Chief Executive asked each of the nine Place Directors to develop objectives with representatives from their respective places. This report sets out the objectives for the Place Director (Wirral) as agreed with system partners and, as the Wirral Place Based Partnership Board is a meeting in public, places them in the public domain.

2.0 OTHER OPTIONS CONSIDERED

2.1 The option of producing objectives for the Place Director (Wirral) without reference to partners in place was discounted as it would not demonstrate the connectivity of this role to the place, would not ensure ownership by place partners of these objectives and would not be open, collaborative, and transparent.

3.0 BACKGROUND INFORMATION

3.1 NHS Cheshire and Merseyside's Chief Executive asked each of the nine Place Directors to develop objectives with representatives from their respective places. The intention was that the objectives of the Place Director are align to, owned, and delivered by each place collaboratively.

3.2 The attached objectives (Appendix 1) were developed by the Place Director during June and July 2022 in dialogue with key system partners. The objectives reflect the ambitions of the Wirral Plan 2026 and key areas of delivery for the Wirral health and care system in 2022/23. The objectives also link to the strategic aims of NHS Cheshire and Merseyside. The objectives were approved by the Chief Executive of NHS Cheshire and Merseyside in August 2022. The objectives were endorsed by the Wirral Place Based Partnership Board on 13th October 2022. This report provides an update of progress against these objectives as of 5th December 2022.

4.0 FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from this report, the objectives will need to be delivered with the financial envelope set for the Wirral health and care system.

5.0 LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from this report.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 The Place Director's objectives are connected to work that this already in progress in the Borough. This work should already be supported with the

appropriate resources and, where it is not, discussions will be required around the resource requirements to support delivery.

7.0 RELEVANT RISKS

7.1 The Place Director's objectives are based on work that is already underway in the Borough, work that has associated delivery plans. The risks associated with these delivery plans are managed within each work programme. NHS Cheshire and Merseyside is developing a risk framework for application in each of the nine places. The Wirral Place Based Partnership Board will also be receiving a report on this at a future meeting.

8.0 ENGAGEMENT/CONSULTATION

8.1 The Place Director's objectives were developed through a dialogue with the Chair of the Adult Social Care and Public Health Committee and officers from Wirral Council. The Chief Executives of Wirral's key NHS provider trust were also engaged in this process, as were representatives from general practice and the voluntary, community, faith, and social enterprise sector. Evidence of such engagement was a prerequisite for agreement of the Chief Executive, NHS Cheshire and Merseyside to these objectives.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council and NHS Cheshire and Merseyside have a legal requirement to make sure their policies, and the way they carry out their work, do not discriminate against anyone. The Place Director's objectives have been developed with an awareness of the general duty requirements and place equality considerations. No Equality Impact Assessment is required for this report.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 Wirral Council and NHS Cheshire and Merseyside are committed to carrying out their work in an environmentally responsible manner, and these principles will guide the delivery of the Place Director's objectives in Wirral.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 Community Wealth Building in Wirral focusses on partnerships and collaboration. These partnerships are led by Wirral Council with external partners and stakeholders, including residents. NHS Cheshire and Merseyside will support the Council in community wealth building by ensuring health and care organisations in the borough have a focus on reducing health inequalities and contribute to the development of a resilient and inclusive economy for Wirral.

REPORT AUTHOR: **Simon Banks**
Place Director (Wirral), NHS Cheshire and Merseyside
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APPENDICES

Appendix 1 Place Director (Wirral) Objectives Update

BACKGROUND PAPERS

Strategic Aims of Integrated Care Systems, accessed at: NHS England » What are integrated care systems?

NHS Cheshire and Merseyside priorities, accessed at: Our priorities - NHS Cheshire and Merseyside

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Wirral Place Based Partnership Board	13th October 2022

APPENDIX 1 PLACE DIRECTOR (WIRRAL) OBJECTIVES UPDATE

Simon Banks, Place Director (Wirral)
Objectives – 2022/23
August 2022
Progress Update as of 5th December 2022

Strategic Aims of Cheshire and Merseyside Integrated Care System

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience, and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
1	1-4	**Work together to deliver NHS Operational Planning Priorities 2022/23 and local Place priorities, aligned to Wirral Plan 2026 and Health and Wellbeing Strategy.**	Agreed Wirral Place Plan.	September 2022.	Ratification by Wirral Place Based Partnership Board (WPBPB). **Update:** Completed - This was ratified at the WPBPB in October 2022, September meeting postponed.
			Refresh Wirral Place Plan as new guidance emerges.	As required.	**Update:** Awaiting planning guidance 2023/24.
			Demonstrate progress of delivery of Wirral Place Plan through reporting to Wirral Place Based Partnership	November 2022.	Development of Wirral Place outcomes monitoring framework and dashboard modelled on good practice from other Places.

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
			Board (WPBPB).		**Update:** In progress, work ongoing across places in NHS Cheshire and Merseyside to develop reporting approach.
2	1-3	**Work together to enable greater independence for adults and older people in their own homes and local environment.**	We will demonstrate this by delivering a virtual ward service model in Wirral during 2022/23 for frailty and acute respiratory illness.	December 2022 March 2023	Baseline 20 frailty beds mobilised. Baseline 10 acute respiratory illness beds mobilised. Additional 10 (total 30) frailty beds mobilised. Additional 15 (total 25) acute respiratory illness beds mobilised. **Update:** Both Virtual Wards went live on 31st October 2022. Respiratory are on track to support 58 patients in the first month while frailty may be slightly short of achieving the target of 40 patients due to a delayed start date for staff. Recruitment has taken place to increase bed numbers for the end of December 2023, bed numbers will be increased in line with recruitment to ensure safe patient care Beds planned to increase for both services: 10 November and December 2022, 20 beds January – March 2023 and 30 beds April 2023 onwards.

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
3	1-2	**Work together for brighter futures for our children, young people, and their families by breaking the cycle of poor outcomes for all regardless of their background.**	We will demonstrate this by the delivery of the key milestones in our SEND Action Plan, moving Wirral towards the removal of the Statement of Action.	March 2023	The SEND Action Plan is monitored by the Department for Education and NHS England. Progress and milestones will be demonstrated in reporting to these organisations, which will be shared with WPBPB.
4	1-2	**Work together to provide happy, active, and healthy lives for all, with the right care, at the right time to enable residents to live long and healthier lives.**	We will demonstrate this through developing enhanced case finding for hypertension, using digital technologies (AccuRx), and working with Primary Care Networks, to identify those most at risk and provide appropriate support. 80% of people that are diagnosed with hypertension receive treatment, according to the target in NICE guidelines.	March 2023 January 2023	No. of new Hypertension diagnoses in the past 12 months. (Variable by PCN) **Baseline:** 2,430 (Total no. of Hypertension Floreys sent Jan22-Jun22) **Target:–** 7,000 (Aug22-Jan23 - 5% monthly increase per PCN from Jun22 onwards) (To be validated by clinical lead) <u>Nov-22 Update:</u> **Target**: 7,000 additional floreys to be sent from Aug-22 to Jan-23. **Actual (Oct-22):** 5,366 **Status:** On track

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
				March 2023 March 2023 March 2023	BPQI Toolkit uptake increase **Baseline:** 78% **Target:** 90% by Mar23 (To be validated by clinical lead) <u>Nov-22 update:</u> **Target:** 90% by Mar23 **Actual (Oct-22):** 98% **Status:** Achieved Increased response rate for Hypertension floreys **Baseline:** 35% **Target:** 50% by Mar23 (To be validated by clinical lead) <u>Nov-22 update:</u> **Target:** 50% by Mar23 **Actual (Oct-22):** 42% **Status:** On track BP@Home recordings for Hypertensive patients **Baseline:** 4,270 Aug21-Mar22 **Target:** 4,700 Aug22-Mar23 (10% increase) (To be validated by clinical lead)

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
					<u>Nov-22 update:</u> **Target:** 4,700 between Aug22-Mar23 **Actual (Oct-22):** 2,527 **Status:** On track Healthy Wirral Hypertension Metrics dashboard: https://app.smartsheet.eu/b/publish?EQBCT=e6259812e40944549ea4d7a6698f6ff3
5	3-4	**Work together for a prosperous, inclusive economy - helping businesses to thrive and creating jobs and opportunities for all.**	We will demonstrate this by producing a health and care workforce strategy and plan for Wirral that supports integration and collaboration in our place, across organisations.	September 2022 January 2023	Re-establish Wirral Place Workforce Group. **Update:** In progress. Group membership established and initial meeting held. Key presentations on Primary Care and VCFSE Workforce issues. Awaiting establishment of Provider Partnership Board and associated governance in order to establish the enabling group and provide strategic oversight. Wirral Place workforce strategy and implementation plan. **Update:** A Wirral Place workforce strategy and implementation plan will not be completed for January 2023. This is work in progress.

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
					Progress has been made in Care Market Workforce plans. Recruitment programme established, Real Living Wage rates agreed with providers, Incentive schemes developed including e-Bike loans and Care Friends incentive scheme to encourage new workforce. Engagement with College and Sixth Form Heads around Health and Care workforce position, and entry level opportunities, including 'T' level. Human Resources Directors and Workforce Leads for Wirral Place contacted to complete workforce questionnaire to inform strategy
				March 2023	An increase in available Care and Reablement Workforce from baseline levels and a concomitant reduction in turnover. Baseline Workforce:828 Trajectory: Increase in number of staff in Domiciliary Care Agencies to 1,217 by March 2023. **Update:** October 2022, 1,206 against target of 1,187. Turnover: 79 new starters, 54 leavers.

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
6	1-3	**Work together to ensure that primary care is integrated into Place governance and delivery mechanisms in Wirral.**	Engage primary care (general practice, community optometry, community pharmacy and community dental services) in governance and engagement arrangements in Wirral.	September 2022	Secure representation from primary care on WPBPB and Primary Care Committee. **Update:** Partially completed. Primary care represented on WPBPB. Primary Care Committee is now a Primary Care Group, representation still being secured.
				October 2022	Secure representation from primary care in Wirral Provider Partnership arrangements. **Update:** Primary Care will be represented on Wirral Provider Partnership. First meeting held on 5th December 2022.
				Ongoing	Ongoing engagement with Local Representative Committees, Primary Care Council, Primary Care Network Clinical Directors and emerging Wirral Primary Care Collaborative. **Update:** Engagement with primary care through these mechanisms continues.
			Support PCNs to become the essential core building block for integrated care.	October 2022	Engage PCNs in development of revised neighbourhood/care communities strategy for Wirral.

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
					Update: Project plan has been prepared to re-establish the neighbourhood programme and this is now out for feedback from Wirral. This includes meetings with key primary care representatives to ensure their involvement in the development and delivery of the programme. Primary Care Network (PCN) representatives are to be members of the Steering Group and each of the 9 Neighbourhood Core groups.
				October 2022	Ensure primary care is engaged in the Wirral Provider Partnership. **Update:** See above, completed.
				~~October 2022~~ March 2023	Revisit PCN maturity matrix (October 2021) and update assessment, with the addition of peer feedback. **Update:** Maturity matrix not updated with PCNs peer feedback due to new Enhanced Access service plan development/mobilisation through August to September 2022 and commencement of the from 1st October 2022; plus revised submissions required on new

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
					NHSE System Development Fund which incorporated previously PCN Development Fund used for organisational development, re-purposed as GP Transformation Fund – bids submitted during October/November 2022 – awaiting final decisions from NHSE on bids – given the additional work to be completed by PCNs with their SDF allocations, proposed revised "By when" date is March 2023.
				~~December 2022~~ March 2023	Develop plan to progress each PCN at least one step on the framework/maturity matrix. **Update:** Propose revising date to fit with previous update so March 2023.
7	1, 2 and 4	**Work together to mitigate the impact of cost-of-living increases on our population**	We will work together to mitigate the potential impact of cold homes and fuel poverty on our population and health and care services in Winter 2022/23.	Complete August 2022	Complete the baseline assessment tool for Excess winter deaths and illnesses associated with cold homes (NICE public health guideline NG6). Consider the outcomes of the baseline assessment tool and how these will impact on place-based actions. **Update:** Completed review, has influenced response by health and care to cost of living challenges.

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
				September 2022	Wirral Council to lead a strategic, population-based approach to mitigation of cost-of-living increase. Health and care to augment and align with this strategy and support operational delivery. **Update:** Completed, Wirral Council has established strategic co-ordination mechanisms across the borough to mitigate cost-of-living increases. A Health and Care Cell has been established to address the sector's response to (a) people who work in the sector and (b) people who the sector provides services for.
				October 2022	Use local population health intelligence to target those cohorts who are at greater risk of fuel poverty and ill health, developing campaigns and targeted interventions involving all partners in Wirral. **Update:** Primary Care Networks have agreed to target specific population cohorts (e.g. people with a learning disability, veterans) who may require additional support. This is in addition to existing clinical interventions. All services are working with Wirral Council

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
					colleagues to ensure that front line staff have information to support them in signposting patients to sources of support. This will primarily be through Wirral Info Bank which includes information on food banks, warm hubs and social supermarkets.
8	3 and 4	**Work together to maximise the use of public sector estate and ensure that this is linked to Wirral Council's Local Plan and regeneration work.**	Ensure that Wirral place governance links health and care providers into Wirral Council's Strategic Estates Board.	September 2022 September 2022	Representation from NHS on SEB. **Update:** C&M SEB been deferred due to membership and changes in structure and have not met for some months. Very little communication or priorities established because of this. Locally the Council join Wirral SEG and NHS colleagues have asked that we are represented on the Wirral Council Master Planning meetings. The lead for the Estates work has met a few times with Wirral Council and have agreed to develop a joint high level prospectus establishing a health and social care strategy. Ensure Wirral Health and Care Estates Group has inclusive membership. **Update:** WSEG well established with good membership across all sectors.

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
					A key priority in Wirral is the development of Wirral Health and Social Care Joined up Strategy Prospectus, progress is good with the intention of sharing at system leader workshops early 2023. **Sustainability Group**: Developing the ToR for the Wirral Place Sustainability Group and a cycle of business for the year ahead. National Climate Adaptation Risk Assessment pilot expected to commence in next couple weeks (WUTH is one of 4 Trusts in C&M who are part of the Pilot study) - we will report progress to the Wirral Place Sustainability Group.
				September 2022	Establish Finance, Investment and Resources Group (FIRG) to report to WPBPB, through which estates and sustainability issues will be reported. **Update:** FIRG met for first time in November 2022.
			Produce an integrated Estates Strategy	October 2022	Baseline of current estate owned or leased by health and care sector.

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
					Update: Asset Baseline: Through the Wirral SEG membership we have developed an asset capture tracker. There has been a good response to the Asset capture database with 8 out 10 partners responding. Next Steps is to validate the data received and consolidate this, which is being developed in collaboration with programme support Health Wirral Programme Director. This will identify key Estate's information to support Estate's place plans. NHS Strategic Health Asset Planning and Evaluation (SHAPE) is available, however; the review indicated that SHAPE is out of date. Additionally established Electronic Property Information Mapping Service (EPIMS) as the Council led system for property captures. May need to consider investment in one system approach and onward management to ensure date is kept up to date. There was a Liverpool City Region (LCR) place plan workshop on 21st November 2022 (GB Partnership led) to build on the work GB

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
					Partnership have been undertaking on behalf of Liverpool City Region Combined Health Authority. This commission is looking to develop Place Estates plans which incorporates a baselining exercise of estates information the data collected at WSEG level will support this commission.
				November 2022	Align NHS provider's strategic estates deliverables and work plans, considering Wirral SEB intentions and NHS Cheshire and Merseyside requirements. **Update:** C&M SEB stood down for several months causing some delays in understanding C&M aspirations, both strategic and operational delivery requirements, where Wirral can underpin. In the meantime, Wirral SEG needs to focus its efforts developing an understanding of Wirral place strategic plans to ensure appropriate estates strategies enable clinical and back-room office requirements.
				December 2022	Draft strategy produced. **Update:** Identified that C&M have

No	ICS aims	Core Objective	Critical success factor (How will you measure the objective has been achieved?)	By when (Date)	Planned progress in-year/Update (e.g. deliverable(s) and date(s) in year to support achievement)
				February 2023	collaborated with LCR and appointed GB Partnerships to develop One Public Estate (OPE) Wirral Place Estates Strategy and WSEG support will inform the overarching OPE Wirral place estates strategy. Final strategy agreed. **Update:** OPE set for completion March 2023 via GB Partnerships.

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WIRRAL PLACE BASED PARTNERSHIP BOARD

12th JANUARY 2023

REPORT TITLE:	**WIRRAL DELIVERY PLAN – DELIVERY UPDATE**
REPORT OF:	**ASSOCIATE DIRECTOR FOR TRANSFORMATION AND PARTNERSHIPS (WIRRAL) NHS CHESHIRE AND MERSEYSIDE**

REPORT SUMMARY

The Wirral Delivery Plan outlines the Wirral Place key health and care priorities for 2022/23 and how we will adopt a new way of working by adhering to the principles shared in the Plan that will underpin how we will work together on the delivery of our Plan. This report shares an update of progress against our key priorities for 2022/23.

The Plan has been developed collaboratively between commissioners and providers and is cognisant of key national and local strategic plans and policies.

This Wirral Delivery Plan was approved by the Wirral Place Based Partnership Board in September 2022. This matter affects all Wards within the Borough.

RECOMMENDATION/S

The Wirral Place Based Partnership Board is asked to note the update of the progress of the key priority programmes within the Delivery Plan.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 This report sets out the key health and care priorities that the Wirral Place will need to deliver this year or progress on significantly. There are a number of work streams underway in Wirral to deliver improvements to our services and the experience and outcomes of those that use our services. This plan has been developed collaboratively with commissioners from NHS and the Local Authority and our key providers. By asking for the Wirral Place Based Partnership Board to note the updates of progress against the work streams it will enable progress to be shared across Wirral.

2.0 OTHER OPTIONS CONSIDERED

2.1 The Delivery Plan is a collaborative plan across the Wirral Place and therefore the update on progress against delivery of the Plan does require to be noted by the Wirral Place Partnership Board.

3.0 BACKGROUND INFORMATION

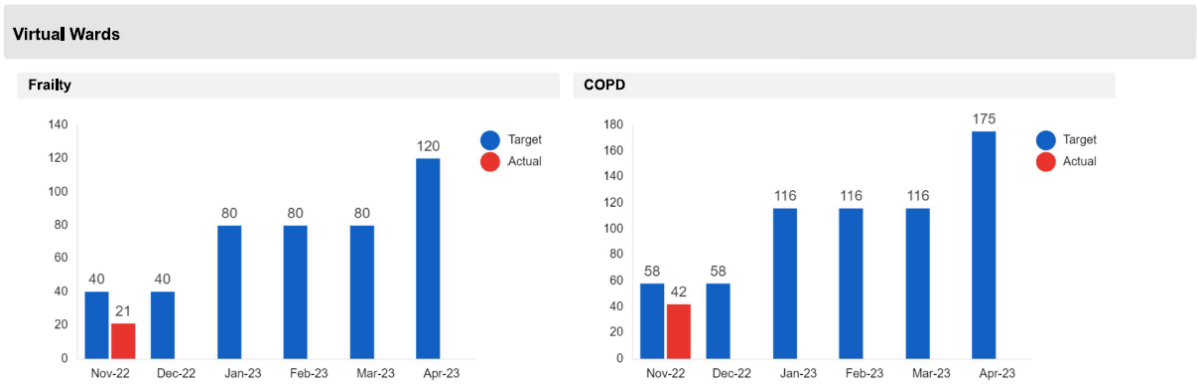
3.1 Imminent changes to the way we work together as a result of the new Health and Care Act, the adult social care reform white paper, the impact of the pandemic and the fuel poverty crisis will require us to work differently this year.

3.2 The Delivery Plan was approved in September 2022 and outlines the Wirral Place key health and care priorities for 2022/23 and how we will adopt a new way of working by adhering to the principles that will underpin how we will work together.

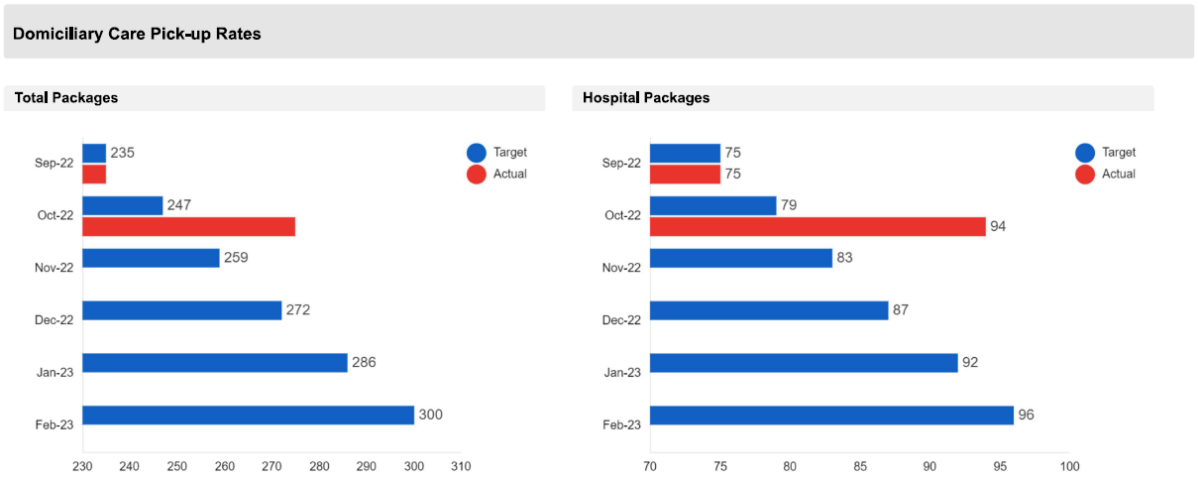
3.3 This update shares the progress to date of the top key priorities within the Delivery Plan as below:-

3.3.1. SEND (Special Educational Needs and Disability) the progress against the statement of action has already been shared with the Board in September 2022. The work involved in delivering the statement of action now also includes the priority within the Delivery Plan of improving the transition planning for young people with complex needs.

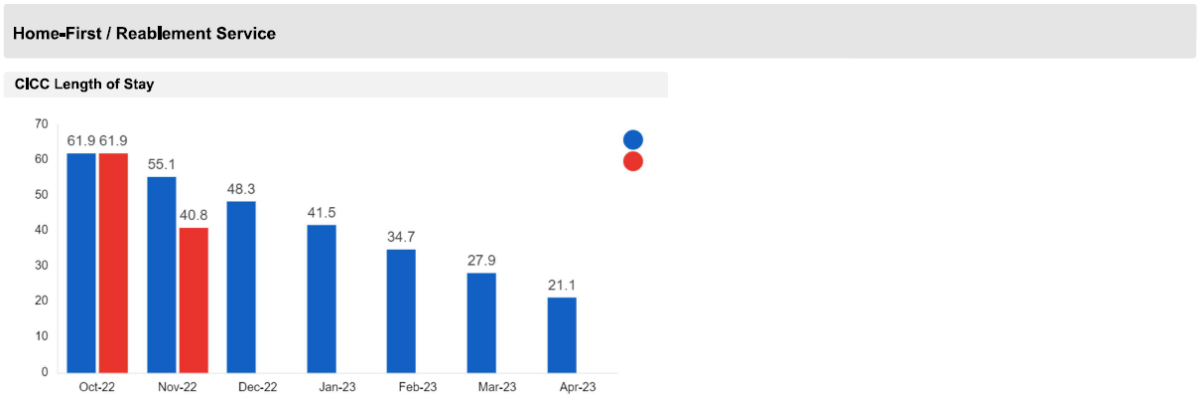
3.3.2 Virtual wards are now established on Wirral and this programme enables people to be cared for at home and not within the hospital. This programme is a national ask of the NHS to set up virtual wards for people diagnosed with frailty and also respiratory complications. Both virtual wards are below their targets for the number of patients as a result of delays in recruitment to the clinical team. The performance for November 2022 is shown in the charts below. These show that the Frailty Virtual Ward has received 21 patients against a target of 40 and the Respiratory Virtual Ward (titled COPD) has received 42 patients against a target of 58.



3.3.3 The Care market sustainability programme has a number of initiatives to increase the pick up rate for new packages in domiciliary care and also care homes responsiveness to new admissions from hospital patients. The programme has achieved its goals and the below chart shows the actual rate of domiciliary care pick up against the programme trajectory. The charts show that in October 2022 the total pick up rate for packages of care was much higher than the target of 247. Of the new packages of care for people leaving hospital the performance was 94 against the target of 79.



3.3.4 As part of the Discharge to Assess and Reablement programme we are testing a new model of enabling people to go home from hospital and to then have an assessment of their ongoing care needs at home rather than as a patient within a Discharge to Assess in patient facility. This is known as 'home first' and initial results are very positive and at the time of writing this report 339 have been discharged via the home first scheme and of them only 53 required on going care, showing the important of assessment in people's homes. The aim of this programme is also to reduce the length of stay in our Clatterbridge Intermediate Care Centre (CICC) and the below chart demonstrates the progress made to date. The chart shows that the average length of stay in November 2022 was 40.8 days against the target of 55.1 days



3.3.5 To reduce mental health adults out of area placements to zero is a national requirement that we are expected to meet. Unfortunately little progress has been made in moving towards zero out of area placements. As of 17/11/2022 there were 10 Wirral residents placed out of area of our mental health provider Cheshire Wirral Partnership NHS Foundation Trust. The long lengths of stay of existing patients and the number of patients that are clinically ready for discharge but remain in hospital are the primary reasons. A number of actions are being taken to try and improve the current position which include an additional 7 adult acute beds being open in December 2022.

3.3.6 A programme of work in now underway to refresh the Wirral Neighbourhood model. Our plan is that neighbourhoods and communities will form the foundation for how we, on Wirral, and our health and care system will tackle health inequalities. This will be a bottom up, community asset approach and the relationships with people and the full range of organisations in each of our 9 neighbourhoods will be key. Each neighbourhood will review their population health data and use their local intelligence to agree what their priorities will be to tackle their health inequalities. The focus will be on prevention, but broader than a clinical approach, it will also focus on the wider determinants of health.

3.3.7 The programme to review our Workforce plan has progressed and an Enabling Group has been established and an initial meeting held. A decision was made to await the establishment of the Wirral Provider Partnership Board and associated governance in order to fully establish the enabling group and provide strategic oversight for the development of a Wirral Place workforce strategy and implementation plan. However work has progressed in Care Market Workforce plans. A recruitment programme has been established, Real Living Wage rates agreed with providers and incentive schemes developed including e-Bike loans and Care Friends incentive scheme to encourage new workforce. Recruitment events around the borough including New Brighton Pavilion and Arrowe Park Hospital have resulted in uptake of posts from new entrants. An increase in available Care and Reablement Workforce from baseline levels and a concomitant reduction in turnover has been observed following the work undertaken. Data for October shows the

following:

- Number of Staff by end October 2022: 1206 against target of 1187
- Turnover (Oct): 79 new starters, 54 leavers

3.3.8 Work has been undertaken this year to increase the uptake of Direct Payments and there are a number of actions agreed. One such example is to increase the number of appropriately trained staff that will be able to support people with more complex needs that are eligible for direct payments. The intention is to provide training pathways for Personal Assistants (PAs) enabling them to access opportunities to enhance their skill set leading to more people in need of specialist support being able to access a Direct Payment. Developing a skilled workforce could support more people to stay at home and reduce reliance on costly commissioned services and out of area placements. As a result, a stratified rate of pay could be introduced to reflect the skill set of PAs. Cheshire and Merseyside Integrated Care System has priority actions for increasing the utilisation of Personal Health Budgets (PHBs) and Wirral Place is involved in this work. This includes:-

- Developing a best practice peer supported network to spread utilisation
- Inclusion in scope of the Continuing Health Care operating model review to streamline and standardise commissioning practices for PHBs as business as usual.
- Working with the voluntary sector to stimulate innovation, increase uptake and remove barriers to use of PHBs through a Dragon's Den to fund innovation at Place.

4.0 FINANCIAL IMPLICATIONS

4.1 There are potential financial implications arising from this report, the work programmes that are a key priority, particularly for the delivery of additional capacity across the Wirral Place during the winter have already required additional funding which have been agreed by Wirral key partners. For the majority of the Plans there is an expectation that they will need to be delivered with the financial envelope set for the Wirral health and care system. If there are further calls on resources beyond those mentioned above, approval will be sought through the appropriate processes.

5.0 LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from this report.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 The Delivery Plan includes programmes of work that are already in progress in the Borough and a number of these are ‘must do’s’ for the Wirral Place to complete. This work should already be supported with the appropriate resources and, where it

is not, discussions will be required around the resource requirements to support delivery.

7.0 RELEVANT RISKS

7.1 Within the Delivery Plan there are some 'must do's that do require to be completed within timescales during 2022/23. The Plan and its deliverables will be monitored monthly and escalation to key partners will take place if progress of achievements and expected outcomes are not realised. Alongside this, the risks associated with each of the programmes within the Delivery Plan are managed within each work programme. The Wirral Place Based Partnership Board will also be developing a risk framework.

8.0 ENGAGEMENT/CONSULTATION

8.1 The Wirral Delivery Plan has been developed collaboratively across commissioners of both NHS and Wirral Council and also the Directors of Strategy and Chief Operating Officers of our key NHS providers. The Delivery Plan has also been shared with the Chief Executives of Wirral's key NHS provider trust.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council and NHS Cheshire and Merseyside have a legal requirement to make sure their policies, and the way they carry out their work, do not discriminate against anyone. Within the Delivery Plan there is a framework for our approach to tackling health inequalities and each programme of work will complete impact assessments to ensure any adverse impact is identified and mitigating actions but in place where possible.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 Wirral Council and NHS Cheshire and Merseyside are committed to carrying out their work in an environmentally responsible manner, and these principles will guide the delivery of the Place Director's objectives in Wirral.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 Community Wealth Building in Wirral focusses on partnerships and collaboration. These partnerships are led by Wirral Council with external partners and stakeholders, including residents. NHS Cheshire and Merseyside will support the Council in community wealth building by ensuring health and care organisations in the borough have a focus on reducing health inequalities and contribute to the development of a resilient and inclusive economy for Wirral.

REPORT AUTHOR: **Nesta Hawker**
Associate Director for Transformation and Partnerships (Wirral)
NHS Cheshire and Merseyside (nesta.hawker@nhs.net)

APPENDICES

N/A

BACKGROUND PAPERS

- NHS Core 20 plus 5
- NHS Planning Guidance 22/23
- Wirral Plan 2021 – 26
- Health and Wellbeing Strategy
- Statement of Education Needs and Disability (SEND) Wirral Statement of Action
- Wirral Delivery Plan

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Wirral Partners Board	**September 2022**

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WIRRAL PLACE BASED PARTNERSHIP BOARD

12th January 2023

REPORT TITLE:	**PLACE PARTNERSHIP BRIEFING – NHS CHESHIRE AND MERSEYSIDE PUBLIC ENGAGEMENT FRAMEWORK**
REPORT OF:	**PLACE DIRECTOR, NHS CHESHIRE AND MERSEYSIDE**

REPORT SUMMARY

This briefing is intended to update and seek the involvement of Place Partnerships in the development of NHS Cheshire and Merseyside's Public Engagement Framework (our draft strategy for working with people and communities). Place Partnerships are key to developing effective public involvement mechanisms for local people, that in turn, can inform the work of Integrated Care System (ICS) partners.

Healthwatch, the Voluntary, Community, Faith and Social Enterprise Sector (VCFSE), our Councils, hospitals, providers of primary care, and other partners already have well-established ways of involving people and communities at a local level. Cheshire and Merseyside's legacy Clinical Commissioning Groups also left an involvement infrastructure, which will provide a basis for some of our future work in Place.

As a new statutory organisation, NHS Cheshire and Merseyside wants to connect with, and build on these strengths and assets in the delivery of our legal duties for public involvement. The draft Public Engagement Framework is built around 10 key principles for working with people and communities (pg. 13). These principles were developed by NHS England, the Local Government Association, Healthwatch England and the National Association for Voluntary and Community Action. They have recently been the subject of national public consultation and have been published in statutory guidance.

It is proposed that, following the establishment of NHS Cheshire and Merseyside, and the recent relaunch of the Health and Care Partnership ('the ICP') on a new statutory footing, that ICS partners endorse and collectively 'sign up' to these principles - as a first step in co-producing a coherent and connected to approach to public involvement in C&M.

RECOMMENDATION/S

The Wirral Place Based Partnership Board is recommended to

1) Endorse the ten key principles for working with people and communities, as set out in NHS Cheshire and Merseyside's *draft Public Engagement Framework* (pg.13) and

NHS England's *Working in partnership with people and communities: statutory guidance*.

2) Provide feedback and comments on the draft Public Engagement Framework

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

NHS Cheshire & Merseyside is seeking endorsement for the key principles outlined in the draft Public Engagement Framework and seeking comments and feedback from Place Partnerships.

2.0 OTHER OPTIONS CONSIDERED

No other options were considered as the framework applies to NHS Cheshire and Merseyside and the purpose of this paper is to inform and seek comment.

3.0 BACKGROUND INFORMATION

3.1 As a statutory body, NHS Cheshire and Merseyside has a legal duty to involve the public and is required to have a strategy for working with people and communities. Each shadow Integrated Care Board (ICB) was required to submit a draft strategy to NHS England's Transformation and Participation team by the national deadline of 27 May 2022.

3.2 As part of national readiness to operate requirements for ICBs, the strategy was to be drafted in line with ICS implementation guidance for working with people and communities, recently superseded by the publication of statutory guidance for ICBs and NHS providers (following national consultation) on 12 July, against a nationally prescribed content guide.

3.3 Work to develop the 'Public Engagement Framework' – was first launched at the C&M Partnership Assembly meeting of 14 December 2021 and subsequently presented at the ICS Development Advisory Group meeting of 31 March 2021.

3.4 Strategy development was then taken forward by a Task and Finish group mobilised on 1 April 2022 as part of the ICS Transition Programme, including an engagement representative from each CCG (now Place) – tasked with linking with local multi-agency forums in Place.

3.5 Cheshire and Merseyside's local Healthwatch and VCFSE leaders were members of the T&F group (as subject matter experts) and were also commissioned to co-produce the framework and run a series of workshops in each of the nine C&M Places.

3.6 As part of this commissioned activity, local Healthwatch and VCFSE produced feedback reports - that have been used to shape the further development of the draft Public Engagement Framework - and will be used moving forward as key insight and

intelligence to inform the development and connectivity of effective public involvement at Place, that inform and influence ICS partners.

3.7 During the initial design and drafting phase (pre-July 1) the following Place forums – which include both networks for communications/involvement/patient experience professionals, and patient/public engagement and involvement groups – were invited to take part in discussions about development of the strategy:

Cheshire Communications and Engagement Group

Liverpool Health and Care Communications and Engagement Network

Knowsley Communications and Engagement network

Wirral Communications Collaborative

Sefton Engagement and Patient Experience Group and Health Information and Communications Group

Warrington Communications and Engagement Network

St Helens Stakeholder Forum

3.8 The Public Engagement Framework was presented and adopted as a work-in-progress draft at the first ICB meeting of 1 July, at which a clear commitment was made to ongoing engagement with ICS partners and Place Partnerships to develop our approach to working with people and communities. Following the ICB meeting of 1 July, the Public Engagement Framework has been worked up into an initial designed format, and updated in line with:

- Feedback from ICB Board members
- Feedback from the engagement activity reports commissioned from Local Healthwatch and VCFSE partners
- Feedback from NHS England's National Participation Team (via the national ICB moderation process)
- The publication (following national public consultation) of Statutory Guidance for Working with People and Communities

3.9 As part of the ongoing process to develop NHS Cheshire and Merseyside's draft Public Engagement it is being presented to each Place Partnership for their feedback.

3.10 As part of this engagement exercise, we are seeking endorsement and 'collective sign up' by Place Partnerships to the 10 key principles (pg.13) - as a springboard for further work to co-produce a coherent and connected to approach to public involvement in Cheshire and Merseyside.

3.11 Once this initial round of engagement with Place Partnerships has been undertaken, it is intended that a further update will be taken to the ICB in early 2023, and a presentation made to the Health and Care Partnership, to make recommendations that inform next steps.

4.0 FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from this report.

5.0 LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from this report.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 Wirral Council are supporting the Wirral Place Based Partnership Board and, when required, the Joint Strategic Commissioning Committee. NHS Cheshire and Merseyside will support the remaining governance and assurance infrastructure.

7.0 RELEVANT RISKS

7.1 NHS Cheshire and Merseyside are developing a risk management and assurance framework, which will include Place.

8.0 ENGAGEMENT/CONSULTATION

8.1 Engagement with system partners has taken place in the development of the Public Engagement Framework.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council and NHS Cheshire and Merseyside have a legal requirement to make sure their policies, and the way they carry out their work, do not discriminate against anyone. This is a draft NHS Cheshire & Merseyside framework which is being shared with Boards and Committees in each of the 9 places across Cheshire and Merseyside for the purposes of review and comment. Any equality implications arising from this draft framework will be considered by the Board of NHS Cheshire and Merseyside as part of its governance process. No Equality Impact Assessment is required for this report as there is no immediate direct impact for Wirral.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 Wirral Council and NHS Cheshire and Merseyside are committed to carrying out their work in an environmentally responsible manner, these principles will be followed by these groups.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 Community Wealth Building in Wirral focusses on partnerships and collaboration. These partnerships are led by Wirral Council with external partners and stakeholders, including residents. NHS Cheshire and Merseyside will support the Council in community wealth building by ensuring health and care organisations in the borough have a focus on reducing health inequalities and contribute to the development of a resilient and inclusive economy for Wirral. The groups referred to in this report will take account of this in their work.

REPORT AUTHOR: **Michael Chantler**
Assistant Director (Wirral), NHS Cheshire and Merseyside
email: michaelchantler@nhs.net

APPENDICES

Appendix 1 CM Public Engagement Framework Draft 101022
Appendix 2 B1762 Guidance on working in partnership with people and communities

BACKGROUND PAPERS

CM Public Engagement Framework Draft 101022 - NHS Cheshire and Merseyside Integrated Care Board Papers - 1st July 2022

220701-icb-papers.pdf (cheshireandmerseyside.nhs.uk)

SUBJECT HISTORY (last 3 years)

Council Meeting	Date

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NHS
Cheshire and Merseyside

Cheshire and Merseyside Public Engagement Framework 2022/23

Our strategy for involving people and communities in Cheshire and Merseyside

Contents

Foreword

NHS Cheshire and Merseyside is committed to involving people and communities to identify what will help to improve their health and wellbeing, and to work together to shape services.

We are therefore pleased to present our draft Public Engagement Framework as the first step in delivering on that commitment. We will be using the framework to look at locally-available resources to help people improve their health and care, use their skills, and tell us what they want and need.

We are proud that this framework has been co-produced with Healthwatch and local voluntary community, faith and social enterprise (VCFSE) sector partners.

We want to continue that relationship and engage with the public and our partners to seek their views on this framework and help further shape our approach at Cheshire and Merseyside at a system-level across our nine Places, and in our neighbourhoods.

Healthwatch, the VCFSE sector, our councils, hospitals and other partners already have well-established ways of engaging together with people and communities and we need to build on these strengths and assets. We want our approach to be one of evolution, not revolution.

If we are to help reduce inequalities and continuously improve health and care outcomes for all, we must communicate with, and listen to the views and experiences of people and communities in relation to their health and wellbeing.

The publication of this Public Engagement Framework should act as a springboard for our work to develop new engagement mechanisms for NHS Cheshire and Merseyside. Looking ahead, it will be integrated with strategies for communications, equality, diversity, and inclusion, and will be underpinned by detailed action plans at Cheshire and Merseyside system-level, at Place and in our neighbourhoods.

Raj Jain
Chair

Graham Urwin
Chief Executive

1. Context and introduction

1.1 Purpose

The purpose of our Public Engagement Framework is to describe NHS Cheshire and Merseyside's ambition to empower people and communities. It also outlines how our engagement will help us to further tackle the inequalities in our area.

The draft framework has been co-produced with local Healthwatch and voluntary, community, faith and social enterprise (VCFSE) sector organisations across Cheshire and Merseyside.

Public engagement will be undertaken to further design our approach, specific engagement mechanisms, and an action plan, following the national consultation and publication of statutory guidance in July 2022.

We will undertake an Equality Impact Assessment on our framework to ensure that we are paying due regard to the Public Sector Equality Duty, that our processes are fair, and do not present barriers to involvement or disadvantage any protected group. Our impact assessment will also cover health inequalities.

This framework sets out how NHS Cheshire and Merseyside, as a statutory organisation, will involve people and communities. Whilst the framework and the subsequent action plan will be underpinned by partnership working, at system-level and in Place, it is not intended to be prescriptive or a mandate for how involvement is undertaken locally.

1.2 Language

In this framework, we talk about 'involving' and 'empowering' people and communities. We use these phrases to cover a variety of approaches such as engagement, participation, co-production, and consultation. These terms often overlap and mean different things to different people and sometimes have a technical or legal definition too.

By 'people', we mean everyone of all ages, their representatives, relatives, and unpaid carers. This is inclusive of whether they use or access health and care services and support. 'Communities' are groups of people that are interconnected, by where they live, how they identify or their shared interests.

'Community-centred approaches' recognise that many of the factors that create health and wellbeing are at a community level, including social connections, having a voice in local decisions, and addressing health inequalities.

By 'empowering', we mean that people and communities are able to use and share their knowledge, skills and experience to improve access and outcomes.

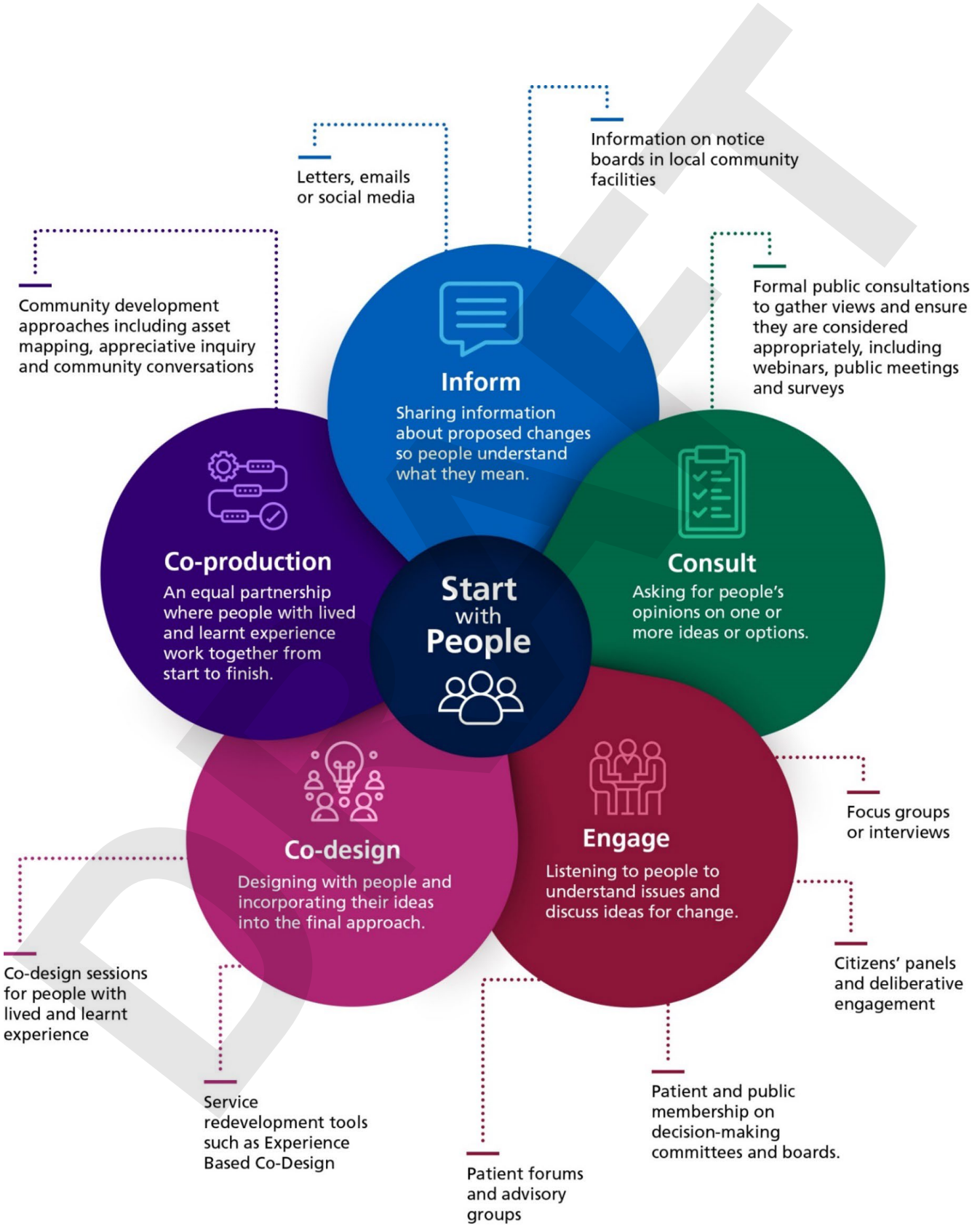
'Co-production' is a way to involve people by sharing power with them. **The Coalition for Personalised Care** defines co-production as:

'a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.'

The guiding principle is that people with 'specific lived experience' are often best placed to advise on what support and services will make a positive difference to their lives. When done well, co-production helps to ensure discussions are honest, reflective, and that they maintain a person-centred perspective.

1.3 Different ways of working

The diagram sets out different ways of working with people and communities:



1.4 Our Integrated Care System (ICS)

Cheshire and Merseyside ICS embodies a new way of working which brings together all the health and care organisations in our area, so they can work more collaboratively and empower the people and communities who live and work here.

Our health and care organisations have already been successfully working in this integrated way, particularly through the COVID-19 pandemic –an Integrated Care System (ICS) is the next step in recognising this success.

Our ICS is responsible for looking after and delivering all the health and care services in the area we cover. We are made up of an Integrated Care Board and an Integrated Care Partnership, working together.

What is our Integrated Care Board (ICB)?

NHS Cheshire and Merseyside ICB holds responsibility for planning NHS services, including those previously planned by NHS clinical commissioning groups (CCGs). As well as our Chair and Chief Executive, membership of the board includes 'partner' members drawn from local authorities, NHS trusts and general practice.

The ICB will ensure that services are in place to deliver the Integrated Care Strategy developed by the Integrated Care Partnership (ICP). NHS Cheshire and Merseyside ICB was created as a statutory organisation on 1 July 2022.

What is our Integrated Care Partnership (ICP)?

Cheshire and Merseyside Health and Care Partnership (the ICP) is a statutory committee made up of partners from across the local area, including Healthwatch, VCFSE sector organisations and independent healthcare providers, as well as representatives from the ICB.

One of the key roles of the partnership is to assess the health, public health and social care needs of people living and working in Cheshire and Merseyside and to produce a strategy to address them. This, in turn, will direct the ICB's planning of health services and local authorities' planning of social care services.

The ICP will work in partnership with Cheshire and Merseyside Public Health Collaborative (Champs) and the nine Directors of Public Health to develop strategies that improve public health, reduce health inequalities and ensure the health and care system across Cheshire and Merseyside is sustainable.

The ICP have a responsibility to improve the health and wellbeing of our population. We will do this by:

- coordinating plans to make sure our services continue to meet everyone's needs
- joining up services to provide better care, closer to home
- ensuring all our partners across Cheshire and Merseyside focus on addressing the causes of poor health, as well as improving diagnosis and treatment.

Members of the ICB and ICP will listen to, and represent the views of the people and communities we serve. This framework marks the start of a conversation about how we connect with our population and the different needs within it.

Local Healthwatch and VCFSE sector organisations are our key partners. They have used their expertise in representing and advocating for people and communities to co-produce this framework.

We will continue to work together to develop the best arrangements for people to share their views and get involved in decisions that affect their wellbeing, health, and care.

Provider Collaboratives

There are two Provider Collaboratives for Cheshire and Merseyside:

- The Cheshire and Merseyside Acute and Specialist Trusts (CMAST)
- Mental Health, Community, Learning Disability Collaborative (MHLDSC).

Both have agreed specific objectives with the ICB that will help deliver Cheshire and Merseyside's strategic priorities. The two Provider Collaboratives are also committed to working together to support the delivery of benefits of scale and mutual aid across multiple Places or systems.

Place-Based Partnerships

Our Integrated Care Board will arrange for some of its functions to be delivered, and decisions about NHS funding to be made in the region's nine Places – through wider Place-Based Partnerships.

The ICB will remain accountable for NHS resources deployed Place-level. The ICB is represented by designated Place Directors within local Place-Based Partnerships.

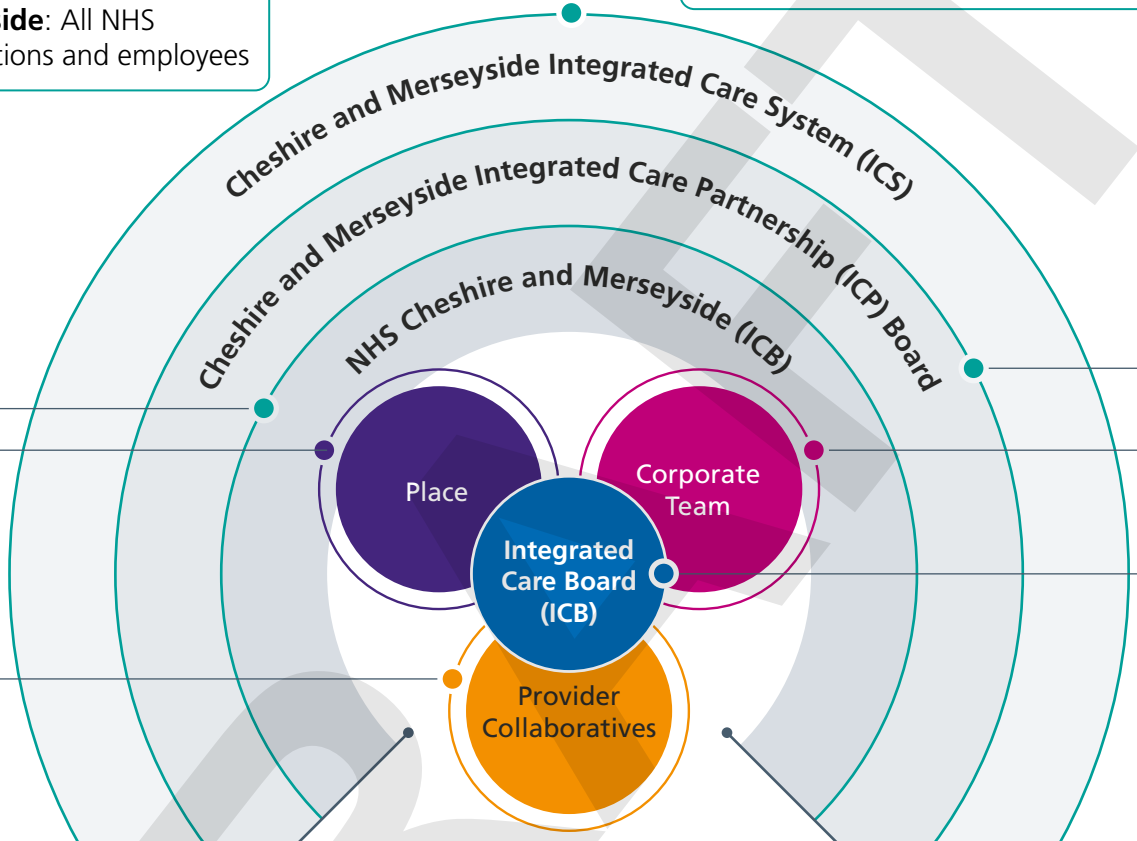
Health and Wellbeing Boards (HWBs) will continue to develop the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, which both the ICP and ICB will give due regard.

Our new integrated care structure

ICS: The **entire** health and care system for Cheshire and Merseyside

NHS NHS Cheshire and Merseyside: All NHS organisations and employees

ICP: The **Board** that brings together **Local Authorities** with the **local NHS** and **Voluntary Sector** to produce an Integrated Care Strategy to meet the health and wellbeing needs of the population



ICS PURPOSE

- Improve outcomes
- Enhance productivity and value for money
- Tackle inequalities
- Support broader social and economic development

9 Places across C&M
Partnerships of NHS, Local Authority and voluntary sector organisations

Providers working together
Two Provider Collaboratives
Primary Care Forum

The Statutory NHS Board
Oversees the NHS budget in Cheshire and Merseyside

The ICB Executive Team that supports the ICB

1.5 About our population

Cheshire and Merseyside is home to **2.7 million people across our nine 'Places'**. Halton is the smallest Place in Cheshire and Merseyside, with a population of 129,000 – compared with Liverpool which has a population of approximately 500,000.

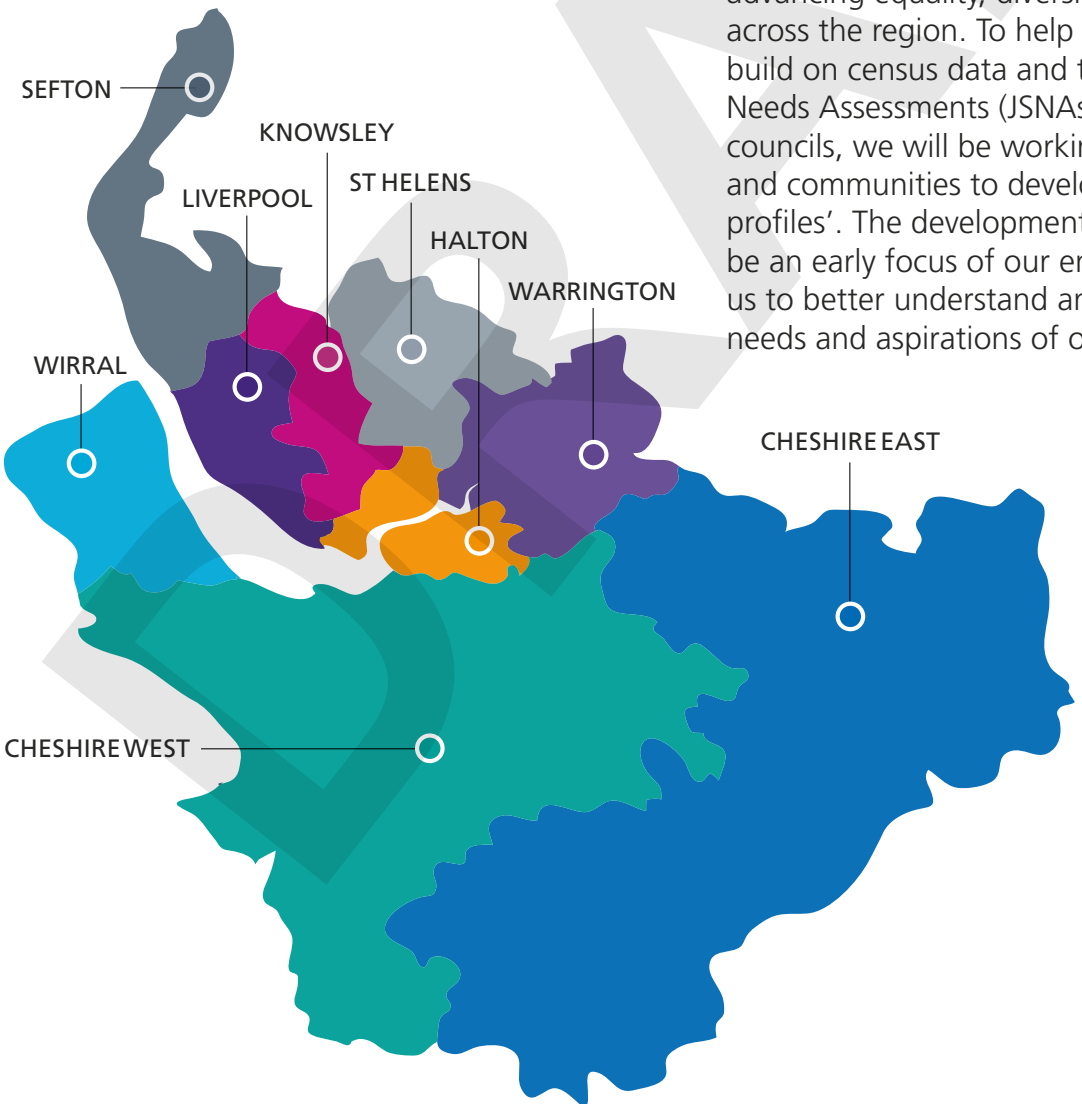
Compared to the England average, the region currently has higher rates of premature cancer, cardiovascular disease (CVD) and respiratory deaths.

One third of our population live in the most deprived 20% of neighbourhoods in England. One in four people in Liverpool and Knowsley live in poverty. Even within the wealthier areas in the region, there is substantial deprivation and associated poor health – while 31% of neighbourhoods in Cheshire West and Chester are in the top two income deciles, compared to an England average of 20%, 16% of neighbourhoods in Cheshire West and Chester are in the lowest income deciles.

Whilst levels of deprivation are not as high in Cheshire, there are stark pockets of deprivation and health outcomes for some long-term conditions, while alcohol misuse and self-harm are worse than the England average.

Demand for health and care services across the region is high and growing. With demand outstripping available resources, we must work together to place emphasis on prevention and the promotion of positive health and wellbeing

All system partners are fully committed to advancing equality, diversity and inclusion across the region. To help us do that and build on census data and the Joint Strategic Needs Assessments (JSNAs) produced by our councils, we will be working with people and communities to develop detailed 'Place profiles'. The development of these profiles will be an early focus of our engagement and help us to better understand and respond to the needs and aspirations of our population.



2. Key principles

2.1 The 10 principles

There are 10 key principles that will guide how we work with people and communities in Cheshire and Merseyside. These principles have been developed through national consultation, but we want to make sure they resonate with local people as part of a wider conversation about our Public Engagement Framework.

Alongside our partners from local Healthwatch and VCFSE sector organisations, we will continue to test these principles with people and communities in Cheshire and Merseyside and adapt them for local use – based on the feedback we receive.

As Cheshire and Merseyside is a very large and complex system, there can be no 'one size fits all' approach within our system, Places and neighbourhoods. These principles will help our health and care organisations develop ways of working with people and communities – depending on local circumstances and population health needs. They should be applied throughout Cheshire and Merseyside, whether activity takes place within neighbourhoods, in Places, or at system-level.

It is important to reflect that whilst the principles are shown and described separately, they are interlinked and all together will encourage collaboration.


10
principles for working with people and communities
01
Centre decision-making and governance around the voices of people and communities.
02
Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions.
03
Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working.
04
Build relationships based on trust, especially with marginalised groups and those affected by health inequalities.
05
Work with Healthwatch and the voluntary, community and social enterprise sector.
06
Provide clear and accessible public information.
07
Use community-centred approaches that empower people and communities, making connections to what works already.
08
Have a range of ways for people and communities to take part in health and care services
09
Tackle system priorities and service reconfiguration in partnership with people and communities.
10
Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.

2.2 Turning the principles into action

Our Public Engagement Framework will be used in our work with system partners to develop plans in 2022/23 that turn the principles into action.

1. Centre decision-making and governance around the voices of people and communities

- Build the voices of people and communities into governance structures so that people are part of the decision-making processes
- Recognise the collective responsibility at board level for upholding legal duties, bringing in lay perspectives but avoiding creating isolated, independent voices
- Make sure that boards and communities are assured that appropriate involvement with relevant groups has taken place (including those facing the worst health inequalities); and that this has an impact on decisions
- Ensure that effective involvement is taking place at the appropriate level, including system, Place and neighbourhood, and that there is a consistency and coordination of approaches
- Support people with the skills, knowledge and confidence to contribute effectively to decision-making and governance
- Make sure that senior leaders set an example for inclusive and collaborative ways of working.

2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions

- Take time to plan and budget for participation; recognising that engagement and co-production needs time and resources
- Start involving people as early as possible so that it informs options for change and subsequent decision-making
- Involve people and communities on a continual basis, embed relationships, rather than taking a stop-start approach when decisions are required. As a result, there will be much greater, ongoing awareness of the issues, barriers, assets and opportunities
- Be clear about the opportunity to influence decisions, what taking part in decision-making can achieve, and what is out of scope
- Vary the voices, record and celebrate people's contributions and give feedback on the results of involvement – including changes, decisions made and what has not changed and why
- Keep people informed of changes that take place sometime after their involvement and maintain two-way dialogue so people are kept updated and can continue to contribute
- Take time to understand what works and what could be improved
- Value and appreciate people's contributions.

3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if changes are working

- Use data about the experiences and aspirations of people who use (and do not use) health services, care and support and have clear approaches to using this information and insight to inform decision-making and quality governance
- Work with what is already known by partner organisations, from national and local data sources, and from previous engagement activities including those related to the wider determinants of health
- Share data with communities and seek their insight about what lies behind the trends and findings. Their narrative can help inform about the solutions to the problems that the data identifies
- Understand what other engagement might be taking place on a related topic and take partnership approaches where possible, benefiting from combined assets and avoiding 'consultation fatigue' amongst communities by working together in an ongoing dialogue that is not limited by organisational boundaries
- Build on existing networks, forums and community activities to reach out to people rather than expecting them to come to us. Be curious and eager to listen; don't assume we know what people will say or what matters to them.

4. Build relationships based on trust, especially with marginalised groups and those affected by inequalities

- Proactively seek participation from people who experience health inequalities and poor health outcomes – connecting with trusted community leaders, organisations and networks to support this
- Consider how to include people who do not use services, whether because they do not meet their needs or are inaccessible, and reach out to build trust and conversations about what really matters to them
- Recognise and engage with our partners who have trusted relationships with our population – like community health staff and the Fire Service
- Work with people and communities from the outset, taking time to build trust, listen and understand what their priorities are being realistic about what is in scope and where they can set the agenda for change
- Tailor our approach to engagement to include people in accessible and inclusive ways so we include those who have not taken part before
- Recognise that some communities will not feel comfortable discussing their issues and needs in wider meetings, so may need separate, targeted activities. They may need additional support to take part including reimbursements for their time
- When reporting on engagement activity, explain the needs and solutions for different communities rather than simply aggregating all data and feedback together.

5. Work with Healthwatch and the voluntary, community, faith and social enterprise sector as key partners

- Continue to strengthen our partnership with Healthwatch and the VCFSE sector to bring their knowledge and reach into local communities. Work with them to facilitate involvement from different groups and develop engagement activities
- Recognise the added value that VCFSE can bring by coordinating and engaging with networks and communities that are seldom-heard
- Understand the various types of VCFSE sector organisations in our area, their different features and how we can connect with them
- Value the qualitative work of VCFSE and Healthwatch, and the stories they tell from direct engagement with communities and give equal value to this alongside quantitative data
- Give due consideration to who is commissioned to support engagement activity
- When we commission other organisations to work with communities, ensure that our decision-makers remain personally involved and hear directly what people have to say
- Consider how we use, support and reward volunteers across the system.

6. Provide clear and accessible public information

- Develop information about plans that is easy to understand, recognising that everyone has different needs and testing information where possible
- Where Easy Read documents are required, they should be prepared at the same time as other materials
- Providers of NHS care must meet their requirements under the **Accessible Information Standard** for the information and communication needs of people in their own care.
- These principles should also be applied to public information so that is clear and easy to understand
- Be open and transparent in the way we work, being clear about where decisions are made and the evidence base that informs them, along with resource limitations and other relevant constraints
- Where information must be kept confidential, explain why
- Make sure we describe how communities' priorities can influence decision-making, how people's views are considered, and that we regularly feedback to those who shared their views and others about the impact this has made
- Provide feedback in an inclusive and accessible way that suits how people want or can receive it
- Be aware of using public sector terminology, which is alien to many people and communities
- Make sure information on opportunities to get involved is clear and accessible and encourage a wide range of people to take part
- Ensure that there is information that 'closes the loop', and they are kept informed on how engagement has influenced change.

7. Use community-centred approaches that involve people and communities, building on what works already

- Support and develop existing community assets, such as activities and venues which already bring people together such as faith communities, schools, community centres, employers and local businesses, public spaces and community-centred services like link workers, community champions and peer support volunteers
- Build trust and meaningful relationships in a way that makes people feel comfortable sharing ideas about opportunities, solutions and barriers
- Work with communities to design, deliver and evaluate solutions that are built around existing community infrastructure
- Recognise existing volunteering and social action that supports health and wellbeing and create the sustainable conditions for them to grow
- Share best practice from across the system to support local approaches.

8. Have a range of ways for people and communities to take part in health and care services

- Choose a method of working with people and communities that is appropriate to specific circumstances, ensuring it is relevant, fair and proportionate
- Use methods that are suitable to the situation and blended methods where appropriate
- Design engagement activities to take place at a time and in a way that encourages participation, and consider the support people may need to take part, such as reimbursements for their time
- Recognise that people are busy and have other priorities such as work and caring responsibilities and ensure that there are different ways to get involved with varying levels of commitment
- Include approaches such as co-production, where professionals share power and have an equal partnership with people to plan, design and evaluate together
- Where decisions are genuinely co-produced, then people with specific lived experience work as equal partners alongside health and care professionals (those with learnt experience), and jointly agree issues and develop solutions
- Recognise the time and resource that co-production takes and plan accordingly
- We will ensure that engagement reaches beyond the hours of 9am to 5pm, Monday to Friday. We will also ensure there is a fair mix of face-to-face and online formats.

9. Tackle system priorities and service reconfiguration in partnership with people and communities

- People who use health and care services have knowledge and experience that can be used to improve services with cost-effective and sustainable ideas
- Embracing these ideas can lead to changes that better meet the needs of the local population
- Communities often have longer memories than our staff who may change roles and move therefore understanding the changes experienced by local communities helps to learn and build trust with people
- When people better understand the need for change, and have been involved in developing the options, they are more likely to advocate the positive outcomes and involve others in the process.

10. Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places

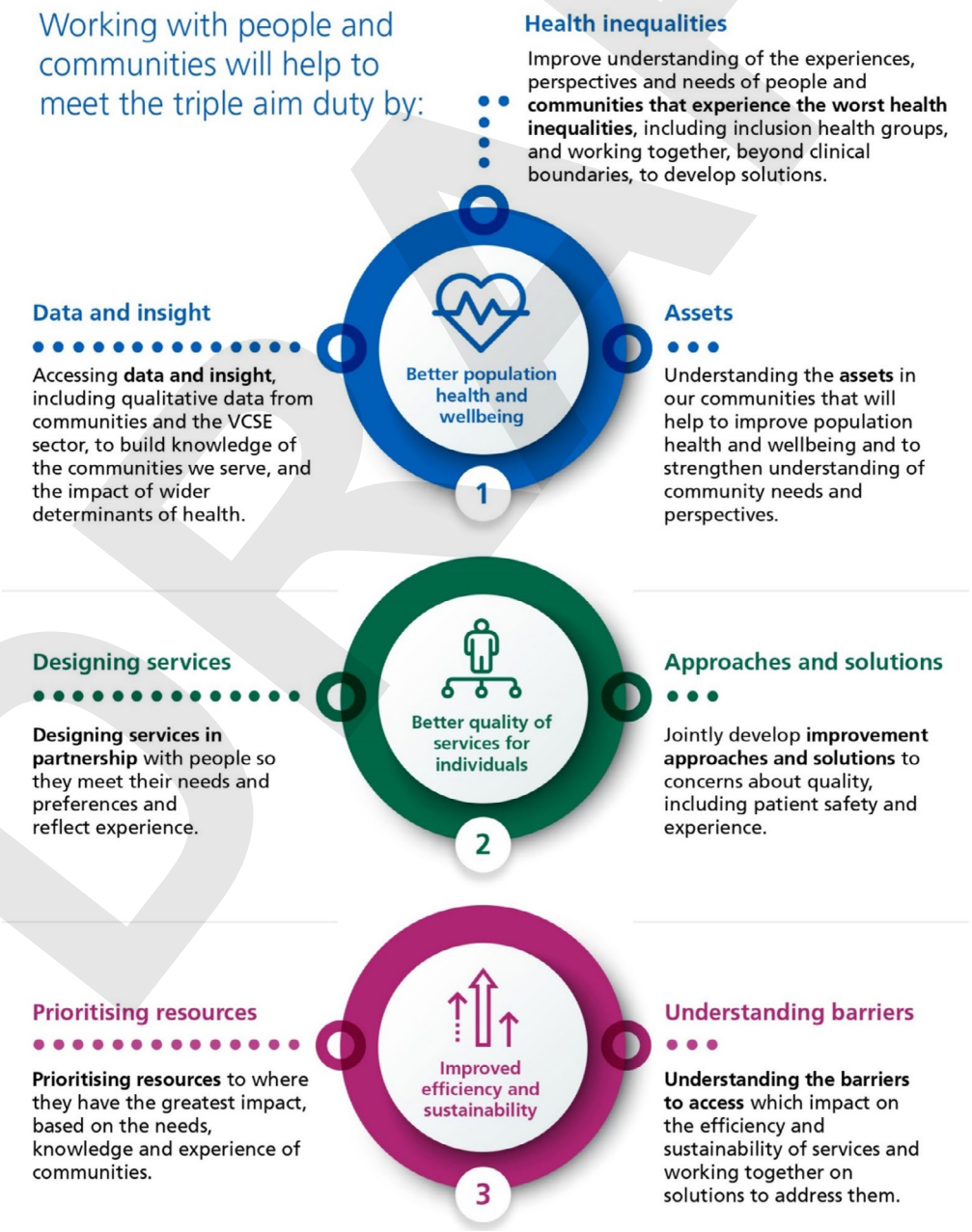
- Collaborate with partners across our system to build on their skills, knowledge, connections and networks
- Reduce duplication by understanding what is already known and what has already been asked, before designing the approach to engagement
- Learn from approaches taken elsewhere in the country and how they can be adapted and applied locally
- Plan together across Places so that partnership work with people and communities is coordinated, making the most of partners' skills, experiences and networks
- It is also important to learn lessons from what hasn't worked and learn from complaints, concerns and incidents.

3. The triple aim duty

NHS England, ICBs, NHS trusts and NHS foundation trusts are subject to the new 'triple aim' duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively). This requires these bodies to have regard to 'all likely effects' of their decisions in relation to three areas:

1. Health and wellbeing and its effects in relation to health inequalities
2. Quality of health services for all individuals, including the effects of inequalities in relation to the benefits obtained from those services
3. The sustainable use of NHS resources.

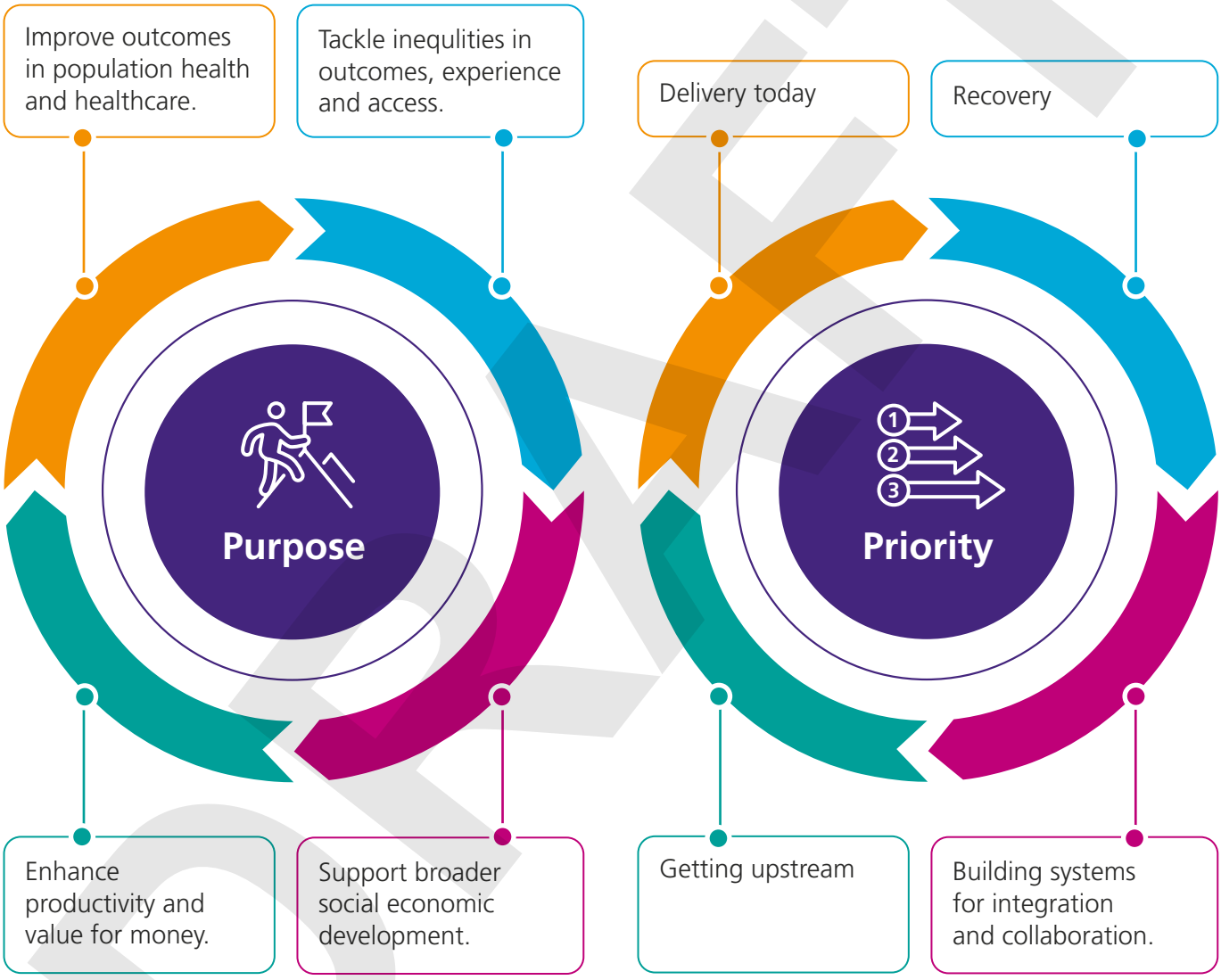
Effective working with people and communities is essential to deliver the triple aim, as shown in the diagram below:



4. Priorities for 2022/23

4.1 System priorities

All ICSs have four core purposes. In Cheshire and Merseyside, we have also set out our shorter-term priorities:



Improve population health and healthcare

- Reduce deaths from cardiovascular disease, suicide and domestic abuse
- Reduce levels of obesity
- Reduce harm from alcohol
- Provide high-quality, safe services
- Provide support to all those experiencing 'long COVID'
- Provide integrated, high-quality, mental health and wellbeing services for all people requiring support from low levels of intervention to crisis management and inpatient care
- Underpin improvements in health and healthcare with Research and Innovation by supporting collaboration between Cheshire and Merseyside academic partners, and making them a key part of our Health and Care Partnership (ICP).

Tackling unequal outcomes and access

- Reduce the life expectancy gap in the most deprived communities, in children and those with mental health conditions and help people live extra years in good health
- Improve early diagnosis, treatment and outcome rates for cancer
- Improve waiting times for children and adult mental health services
- Target those with chronic diseases so they access services – especially those in our most deprived areas
- Reduce the impact of poor health and deprivation on educational achievement.

Enhancing productivity and value for money

- Prioritise making resources available to prevention and wellbeing services
- Plan, design and deliver services at scale (where appropriate) to drive better quality, improved effectiveness and efficiency
- Maximise opportunities to reduce costs by procuring and collaborating on corporate functions at scale
- Develop whole system plans to address workforce shortages and maximise collaborative workforce opportunities
- Secure value for money
- Develop a whole system Estates Strategy.

Support broader social and economic development

- Embed a commitment to social value in all our partner organisations
- Establish the 'Anchor Institution' in Cheshire and Merseyside, offering significant employment opportunities for local people
- ICS will be involved in regional initiatives to develop economy and support communities in Cheshire and Merseyside
- Develop a programme in schools to support mental wellbeing of young people
- Develop a programme in schools to help inspire careers in health and social care
- Work with local economic partnerships (LEPs) to connect ICS partners with business and enterprise.

4.2 Our programmes

There are several system-wide programmes that will help us to meet our priorities. The involvement of people and communities in our programmes is essential to help us improve wellbeing, provide better services and design smoother care pathways.

Programme	Summary
Ageing Well	Urgent community response, enhanced health in care homes and helping people with complex needs to stay healthy.
Beyond Programme (children and young people)	Healthy weight, emotional wellbeing, respiratory health, and care for people with a learning disability and autism.
Cardiac Board	Initiatives focussed on prevention and early intervention, population health and creating stable services.
Diagnostics	Includes all diagnostic tests including, pathology, imaging, endoscopy, screening programmes, cardio and respiratory, neurophysiology and more.
Digital	Tackling digital exclusion, driving integration of care records and population health management, systems to support transformation – including remote monitoring, digital primary care and digital social care, cyber security and service recovery plans to improve treatment times.
Elective Recovery	Reducing waiting lists, restoring services to pre-COVID levels, and embedding sustainable services.
Medicines and Pharmacy	Reducing unwanted variation and creating equitable service provision across Cheshire and Merseyside.
Mental Health	Community mental health, crisis care, psychological therapies, maternal and perinatal mental health, support for our workforce.
Neuroscience	Building on new clinical pathways and increasing the range of services to improve population health.
Population Health	Improving population health and healthcare, tackling health inequalities, and improving outcomes and access to services.
Women's Health and Maternity	Transforming and improving support for women's health, improving wellbeing, life chances and outcomes for women and babies.
Diabetes	Improving treatment targets, multi-disciplinary footcare teams in all Places, specialist nursing and flash glucose monitoring.
Palliative and End of Life Care	For adults, children and young people to live well, before dying in peace and with dignity in the place they would like to die – supported by the people important to them.
Respiratory	Quality assured diagnostic spirometry, pulmonary rehabilitation and psychological support to manage respiratory disease.
Stroke	Reducing the number of strokes in Cheshire and Merseyside by focusing on prevention, reducing health inequalities, improving access and enabling community rehabilitation.

Case studies – Involvement in the Digital Programme

The Cheshire and Merseyside Health and Care Partnership's Digital Programme is working on updating its **Digital Strategy 2018-23**, with a Digital and Data Strategy that better supports recent policy context (as set out in **What Good Looks Like** and **Data Saves Lives)**, and the massive acceleration of digital transformation accelerated by COVID-19.

As part of this piece of work, several engagement exercises are being undertaken with members of the public and health and care professionals living and working in Cheshire and Merseyside. These will help to ensure that the strategy helps to digitally empower the diverse population we serve to take control of their own health and wellbeing. The Digital Programme also enables our health and care workforce to deliver safer, more effective, and efficient care to their patients.

To help illustrate the breadth and depth of this engagement work, the following two case studies have been included to highlight exercises we've started, and how they'll shape our work moving forward.

Digital Inclusion Heatmap and Insight Project

The COVID-19 pandemic has exacerbated inequalities within society – including the digital divide. This was at a time when having full access to computers and the internet could not be more important in allowing people to access online health and care services.

Furthermore, digitally-excluded people (such as older people, financially disadvantaged people and disabled people) – who may be unable to get online due to factors such as access, confidence, motivation, and skills – are some of the heaviest users of health and care services.

To enable better targeting of interventions to support digitally-excluded people across Cheshire and Merseyside, our Digital Inclusion programme has commissioned the development of a 'Digital Inclusion Heatmap for Cheshire and Merseyside'.

Heatmap is a tool that uses data sets supplied by primary care, social care and local authority partners to provide an up-to-date snapshot (that can be updated over time) of digital inclusion initiatives and resources available across the nine local authority areas or 'Places' in Cheshire and Merseyside.

A focused piece of insight is being undertaken to gather attitudes of digitally-excluded people and the barriers and issues that they face when it comes to accessing health and care online – with a specific focus on the NHS App.

Multiple methods are being used, including focus groups, in-depth surveys, community outreach, and engagement with local businesses, to ensure the views of a wide range of people both living and working in Cheshire and Merseyside are captured.

It is hoped that Heatmap and insight work will provide us with a broader understanding of the barriers faced by digitally-excluded people in our area across a variety of settings, when trying to access digital equipment, data, and skills.

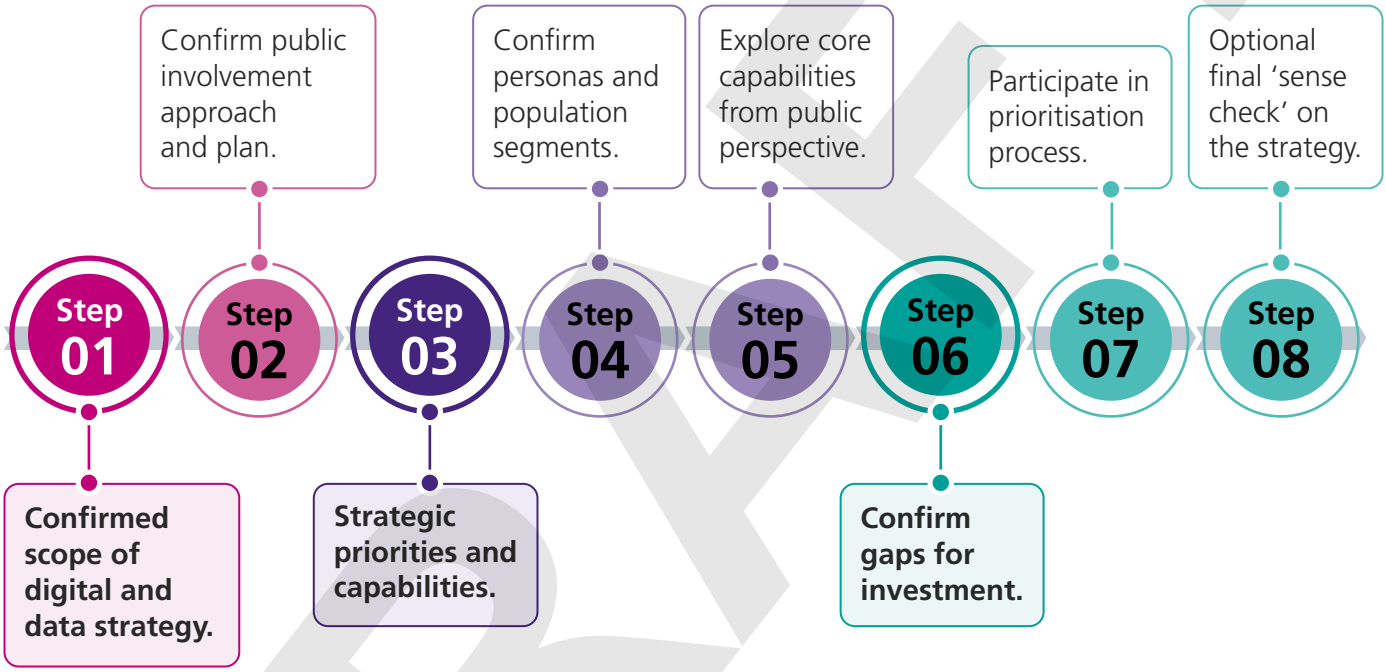
Our aim is to ensure that everyone who is unable to access and engage digitally in Cheshire and Merseyside has the opportunity (as far as possible) to do so or are provided with an alternative solution. This avoids people being left behind as we move towards a 'digital first' culture.

Public Involvement Panels

In order to create a person-centred digital programme we are co-producing our strategy. We have identified several 'touchpoints' where public involvement is helping to test our proposals for digital architecture and systems that span Cheshire and Merseyside.

These touchpoints are shown below as solid circles in the strategy development timeline:

ICS Digital and data strategy development phases and public involvement milestones



The deliberative method we are using incudes 'online group work involving Public Advisers from the National Institute for Health and Care Research (NIHR) and Applied Research Collaboration (ARC) Northwest Coast. Advisers are drawn from across Cheshire and Merseyside to represent diverse communities from our area. They have received training and support from the ARC to participate in this activity.

For children and young people, we are partnering with Youth Federation to involve young people in online events. We have also run an online session with Alder Hey Hospital's Children and Young People's Forum.

These initial events focussed on testing population segments or 'personas', which we created for the purposes of the strategy. Our next events will focus on the core capabilities to be commissioned by ICS digital to ensure these meet the aspirations of the personas.

5. Advancing equality

5.1 Health inequalities

Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. Tackling the causes and consequences of health inequalities is a central priority for the Cheshire and Merseyside ICS. This is also helping to ensure we met the new triple aim duty.

One of the key priorities of our Public Engagement Framework is to build relationships with excluded groups – especially those who are affected by inequalities – so that we can understand and meet their needs and aspirations for wellbeing, health, and care.

Our work will build on the **CORE20PLUS5** approach – a national framework that helps define the population groups in each system experiencing health inequalities. Hearing their experiences and understanding the barriers these groups face in accessing care and treatment is an important part of addressing unequal access to services.

Citizens' Panel

A Citizens' Panel is a large, demographically-representative group of citizens regularly used to assess public preferences and opinions. It aims to be a consultative body of citizens and is typically used by statutory agencies to identify local priorities and to consult members of the public (some of whom may use services) on specific issues.

NHS Cheshire and Merseyside's Citizens' Panel is at an early stage of development and will be 'testing' various approaches to elicit citizens' feedback with the aim of recruiting a sample of up to 1,000 people living and working in the region.

Reducing health inequalities within the nine Places of Cheshire and Merseyside is a key objective. Therefore, it is important that the Citizens' Panel is a diverse cohort focusing on people and communities most affected by heath inequalities in our cities, towns and villages.

Panellists recruited will be representative of the population of Cheshire and Merseyside and, alongside self-selecting engagement partners from existing forums, will be consulted on system health and care issues. Panellists will also inform decision-making and help to shape engagement approaches.

It's essential that we embed the citizens' voice in the commissioning cycle. This is key to strengthening our ability to demonstrate the impact that people's experiences, insights and aspirations have on our work.

There are already some excellent examples of Healthwatch and local authority partners gathering insights from people and communities in Cheshire and Merseyside.

We want to join-up and build on this work at system level, with a particular emphasis on the people and communities who are most affected by heath inequalities in our cities, towns and villages.

We will work with Healthwatch, the VCFSE sector and local authority partners to support the development our Citizens' Panel, which will seek to better understand the barriers faced by ethnic communities and people affected by poverty, unemployment and housing issues, in order to capture a holistic picture of inequalities and work with people and communities on joined-up solutions.

The social determinants of health (such as local neighbourhoods, access to greenspace, opportunities for being more active and access to healthy food) as well as physical and mental wellbeing are key. As a listening organisation, we want to develop an ongoing discussion with panellists about:

- health and care services
- health and wellbeing issues and their ideas to resolve them
- aspirations for better services and care pathways.

The response to COVID-19 has seen people in Cheshire and Merseyside support family, friends and neighbours including those self-isolating and encouraging vaccine take-up. The learning from this should be transferred to help us meet other challenges that health and care services face by listening to people and working with them to decide what will work best locally.

Health inequalities can be reduced by identifying solutions that are developed in partnership with people using community-centred approaches. Understanding the experiences and perspectives of those who face barriers to care and support, and have different outcomes, will help to develop opportunities for improvement and investment. By building trust and mutual understanding of the full range of our marginalised communities we will start to address unequal access to services and health outcomes.

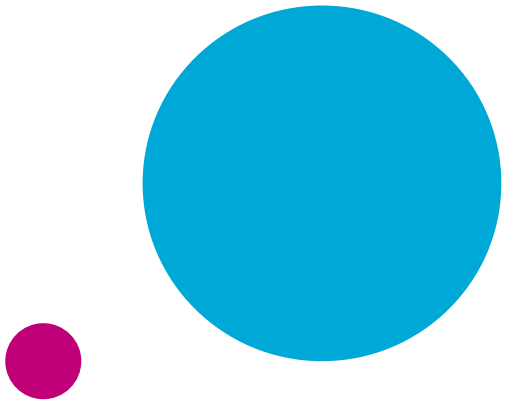
5.2 Equality, Diversity and Inclusion

It is important that we listen, respond to, and make every effort to involve individuals from all protected characteristic groups for example young people, older people, and lesbian, gay, bisexual, transgender, and questioning (LGBTQ) groups. In Cheshire and Merseyside, we celebrate the diversity of our communities.

It is also important that we listen to other underserved groups such as people with specific health conditions, people experiencing homelessness, refugees and asylum seekers, or people living in deprivation and/or rural communities to make sure we reach a diverse range of people to give them the opportunity to share their views.

We will use Equality Impact Assessments to help us understand which groups may need to be specifically targeted for a programme of work. We will be informed by Public Health and their needs assessments and evidence on health inequalities.

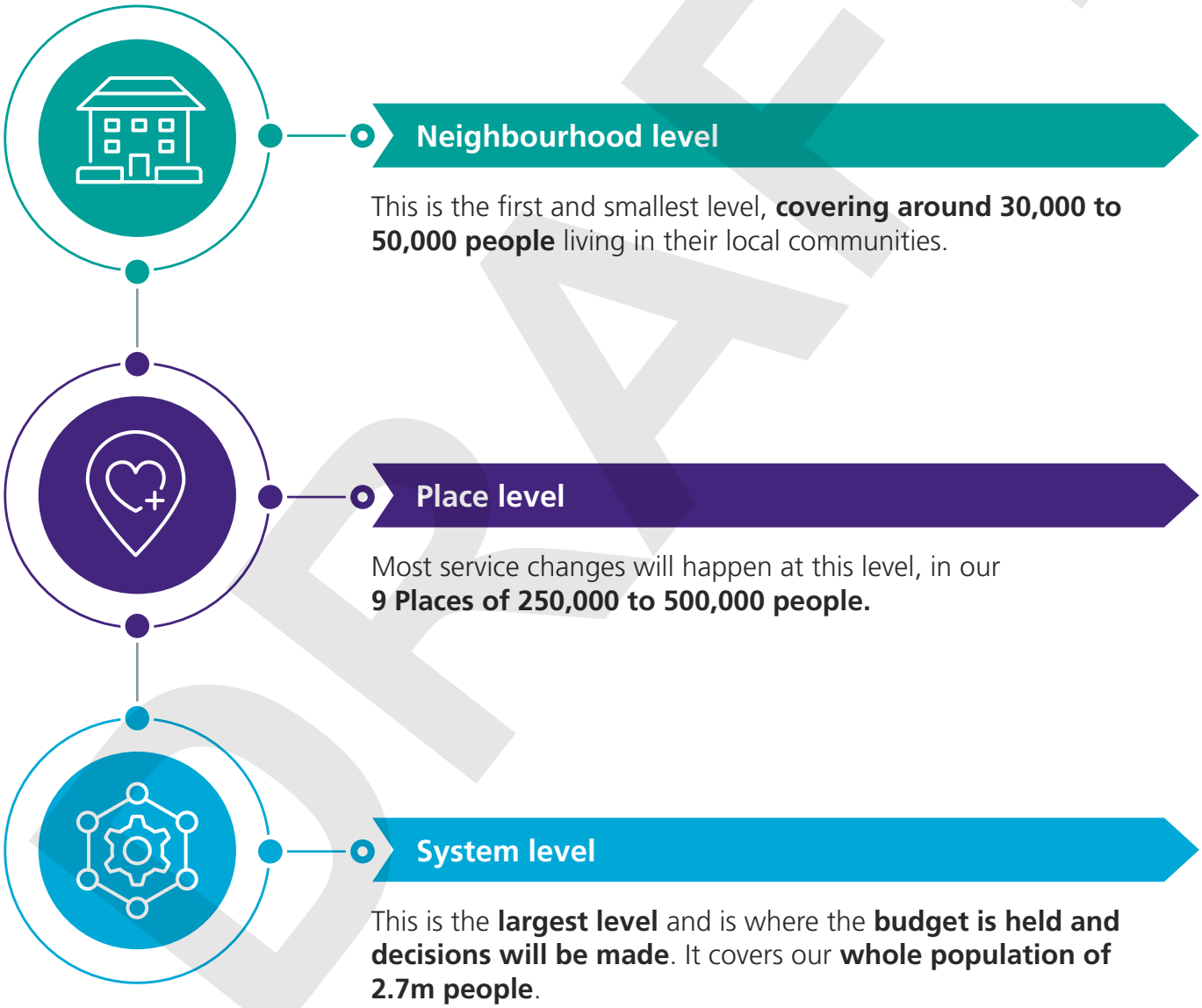
Healthwatch has developed a checklist for assessing the quality of Equality Impact Assessments which can be used to provide the checks and balances to hold the system to account.



6. Involving people and communities

6.1 Levels of engagement

Our Cheshire and Merseyside Public Engagement Framework will support us to work with people and communities at different levels:



Neighbourhood level

This is the first and smallest level, **covering around 30,000 to 50,000 people** living in their local communities.

Place level

Most service changes will happen at this level, in our **9 Places of 250,000 to 500,000 people.**

System level

This is the **largest level** and is where the **budget is held and decisions will be made**. It covers our **whole population of 2.7m people**.

Neighbourhood

At neighbourhood level, our GPs, opticians, dentists and community pharmacists are working together to deliver 'primary care', which is care that takes place outside of a hospital setting. They work together in your local area to form a Primary Care Network (PCN). All doctors and primary care professionals are part of one of these networks so they can work with people and communities to shape and improve local services.

Nine Places

Our Places are the areas covered by our nine local authorities and include several neighbourhoods. This is where most health and care services are delivered, including hospital care.

There are Place-based partnerships, where local hospitals, care providers, local councils, doctors, Healthwatch and the VCFSE sector are coming together to discuss key health and care issues with local people and communities.

Cheshire and Merseyside 'System'

Our Cheshire and Merseyside Integrated Care System, which is responsible for running health and care services, is made up of two key bodies:

Integrated Care Partnership (ICP)

This links in with all the wider partners - including Healthwatch the VCFSE sector, employment and health - at Place level. Through discussion with people and communities, the partnership will use the information about the local population to create a strategy for helping everyone who lives and works in the system area to live healthily.

Integrated Care Board (ICB)

The ICB oversees the NHS budget and makes sure the services are in place to ensure the strategy becomes a reality on a reality on the ground.

6.2 Using the framework

This framework is not a finished product. It reflects a moment in time, providing our early blueprint for working with people and communities. The longer-term strategy and delivery plan for Cheshire and Merseyside must be co-produced with residents, partners, staff and stakeholders.

Developing our Public Engagement Framework will require us to test approaches, learn and evolve over time. We must challenge ourselves, be flexible and collaborate with people and communities to meet longer-term goals.

Core priorities include developing a culture of co-production and embedding the residents' voice in the way we plan, develop and deliver services.

People and communities have the experience, skills and insight to transform how health and care are designed and delivered. The ambition is for the Cheshire and Merseyside ICS to build positive and enduring relationships with communities to improve services, support and outcomes for people.

This means:

- listening more and broadcasting less
- being flexible and responsive
- ongoing involvement and engagement of people and communities that is iterative and not only done in isolation, when proposing to change services
- focussing on what matters to communities, including people from marginalised groups and those who experience the worst health inequalities
- supporting approaches around existing networks, community groups and other Places where people come together
- developing plans and strategies that are fully informed by people and communities
- providing clear feedback about how people's views will lead to improvement, impact and change
- Involving communities to develop their own solutions to improving the health of all.

Working in this way will enable better decisions with people about service changes, and improve operational effectiveness, Care Quality Commission (CQC) inspection outcomes, safety, quality, experience and performance.

It is vital – whether working at a system-level, in one of our Places or local neighbourhoods – that engagement is carefully planned and designed to ensure that partners, people and communities get the best out of our work together.

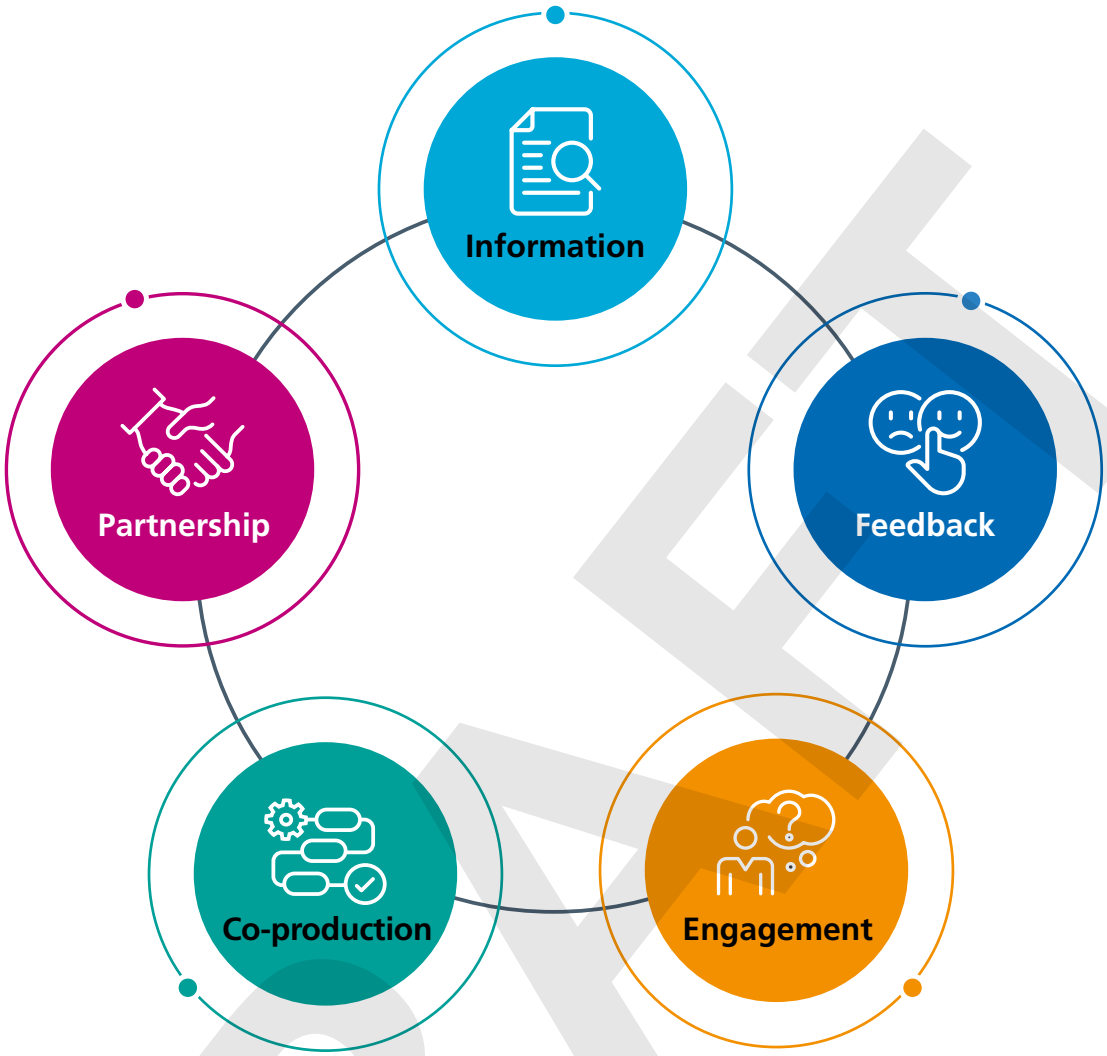
6.3 People's voice

We recognise how important it is for us to be open and transparent about how the feedback we receive informs our planning and decision making. The diagram below simply illustrates the feedback loop that we will use to keep people informed.

To plan, develop and deliver wellbeing, health and care services and support that the people of Cheshire and Merseyside need, we will constantly evaluate feedback from a wide range of sources. We will use the feedback we gather, alongside the quantitative data we collect, to develop a repository of intelligence that we will use to identify actionable insights and ensure people's voice is at the centre of our decision-making.

During the year, we will bring that information together to produce 'Insight and Intelligence' reports at system and in Place. These can be used by our teams to shape programme plans and service change activity.

We will publish these reports to show what we have captured, and we'll also publish details of how feedback has been used and the impact it has had.



6.4 Our approach

1. Reach out to people and ask them how they want to be involved
2. Promote equality and inclusion and encourage and respect different beliefs and opinions
3. Proactively seek the involvement of people who are underserved and who experience health inequalities and poorer health outcomes
4. Value people's specific lived experience and use all the strengths and talents that people bring to the table
5. Provide clear and easy-to-understand information and recognise that everyone has different needs
6. Take time to plan with and involve people as early as possible
7. Be open, honest, and transparent in the way we work – explain decisions, be clear about resource limitations and constraints
8. Where information must be kept confidential, explain why
9. Invest in partnerships, engage in ongoing dialogue and provide information, support, and training to enable leadership from those with specific lived experience
10. Review people's experiences and learn from them to continuously improve how people are involved
11. Recognise, record, and celebrate people's contributions and give feedback on the results of involvement and engagement.

7. Collaboration and partnership working

This is about building relationships with organisations and local communities in a way that treats partners equitably, and that recognises the contribution that can be made to improving the health and care system.

Working collaboratively and in partnership gives us a far greater opportunity to ensure that our services meet people's needs, and that experiences and outcomes can be improved. People and communities have the knowledge, skills, experience and connections to support and improve health and wellbeing.

We want to identify and deliver 'shared outcomes' that meet the needs of communities. This is particularly relevant in the context of population health management and reducing health inequalities. Our health and wellbeing can be affected by many things – housing, unemployment, financial stress, domestic abuse, poverty and lifestyle choices.

Within our partnership Healthwatch, the VCFSE sector, and our local authorities bring vital strengths in working with people and communities – and vast experience of working with people to design and deliver services that meet local needs and build community assets.

In Cheshire and Merseyside, we have very well-established partnerships at a local level, and have had for many years. Our partners work together to improve the health and wellbeing of local people and communities through policies and plans for housing, early years, growth, skills and employment.

Our Integrated Care System puts us in an even better position to respond to these challenges in Cheshire and Merseyside, alongside our local authorities, Healthwatch and the VCFSE sector.

In co-producing our Public Engagement Framework, we have identified a set of principles that will enable us to strengthen our partnership with Healthwatch and the VCFSE sector.

7.1 Working with Healthwatch

What will good look like?

The strength and value of the independent, statutory role of Healthwatch is recognised as fundamental to the planning and delivery of health, care and wellbeing services throughout Cheshire and Merseyside.

'What good will look like' includes:

- Building strong relationships with the local Healthwatch network to help ensure services are shaped around the needs of people and communities
- Partners respecting, valuing and supporting the core duty of Healthwatch to engage with people and communities across all health and care services and the whole 'life-course'
- Acknowledging and benefitting from the unique position Healthwatch holds both outside and inside the wider system, as a voice for people and communities – including those not regularly heard and as a constructive, critical friend with statutory powers

- Working in partnership with Healthwatch to ensure people and communities are able to share their experiences and be involved in service design, planning and delivery, knowing their input is respected, heard and responded to
- Ensuring the statutory functions, activities and duties of Healthwatch are maximised to plan, design and deliver quality services
- Insight and intelligence from Healthwatch reports, and 'Enter and View' programmes of work, regularly being used and referred to for quality planning and assurance of services
- Early inclusion of Healthwatch in designing, planning and delivering engagement activities, ensuring resources and mechanisms are in place to deliver
- Recognising the co-location of local Healthwatch groups within each of the Cheshire and Merseyside Places – their commitment to working collaboratively, and the ability to carry out their role at neighbourhood, Place, system and national-level.

7.2 Working with the VCFSE sector

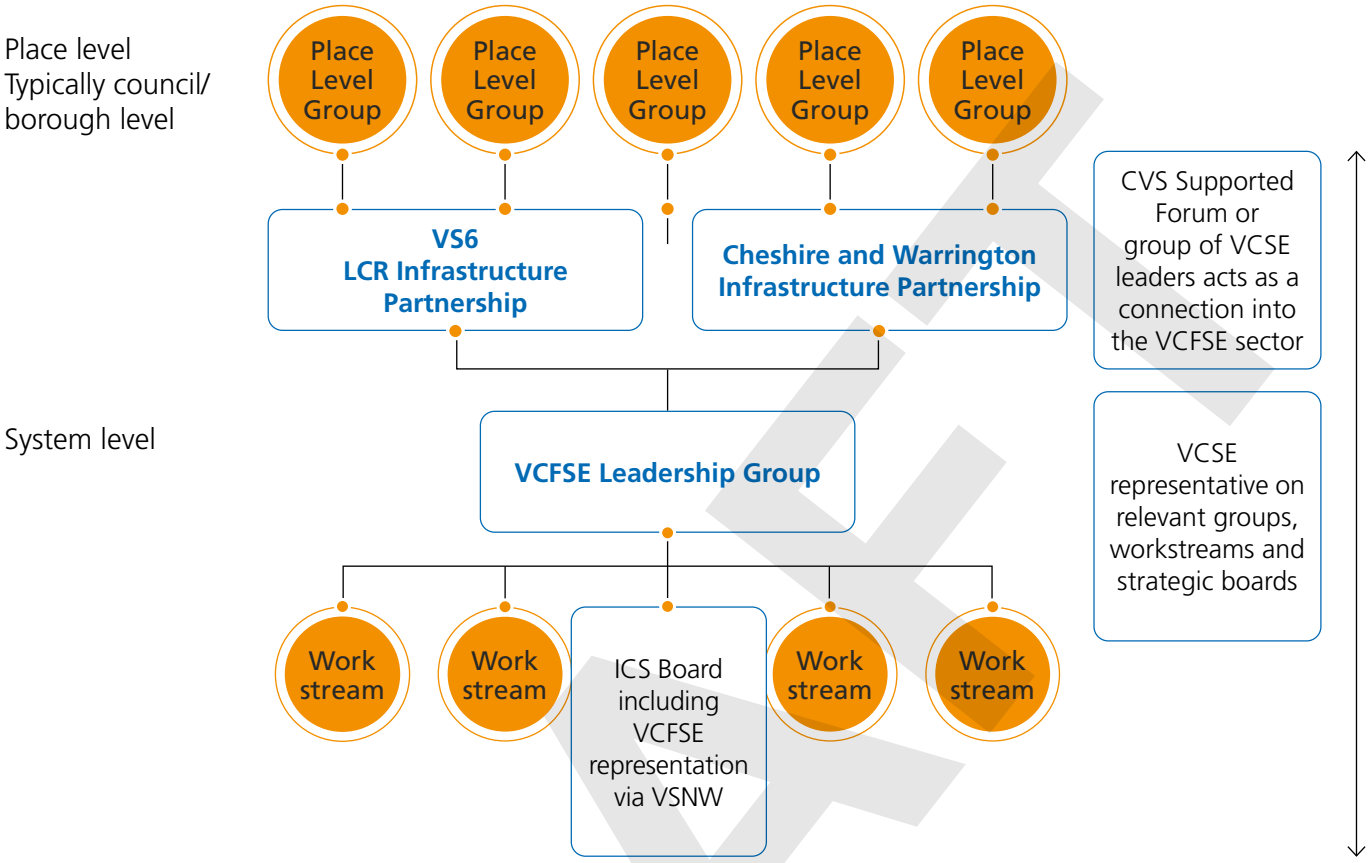
The VCFSE sector has always provided a wide range of support to health, care and wellbeing services including helping community voices to be heard. Working with the Cheshire and Merseyside VCFSE infrastructure provides access to a network of over 15,000 VCFSE organisations, ensuring a stronger collective voice across our diverse communities.

'What good will look like' includes:

- Recognising that the VCFSE sector has a rich source of insight and data, that reflects local community need which is used to inform planning and delivery
- Increased opportunities for community engagement, designed and led by the VCFSE sector, delivering meaningful engagement to provide up-stream solutions with opportunities to co-design, to help influence and shape service provision
- Ensuring leaders and advocates across the VCFSE sector are fully engaged on decision-making programmes and project boards
- Increasing engagement though the extensive VCFSE reach within our diverse and seldom-heard communities to share views and experiences to shape and influence service redesign and encourage co-production
- Using resources and investment to ensure the VCFSE has the capacity to engage as an equal partner across local and regional systems.
- Utilising local infrastructure and established relationships across the Cheshire and Merseyside strategic ecosystem of boards, forums and groups, ensuring credibility and assurance when representing the views of the sector.

VCFSE infrastructure organisations are recognised and used as a key channel for two-way communications with NHS Cheshire and Merseyside, providing a consistent approach to engagement.

Local model for strategic VCFSE engagement:



7.3 The benefits

Accountability and transparency

Our organisations should be able to explain to people how decisions are made in relation to any proposal and how their views have been taken on board. Transparent decision-making with people and communities involved in governance will help make our ICS accountable to communities.

Participating for health

Being involved can reduce isolation, increase confidence and improve motivation towards well-being. Individuals' involvement in their own care can lead to involvement at a service level and to more formal volunteering roles and employment in the health and care sectors. It is well recognised that doing something for others and having a meaningful role in your local community supports wellbeing. Getting involved, being part of a community and being in control is good for our health.

Better decision-making

We view the world through our own lens, and that brings its own judgements and biases. Business cases and decision-making are improved when insight from local people is used alongside financial and clinical information to inform the case for change. People's insight can add practical weight and context to statistical data, and fill gaps through local intelligence and knowledge.

Improved quality

Partnership approaches mean that services can be designed and delivered more appropriately, because they are personalised to meet the needs and preferences of local people. Without insight from people who use (or may not use) services, it is impossible to raise the overall quality of services. It also improves safety, by ensuring people have a voice to raise problems which can be addressed early and consistently.

Value for money

Services that are designed with people and therefore effectively meet their needs are a better use of public sector resources. They improve health outcomes and reduce the need for further, additional care or treatment because a service did not meet people's needs the first time.

Meeting legal duties

Failure to meet the relevant legal duties risks legal challenge, with the substantial costs and delays that entails as well as damage to relationships, trust and confidence between organisations, people and communities.

7.4 Culture and leadership

Our communities and staff will look to system leaders to role model a culture of partnership. This will help to demonstrate that their views are taken seriously, and that power is shared so they can play a genuine part in decision-making. Leadership can be a joint endeavour, with leaders from our system and from within communities working together.

Collaborative and inclusive leadership means seeing involvement as everybody's business (not just a handful of people with a relevant job title) and is fundamental to meeting shared objectives. It means making sure that professionals and communities can work, learn, and improve together.

Senior leaders must:

- promote involvement and co-production through culture and behaviour
- identify areas of work where co-production can have a genuine impact and involve people at the earliest stages
- invest in training and development so that people with specific lived experience and people working in the system know what co-production is and how to make it happen
- hold the system, Places and neighbourhoods to account by seeking assurance that involvement and co-production is happening

7.5 Our workforce

WE ARE ONE

'We Are One' is the term we use to create a 'one team' ethos for our ICS workforce. We must support and give our staff permission to innovate and collaborate in new ways and give them the permission and autonomy to try things out, to learn and to celebrate success.

Our staff are our most valuable resource, and we must invest in training and development opportunities to support them and the effective delivery of our Public Engagement Framework. In Cheshire and Merseyside, we believe involvement is everyone's business.

This requires a commitment for the resources, training and support to do so effectively, and allowing people time to build trust and relationships. One way of doing this effectively is using community-centred approaches that enable staff to work with diverse communities to develop their skills, in a way that supports people and communities to take more control of their health. This will help realise the potential of both groups.

Our Chair, Chief Executive and board members are all committed to creating the right conditions to ensure that our workforce collaborates to involve people and communities in Cheshire and Merseyside.

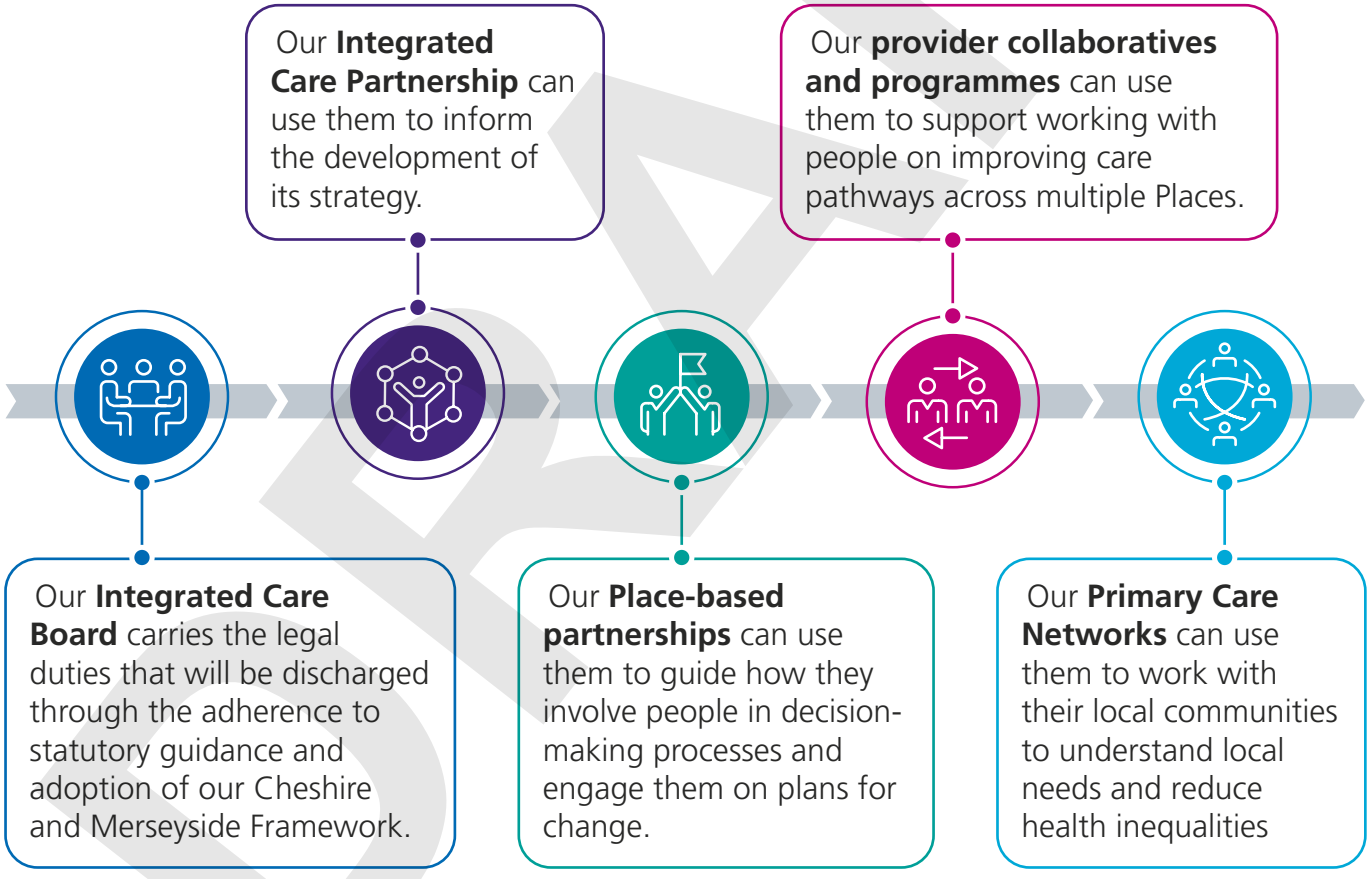
7.6 Meeting legal duties

Following national public consultation, the new **Statutory guidance for working with people and communities** was published in July 2022. The System Partnerships team at NHS England has also recently published (February 2022) **Major Service Change: An Interactive Handbook**.

ICS partners must give regard to this guidance alongside meeting other legal duties, such as;

- **Equalities:** The Public Sector Equality Duty (PSED), section 149 of the Equality Act 2010
- **Health inequalities:** The Health and Social Care Act 2012
- **Triple aim duty:** The Health and Care Bill 2021
- **Social value:** Public Services (Social Value) Act 2012.

National statutory guidance and our Cheshire and Merseyside Public Engagement Framework are relevant to the entire health and care system:



8. Resources

Effective involvement of people and communities requires an investment and resources;

8.1 Supporting people

- Expenses for those people who are participating – these will include travel expenses, carers expenses, childcare costs, additional costs of regularly joining online meetings and personal assistance reimbursement
- Consideration of budgets for commissioning organisations to undertake involvement activity and events on our behalf
- Venue costs for accessible meetings – additional costs may include interpreters, hearing loop systems.

8.2 Reward and recognition

It is essential that people and communities feel valued and are rewarded for their contribution – in addition to out-of-pocket expenses. We will consider offering prize draws and vouchers to encourage involvement and hold 'thank you' events.

8.3 Staff

Time is a major factor. There needs to be a clear understanding that for true co-design and co-production, time is needed and no involvement work is rushed or seen as a token gesture. This will impact on staff's capacity and resource, but it is essential that this is factored in.

8.4 Software and subscriptions

Resources will need to be considered that enable and support involvement including survey software and subscriptions to organisations such as the Consultation Institute.

8.5 Training

It is essential that staff have the appropriate level of training to enable them to effectively carry out their involvement roles. This can be sourced in-house and peer support will be encouraged though external training courses.

We will offer training that informs people about the health and care landscape and empowers them to effectively influence service developments.

9. Monitoring and evaluation

We are working with NHS England and other systems to develop a formative approach to the evaluation of our engagement with people and communities. This will be further informed by a new Oversight Framework.

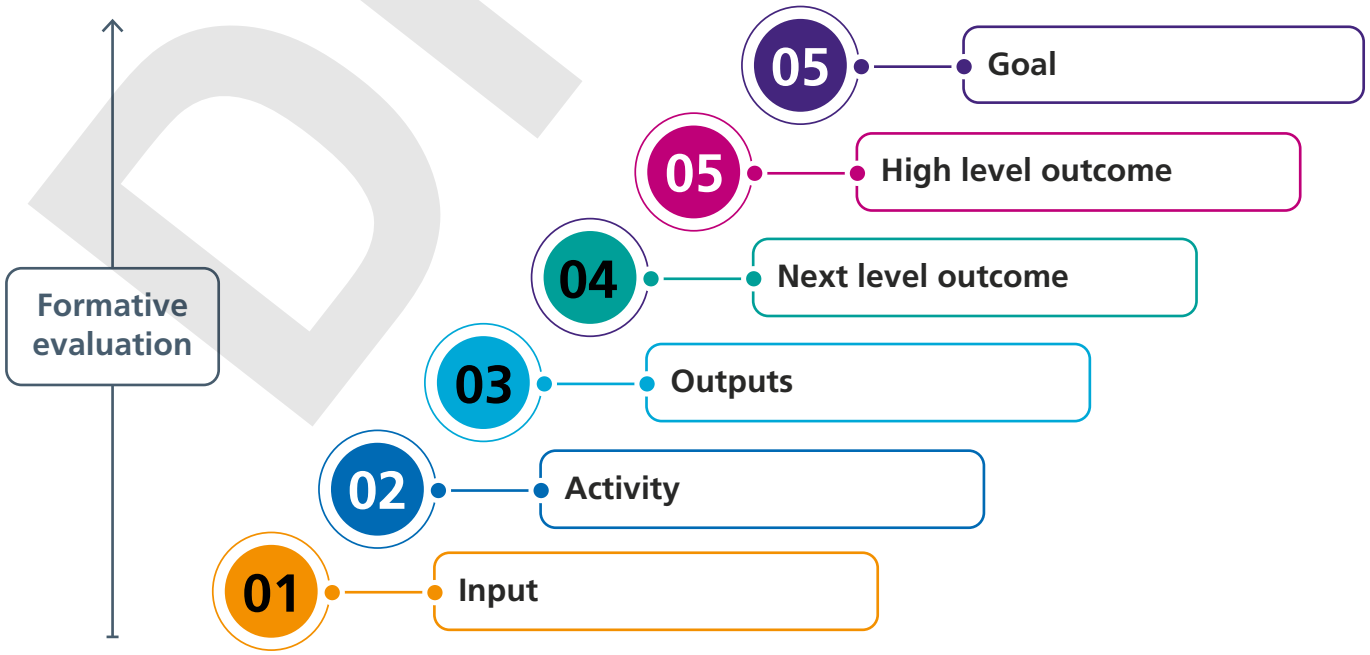
Our aim is to develop an evaluation approach (using a basic 'theory of change' model) that meets our specific ICS priorities, whilst being aligned to national oversight and quality assurance measures.

By working in this way, we can:

- demonstrate the impact of working with people and communities
- learn as we develop
- be held accountable to people, communities, regulators, and our partners.

Healthwatch will also play a vital role in the evaluation of our engagement. We are keen to have independent mechanisms to regularly review if our principles are working.

Approach	Benefits
1. Co-produce a 'people and communities' theory of change through workshops with other ICSs	Share good practice and inform national Quality Assurance Framework
2. Develop a shared evaluation toolkit	Practical tools that system partners can use to meet national standards
3. Develop a Local Evaluation Framework	Robust local mechanisms to assure people, communities, regulators and our partners



10. Progress and next steps

We have already made lots of progress in working with people, communities and health and care staff, but there is much work to do to build on this in 2022/23.

10.1 Progress

- Ongoing engagement with elected members, hospital governors and non-executive directors in developing our ICS
- Work with the Institute for Health Equity to co-produce interventions and actions with communities, including nine Place-based health inequalities workshops
- Work with the Cheshire and Merseyside Public Health Collaborative (Champs) and Population Health Board to develop:
  - Combined Intelligence for Population Health Action (CIPHA)
  - Community alcohol licencing plans
- The national award-winning 'Getting Under the Skin' research campaign, to understand and respond to the impact of COVID-19 on ethnic communities in Cheshire and Merseyside
- The 'Kind to Your Mind' campaign – development of dedicated telephone and website for support for mental wellbeing, advice and signposting
- Cheshire and Merseyside Opening Doors programme – aimed at improving the health of people in social housing and offering opportunities for residents to develop the skills to work in social care
- Work with people with a learning disability and autism via the Cheshire and Merseyside Transforming Care Partnership
- Council-led Community Champion and inspirers initiatives to influence the policy agenda
- The draft Public Engagement Framework was presented to the public board meetings of both NHS Cheshire and Merseyside (the ICB) and Cheshire and Merseyside Health and Care Partnership (the ICP) following their establishment on 1 July 2022.

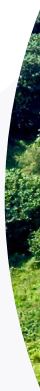
10.2 Next steps

The framework will be adopted following the publication of national statutory guidance.

A shorter document in plain English and that is jargon-free will be published and used to support engagement with people and communities.

NHS Cheshire and Merseyside's engagement team will use the Public Engagement Framework to respond to the feedback gathered through engagement activity led by Healthwatch and VCFSE partners. Engagement leads will also design specific mechanisms to deliver effective involvement opportunities at system, Place and neighbourhood levels, that ensure:

- clear and transparent mechanisms for developing integrated health plans with people and communities
- clear and accessible public information about its vision, plans and progress
- annual reporting on the involvement of people and communities at ICS and in Place
- collaboration with Healthwatch and the VCFSE sector as key engagement partners
- involvement with people and communities representing equality protected groups and people affected by inequalities



- that involvement is monitored and audited
- that people and communities are represented in priority setting and decision-making forums
- that the participation of people and communities is supported by ensuring there is a training and development offer that equips people to contribute to governance arrangements
- that the experiences and aspirations of people and communities are gathered, reviewed, and responded to
- that these experiences and aspirations are used to produce insight and intelligence reports to inform decision-making and quality governance.

NHS Cheshire and Merseyside's engagement team will develop and publish detailed action plans at both system and Place-levels.

The Senior Responsible Officer with oversight and responsibility for implementation of the framework and subsequent action plan is Maria Austin, Associate Director of Communications and Empowerment, NHS Cheshire and Merseyside.

11 Appendix

11.1 How the framework was developed

Cheshire and Merseyside's Public Engagement Framework was developed by a task and finish group which drew its membership from our Health and Care Partnership.

The task and finish group held fortnightly meetings, and members undertook extensive engagement with forums at system, Place and neighbourhood levels over a period of three months from 1 April to 30 June 2022.

The framework was developed in line with **ICS implementation guidance** for working with people and communities, and following the national content guide provided by NHS England.

Oversight of strategy development was provided by the following ICS forums:

- The Cheshire and Merseyside Partnership Assembly
- The Cheshire and Merseyside ICS Development Advisory Group
- The Cheshire and Merseyside Transition Programme Board.

The framework was co-produced with Healthwatch and the VCFSE sector who undertook the engagement activity set out below, to inform its development. The feedback and insights from this activity will be taken forward by NHS Cheshire and Merseyside's engagement team.

11.2 Healthwatch engagement activity

Healthwatch	Who	How feedback was collected
Liverpool	Community engagement board (made up of representatives of organisations working with local communities especially often ignored communities). Staff and volunteer team.	Online focus groups
Wirral	Survey sent through community networks.	Survey
Sefton	Focus groups with staff team, board, and volunteers.	Focus groups
Knowsley	Focus groups with Knowsley residents, and Healthwatch Knowsley board.	Focus groups
St Helens	Meetings, web form and survey for staff team, board, volunteers and local community groups.	Webform/survey, visits to groups, team meetings.s
Cheshire East and Cheshire West	Staff team, volunteers, board members. Supported conversations on engagement activities.	Using a mixture of: ▪ Comments on full draft ▪ Feedback collected verbally at meetings and recorded based on 10 principles ▪ Survey of small cohort of people, to include members of Healthwatch Cheshire's Citizen's Focus Panel.
Halton	Staff team Advisory board focus group Small group of volunteers Survey to virtual People's Panel	Focus group with staff, board and volunteers
Warrington	Staff, board members and volunteers, People's Panel, Virtual Voices Panel, small focus groups.	Survey feedback

11.3 VCFSE engagement activity

VCFSE	Who	How feedback was collected
VS6	VS6 is the Liverpool City Region network of Chief Executive Officers (CEOs) leading infrastructure support. It's membership includes: ▪ Together Liverpool (Faith) ▪ Sefton Council for Voluntary Service (CVS) ▪ One Knowsley ▪ Voluntary Sector North West (VCAW) ▪ Halton and St Helens Voluntary and Community Action (VCA) ▪ Liverpool Charity and Voluntary Services (CVS) ▪ Network for Europe ▪ Community Foundation Merseyside ▪ Merseyside Youth Association ▪ It is Chaired independently by Rev Canon Dr Ellen Loudon, Director of Social Justice and Canon Chancellor, Diocese of Liverpool.	Online facilitated focus group
CWIP	Cheshire and Warrington Infrastructure Partnership is a network of CEOs leading infrastructure support. Its membership includes: ▪ Warrington Voluntary Action (VA) ▪ Cheshire East Council for Voluntary Service (CVS) ▪ Cheshire West Voluntary and Community Action (VCA).	Online facilitated focus group
Liverpool	Health and Wellbeing Network	Online facilitated focus group
Wirral	Wirral CVS VCFSE Board and established network of VCFSE leaders	Online facilitated focus group
Sefton	Health and Wellbeing Network	Online facilitated focus group
Knowsley	Health and Wellbeing network, VCFSE Leaders network	Online facilitated focus group
St Helens	VCFSE forum	Online facilitated focus group
Halton	VCFSE forum	Online facilitated focus group

VCFSE	Who	How feedback was collected
Warrington	VCFSE Health and Wellbeing Alliance VCFSE Health Engagement Event	Face-to-face focus group
Cheshire East and Cheshire West	Sector Leadership Group from the membership of Cheshire West Voluntary Action (CWVA).	Facilitated conversation by Michelle Whitaker, Health and Wellbeing Programme Lead office for Health Improvement and Disparities, Northwest Region.

11.4 Emerging Place priorities

Place-based partnerships are starting to identify and develop priorities, in collaboration with Health and Wellbeing Boards, that will be further tested through engagement with people and communities in 2022/23.

Place	Key priorities
Cheshire East	We have some clear goals that we are working collectively to: ▪ deliver a sustainable, integrated health and care system ▪ create a financially-balanced system ▪ create a sustainable workforce ▪ significantly reduce health inequalities.
Cheshire West	To identify Cheshire West population health needs now and in the future, proactively detecting and preventing ill-health, whilst promoting wellbeing and self-care to our residents. To reduce health inequalities by continuing to develop our approach to population health management (PHM), using data and analytics to prevent ill-health, address health inequalities, and identify those residents who are at higher risk of their health deteriorating, enabling us to deliver preventive interventions. Improving the quality of services that are delivered within Cheshire West, expanding on efficiencies, and delivering safe and effective care.

Place	Key priorities
Halton	To improve the employment opportunities for people in particular where it affects children and families. To enable children and families to live healthy independent lives. To provide a supportive environment where systems work efficiently and support everyone to live their best life. To enable older adults to live full independent healthy lives.
Knowsley	A targeted approach to population health and reducing health inequalities starting with Northwood (our most deprived area). A single front door to health information, guidance and advice as part of the Knowsley Offer. To reduce avoidable attendances and admissions to hospital. To improve access to general practice.
St Helens	The St Helens People's Plan covers three priorities to improve the health and well-being outcomes of residents in the borough. The priorities are resilient communities, mental health and healthy weight. These are underpinned by the crosscutting theme of tackling health inequalities. **Resilient communities:** To support people to live independently, reduce social isolation and loneliness, embed a multi-sector/disciplinary team working in our four localities/networks and to develop a health innovation hub. **Mental wellbeing:** To prevent and reduce self-harm and suicide, to expand the voluntary and community service capacity to support mental health and wellbeing, and to improve the wellbeing of children and young people. An action plan is being developed using the Office for Health Improvement and Disparities (OHID) prevention concordat for better mental health. **Healthy weight:** To support healthy eating choices in the borough, to encourage residents to lead a more active life, and with a focus on diabetes prevention. The Active Lives strategy and action plan has been developed and the group are working with Food Active on a health weight declaration.
Liverpool	To target action on inequalities, at scale and with pace. To offer empowerment and support for wellbeing. To radically upgrade prevention and early intervention. To provide integrated and sustainable health and care services.

Place	Key priorities
Sefton	To improve mental health. To tackle obesity. To support community resilience by developing resources to enable people and communities to improve their quality of life and reduce health inequalities. We will be using a whole-life approach to tackling these priorities. This means our plans support local people from having the best start in life through to improving care for those in their older years. We will also aim to reduce health inequalities that lead to poor health and quality of life by adapting our work to the needs of our different communities across the borough.
Warrington	Mental health. Living well. Food poverty.
Wirral	To recover from the COVID-19 pandemic and transform our Place by implementing the Wirral Plan 2021-26. To refresh, refocus and strengthen partnerships and collaboration in Wirral to support delivery of our plans, including co-production. To improve population outcomes and tackling health inequalities by addressing the needs of our population in a more targeted way.

Classification: Official

Publication approval reference: B1762

NHS England

Department of Health & Social Care

Working in Partnership with People and Communities

Statutory Guidance

Version 1, 4 July 2022

About this guidance

This guidance has been developed by NHS England with the following partners:

- Care Quality Commission
- Centre for Governance and Scrutiny
- Department of Health and Social Care
- Healthwatch England
- Local Government Association
- National Voices
- NHS Confederation
- NHS Providers
- Patients Association
- The Health Creation Alliance
- Integrated Care Systems in Dorset, North East and North Cumbria, Sussex and West Yorkshire.

It also had input from NHS England's public participation networks and forums. NHS England undertook a public consultation on this guidance during May 2022.

This statutory guidance is made up of a suite of documents – the main body and two annexes:

1. Guidance on working with people and communities: this sets out how the guidance should be used; the main legal duties; reasons for working with people and communities; and the leadership needed to realise these benefits. It gives 10 principles to follow to build effective partnerships with people and communities.
2. Annex A gives the detail on putting it into practice. It describes the approaches to take for different contexts and how organisations can work together to create genuine and authentic relationships with local communities.
3. Annex B explains the public involvement legal duties in more detail and organisations' responsibilities for working with people and communities.

Further information about all the case studies can be found on the NHS England website. It links to other relevant guidance on integrated care and to further resources on working effectively with people and communities.

This information is available in easy read and other alternative formats and languages upon request. Please email england.contactus@nhs.net or telephone 0300 311 22 33.

Contents

Forewords

Edward Argar, Minister of State for Health

People and communities are at the heart of everything the NHS does. Working with people and communities is critical if we are to create a health and care service which offers personalised care, is tailored to the needs of each individual, and which works for everyone.

The Health and Care Act 2022 is designed to enable a more joined up, collaborative system. System leaders from across health and local government told us they wanted to work better together to tackle the big challenges in health and care. The Act ensures that every part of England is covered by an Integrated Care System, which brings together NHS, Local Government and wider system partners to empower them to put collaboration and partnership at the heart of planning. To achieve real impact, we need systems to look beyond those who are typically involved – building partnerships across traditional boundaries and working with people, communities and those who represent them to create real change.

The Act also introduces a new duty on NHS organisations to have regard to the effects of their decisions on the 'Triple Aim' of the health and wellbeing for the people of England, quality of services provided or arranged by NHS bodies, and sustainable use of NHS resources. The previous legislative framework directed organisations to work primarily in the best interest of their own organisations and their own immediate patients - but this does not fully support the delivery of integrated, patient-centred care. The new duty requires organisations to think about the interests of the wider system and provides common, system-wide goals that need to be achieved through collaboration. We expect NHS organisations to draw on the knowledge and experience of wider partners, including the voluntary, community and social enterprise (VCSE) sector, local authorities and Healthwatch, alongside their communities when considering how to meet this duty.

By working with people across places, we can better tailor services to meet their needs and preferences, so that they are designed and delivered more effectively. This ensures that locations, opening times, models of care, and patient information are suitable for the communities we serve. Involvement helps us prioritise resources to have the greatest impact; and helps us make better decisions about changing services. Information from involvement activities can be used alongside financial or clinical information to ensure that services are delivered in a way that works for patients and their carers, and can be tailored to the needs of a particular area.

This guidance has been developed in partnership with organisations with experience of working with communities and ensuring their voices are heard in health and care services. It is intended to support health and care systems to build positive and enduring partnerships with people and communities in order to improve services and outcomes for everyone. It is an important next step in realising the benefits of the changes brought about by the Health and Care Act 2022.

Amanda Prichard, Chief Executive, NHS England

The NHS has always been at the heart of communities. Our hospitals, primary care and community health services provide services to millions of people every week, and a reassuring physical and psychological presence for many more. And never has the NHS been a source of more reassurance and more pride for communities than during the COVID-19 pandemic.

The NHS response to the pandemic – both the initial efforts to protect people from the virus, and especially our delivery of the vaccine programme – has depended in large part on our ability to work with and through communities, not just to spread broadcast messages, but more importantly to understand and overcome barriers to accessing services.

As we move into a new phase, our mission now is to continue recovery and tackle Covid backlogs, reform for the future and build resilience to future pressures. But we must also do so with respect for our patients and communities, ensuring their needs and opinions are central to how we plan, deliver and improve services.

Through Integrated Care Systems (ICSs) – particularly now they are underpinned by statutory Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) - we have an opportunity to further strengthen the relationship with the communities we serve collaboratively, with our Local Government and Voluntary Sector partners. The involvement of our people and communities sits right at the heart of this relationship; we can’t achieve the best outcomes in the most effective way, without working with the people we treat and care for.

The public rightly have high expectations of the NHS. But equally they understand the challenges we face, and want ways to be involved in finding solutions. They have knowledge, skills, experiences and ideas to develop solutions that best meet their needs and support their health and wellbeing. Without insight from people who use, or may use, services, it is impossible to make truly informed decisions about service design, delivery and improvement.

This is particularly important in addressing the health inequalities highlighted by the pandemic; we need to take this opportunity to address the barriers and challenges people experience and ensure we improve the health and wellbeing of the people who need care and support the most. And sometimes this means having the courage to be challenged on our current and historic performance.

Fortunately, we are not starting from scratch. As this guidance sets out, we can build on examples of existing collaboration already taking place in ICSs and on the benefits we have already seen and are seeing from working with communities this way.

Sam Allen, Chief Executive, North East & North Cumbria Integrated Care Board

Listening and involving the communities and citizens we serve through open conversations, to truly make a difference together, and with the aim of reducing inequalities is at the heart of our Integrated Care System. People and communities are why we are here, and we are in service to them. We will draw on their lived experience, wisdom and expertise and involve them as partners in our work.

Adam Doyle, Chief Executive, Sussex Integrated Care Board

I am very pleased to support the guidance for all ICBs and ICSs. The communities that we serve are best placed to help shape and co-produce health and care services that are meaningful to them. I encourage all colleagues to consider this guidance in as they take forward their 5-year strategy in each of their systems.

Patricia Miller, Chief Executive, Dorset Integrated Care Board

I am very privileged to confirm my support for a new approach to involving communities. If we are going to fulfil the ambition of integrated care systems around reducing inequalities, we need to understand the lived experience of our communities and design solutions with them that enable them to live their best lives and thrive. Our citizens should be at the centre of every decision we take.

Kate Shields, Chief Executive, Cornwall Integrated Care Board

Our view about person voice is really clear. Without the voices of our people and our communities we will fail from the start. What we do and how we do it has to be aligned with what matters to the people we serve.

People and their communities will increasingly be engaged in our services re-design across our system and we'll ensure their voice is heard in our ICB and be at the heart what we do in Cornwall and the Isles of Scilly.

Executive summary

The Health and Care Act 2022 mobilises partners within Integrated Care Systems (ICSs) to work together to improve physical and mental health outcomes. These new partnerships between the NHS, social care, local authorities and other organisations will only build better and more sustainable approaches if they are informed by the needs, experiences and aspirations of the people and communities they serve.

This is statutory guidance for Integrated Care Boards (ICBs), NHS trusts and foundation trusts, and is adopted as policy by NHS England. It supports them to meet their public involvement legal duties and the new 'triple aim' of better health and wellbeing, improved quality of services and the sustainable use of resources. It is relevant to other health and care organisations, including local government, to ensure that we work collaboratively to involve people and communities, in ways that are meaningful, trusted and lead to improvement.

The public involvement legal duties require arrangements to secure that people are 'involved', and this can be in a variety of ways. ICBs, trusts and NHS England need to be able to demonstrate that they assess whether that the duties apply to decisions about services and, where they do, that they are properly followed. NHS England's assessment of ICBs' performance will include how they meet their legal duties. There are also policy requirements for Integrated Care Boards (ICBs), Integrated Care Partnerships (ICPs), place-based partnerships and provider collaboratives to involve people, including in their membership and when developing plans and strategies. Involvement is a contractual responsibility for Provider organisations, including General Practice, as set out in the NHS Standard Contract.

While involving people and communities is a legal requirement, working with them also supports the wider objectives of integration including population health management, personalisation of care and support, addressing health inequalities and improving quality. The legal duties provide a platform to build collaborative and meaningful partnerships that start with people and focus on what really matters to our communities. However, the ambition is for health and care systems to build positive, trusted and enduring relationships with communities in order to improve services, support and outcomes for people.

There are clear benefits to working in partnership with people and communities. It means better decisions about service changes and how money is spent. It reduces risks of legal challenges and improves safety, experience and performance. It helps address health inequalities by understanding communities' needs and developing solutions with them. It is about shaping a sustainable future for the NHS that meets people's needs and aspirations.

Senior leaders have a particular role in making this happen. They should ensure that they:

- understand and act on what matters to people
- demonstrate how their organisations meet met the legal duties to involve
- work with partners to put people are at the centre of everything they do
- ensure there are resources for their organisations to do this work effectively
- spend time personally listening to and understanding their local communities.

This guidance is structured around 10 principles. These have been developed from good practice already taking place, and will help organisations achieve the benefits of effective working with people and communities:

01
Centre decision-making and governance around the voices of people and communities.

02
Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions.

03
Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working.

04
Build relationships based on trust, especially with marginalised groups and those affected by health inequalities.

05
Work with Healthwatch and the voluntary, community and social enterprise sector.

06
Provide clear and accessible public information.

07
Use community-centred approaches that empower people and communities, making connections to what works already.

08
Have a range of ways for people and communities to take part in health and care services

09
Tackle system priorities and service reconfiguration in partnership with people and communities.

10
Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.

Applying the principles means taking a variety of approaches to working with people and communities, depending on context and objectives. Regardless of the approach used, organisations should start with existing insight about the needs and experiences of their communities, and work with partners that already have links to them. They should also consider taking community-centred approaches – ones that recognise the strengths within communities and that build on existing assets that support people's health.

To ensure legal duties are met, all approaches should be fair, proportionate and have regard to equalities, so that all relevant groups can take part. They should be designed to take account of the contexts that people live their lives in. This means building trust, safety, and shared understanding.

Integrated care gives an opportunity for the NHS to collaborate with partners on working with communities. This is both within the NHS (for example, commissioners and providers coordinating their involvement activities so they do not duplicate), and between the NHS and other partners – including local authorities, social care providers, Healthwatch and voluntary, community and social enterprise (VCSE) sector organisations that already have links to and knowledge of communities.

Terminology
In this guidance we talk about **working in partnership with people and communities**. We use this phrase to cover a variety of approaches such as engagement, participation, involvement, co-production and consultation. These terms often overlap, mean different things to different people, and sometimes have a technical or legal definition too.

By **people** we mean everyone of all ages, their representatives, relatives, and unpaid carers. This is inclusive of whether or not they use or access health and care services and support. **Communities** are groups of people that are interconnected, by where they live, how they identify or shared interests. They can exist at all levels, from neighbourhood to national, and be loosely or tightly defined by their members.

Community-centred approaches recognise that many of the factors that create health and wellbeing are at community level, including social connections, having a voice in local decisions, and addressing health inequalities.

We refer to **health and care systems** as all organisations working to improve people's physical and mental health, nationally and locally, including the NHS, local authorities and social care providers. We use the term **trusts** to refer to NHS trusts and NHS foundation trusts.

Integrated Care Systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services, and to improve the health of people who live and work in their area. Each ICS consists of an:

- **Integrated Care Board (ICB):** a statutory organisation that brings the NHS together locally to improve population health and care

- **Integrated Care Partnership (ICP):** a statutory committee (established by the ICB and relevant local authorities) that is a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population.

ICSs also include p**lace-based partnerships** and p**rovider collaboratives.** The King's Fund animation explains more about the new organisations in the NHS and how they can collaborate with partners to deliver joined-up care.

Guidance on Working in Partnership with People and Communities

1. Introduction

This new guidance sets the ambition and expectations for how Integrated Care Boards (ICBs), NHS trusts and foundation trusts should work in partnership with people and communities in this new collaborative environment. It is also adopted as policy by NHS England and will be useful for local authorities and other partners to understand the statutory duties on NHS England, ICBs and trusts.

Many colleagues across these organisations already recognise the value of working with people and communities, and the experiences and knowledge that they contribute to improving health and care services. People and communities have the skills and insight to transform how health and care is designed and delivered. Working with them as equal partners helps them take more control over their health and is an essential part of securing a sustainable NHS.

This guidance aims to spread effective practice across all systems by building on the expertise and experience that exists and approaches already being applied.[1] It provides practical advice and signposts to further information including training and resources. It also shares learning from areas where partnership is already making the vision a reality and makes clear the difference that working with people and communities makes.

The response to COVID-19 saw communities mobilise themselves to support family, friends and neighbours including those self-isolating and to encourage vaccine take-up; developing approaches that fitted local circumstances and needs[2]. Communities worked alongside health and care partners to find innovative solutions to new challenges[3]. There was agreement between communities and the organisations that provide services about the shared priorities. This led to joint working often with communities leading and systems responding to the needs and preferences voiced by people.

This learning should be transferred to help meet other challenges that health and care services face by listening to people and working with them to decide what will work best for them. The pandemic brought into sharp focus the disproportionate impact on certain population groups. A key part of how we address physical and mental health inequalities is to begin by listening to diverse communities and working with their knowledge, commitment and resources to improve access, experience and health outcomes.

[1] Community-centred public health: taking a whole system approach, Public Health England, January 2020; Health and wellbeing: a guide to community-centred approaches, Public Health England, February 2015.
[2] The community response to coronavirus (COVID-19), UK Health Security Agency, June 2020; Learning from the community response to COVID-19; how the NHS can support communities to keep people well, The Health Creation Alliance, April 2021.
[3] Unlocking the digital front door - keys to inclusive healthcare | National Voices May 2021

Who is this guidance for?

This is statutory guidance issued by:

- NHS England for ICBs under section 14Z51 of the National Health Service Act 2006 in relation to their 'public involvement' duty under section 14Z45
- the Secretary of State for Health and Social Care for NHS trusts and NHS foundation trusts under section 242(1G) in relation to their 'public involvement' duty under section 242(1B).

It replaces the 2017 statutory guidance for commissioners, the 2008 statutory guidance for trusts and the 2021 Implementation Guidance for ICSs.

As statutory guidance, this means that ICBs and trusts must have regard to this guidance. They must consciously consider the guidance and, where appropriate, be able to explain any substantial departure from it.

NHS England has its own 'public involvement' duty (section 13Q of the National Health Service Act 2006). It is NHS England's policy to have regard to this guidance in the same way that ICBs and trusts are required to as statutory guidance.

NHS England is also required under section 14Z59 to conduct a performance assessment of ICBs that must (amongst other things) include how well the ICB has discharged its public involvement duty.

While it is statutory guidance for the ICBs and trusts, it supports the vision of integrated care where organisations work in genuine partnership. It is therefore relevant to the entire health and care system.

NHS England	**Status:** Policy	**Public involvement duty:** NHS Act 2006, as amended by the Health and Care Act 2022
Integrated Care Board	**Status:** Statutory guidance	**Public involvement duty:** NHS Act 2006, as amended by the Health and Care Act 2022
NHS trust and foundation trust	**Status:** Statutory guidance	**Public involvement duty:** NHS Act 2006, as amended by the Health and Care Act 2022
Integrated Care System partners	**Status:** Good practice	**Public involvement duty:** N/A

For ICS partners it will be used by:

- **Integrated Care Partnerships (ICPs)** to help inform their strategies, during the development of which they must involve people
- **place-based partnerships** as a guide on how they involve people in decision-making processes and engage them on plans for change
- **provider collaboratives, clinical networks and Cancer Alliances,** as it supports working with people on improving whole care pathways across multiple places and systems
- health and care partners involved in **research**, as the guidance supports working with communities to identify research needs (both locally and across care pathways), and to be involved in shaping research studies that align with what matters to communities
- **Primary Care Networks** for their work at neighbourhood level with local communities, to understand local needs and reduce health inequalities.

It will also be of interest to other partners within health and care systems as good practice, including local authorities – in particular health overview and scrutiny committees (HOSCs), health and wellbeing boards (HWBs) and other local democratic structures – voluntary community and social enterprise (VCSE) sector organisations, social care providers, local Healthwatch and patient groups. Finally, it is relevant to people interested in how their NHS should work with them.

This guidance complements separate guidance on involving people in their own health and care.[4]

Setting the ambition

The ambition is for health and care systems to build positive, trusted and enduring relationships with communities to improve services, support and outcomes for people.

This means a health and care system that:

- listens more and broadcasts less
- undertakes engagement which is ongoing and iterative, not only when proposing changes to services
- is focussed on and responds to what matters to communities and prioritises hearing from people who have been marginalised and those who experience the worst health inequalities
- works with and through existing networks, community groups and other places where people identify and feel comfortable
- develops plans and strategies that are fully informed and understood by people and communities

[4] There are legal duties on involving people in their own health and care, covered in separate guidance. An update to this guidance will be published in 2022.

- learns from people and communities, using insight, data and a range of approaches to understand whether their needs are being met and what their priorities, ambitions and ideas are
- provides clear feedback about how people's involvement leads to improvement
- invests in different approaches to working with people and communities, enabling them to contribute meaningfully in ways that are safe and accessible for them
- shares power with communities so they have a greater say in how health services are shaped and can take responsibility to improving their health.

2. Legal duties and responsibilities

Public involvement legal duties

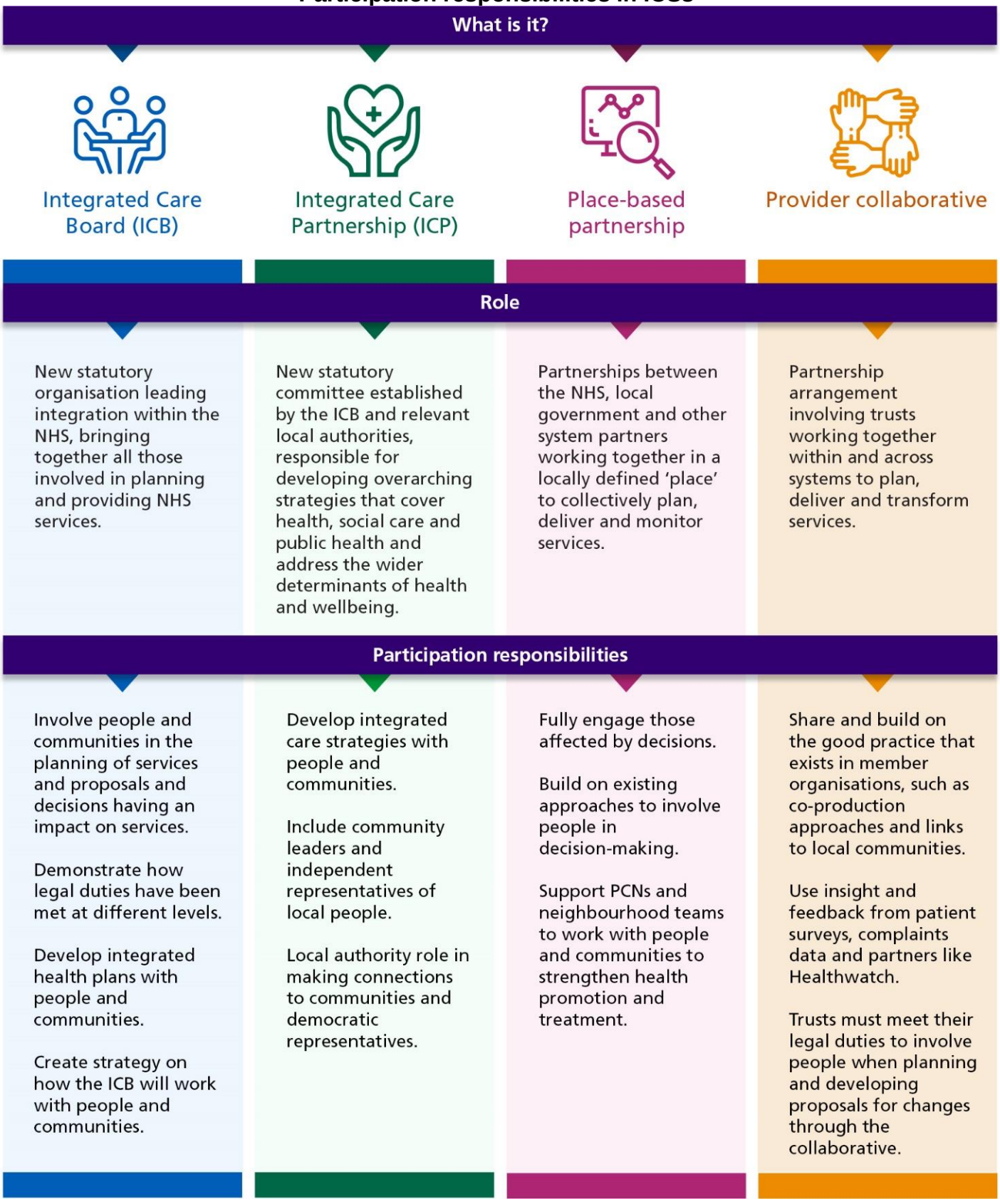
The legal duties on public involvement require organisations to make arrangements to secure that people are appropriately 'involved' in planning, proposals and decisions regarding NHS services.

Annex B provides the detail on these legal duties, when they are likely to apply and how they can be met. Key requirements of ICBs, trusts and NHS England include that they:

- assess the need for public involvement and plan and carry out involvement activity
- clearly document at all stages how involvement activity has informed decision-making and the rationale for decisions
- have systems to assure themselves that they are meeting their legal duty to involve and report on how they meet it in their annual reports.

ICPs, place-based partnerships and provider collaboratives also have specific responsibilities towards participation, summarised below. There are statutory requirements for ICBs and ICPs to produce strategies and plans for health and social care, each with minimum requirements for how people and communities should be involved (see Annex B).

Participation responsibilities in ICSs



The triple aim duty

NHS England, ICBs, NHS trusts and NHS foundation trusts are subject to the new ‘triple aim’ duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively). This requires these bodies to have regard to ‘all likely effects’ of their decisions in relation to three areas:

1. health and wellbeing for people, including its effects in relation to inequalities
2. quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services
3. the sustainable use of NHS resources.

Effective working with people and communities is essential to deliver the triple aim, as shown in the diagram below.

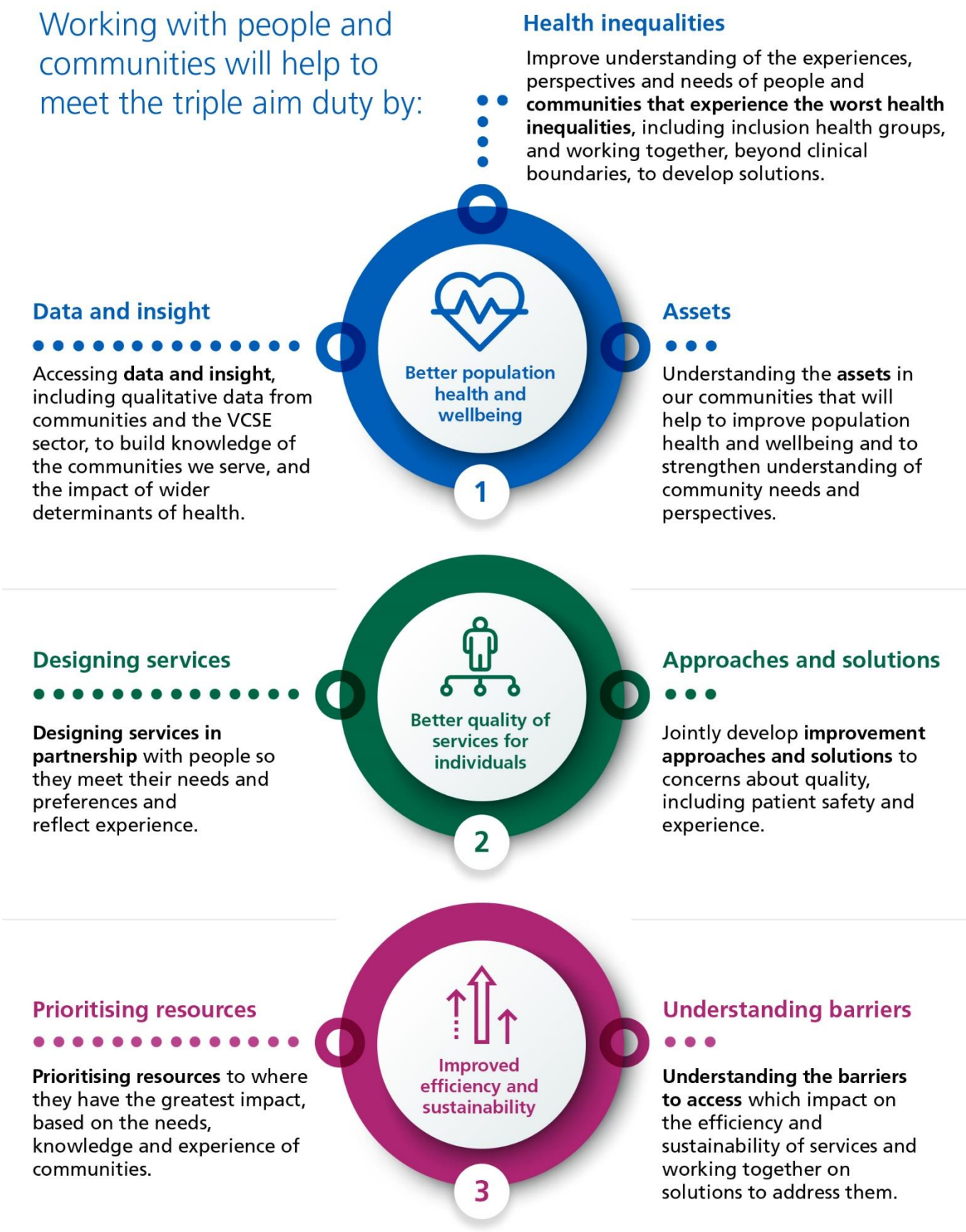
Other relevant legal duties

Effective working with people and communities will also inform and support organisations in meeting other legal duties:

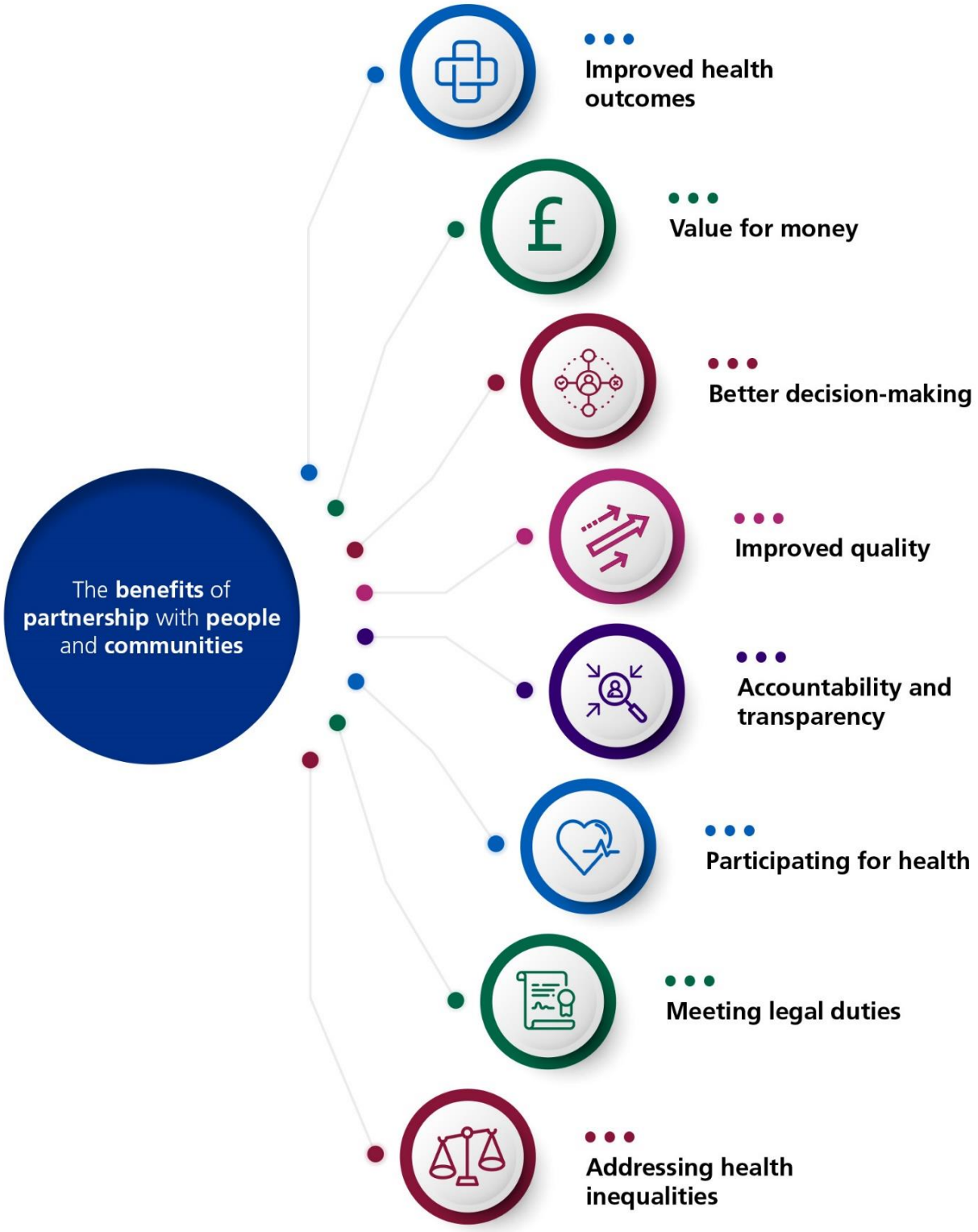
- *Equalities:* The Public Sector Equality Duty (PSED) of the Equality Act 2010
- *Health inequalities:* The National Health Services Act 2006
- *Social value:* Public Services (Social Value) Act 2012.

Annex B explains how working with people and communities can help meet these duties.

The triple aim duty and participation



3. Why work in partnership?



The benefits of partnership

Improved health outcomes
Working in partnership with people and communities creates a better chance of creating services that meet people's needs, improving their experience and outcomes. People have the knowledge, skills, experiences and connections services need to understand in order to support their physical and mental health. Partnership working contributes to defining 'shared outcomes' that meet the needs of their communities.[5] This is particularly relevant in the context of population health management and reducing health inequalities.

Value for money
Services that are designed with people and therefore effectively meet their needs are a better use of NHS resources. They improve health outcomes and reduce the need for further, additional care or treatment because a service did not meet their needs first time.

Better decision-making
We view the world through our own lens and that brings its own judgements and biases. Business cases and decision-making are improved when insight from local people is used alongside financial and clinical information to inform the case for change. Their insight can add practical weight and context to statistical data, and fill gaps through local intelligence and knowledge. Challenge from outside voices can promote innovative thinking which can lead to new solutions that would not have been considered had the decision only been made internally.

Improved quality
Partnership approaches mean that services can be designed and delivered more appropriately, because they are personalised to meet the needs and preferences of local people. Without insight from people who use, or may not use, services, it is impossible to raise the overall quality of services. It also improves safety, by ensuring people have a voice to raise problems which can be addressed early and consistently.

Accountability and transparency
The NHS Constitution states: 'The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff.' Organisations should be able to explain to people how decisions are made in relation to any proposal – and how their views have been taken onboard. Transparent decision-making, with people and communities involved in governance, helps make the NHS accountable to communities. Engaging meaningfully with local communities build public confidence and support as well as being able to demonstrate public support for proposals.

Participating for health
Being involved can reduce isolation, increase confidence and improve motivation towards wellbeing. Individuals' involvement in delivering services that are relevant to them and their community can lead to involvement at a service level and to more formal volunteering roles and employment in health and care sectors. It is well recognised that doing something for others and having a meaningful role in your local community supports

[5] Health and social care integration: joining up care for people, places and populations, DHSC, February 2022

mental health. Getting involved can be health creating – being part of a community and being in control is good for our health.

Meeting legal duties
Although this should not be the primary motivation, failure to meet the relevant legal duties risks legal challenge, with the substantial costs and delays that entails, and damage to relationships and trust and confidence between organisations, people and communities.

Reducing health inequalities

Joint solutions
Tackling the causes and consequences of health inequalities is a central priority for health and care systems. It is one that has been given new momentum by the disproportionate impact of the COVID-19 pandemic on those people and communities who already face the worst inequalities.[6]

Health inequalities can be reduced by jointly identifying solutions, developed in partnership with people using community-centred approaches. This builds on the approach of CORE20PLUS5 – a national framework that helps define the population groups in each system experiencing health inequalities. Hearing their experiences and understanding the barriers these groups face in accessing care and treatment is an important part of addressing unequal access to services. From there we can work with them to co-create community-centred solutions.

Focussing engagement on groups who have been marginalised and excluded helps tackle the inverse care law, whereby those with the most need for services are the least likely to receive them and least likely to feel safe to participate. By building engagement approaches that include people who are currently not well supported by existing services, systems can design models of care that meet the needs of all their communities and address inequalities. This includes recognising that some communities may require different approaches to meet their needs. Population groups facing the worst health inequalities are often the most disempowered, with the lowest levels of various markers for control, belonging and wellbeing. Working with the most marginalised groups needs to be based on building trust and connection as an important foundation for improving their health outcomes.

Collaborative approaches
The NHS cannot do this alone. Wider determinates of health – for example, poverty, discrimination, educational attainment, employment and housing – relate to barriers that the NHS by itself cannot overcome. Collaboration brings an opportunity to capture a holistic picture of inequalities and work with people and communities on joined up solutions. Local authorities and other partners are well placed to understand the social determinants of health and how they can be addressed together.

There is also an opportunity to share power and strengthen relationships with people that experience inequalities. They can be involved in agreeing ambitions, shared outcomes and plans to improve health outcomes through commissioning and service delivery. For

[6] COVID-19: review of disparities in risks and outcomes, Public Health England, June 2020.

example, they could work with the groups identified through CORE20PLUS5 to make decisions collaboratively on how to address their specific health and care needs. This helps ensure intended objectives are relevant, achievable, and based on skills, experiences and what really matters to the people they are intended to help. This means proactively seeking their participation and using approaches that enable diverse communities to contribute and take more control.

It is important to recognise that boosting the power of communities to make decisions and encouraging them to take more responsibility has a strong health creating effect. If the NHS can support people and communities to take more control, they will be helping to improve health and address inequalities.[7]

Building a culture of partnership

Leadership is vital to achieving these benefits. Communities and staff will look to system leaders to role model a culture of partnership, to demonstrate that their views are taken seriously and that they prioritise giving people a genuine part in decisions about how services are designed and delivered.[8] Leadership can be a joint endeavour, with leaders from systems and from within communities working together.

Collaborative and inclusive leadership means seeing participation as everybody's business and fundamental to meeting shared objectives. This means leadership teams that value participation as part of all their roles and seeking assurance that it is happening within their organisation, rather than being delegated to one individual who is accountable for ensuring it happens. This sets the tone for practitioners and communities to work, learn, and improve together. It creates the culture to enable staff to innovate and collaborate in new ways and gives them permission and autonomy to try things out, to learn and to celebrate success.

This requires a commitment for sufficient funding, resources, training and support to do so effectively, and allowing time to build trust and relationships. This will support working with all groups of people and communities, including those whose voices are not currently heard in a meaningful way.

Senior leaders and decision-makers will want to make sure that they understand and take action on what matters to people in the decisions that they are responsible for and to work with partners to really make sure that people are at the centre of everything they do. Spending time with local communities, listening to and building understanding about their experiences is essential. This visible leadership helps to unlock potential and demonstrates that working in partnership with people is everyone's business.

[7] NHS England will publish guidance on addressing health inequalities in 2022/23.
[8] Understanding integration: How to listen to and learn from people and communities, King's Fund, July 2021

4. Ten principles for working with people and communities

The guidance is based on ten principles that will help health and care organisations develop their ways of working with people and communities, depending on local circumstances and population health needs.

They are intended to be a golden thread running throughout systems, whether activity takes place within neighbourhoods, in places, across system geographies or nationally.

They have been developed from good practice already taking place and are intended to support existing approaches which may exist locally. They will form the basis of NHS England's assessment of how well ICBs meet their legal duties. However, they can be used by all organisations to develop effective ways of working in partnership.

1. Ensure people and communities have an active role in decision-making and governance

- Build the voices of people and communities into governance structures so that people are part of decision-making processes
- Recognise the collective responsibility at board level for upholding legal duties, bringing in lay perspectives but avoiding creating isolated, independent voices
- Make sure that boards and communities are assured that appropriate involvement with relevant groups has taken place (including those facing the worst health inequalities); and that this has an impact on decisions.
- Ensure that effective involvement is taking place at the appropriate level, including system, place and neighbourhood, and that there is a consistency and coordination of approaches
- Support people with the skills, knowledge and confidence to contribute effectively to decision-making and governance
- Make sure that senior leaders role model inclusive and collaborative ways of working.

Case study: Building a consistent approach to involvement across North West London ICS

In December 2019, North West London ICS launched the EPIC (Engage – Participate – Involve - Collaborate) programme to try to address some of the challenges around how it works with residents. A key strand of the programme was co-production of a future, best practice approach to resident involvement in the CCG and future ICS. Despite some very good practice, the public had not previously been involved systematically in shaping the ICS's work and many communities were not being effectively engaged. The ICS's approach now includes:

- **'Collaborative spaces'** – open meetings where health and care colleagues come together with people to discuss health and care issues
- **Outreach** with all our communities including **targeted involvement** of groups we have not successfully involved in the past
- **Lay partners** to sit on key programmes/workstreams as appropriate

This approach is assured via North West London's Involvement Charter.

2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions

- Take time to plan and budget for participation and start involving people as early as possible so that it informs options for change and subsequent decision-making
- Involve people and communities on a continual basis, as part of meaningful partnerships, rather than taking a stop-start approach when decisions are required. As a result, there will be much greater, ongoing awareness of the issues, barriers, assets and opportunities
- Be clear about the opportunity to influence decisions; what taking part can achieve; and what is out of scope
- Record and celebrate people's contributions and give feedback on the results of involvement, including changes, decisions made and what has not changed and why
- Keep people informed of changes that take place sometime after their involvement and maintain two-way dialogue so people are kept updated and can continue to contribute
- Take time to understand what works and what could be improved.

3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working

- Use data about the experiences and aspirations of people who use (and do not use) health and care services, care and support; and have clear approaches to using this information and insight to inform decision-making and quality governance

- Work with what is already known by partner organisations, from national and local data sources, and from previous engagement activities including those related to the wider determinants of health
- Share data with communities and seek their insight about what lies behind the trends and findings. Their narrative can help inform about the solutions to the problems that the data identifies
- Understand what other engagement might be taking place on a related topic and take partnership approaches where possible, benefiting from your combined assets. This will also help avoid 'consultation fatigue' amongst communities, by working together in an ongoing dialogue that is not limited by organisation boundaries
- Build on existing networks, forums and community activities to reach out to people rather than expecting them to come to you. Be curious and eager to listen; don't assume you know what people will say or what matters to them
- Involve people in designing evaluation frameworks and deciding what 'good' looks like, using measures of change that matter to them. Include evidence collection in engagement plans to demonstrate the impact that working with people and communities has had.

Case study: Community conversations on public mental health

Poor mental health is a major challenge facing London, and the prevalence of mental health problems is often much higher in the communities facing the deepest inequalities. Recognising this, in 2017/18 the Mental Health Foundation and Thrive LDN co-ordinated 17 community conversations across half of the city's boroughs, involving more than 1000 Londoners, with the aim of finding out how local systems could best implement a public mental health approach.

These conversations went far beyond the consultations that communities had previously seen on mental health services: as well as getting ideas for providing 'services when and where needed' they were designed to find ways of improving the determinants of mental health to enable prevention for everyone, early intervention for those at risk, and effective support for those who need it.

Evaluation of these conversations by the Mental Health Foundation found several ways that they tangibly influenced public mental health initiatives in the areas where they were held. For example:

- in Hackney, they brought together public health and planning teams around the design of a new leisure centre to ensure high quality community space
- in Enfield, the community conversation influenced the plans for a major regeneration, prompting greater focus on creating 'mentally healthier' places with better access to green and community space.

The community conversations also led to the development of a network of mental health champions across London and new job roles, including a specialist public mental health position and a voluntary sector liaison post.

More information on the process and results are in the Londoners Said and Londoners Did reports from the Mental Health Foundation.

4. Build relationships based on trust, especially with marginalised groups and those affected by inequalities

- Proactively seek participation from people who experience health inequalities and poorer health outcomes, connecting with trusted community leaders, organisations and networks to support this
- Consider how to include people who do not use services, whether because they do not meet their needs or are inaccessible, and reach out to build trust and conversations about what really matters to them
- Work with people and communities from the outset, taking time to build trust, listen and understand what their priorities are
- Be honest and realistic about what is in scope and where they can set the agenda for change
- Tailor your approach to engagement to include people in accessible and inclusive ways so you include those who have not taken part before. This includes recognising that some communities will not feel comfortable discussing their issues and needs within wider meetings, so may need bespoke approaches. They may need additional support to take part including reimbursements for their time
- When reporting on engagement activity, explain the needs and solutions for different communities rather than simply aggregating all data and feedback together. This also supports equality impact assessments.

Case study: Embedding Cultural Awareness in Maternity and Neonatal Care

For over 10 years, the East of England Local Government Association via the Strategic Migration Partnership has been delivering a wide range of engagement and integration projects with ethnic minority groups in the East of England.

They understand the challenges health and care staff can experience when supporting a wide range of culturally diverse and dynamic groups. This can include language barriers, a reluctance to engage with professionals and a mistrust of the NHS system because of past relationships with authorities in countries of origin. They also understand that for many ethnic minority groups, healthcare in the UK can be seen as confusing and often inaccessible due to a lack of appropriate information and a reliance on people having access to digital devices.

In response to the challenges faced by the healthcare professionals and ethnic minority groups, they have worked to create cultural awareness workshops, which are both effective and efficient at ensuring the development of sustainable maternity and neonatal care pathways for different groups across the region.

The workshops were an opportunity to identify engagement issues specific to the East of England and delivered by members and advocates of ethnic minority groups considered hard to engage with across the region, including LGBTQ+ groups, African groups, Orthodox Jewish groups, Gypsy and Traveller groups, Roma groups, South Asian groups, Eastern European groups, Asylum Seekers and Refugees.

5. Work with Healthwatch and the voluntary, community and social enterprise sector as key partners

- Build strong partnerships with Healthwatch and the VCSE sector to bring their knowledge and reach into local communities. Work with them to facilitate involvement from different groups and develop engagement activities
- Understand the various types of VCSE sector organisations in your area, from larger national charities to local user-led groups, their links to different communities and how the NHS can connect with them
- Recognise that resources can be limited and that organisations may need financial support and capacity building to take on partnership roles
- When commissioning other organisations to work with communities, ensure that decision-makers remain personally involved and hear directly what people or their representatives have to say.

6. Provide clear and accessible public information

- Develop information about plans that is easy to understand, reflecting the communication needs of local communities and testing information where possible
- Where accessible formats such as easy read and translations into other languages are used, these should be ready at the same time as other materials
- Providers of NHS care must meet their requirements under the Accessible Information Standard for the information and communication needs of people in their own care. The same principles can be applied for public information so that it is clear and easy to understand, for example, taking steps to ensure that people receive information which they can access and understand, and receive communication support if they need it
- Be open and transparent in the way you work, being clear about where decisions are made and the evidence base that informs them. Provide people with an honest picture of the health and care landscape, along with resource limitations and other relevant constraints. Where information must be kept confidential, explain why
- Make sure you describe how communities' priorities can influence decision-making, including how people have influenced research priorities or planning for future health care ambitions; and how people's views are considered. Also ensure that you regularly feedback to those who shared their views and others about the impact this has made
- Provide feedback in inclusive and accessible ways, that suit how people want or are able to receive it
- Make sure information on opportunities to get involved is clear and accessible and encourage a wide range of people to take part; including targeting information at particular communities who might traditionally not be involved.

7. **Use community-centred approaches that empower people and communities, making connections to what works already**

- Support and build on existing community assets, such as activities and venues which already bring people together such as faith communities, schools, community centres, local businesses and community-centred services, including those that involve link workers, community champions and peer support volunteers.
- Use approaches such as Asset Based Community Development and community-led research to understand how these assets can support people's physical and mental health. Link with local authorities where they already have approaches in place and consider jointly funding
- Build trust and meaningful relationships in a way that people feel comfortable sharing ideas about opportunities, solutions and barriers. Design, deliver and evaluate solutions together that are built around existing community infrastructure
- Recognise existing volunteering and social action that supports physical and mental health and create the sustainable conditions for them to grow (for example, by providing places to meet, small grants or community development support).

Case study: working at neighbourhood level in Morecambe Bay to reduce health inequalities

This project was designed to explore what access issues and inequalities were being experienced by a range of health inclusion and other key groups. It started with the Primary Care Networks (PCNs) using population health management approach to identify groups of patients that may experience health inequalities. There was then an asset mapping process with each PCN group supported to identify local people and organisations that could potentially support with the work. Next, engagement took place with groups of patients and local people including young people, adults with learning disabilities and their carers and workers from migrant communities. A workshop supported people to plan how they would share what they had found and what they planned to do next with the communities they had focused on.

The PCNs have changed their services based on what they found through this work. For example, for people with learning disabilities, annual learning disability health checks are being reassessed to improve uptake and providing care in a way that makes patients feel comfortable, cared for and listened to.

Overall, participants report feeling more confident around how to engage with their local communities, and how the process can be applied to other groups experiencing health inequalities to inform other improvement initiatives.

It was undertaken by Morecambe Bay CCG, North Cumbria ICS, Morecambe Bay PCNs, Co-create and other local partners.

8. Have a range of ways for people and communities to take part in health and care services

- Choose the ways of working with people and communities depending on the specific circumstances, ensuring they are relevant, fair and proportionate. Use a combination of approaches where appropriate. The approach that gives the greatest opportunity for people to take part in decision-making should be used that is suitable for the situation.
- Design activities to take place at times and in ways that encourages participation and consider the support people may need to take part, including reimbursements for their time and expenses
- Recognise that people are busy and have other priorities such as work and caring responsibilities. Ensure that there are different ways to get involved with varying levels of commitment
- Include approaches such as co-production where professionals share power and have an equal partnership with people to plan, design and evaluate together
- Using different approaches can bring in a wider range of voices beyond those who already contribute and ensure findings are more representative of the whole population
- Have clear, achievable and actionable goals that can comprise both quick wins to inspire people, as well as longer term goals that may be more challenging to achieve but may ultimately be more transformative
- Where decisions are genuinely co-produced, then people with lived experience work as equal partners alongside health and care professionals (those with learnt experience), jointly agreeing issues and developing solutions.

Case study: Co-producing a new model of community mental health support

In Somerset, the NHS, local authority and VCSE sector partners have worked with people with lived experience of mental illness to co-produce community mental health services. The involvement of experts by experience as equal partners has been embedded across the programme from the beginning, and the lived experience perspective they represent has influenced key decisions about the service. They co-designed the Open Mental Health model, whereby 24/7 support is available to adults in Somerset who are experiencing mental health issues. Provision is offered through an alliance of provider organisations from the VCSE sector, NHS and social care working in partnership. Experts by experience have an ongoing role as partners in the governance, continuous development and evaluation of the service.

There is more about Open Mental Health on the Rethink Mental Illness website.

9. **Tackle system priorities and service reconfiguration in partnership with people and communities**

- People who use health and care services have knowledge and experience that can be used to help make services better. They can put forward cost-effective and sustainable ideas that clinicians and managers have not thought of, which inform planning for future healthcare development
- Communities often have longer memories than the professionals who may change roles and move. Understanding the local history of change that communities have experienced helps to learn and build trust with people
- When people better understand the need for change, and have been involved in developing the options, they are more likely to advocate the positive outcomes and involve others in the process.

10. **Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.**

- Collaborate with partners across your system to build on their skills, knowledge, connections and networks
- Reduce duplication by understanding what is already known and what has already been asked, before designing the approach to engagement.
- Learn from approaches taken elsewhere in the country and how they can be adapted and applied locally
- Plan together across systems so that partnership work with people and communities is co-ordinated, making the most of partners' skills and networks.

Annex A: Implementation

A1. Different ways of working with people and communities

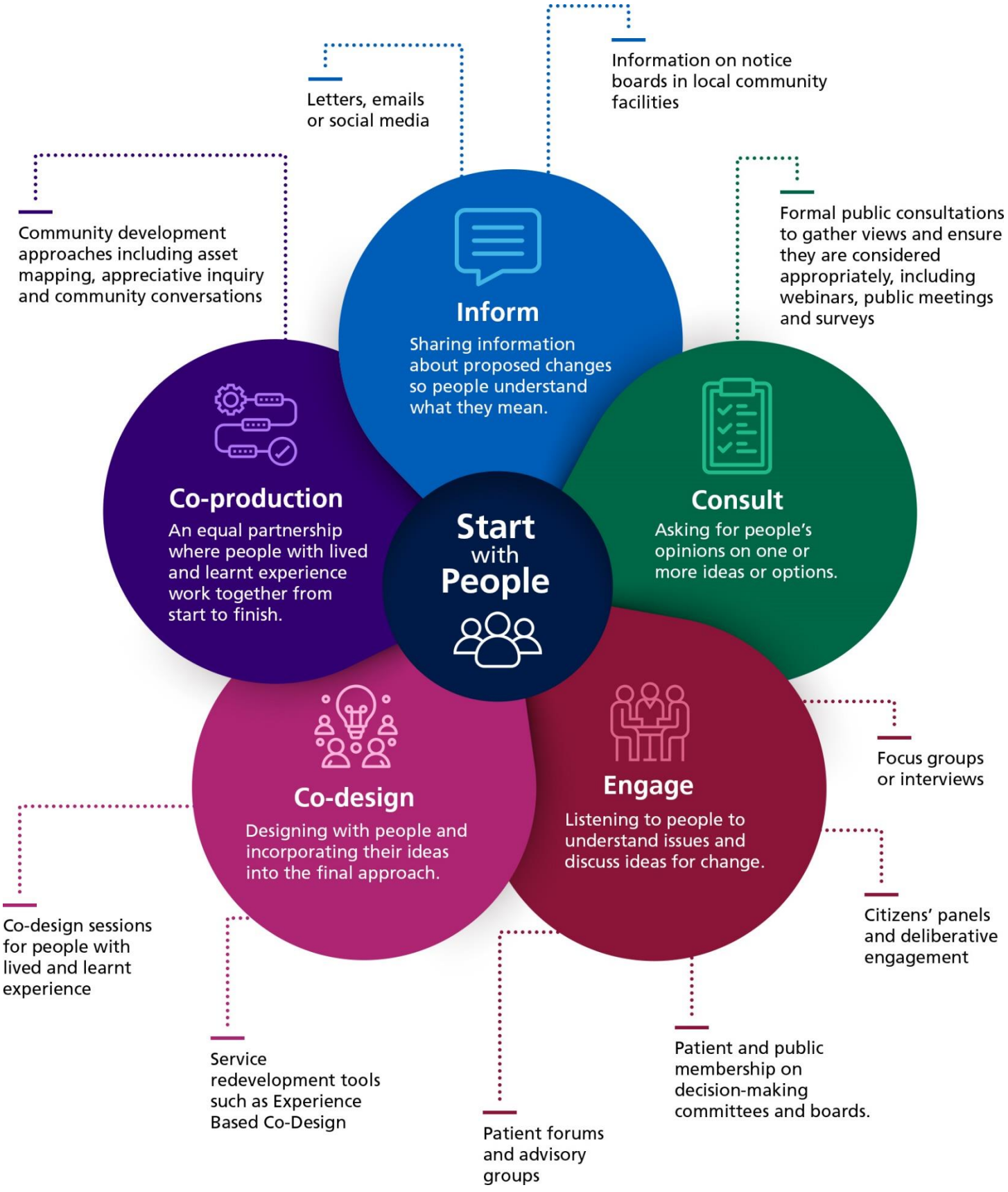
This chapter sets out a variety of approaches to working with people and communities however there is no ‘one size fits all’. The options for doing so will vary depending on the context and objectives, and there needs to be flexibility depending on the aims and scale of the programme.

A blended approach can also work well, with different approaches and ways of working used at different stages of a project to build a more detailed picture of what matters to people and what improvements can be made.

Some of the main ways to work with people are set out below. They each offer different levels of involvement, from sharing information through to more extensive ways of working such as co-design and co-production, where there is a greater opportunity for people to have influence. As a general principle, partnership should be achieved by using the most effective approach (or combination of approaches) as is feasible and suitable in any given situation.

Starting with people means going to the neighbourhoods and places where they already are and begin by listening to them about their priorities. From this we can design approaches that should ensure relevant communities can take part, recognising that different approaches work better for different groups.

Different ways of working with people and communities



For all the approaches used, there are three main pitfalls to avoid:

1. ***Tick box exercises.*** *Involvement is not an obstacle to overcome on the way to achieving a predetermined outcome. Any perception that it is tokenistic or that a strategy or service change has not been informed by insight from the public, will not only undermine trust, it is unlikely to be supported at local, regional or national level.*

2. ***Unrealistic timescales.*** *Service design and service changes should be planned to achievable timescales that allow for early, ongoing and effective public involvement, including careful consideration and discussion of the views expressed by people and communities.*

3. ***Limiting public dialogue to service change proposals.*** *While consultations necessarily focus on the proposals being consulted on, involvement should not only take place when a system wants to make changes – it should be part of how every system operates, with insights from community conversations informing and driving policy decisions. Systems should be in regular dialogue with people and communities; enabling them to also influence the agenda.*

Case study: Northern Cancer Alliance's work with communities in the recovery of urgent cancer referrals

The COVID-19 pandemic had a dramatic effect on the rate of cancer referrals across England. At the start of the pandemic the Northern Cancer Alliance saw referral rates across the region drop to 40.9% of pre-pandemic levels (April 2020). The Alliance decided to build on the national 'Help Us to Help You' campaign with locally produced material. This local campaign focussed on health inequalities by focussing on specific tumour groups and communities where recovery levels were slowest.

Key to all aspects of the Northern Cancer Alliance work plan is the effective involvement of the public. The Alliance value to '*always involve the right people at the right time'* was a fundamental aspect of the design and delivery of the campaign. With a focus on health inequalities, the Cancer Alliance brought together the Alliance Lay Representatives, people with lived experience, the Be Cancer Aware team and community groups to co-produce the campaign.

The campaign produced short films made by people with lived experience of cancer, people with a learning disability and people from minority ethnic groups in different languages. There was also patient information and campaign webpages produced by the Northern Cancer Alliance Lay Representatives.

To reach as many people as possible, the campaign worked with community assets, for example, by distributing leaflets, posters and magazines via food banks and other venues in the most deprived areas across the region. This element of the campaign was supported by local community organisations who already had links to wider groups of people and the Alliance Cancer Community Awareness Workers. As a result, the campaign contributed to a recovery of urgent cancer referrals.

Existing sources of feedback and insight

The starting point for any involvement is to consider existing sources of insight about the needs and experiences of different groups of people – what do you already know, what have people already told you? A review of existing information can save time and money and point to gaps in insight, while also avoiding asking people to repeat themselves. This helps to ensure that involvement is focused, meaningful and avoids duplication. This may be information held by partner organisations, including patient feedback, complaints, needs assessments and insights collected during previous activities. Consider whether the context of this previous work has changed significantly and when it took place to understand whether it is still relevant.

Involving partners in the planning process helps identify what is already known and also where the gaps are. Some people, such as those in inclusion health groups (see next chapter) and others who face social exclusion, may be systematically missed in feedback, qualitative and quantitative data sources. For example, if existing ways to give feedback are not accessible for people with learning disabilities, then their views are more likely to be missing.

One source of insight into population health needs are the intelligence functions that ICSs are building. These are system-wide, multi-disciplinary collaborations which share data and provide analytical support to help understand their local contexts. A key purpose of the intelligence function will be to support a population health management approach to care, including by pooling information and data held by partners on a local population's health and care needs, such as granular intelligence on inequalities across different population groups.[9] Intelligence functions should work with patient experience and engagement colleagues to ensure that qualitative and quantitative insights about the population are informing the interpretation of other analyses and are given equal weight in decision-making. Contextualising this intelligence with people and communities is essential and needs to be undertaken in sensitive and accessible ways.

ICBs and trusts can work in partnership with local authorities (in particular local health scrutiny functions and public health, social care and housing teams), other ICS partners and local communities to share insight and develop a detailed understanding of population health needs. A combination of national data tools, insight collected by partners and local engagement can be used to understand what works for different communities. Combined with insights drawn from the community, data can support primary care and neighbourhood teams to increase uptake of preventative services while also tackling health inequalities by identifying those groups that may currently be underserved.[10] One approach some ICSs are taking is to set up a network of engagement colleagues across partner organisations to share insight and coordinate engagement (see case study below).

[9] See NHS England resources for more on population health management

[10] Next steps for integrating primary care: Fuller Stocktake report, NHS England, May 2022

Examples of insight and feedback sources:

- National patient surveys
- Friends and Family Test
- Local surveys and engagement by the NHS and local authorities
- Social media and review websites
- Local Healthwatch reports and Healthwatch England national reports
- Intelligence from the VCSE sector and local authorities
- Care Quality Commission (CQC) reviews, surveys and reports
- Patient Participation Groups (PPGs)
- Complaints and compliments
- Patient Experience Library
- Patient Safety Specialists
- Patient experience discussions at System Quality Groups
- Staff feedback including their own views
- Mapping of previous consultation and engagement activities including those by partner organisations
- Local Health Profiles
- ICS intelligence functions
- Local authority reports including Director of Public Health annual report, joint strategic needs assessment and joint health and wellbeing strategy and reviews by scrutiny committees

Case study: System Insight Group and Patient and Public Insight Library at Derby and Derbyshire ICS

During the early stages of COVID-19, partner organisations within the Derby and Derbyshire ICS wanted to gather insights on how people were experiencing the pandemic and how it affected their lives. Residents in Derby and Derbyshire began to get inundated with separate requests to share their experiences and fill in surveys.

To avoid duplication, these efforts needed to be co-ordinated, so the ICS set up a System Insight Group, bringing together patient and public experience and engagement leads from NHS trusts, the local authorities and the VCSE sector. Its vision is to develop a culture of making insight-led decisions across the ICS. Insight could be from evidence, research, reflections, conversations, observations, and from any number of different sources. The aim of the System Insight Group was to link the types of insight together.

The System Insight Group has developed a Patient and Public Insight Library set up on the NHS Future platform. New insight is being added to the library on a regular basis, and any member of staff can join. The aim is to assist decision-makers to find current insight in the system, with the aim of avoiding duplication and consultation fatigue.

The group has also produced a report on Remote Access to Health and Care during the pandemic. The report pulled together a large proportion of insight and summarised the key themes. The report is being used by ICS partners when making decisions about the recovery of services, meaning that additional engagement will only be needed if it fills a gap in insight within the report. A digital inclusion checklist was developed using the report and will be promoted to all service providers to ensure good practice in remote access implementation programmes.

Patient Participation Groups

It is a contractual requirement for every GP practice to have a Patient Participation Group (PPG). The form a PPG takes is not specified and this provides flexibility for practices to work in partnership with people and communities in ways that best support the practice populations. While the PPG is one of the main ways General Practice have used to engage with patients, it should not be the only approach if it does not reach diverse groups, people with the worst health inequalities or people not accessing the services. These groups are more likely to be hesitant about getting involved in traditional PPG models. However, PPGs do not need to be limited to the meeting style group which has become the most common. PCNs and Practices need to consider if the form of the present PPG supports people to take part or if other approaches are also needed to widen participation. This animation has some useful principles to use as a starting point to think through how practices currently hear the voice of their community and where the gaps are. While the main focus of a PPG is on making improvements to its local practice, their insight and experiences can be relevant to its PCN. PCNs can also learn from their practices' PPGs about how different structures can effectively engage diverse groups.

Co-production

Co-production is a way to involve people by sharing power with them. The Coalition for Personalised Care defines co-production as:

> *'a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.'*

Co-production can be used strategically, to design services, make quality improvements, design and undertake research and innovation, and develop participatory budgets. At an individual level, it is the cornerstone of person-centred care such as personal health budgets. As well as being well suited to designing services in places and neighbourhoods, it can also be applied strategically for systems and national organisations.

The starting principle is that people with 'lived experience' are often best placed to advise on what support and services will make a positive difference to their lives. When done well, co-production helps to ground discussions and to maintain a person-centred perspective.

Where partnerships are genuinely equal, professionals are comfortable with not having the answers and with sharing resources, responsibility and power. This can be difficult to achieve without cultural change and support for staff and people to share power and take on co-production roles.

The Coalition for Personalised Care sets out the values and practical steps to make this ambition a reality. These includes:

- senior leaders supporting co-production through culture and behaviour
- identifying areas of work where co-production can have a genuine impact and involving people at the earliest stages
- investing in training and development so that people with lived experience and people working in the system know what co-production is and how to work in ways that enable this.

Case study: Building people's skills and knowledge to take part in co-production

The Peer Leadership Development Programme was launched in 2014 by NHS England with the purpose of enabling people with lived experience to develop their knowledge, skills and confidence to co-produce. Over 200 peer leaders have now been trained.

The programme provides people with an opportunity to learn about how the health and care system works, about local and national policy and about how to share good information. It also teaches about change management theory and communication styles and preferences, and how people can use their personal story to create a narrative for change. This programme enables people with lived experience to access up-to-date information and support, in the same way that people working in the health and care system do. This ultimately enables people with lived experience to co-produce on a level playing field.

Case study: The difference made to the NHS England Musculoskeletal Services (MSK) programme by the Musculoskeletal Lived Experience Group (MSK LEG)

The first COVID-19 pandemic lockdown had a devastating effect on the provision of Musculoskeletal Services (MSK) services. Face-to-face consultations became a rarity, replaced by telephone and video consultations. MSK clinicians had to quickly learn new skills to assess and treat patients in these unfamiliar formats. The number of patients treated by MSK clinicians was significantly reduced as therapists were re-deployed to care for COVID patients.

It was quickly clear that going forward MSK services would need to be remodelled, not only to cope with pandemic times, but also to move into the future. The pandemic created challenges but also opportunities for new and better MSK services.

For such large-scale re-modelling to be successful it was evident that all partners would need to play a part in the development process including, perhaps most importantly, people using the services and their carers. Without their involvement it could easily result in services that people didn't want or were not sufficiently accessible to them.

In June 2020, a MSK Recovery Group was established with lived experience partners alongside healthcare professionals. The intention was to work together collaboratively to assist with restoring and improving MSK services in the wake of the pandemic lockdowns. It evolved into MSK Lived Experience Group (MSK LEG). Each member of the new MSK LEG has experience of a relevant MSK condition and were rigorously interviewed and appointed after an open and accessible selection process.

MSK LEG have already co-produced its own terms of reference and engaged in providing feedback on various MSK pieces of work. The group have helped shape the evolution of the #BestMSKHealth Collaborative programme and some members have presented alongside the National Clinical Director and various MSK clinicians to a range of audiences at events. The MSK LEG team has been developed from strong principles of co-production and has already made a difference to the recovery and advancement of MSK services throughout the UK.

Community-centred approaches

Community-centred approaches build on existing assets to support communities to take more control over their lives and their areas. The diagram below shows the different types of assets that can contribute to creating health. These approaches (which include community development, asset and strength-based approaches) help identify the issues that matter to local people and support them in tackling them, working with the relevant public sector organisations.

Adapted from: Health matters: community-centred approaches for health and wellbeing, Public Health England, 2018.

Recognising assets rather than deficits is an important aspect of how to tackle health inequalities. It builds on strengths and ensures that health action co-produced between communities and services so that it effectively meets local needs. Identifying community assets also reduces the possibility that new interventions inadvertently override what already works well or are not fully used because people still defer to preferred and trusted community initiatives.

This can require a shift in how health services view their communities and, like co-production, requires leadership and support to make a reality. It can need time and

sustained effort before communities can take collective control. Asset based approaches are already well established in parts of local authorities and social care so there may be opportunities to learn from local authority partners.[11]

People often relate closely to their neighbourhood where links between communities and services can be strongest. Neighbourhoods contain a wide range of roles which work closely with their communities including community nurses, GPs, pharmacists, community and mental health teams, Social Prescribing Link Workers, social workers, housing workers and VCSE sector organisations. There are also community-led services, such as peer support workers and community champions whose roles are designed to address local needs and health inequalities.

Primary care networks that are most effective in improving population health and tackling health inequalities are those that work in partnership with their people and communities and local authority colleagues.[12] This includes using co-production to work with marginalised groups to break down barriers to accessing healthcare. In some neighbourhoods general practice is the hub through which many relationships are built between the community and the health and care system. In other neighbourhoods, partnerships are led by others, so it is important that health supports and builds on these existing networks rather than reinventing something new. There is an opportunity to leverage the knowledge and expertise of different workforce groups, including general practice, housing, policing and schools about the concerns and priorities of their communities, including its most vulnerable members whose voices are less likely to be heard.

Communities organise themselves in many ways and understanding where and how they do this is crucial to reaching and hearing diverse voices. An integral part of building a system-wide approach to involvement is to start at neighbourhood level with understanding what matters to people's health and the assets they have. It means that engagement should start with where people are already and aggregate findings to make the links to wider geographies.

Community-centred approaches help understand the specific local context where people live their lives and so design more integrated and preventative interventions that are tailored to local needs. These early public physical and mental health responses can prevent the need for acute services. These can be co-delivered by communities, employing local people and making the best use of the assets in each neighbourhood. This boosts the power of communities to take responsibility and set an agenda for change which has a strong health creating effect.

While for many people their community is at the level of neighbourhood, they may also belong to wider communities. For example, as a member of a national support group for a rare condition, where peers help each other to understand treatment options.

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[11] Evidence for strengths and asset-based outcomes, Social Care Institute of Excellence, August 2019

[12] Next steps for integrating primary care: Fuller Stocktake report, NHS England, May 2022; Health Creation: How can Primary Care Networks succeed in reducing health inequalities? The Health Creation Alliance, February 2020.

Case Study: Local Area Coordination in Derby

Since 2011, Derby City Council and its system partners have been developing an evidence-led approach called Local Area Coordination. They work alongside other areas in England and Wales who have come together to form the Local Area Coordination Network (supported and convened by Community Catalysts CIC). Local Area Coordination sees 'Local Area Coordinators' working closely alongside people, families and communities at a hyperlocal level with populations of around 8,000-10,000. Rooted in community, Local Area Coordinators take the time to build and nurture supportive relationships and partnerships with people and families.

Many of the people they are alongside have pressing concerns around their health and wellbeing. With no eligibility criteria, referral pathway or barriers to access, Local Area Coordinators across Derby can help people identify and build on their strengths and find practical, local (ideally non-service) solutions to any barriers that are preventing them from achieving good lives and making their contribution.

Through a dedicated 'Custodian Group' of system leaders, the approach is offering the Derby system rich insights into all aspects of people and community life including things that need to change. It also provides greater opportunities for reducing siloes, promoting working together and ongoing co-production and collaboration with local people around what good health and wellbeing really looks like and means.

Recently Local Area Coordination Derby has received investment from health programme partner "Team Up" (Derbyshire / Derby). Team Up is an ambitious programme in that aims to create one team across health and social care who see all housebound patients in a neighbourhood. This accounts for 29 practices across five PCNs serving a population of almost 400,000. The investment represents the growing recognition in the value of Local Area Coordination, not least in how it helps areas think and view patient and public involvement through a very different lens.

You can find more about Local Area Coordination here www.lacnetwork.org

A2. Key considerations for all approaches

While the approaches to working with people and communities depend on the specific context, there are some universal considerations that apply. These help meet the legal duties and ensure that people are supported to take part safely.

Fair and proportionate approaches

Whichever approach is taken, it needs to be fair and proportionate. Judgement is needed and it is not an area where definitive advice can be offered without knowledge of the specific circumstances. Where staff need to make a particularly complex or potentially contentious judgement, they may wish to consider seeking legal advice.

The courts have established guiding principles for what constitutes a fair consultation exercise, known as the Gunning principles:

- consultation must take place when the proposal is still at a formative stage
- sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response
- adequate time must be given for consideration and response
- the product of consultation must be conscientiously taken into account.

For more information, see Annex B5. These four principles relate to formal consultation but can be informative for other approaches.

The approach should also be proportionate. NHS organisations need to meet their duties to involve the public alongside their duties to act effectively, efficiently and economically and make sustainable use of NHS resources.

Staff will need to consider the impact of proposals on the different groups of people who may be affected. Generally, the greater the extent of changes and number of people affected, the greater the level of activity that is likely to be necessary. However, the nature and extent of public involvement required will always depend on the specific circumstances.

Decisions in urgent situations

In an urgent situation, it may be necessary to consider the duty to involve the public alongside the public interest in maintaining continuity of care and protecting the health, safety or welfare of patients or staff.

It will only be reasonable to justify carrying out a limited (or no) public involvement exercise on grounds of urgency when the lack of time was genuinely caused by an urgent situation or where there is a genuine risk to the health, safety or welfare of patients or staff. These can arise from staff shortages, estate issues or other causes. It does not permit commissioners or providers to leave public involvement until the last moment without enough time to carry out a fair and proportionate exercise, when the public could and should have been involved earlier or to a greater extent.

Where urgent changes are made on a temporary basis, the legal duties still apply if organisations subsequently consider whether to make them permanent. This equally applies when changes were introduced because of the COVID-19 pandemic; public involvement should be undertaken if there are plans to make them permanent.

ICBs, Provider collaboratives and Trusts are encouraged to maintain an open and ongoing dialogue with ICP members and Health Overview and Scrutiny Committees on the services it regards as at risk and the actions it may need to take in order to maintain patient and staff safety. This can fulfil a valuable function in anticipating and evaluating the impact on patients of urgent changes made in these circumstances and ensuring that health inequalities are not increased. Of course, organisations that have in place ongoing mechanisms of working with people and communities will be in a much better position to undertake rapid engagement as an interim measure.

Equality considerations

Public authorities including ICBs, trusts and NHS England are required to comply with the public sector equality duty of the Equality Act 2010. When it comes to proposals for changes to services, carrying out an equality and health inequality impact assessment can help identify people who experience the greatest health inequalities, including socio-economic groups and those people with protected characteristics under the Equality Act 2010 who may be affected by a particular plan or decision.

The Health Equity Assessment Tool can also help identify what action needs to be taken to reduce health inequalities and promote equality and inclusion.

These can be used alongside the Equality Delivery System for the NHS, a framework to help local NHS organisations, in discussion with local partners including local communities, to review and improve their performance for people who share protected characteristics.

Approaches to working with people should be designed to include these groups and planned to ensure that they are fair and equitable. Involvement plans should consider how to include all groups affected by proposals for changes to services and prioritise hearing from those affected by the greatest inequalities. In practical terms this means recognising that not every type of involvement works for everyone and that there can be additional

complexities to work effectively with some groups, so you may have to carry out a range of activities. This can mean:

- using accessible venues, making reasonable adjustments or specific effort to ensure disabled people, autistic people and people with a learning disability can participate
- working with peer support workers to facilitate the involvement of people who may be struggling with their mental health
- targeting resources and approaches at ethnic minority groups to provide the additional support that some of their members will need because of the health disparities that they experience
- recognising that deprivation and poverty can prevent people taking part in activities unless financial support and resources are in place that enable their involvement
- considering health literacy levels and language. Content should be relatable rather than using NHS terms and acronyms. Jargon can be a barrier for everyone
- accounting for digital literacy and access to digital systems in areas of socioeconomic deprivation
- building people's knowledge of how different parts of the health and care system fit together and where their input will make a difference. People will be at different levels of understanding about the NHS structures.

Auditing and monitoring the participation of certain groups, for example in events and formal governance roles, should be undertaken. This will help identify any gaps in engagement requiring attention; and supports staff to promote the involvement of people who are more reflective of the population in question.

Whilst the Equality Act refers specifically to the protected characteristics, there are also other communities such as inclusion health groups that should be considered and included within engagement.

Inclusion Health Groups

These groups often experience the worst health inequalities through being at risk or living with extremely poor health because of poverty, marginalisation, multi-morbidity and social exclusion, and further impacted by discrimination and stigmatisation, and are not consistently accounted for in electronic records (such as healthcare databases). These can overlap with protected characteristic groups. These are any socially excluded population including, but not limited to:

- Gypsies, Roma, Travellers, Showmen and Liveaboard Boaters
- people experiencing homelessness
- people experiencing alcohol and/or drug dependence
- sex workers
- vulnerable migrants and refugees
  young carers
- victims of modern slavery
- people in contact with the criminal justice system.

There are other groups that experience barriers to accessing services, like people with a learning disability and autistic people, and people with severe mental illness. They can also belong to inclusion health groups.

It is essential to understand the barriers that the system inadvertently creates to the involvement of inclusion health groups. Approaches should be developed in partnership with trusted organisations and people with lived experience and seek to ensure that involvement means that people's voices are heard and understood. These may be national organisations where there is not the local expertise of working with specific groups. Approaches must be trauma informed (see box below), culturally aware and provide a psychologically informed environment for people to take part safely.

PCNs can use a self-assessment tool to assess their engagement with inclusion health groups. Further guidance on inclusion health is here.

Case study: Making sure vulnerable groups are not left behind

To support the COVID-19 vaccine rollout, Bury Council and CCG worked with its PCNs, Healthwatch and VCSE sector organisations to make sure vulnerable groups did not get left behind. They focussed on proactive outreach to groups which the vaccine data, equality impact assessment and community insight showed were at risk of low uptake. This included Gypsy, Roma, Travellers, people experiencing homelessness and people with disabilities.

The partners worked together to engage these groups to see what the potential problems were, making use of their existing links with the communities. For example, the local authority team that works with Gypsy, Roma and Travelling people visited traveller sites to discuss what the issues were.

The response to COVID-19 and delivery of the vaccination programme has been a single endeavour between the council and NHS in partnership with the wider system, for example by working together to identify locations for vaccination centres and pop-up clinics that would meet their different communities' needs.

More information is here.

The impact of wider experiences

Approaches to involvement should be designed to take account of the contexts that people live their lives in and should recognise that everyone experiences health services differently. It should start from a position of building trust, safety, and shared understanding.

This means recognising and reflecting the wider lived experiences of the people we work with and how this can affect how they participate. We should also involve people and communities in a way that considers how social determinants (such as racism, stigma,

discrimination, poverty, access to greenspace and healthy food, poor housing, employment and education) affect physical and mental health. It means recognising intersectionality – that people are affected by several overlapping characteristics and experiences. They can face multiple sources of exclusion, discrimination and disadvantage, which will affect how they want to participate and their perceptions of health and care services.

It is also important to consider that previous involvement experiences, both good and bad, can affect how someone wants to be involved. For example, a bad hospital appointment where someone feels like they have not been listened to, could influence how they respond to invitations to get involved. These things may not seem directly relevant to the conversation you want to have but can matter a lot to those you are wanting to engage.

There is a responsibility to keep people who get involved safe. Being asked repeatedly to go back over bad or even traumatic experiences so professionals can learn how to improve services, will cause distress and increase lack of trust. One way to keep people safe is not to create isolated positions of 'lay representation' which can burden people with the responsibility of bringing a public perspective to a large group of professionals. Instead it can be better to work with groups who can continue to support each other outside of meetings and help each other to take part effectively. Depending on the context, it may be necessary to arrange therapeutic support at activities and afterwards.

Trauma informed approaches

Working with people and communities should start from a position of building trust, physical and psychological safety, and shared understanding. It acknowledges what may be difficult. Trauma informed approaches are often partnership based, working with people and organisations that are trusted, well informed and specifically trained. VCSE sector organisations can have a particular role to work with people who have often experienced significant trauma in their life or who have been excluded by society. Working with community leaders, experts by experience and others who already hold people's trust is often a more appropriate way of reaching people. Acknowledging and validating people's previous and current negative experiences are a key part of this, alongside building shared understanding and authentic relationships.

West Yorkshire Health and Care Partnership has collated resources on trauma informed approaches.

Case study: Improving engagement through online communities

With the move to online working during the pandemic, Shine Cancer Support found that this enabled them to reach people who would not necessarily have engaged with their services or community previously as physical barriers no longer existed. For example, attending in-person retreats was not possible for some due to their treatment, their physical health, or the travel time.

During the pandemic Shine developed several online programmes with shorter sessions over several weeks that enabled people from across the country and at different stages of their treatment to attend at the same time.

Through these programmes people developed strong peer support, shared information and participated in a community that could support them. This has been particularly important for young adults with incurable cancer who are increasing in number but less likely to find someone physically nearby who shares a similar experience. They have been brought together virtually through the Shine Circles programme and they usually continue their support and sharing via WhatsApp groups after the programme ends.

These and other online support groups show how people get information and support for their health and from communities that exist at different levels.

Supporting people to take part

It is important to have a consistent approach to recruiting, training and supporting the range of people who get involved in different roles. This helps ensure they have the knowledge, skills and confidence to contribute effectively, and that opportunities are equally accessible to people on low incomes and those with health and social care needs or disabilities.

The level of support needed will partly depend on the role. Those with ongoing involvement or which include decision-making activities as part of co-production approaches may require specific training, for example to help people to understand their own lived experience in the wider context and have the skills and confidence to influence professionals. This could also include having pre-meetings to help people explore the issues and check their understanding, as well as follow-up debriefs.

It is good practice for organisations to have a written policy giving details about their approach to reimbursing and paying people. A policy helps to clarify the situation for everyone and avoids people being treated differently on different occasions. There are advantages to developing a consistent approach across organisations within an ICS so that people can easily understand whether and how they will be reimbursed. Any policy on payments will need to be compliant with HMRC rules.

Consider the resources required to take part, including the cost to an individual of travelling to a meeting or attending online, especially where they may have limited income or no recourse to public funds. Payments can support participation from more diverse groups and helps recognise the value that organisations place on people contributing their experiences, knowledge and skills. Organisations paying people for their time as part of

involvement activities have a responsibility to ensure that people who receive benefits are supported with independent welfare rights advice.

Beyond financial means, there are many ways to recognise people's contributions including receiving an acknowledgement in writing, support to develop skills and experience, and seeing the improvements made because of their input. Ask people what form of recognition they would value and would support them to take part.

It is important to recognise that there can be a cost to partner organisations such as VCSE organisations or Local Healthwatch. This can be in terms of staff time to provide insight or to take part in advisory groups as well as arranging for communities to participate in engagement activities.

There are also practical considerations to ensure different people can take part by making activities accessible, such as when and where they take place, making reasonable adjustments so everyone can take part, provision of British Sign Language and community language interpretating, and providing accessible information. This links to the recognition that a range of approaches are likely to be needed to involve relevant groups, and that we should go to where they are already, rather than expect them to come to us.

NHS England has a patient and public voice partners policy that sets out how it supports people to be involved in its work. It sets out the different types of roles people can do and includes support and training. There is also a policy on reimbursements and payments.

Case study: Working with young people to develop keyworking in the Black Country

The NHS Long Term Plan includes a commitment that by 2023/24 children and young people with a learning disability and/or who are autistic with the most complex needs will have a designated keyworker. Keyworkers make sure that these children, young people and families get the right support at the right time. They make sure that local systems are responsive to fully meeting the young people's needs in a joined up way.

Black Country Healthcare NHS Foundation Trust worked with children, young people and families from the outset to design its keyworker service. The parents, carers and young people with lived experience knew what they needed and the impact it would make.

Co-production was at the heart of the approach from day one. A steering group was co-chaired by a young expert by experience. Young people were helped by Dudley Voices for Choice to take part with pre-meetings and debriefs; resources and papers were written in plain English, and support was provided for the emotional nature of the work. They worked on all stages of the pilot, including the bid for funding, communications and job descriptions for key workers. A peer support model was also developed alongside as a step down from the key worker model.

The approach is being evaluated by the Challenging Behaviour Foundation. Feedback shows the positive impact keyworkers are having for young people, their families and the wider health and care network – for example there has been a significant reduction in Tier 4 hospital admissions.

A3. Collaboration between the NHS and other partners

This chapter sets out how different organisations can collaborate on how they work with people and communities. Collaboration is about building relationships with partner organisations and local communities, treating all partners equitably with a valid and useful contribution to make to the health and care system.

The partners highlighted in the diagram below can help systems to work with people and communities in terms of contributing views, sharing insights and providing outreach. It is not an exhaustive list and systems should map the different partners in their areas to understand how they can work with them.

Local authorities, social care providers and the VCSE sector may already have well-established mechanisms for including people in decision-making and, where possible, NHS organisations should use the insights from these and work through existing forums and activities, rather than setting up new ones.

There is also an opportunity to coordinate working with people and communities. For example, an ICB and a trust can work together on engagement over changes to hospital services for which they both may have public involvement duties. Their approach could include working with existing forums run by the local authority, or commissioning Healthwatch and the VCSE sector to engage the communities they already have links with.

Joining up conversations across sectors and coming together to involve people about what matters to them can lead to significant improvements and reduces the need for people to contribute separately to each organisation.

Partners for the NHS on working with people and communities

Local authorities and councillors

Local authorities are important partners in working with people and communities. Their membership of ICSs brings their experience of working with people to design and deliver services that meet local needs and build community assets.

The Boards of each ICB must include at least one 'partner member' jointly nominated by the local authorities within the area of the ICB. The ICB, and each responsible local authority wholly or partly within the ICB's area, must establish an Integrated Care Partnership (ICP) as a statutory committee of the ICB.

All local authorities have a role in delivering better health and care and influencing people's health outcomes through the operation of a wide range of statutory powers and duties. These include those relating to children and young people, health and wellbeing, adult social care, housing, environment protection and planning, to name just a few. As such they are all important partners in working with people and communities. Partnerships should exist with councils, including district and other councils such as town or parish councils, and beyond the formal membership of the ICB and ICP.

Local authorities are key partners in designing and commissioning person-centred services. They also have expertise in co-production – especially in relation to direct payments for social care.

They often employ community development workers with experience of community-centred approaches. They are also significant funders of local VCSE sector organisations providing care and support to communities.

Council public health teams work closely with their diverse communities to provide information and support to improve population health and address health inequalities.

Councillors are elected to represent their local communities at ward level. They have detailed knowledge of the communities they serve, including their concerns around health services and the wider determinants of health. They have links to community resources and networks, including neighbourhood forums, and a reach into their communities.

County council and unitary authorities are responsible for health and wellbeing boards – inclusive place-based forums in which political, clinical, professional and community leaders agree shared priorities to improve the health and wellbeing of their communities. The boards have a statutory duty to develop and publish joint strategic needs assessments (JSNA), an invaluable source of information on an area's demographics and the profiles of local communities. The boards are required to publish joint health and wellbeing strategies (JHWS) that identify the priorities for improving health and wellbeing and the actions needed to achieve this. ICBs and their partner trusts must involve the boards in producing the new joint forward plan for each ICS (see Annex B5). In many cases, the JSNA and JHWS are developed with extensive collaboration and co-production with communities and with people who use services.

Unitary and county councils have powers and duties in respect of Health Overview and Scrutiny. This role is usually carried out by a Health and Overview Scrutiny Committee (HOSC) of the local authority for its local area or a joint HOSC appointed by two or more

local authorities to cover a larger area. Working with scrutiny can help systems take a wider perspective and develop effective partnership working.

More information on when consultation with HOSC is required and the role of HOSCs more generally is contained in Annex B.

Case study: Vibrant Communities Partnership Board

Bournemouth, Christchurch and Poole (BCP) Council have a strong track record of working with communities, but acknowledges that to be better, it must involve the VCSE sector into decision-making positions within the council.

The vast majority of public sector organisations work using traditional, deficit-based approaches. This means they are set up to focus on perceived issues or weaknesses of a particular community that, it is believed, require a professional approach to solving. While there are some reasons why this approach may be useful, it can inadvertently take power and responsibility away from the community.

In order to reverse deficit-based public services, BCP Council has developed the 'vibrant communities' approach which focuses on developing strength-based ways of working within individual communities and within council services.

To do this, the Council set up the Vibrant Communities Partnership Board, which is a partnership between the council, the local VCSE sector and the NHS and other partners. The broad overall objective is to deliver strength-based approaches and interventions that focus on the inherent assets of people, communities and organisations. The Board has two co-chairs, one elected by the council and the other by the voluntary sector, so a mixture of community and council priorities are covered; and to empower non-public sector partners by devolving responsibility.

The Board avoids discussing strategic priorities of Board members, but instead focuses solely on operational needs of the community. This is deliberate as a key objective of the Board was to avoid it becoming a smaller 'health and wellbeing board'.

Social care providers

Social care is the term used to describe the personal care given by public or private organisations to help people in society who need specialised assistance to live a comfortable, healthy, fulfilling life. Services aim to provide care for and protect society's most vulnerable and this could include children, young people, adults or older people.

Social care providers can bring an understanding of the needs of the people they support, with advocacy and insight into their experience in the current systems and what will make those better. Social care providers often have frequent and long-lasting connections with the people they work with and can support connections and relationship-building with them. Social care providers can also be experienced at working with co-production so that people can actively shape their care and support they receive.

Healthwatch

Healthwatch is the independent body responsible for understanding the needs, experiences and concerns of people who use health and social care services, and to ensure their views are put at the heart of their care.

Its activities include:

- promoting the involvement of local people in health and care services
- enabling people to monitor standards of care and how services can be improved
- obtaining their views and experiences of services.

At a national level, Healthwatch England provides leadership and support to local Healthwatch organisations. Its other statutory functions include escalating concerns raised by local Healthwatch to the CQC, and to provide advice to Secretary of State for Health and Social Care, NHS England and English local authorities, especially where they hold the view that the quality of services provided are not adequate.

The Health and Social Care Act 2012 put the focus of local Healthwatch at top-tier local authority level. The development of ICSs means that Healthwatch will need to work at both system and place levels if local voices are to be property represented where decisions are made. As local Healthwatch are not ordinarily funded to do this work at system level, ICBs and ICPs will need to consider what additional support Healthwatch will need to make an effective contribution.

Providers of health and social care services are under a duty to allow entry by local Healthwatch. This power to ‘enter and view’ services, offers a way for Healthwatch to undertake their activities and allows them to identify what is working well with services and where they could be improved. Healthwatch can use this evidence to make recommendations and inform changes both for individual services and across the system. There are requirements for the service providers to respond to a Healthwatch report and its recommendations within a set timeframe.

Through their role in obtaining views of local people about their needs and experiences of care, local Healthwatch can provide insight about the breadth of health and care, particularly picking up on issues which go beyond a single service such as integration and the impact on people. ICSs should build on the existing statutory activities of local Healthwatch in their geographies, working with the organisations to resource the co-ordination and analysis of user experience data. This will complement insight collected by commissioners and providers.

Systems can also work with local Healthwatch to involve local people. One of their functions is to support the involvement of local people in the commissioning, provision and scrutiny of care services. Their scrutiny function means they can make recommendations of service improvements to commissioners, providers, Healthwatch England and the CQC. These functions help them have knowledge of how to work effectively with local communities and how services can be improved to meet local needs.

Local Healthwatch must be involved in developing joint strategic needs assessments and integrated care strategies (see Annex B5). Healthwatch organisations may provide views,

reports and recommendations on decisions and decision-making processes based on the evidence available. This includes the option to refer issues to overview and scrutiny where they feel it is appropriate (see Annex B3).

Local Healthwatch organisations have a place on their local Health and Wellbeing Boards, so they can present people's views in strategic discussions. They can have strong relationships with local authorities, working with both service delivery and elected members.

Many ICSs already have some system-level arrangements in place with their local Healthwatch. Arrangements for how Healthwatch can work at both system and place level will vary depending on the geography of the system and different local authority commissioning arrangements. ICSs should consider how they can invest in these partnerships in order that Healthwatch has the resource to take on their roles effectively, including commissioning them to undertake engagement or fulfil the roles at system level.

While Healthwatch have different roles from VCSE sector organisations, their shared values mean they should be seen as complementary rather than competing (and many Healthwatch are hosted by VCSE sector organisations). Strong relationships with both will help ICSs hear the voices of people at all levels.

Case study: Bringing local people's voices to the ICS – Healthwatch in North East London

To ensure that local people's experiences are at the heart of the North East London ICS, the eight local Healthwatch are working together. By combining their knowledge of their local areas, the experiences that people share with them and the different barriers they face, they have been able to identify trends, variations and differences in health and care - helping to tackle and reduce inequalities.

Together the local Healthwatch have been working with the ICS on its engagement strategy and the principles it will follow. They meet regularly with the ICS as a forum for dialogue and a space to highlight local issues. They are actively involved in their place-based partnerships and will participate in ICS governance.

They have been commissioned by the ICS to deliver community insights through a single database across North East London, particularly in relation to COVID-19. The eight local Healthwatch combined their data, using a system already in use by some local Healthwatch to provide ICS level insight. The Community Insights Repository collates feedback for providers from different sources, such as NHS Choices, Care Opinion, Google reviews, website feedback, surveys and complaints

For local Healthwatch, there have been significant benefits too. They now have more evidence to base their work on; they're more quickly able to identify critical issues people are experiencing and have better relationships with communities facing health inequalities.

Healthwatch activities for the ICS are funded through the ICS engagement budget. More information is here.

The voluntary, community and social enterprise (VCSE) sector

Organisations within the VCSE sector have many different roles. They are often providers of services (both commissioned and funded through voluntary or charitable income) to the most disadvantaged communities and consequently can have an excellent understanding of the health and care issues faced by those communities. The sector has a key role in tackling the wider determinants of health by reaching people who experience health inequalities and removing barriers to accessing services. At both national and local levels, the VCSE sector has an important contribution to make in shaping and providing health and care services, and in developing and implementing plans to tackle wider determinants of health.

VCSE sector organisations can bring their knowledge of how to work with people and communities:

- they are often trusted, accessible and skilled at outreach and engagement
- they have routes into and established relationships with different groups, especially those that experience health inequalities, and can help communicate with them
- they provide expertise in directly working with people and communities in service planning and delivery, including experience of community-centred approaches
- they have knowledge of the needs and strengths of those they work with and can support them to be more directly involved in health and care strategies and plans.

Within ICSs, VCSE sector partnerships should be embedded in how they operate.[13] All ICBs should have a formal agreement to work with the VCSE sector in governance and decision-making, building on their existing involvement in place and neighbourhood level forums, and where they have well-established relationships with other NHS organisations and partnerships such as Cancer Alliances. This agreement should consider the role of infrastructure organisations including the new VCSE Alliances or leadership groups that can bring strategic voice to governance of ICSs.

Depending on the engagement taking place, it may mean working with national VCSE sector organisations. For example, if redesigning the pathway for a rare condition, there may not be relevant groups in the system, but a national organisation could advise on what approaches to take and help contact people.

At the other end of the scale, health inequalities manifest at highly localised levels, such as wards. Community organisations are close to the ground and with strong intelligence about their communities. These organisations may not be members of system level partnerships. As such, it is vital that they are factored into the design of engagement and co-production processes to reduce the risk of unintentionally excluding local voices.

It is also important to work with informal groups and networks such as user-led organisations, peer support groups and advocacy organisations. Many people who are excluded or stigmatised by society are often involved in their own community group or user-led organisation.

[13] See the 2021 ICS implementation guidance on partnerships with the VCSE sector.

VCSE sector capacity and infrastructure will vary between areas and some organisations will have only limited resources to facilitate and support engagement. They may need financial support to meet the costs of staff time, training or the direct costs of carrying out engagement with communities. Commissioning VCSE organisations to lead engagement with the groups they work with supports investment in community assets and can secure wider benefits by strengthening local organisations. Building longer-term partnerships beyond short-term projects can support financial planning and build the sector's resilience so that they can help tackle health challenges.

The COVID-19 response saw organisations across the VCSE sector support people and communities. Through ICSs there is an opportunity to deepen partnerships with VCSE sector organisations and, if this does not already exist, to amplify the voices of the communities they work with in decisions about health and care.[14]

Case study: Embedding the VCSE sector in the planning and design of systems in Humber Coast and Vale ICS

There has been close working between the health and care system and the VCSE sector for over 18 months, building strong foundations so that the sector is a key strategic partner in the planning, design and delivery of health and care services.

A well-established VCSE leadership programme has meant that the system has got a mechanism to speak to the sector and the leaders around the table to understand their place. From the outset the approach has always been to make the connections with the partnership and ensure the sector is embedded. This has led to investment in the sector and its involvement in the partnership's governance and strategic planning. It has resulted in the system embracing the value of the VCSE sector and is proactively involving it at the earliest opportunity.

This early engagement with the VCSE sector has many benefits and being part of the design of services rather than 'just' delivery, allows for wider perspectives and different ideas being formed through co-design. Work with the Cancer Alliance has seen the sector shaping proposals around early cancer detection and having a greater reach into targeted communities, which can be delivered by the VCSE. As a result of this increased understanding of the capabilities of the sector, the proportion of the budget allocated for the VCSE is more in line to that for the statutory services, meaning it is seen much more of an equal partnership, rather than an add on.

[14] For more information see Creating Partnerships for Success, NCVO, January 2020 and How health and care systems can work better with the VCSE sector, NHS Confederation, August 2020.

Social Prescribing Link Workers

Social Prescribing Link Workers (SPLWs) support people with practical, social or emotional needs that affect their physical and mental health. As part of Primary Care Networks, SPLWs work with people to co-produce a simple Personalised Care and Support Plan (PCSP) which includes medical needs alongside psycho-social needs. It is a planning process which leads to activities or solutions of care which support the person's goals, and works with the person's skills, strengths, and preferences. It addresses the things that are not working in the person's life and identifies outcomes and actions to resolve these. This could include connecting people to a range of activities, groups and services in their local community, including supporting people to access statutory services, volunteering activities and peer support.

Through their role, SPLWs develop detailed knowledge of their neighbourhood, both in terms of the physical and mental health needs of residents, and the community assets available that can support them. Their local knowledge means that SPLWs may have specific expertise in community-centred approaches and can help facilitate co-production. SPLWs can help identify whose voices need to be heard, and support and facilitate access to engagement opportunities for diverse groups. They can also help identify local community organisations and map existing insight, particularly in relation to health inequalities. In some areas, specialist SPLWs work alongside community development roles to reach specific inclusion health groups and so can act as intermediaries.

Case study: Co-designing a new green social prescribing project to improve people's mental health and wellbeing and reduce health inequalities

In South Yorkshire and Bassetlaw ICS, a green social prescribing project has started to test how connecting with nature, green spaces and the outdoors can improve people's mental health and wellbeing and reduce health inequalities across the community. The project is also looking at how green space can be accessible to everyone, focusing on people negatively affected by the pandemic, including people from ethnic minority communities.

Co-design, which included working with VCSE sector organisations, community groups and people with lived experience was at the centre of the development of new green social prescribing activities to make sure that they are what people want and need and are accessible.

The project team engaged with local communities in a variety of ways, helping people to get involved in the project in the way that worked best for them. This included working with local voluntary and community organisations, attending local green activities and groups to talk to people, workshops, questionnaires, and offering individual meetings and calls.

The project team and community worked in partnership to reach a set of criteria for new services, such as agreeing that referral pathways to social prescribing projects needed to be expanded to help people less likely to go to the NHS for support connect to social prescribing through trusted community connectors and groups. The group also agreed that working through trusted community leaders would help some ethnic minority communities connect with activities and suggested that promoting case studies featuring

people from ethnic minority backgrounds and using communication channels favoured by local communities would increase visibility of support on offer.

People with lived experience of mental ill-health sat on panels to assess grant applications for new green projects and made joint decisions about funding. Working together has helped to form trusting relationships between green spaces and social prescribing services and communities, and funded projects are what people want them to be; accessible, inclusive, and safe to use.

Volunteer and peer roles

These roles provide advice, information and support or organise activities around physical and mental health. They are often part of community-centred services, designed to meet specific local needs and assets. Examples include community champions, research champions, care navigators, health walk leaders and breastfeeding support peers. These are active community members who draw on their local knowledge, skills and experiences to promote physical and mental health. Alongside health improvement and building connections between services and communities, they can support involvement through an in-depth understanding of the different communities' they work with. Like SPLWs, they can have detailed knowledge of health needs and inequalities, and how engagement approaches can be designed to include diverse groups.

Non-executive roles

The Health and Care Act 2022 requires ICB boards to consist of a chair, chief executive and 'ordinary members', appointed by the ICB. Ordinary members can include 'non-executive members' defined as members who bring a perspective independent of local health and care organisations.[15] The ICB's constitution must set out how many of these members will be on the board and any qualifying expertise or experience so they can bring different perspectives to the ICB board. There is a requirement that at least one of the ordinary members has knowledge of services relating to mental illness. These can be directors of public health, VCSE sector representatives, or people with lived experience. Non-executive members can provide knowledge of community involvement in prevention and advocate for it across their system. More broadly, the appointment of non-executive members is an opportunity to reflect the diversity of communities and bring their voice to ICB decisions especially where they have been recruited for their knowledge and experience of local communities.

All NHS trusts and NHS foundation trusts have non-executive directors (NEDs) on their Boards. In addition, NHS foundation trusts have a range of governors who represent staff, patients, unpaid carers and service users, and the public, and are elected by the 'constituencies' they serve.

NEDs are appointed for their wider board experience and independence. They have a key role in accountability and bringing a different viewpoint to deliberations. NEDs can also

[15] Guidance to Clinical Commissioning Groups on the preparation of Integrated Care Board constitutions – Annex, NHS England, May 2022.

support Boards and systems to think strategically about how they connect with local people, having often worked in different sectors, and can be active in and well-connected to the local community.

Public governors provide an important link to local communities, which works in two ways: to help a trust to understand the views of the public; and to help a trust engage with them. They can act as a conduit between patients, the public and trust leadership. However, councils of governors are not restricted to representing members or the interests of a narrow section of the public served by the foundation trust – that is, patients and the public local to the trust or those from governors' own electorates. Instead, governors are expected to take account of the interests of the 'public at large'. This includes the population of the ICS that the trust belongs to. The membership system also provides foundation trusts with a ready pool of people who can be more directly engaged in decision-making, with established routes for communication.

Workforce

In many areas, the local authority and the organisations which make up the local NHS are together the biggest local employer (or at least one of the biggest) – which gives them a significant (and in some cases unique) position within the community. NHS organisations can have a positive impact locally as 'anchor institutions' – contributing to people's sense of local identity, and what defines and makes them proud of where they are from. This also enables organisations to have significant impact on the physical and mental health of the immediate community they serve, for example by reducing congestion and pollution by adopting green transport initiatives for staff.

In thinking about working in partnership with local people, organisations should take care to include their employees as part of this group. Staff members will also be users, or potential users, of services, as well as unpaid carers and supporters of family members, friends and neighbours. They will have views of their own about what could improve the health of local people, and about how services could be improved – so it is important to consider how these can be captured. Unions, professional bodies and staff networks can also bring their members' perspectives.

In addition, staff (particularly in patient-facing clinical and non-clinical roles, such as receptionists, drivers and porters) can be communicators to the public, through informal conversations with people using services. 'Word of mouth' remains the most powerful communication tool, especially when those speaking directly to local people are in the most trusted of all professions (nurses and doctors), so it is essential that staff understand initiatives and the rationale behind them. If staff have been actively involved, they are more likely to become ambassadors for local change processes and encourage other local people to get involved and have their say. Staff can have an important role here given that they are more likely to live in the local area and can be powerful influencers within their communities.

Other health and care partners

Other public bodies and organisations may also be active locally in improving health and care. These might include health and care research collaboratives and local social enterprise and entrepreneur networks, as well as Academic Health Science Networks who work to improve health and generate economic growth.

ICBs have a duty to 'facilitate or otherwise promote research' and to 'promote innovation', and duties around reporting these activities. There is an expectation that communities are involved in these activities.[16] People and communities should be directly involved in identifying unmet health needs and shaping the future research, innovations and health services for their communities. Local and regional research and innovation partnerships often have strong networks with local communities and are a good source of insight into people's current experience of care as well as aspirations for the future of healthcare.

Organisations should coordinate their healthcare delivery and research work with people and communities. Many health and care organisations that deliver services also undertake research, and the findings can be relevant to how services can be commissioned and provided to tackle inequalities most effectively, improve health outcomes and people's experiences. This reduces the risk of communities being excluded or overburdened by many different organisations trying to work with them. A coordinated approach across healthcare delivery and research will make it more likely that research will reflect what matters to people and communities and be put into practice to improve health and care delivery. The appendix contains links to relevant resources and initiatives that support the research community to work effectively with people and communities.

[16] Shared commitment to improve public involvement in research – UKRI

Annex B: Legal duties and responsibilities

B1. Public involvement legal duties

This guidance encourages the involvement of people and communities as an ongoing approach, providing opportunities for people to raise the issues and ideas that matter to them, and make decisions with them about their health and care services. As well as best practice, there are specific legal duties for commissioners and providers of health and care services.

Involvement duties on commissioners and providers

To reinforce the importance and positive impact of working with people and communities, NHS England, ICBs and trusts all have legal duties to make arrangements to involve the public in their decision-making about NHS services.

The main duties on NHS bodies to make arrangements to involve the public are all set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022:

- section 13Q for NHS England
- section 14Z45 for ICBs
- section 242(1B) for NHS trusts and NHS foundation trusts.

A requirement to involve the public is also included as a service condition in the NHS Standard Contract for providers.

Each of the organisations listed above is accountable and liable for compliance with their public involvement obligations. However that does not mean that each organisation should carry out its public involvement activities in isolation from others within the ICS and beyond. Plans, proposals or decisions will often involve more than one organisation, particularly in respect of integration and service reconfiguration, in which case it is usually desirable to carry this out in an joined up and co-ordinated way, reducing the burden on both the public and the organisations themselves.

The legal duties require arrangements to secure that people are 'involved'. This can be achieved by consulting people, providing people with information, or in other ways. This gives organisations a considerable degree of discretion as to how people are involved, subject to the below requirements.

Neither the legal duties, nor this statutory guidance, seek to prescribe exactly how to involve people in any given case. Indeed, what is necessary will always depend upon the circumstances. Therefore, while this guidance is ambitious in its intent, it is not intended to place additional legal obligations on organisations and does not mandate that organisations may only discharge their duties in a particular way.

Public bodies are required to act rationally, and this applies to the arrangements they make to involve people. Public bodies can demonstrate that they are acting rationally by keeping good records of decisions taken about when and how to involve the public.

Statutory duties, such as the involvement duties set out above, are not the only circumstances in which a duty to consult may arise. Under common law, a duty to consult *may* also arise where there has been a promise to consult, where there has been an established practice of consultation, or, in exceptional cases, it would be conspicuously unfair not to consult. There will also be circumstances in which working with people and communities would be beneficial even if doing so is not legal requirement. Therefore, whether or not the involvement duties apply is not the only consideration when deciding whether and how to work with people and communities.

Individuals, carers and representatives

These public involvement duties have applied to commissioners and providers for many years and are largely unchanged. However, a significant change introduced by the Health and Care Act 2022 is that, in respect of NHS England and ICBs, the description of people they must make arrangements to involve has been extended from 'individuals to whom the services are being or may be provided' to also include 'their carers and representatives (if any)'. While it is already common practice to involve carers and their representatives – and to do so is in line with previous statutory guidance on the public involvement duties – this change makes it a legal requirement for arrangements for public involvement to secure the involvement of carers and representatives (if any), as well as service users themselves.

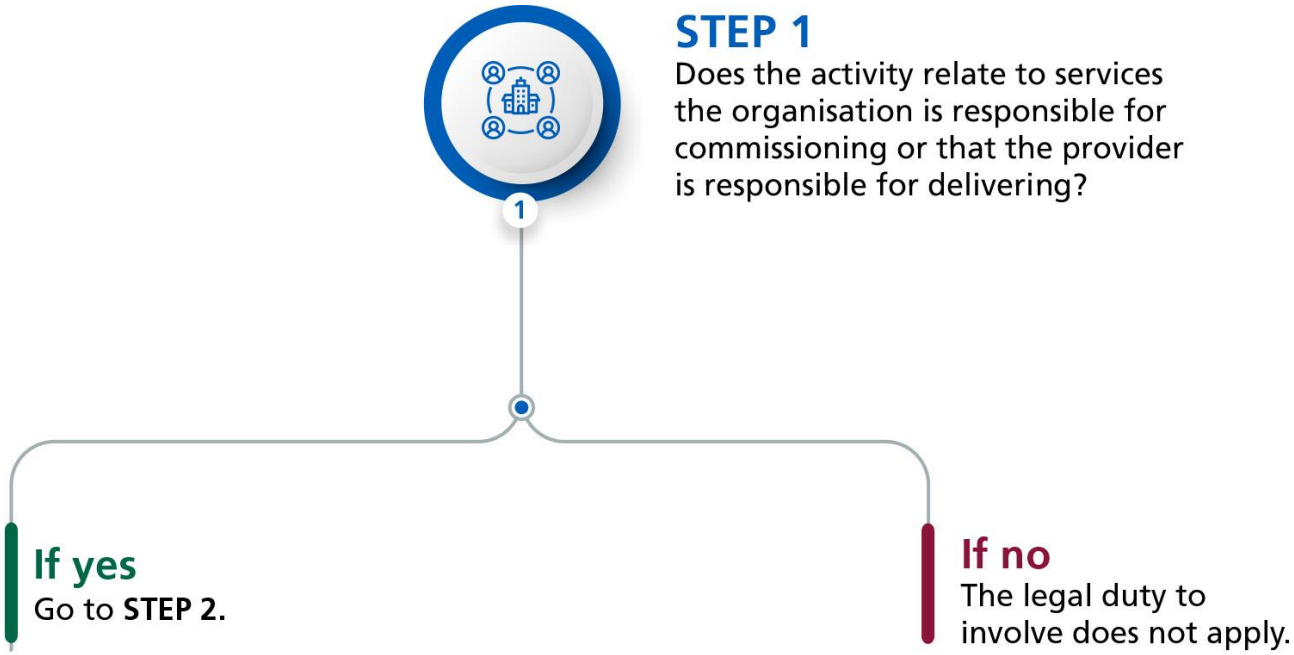
The legislation does not include a definition of carers or representatives. However relevant carers[17] and representatives should be identified by reference to the individuals who use, or may use, the services in question. It is up to local organisations to identify who to involve – depending upon the circumstances, nature of the services and decision-making process in question – but relevant carers and representatives could include young carers, individual patients' advocates or family members who help organise their care, as well as councillors and community leaders, VCSE sector organisations, local Healthwatch and other organisations able to represent the interests of the individuals who use, or may use, the services in question.

A stakeholder analysis can help determine which groups are relevant representatives depending on the context. More than one of these representative groups may need to be involved alongside people with lived experience to ensure that the full range of views can be considered.

[17] NHS England defines a carer as 'anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid…. This is inclusive of both adult and young carers.' Who is considered a carer?

A process for assessing whether the legal duty to involve applies

NHS England has developed a three-step process for assessing whether the legal duty to involve applies. ICBs and trusts may use their own process or adopt this one. They should be able to demonstrate that they assess whether the duties apply to plans, proposals and decisions about services and, where they do, that they are properly followed.



Examples

- A decision about the relocation of a community diabetes service commissioned by an ICB and delivered by a trust does.
- A decision about the relocation of an ICB's or trust's administrative offices does not.

STEP 2

What type of activity is it?
The duty applies to three types of activity.

Planning

Commissioners are required to always have arrangements in place to involve the public in the planning of commissioning arrangements; trusts must have them in place in the planning of provision of these services. If the activity relates to planning, then the legal duty applies regardless of the impact it may have at step 3.

Proposals for change

This activity includes not only the consideration of proposals to changes to how services are commissioned or delivered, but also the development of such proposals. If the activity relates to proposals for change, go to step 3.

Operational decisions

This activity relates to decisions made by the commissioner or trust that change or affect the way a service operates. If the activity relates to operational decisions, go to step 3.

Examples

Planning

- The development of an ICB policy for the commissioning of diabetes services.

Proposals for change

- Development of options for the reconfiguration of urgent and emergency care and the subsequent consideration of any developed options or model.

Operational decisions

- Making changes to the opening hours or location of a service.
- The closure of a clinic for operational reasons.

While the legislation distinguishes between these different types of activity, as can be seen by the examples, they often overlap and sometimes a plan, proposal or decision can fall into more than one category. Where the duty sits with commissioners and providers also overlaps and the duty can apply to both. In these cases there is an opportunity for commissioners and trusts to work jointly with people and communities and meet their legal duties without duplicating effort and activities.

Go to **STEP 3.**

STEP 3

Would there be an impact on service delivery or the range of services?

If yes

If no

The legal duty to involve applies.

An impact on services can arise in two ways:

- An impact on the way services are delivered to individuals, for example the transfer of a service to another location; and/or
- The range of health services available to individuals, for example the closure of a service of limited clinical benefit to fund investment in other services.

The impact on services should be considered from the perspective of patients and not necessarily limited to the clinical services being commissioned or provided. Accessibility, transport links and ambulance availability are all examples of matters that could be significant in considering impact. An Equality Impact Assessment can help identify which groups are likely to be affected.

The legal duty to involve does not apply.

Examples

Impact on services

- The closure of a GP practice would mean patients having to find a new practice to seek treatment. This would impact upon the way in which services are delivered to patients. The degree of the impact will depend on how far individuals will have to travel to access another GP practice as well as any specific care that may have been provided at the practice. In such circumstances it is likely that the legal duty to involve applies.

No Impact on services

- The retirement of a GP from a practice may mean that patients with a preferred choice of doctor will need to be seen by a different GP. However, this would not typically affect the range of services or the manner of their delivery, in which case the legal duty to involve is unlikely to apply.
- The award of a new contract to a podiatry provider, with no change in the specification of such a contract, would not ordinarily be expected to result in changes to the way that services are delivered to patients or the range of services available. In such circumstances it is unlikely the legal duty to involve will apply.

The Gunning Principles

Commissioners and trusts must ensure that their arrangements to involve people are fair. The courts have established guiding principles for what constitutes a fair consultation exercise, known as the Gunning principles. These four principles relate to public consultation processes and do not create a binding legal precedent for how other ways of involving the public should be carried out. However, they will still be informative when making arrangements to involve the public, whatever the form of those arrangements.

1. **Consultation must take place when the proposal is still at a formative stage.**

   Meaningful consultation cannot take place about a decision that has already been made. There is no requirement, and it would be misleading, to consult on options which are not genuinely under consideration, or are undeliverable – but it may be necessary to provide some information about realistic alternatives.

2. **Sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response.**

   Those being consulted should be provided with sufficient information to enable them to understand what the proposal is and the reasons why it is being considered. They should be made aware of the criteria against which proposals have been or will be judged. This may involve providing information about realistic alternatives and the reasons why they are not also being considered. The level of detail provided will depend on the circumstances such as the complexity and impact of the proposal.

3. **Adequate time must be given for consideration and response.**

   People must have enough time to properly consider and respond to the consultation. What is adequate will depend upon the circumstances and is not prescribed by law. However, a time period may be inadequate if it is during a holiday period or only allows a short time for the public to consider complex proposals.

4. **The product of consultation must be conscientiously taken into account.**

   Decision makers must be able to show that they have given consideration to what they have heard during the consultation and that they have borne this in mind when the ultimate decision is taken.

B2. Other relevant legal duties

The Equality Act 2010

The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of protected characteristics. These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

As well as these prohibitions against unlawful discrimination the Equality Act 2010 requires public sector organisations to have 'due regard' to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- and foster good relations between people who share a protected characteristic and those who do not.

This is known as the 'public sector equality duty' (section 149 of the Equality Act 2010).

Working with people with characteristics protected under the Act means understanding how decisions or policies can affect them and whether they will be disproportionately affected. Following this guidance will be an important part of meeting the equality duty.

Health inequalities

NHS England and ICBs are also under a separate statutory duty to have regard to the need to reduce health inequalities of access to health services and the outcomes achieved (sections 13G and 14Z35 of the National Health Service Act 2006, respectively). By understanding the needs of people experiencing health inequalities, services can work with them to reduce barriers to access and design improvements.

Duty to promote innovation and research

ICBs have statutory duties in relation to innovation and research (sections 14Z39 and 14Z40 respectively of the Health and Care Act 2022). These cover how ICBs must promote innovation and facilitate or promote research in the provision of health services. ICBs should explain in joint forward plans how they propose to discharge their innovation and research duties and include in annual reports an assessment of how the ICB has discharged its research and innovation duties. Working with people and communities will play a key role in discharging these duties. NHS England will publish specific guidance in

2022/23 for ICBs on how they can support and facilitate research, including further information on the involvement of people and communities.

Public Services (Social Value) Act 2012

This requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. There are several benefits to local communities in embedding social value in commissioning, including improved service delivery, health creation and an increase in the resilience of communities. Working with a range of VCSE organisations on new approaches to engaging diverse communities in service planning is an example of how NHS organisations can bring social value to their commissioning. This links to the role of the NHS as anchor institutions, using their assets to promote the physical and mental health of their local communities and harnessing their spending power to address health inequalities and invest in health.[18]

[18] Anchor institutions and how they can affect people's health, The King's Fund, September 2021.

B3. Service reconfiguration and public consultation

The Secretary of State's functions in relation to service reconfiguration introduced by the Health and Care Act 2022 will commence at a later date. The Department of Health and Social Care will publish statutory guidance on these functions, alongside updating the 2014 Local Authority Health Scrutiny guidance. NHS England will also update its guidance on substantial service change to reflect the new functions.

Applying the principles to major service change

Changing how services are planned and delivered will happen for several reasons. These include to improve the quality of services and patient experience to address prevailing inequalities in health outcomes in a community, or to adapt to changing clinical practice.

A critical success factor is open community and stakeholder involvement from the first stage of considering change.[19] This means involving people at the earliest opportunity in co-designing what the future health and care services for their area looks like. It means building on the conversations that systems should already be having with people about what a health community might look like and using their existing approaches as a starting point for producing service change proposals.

Service change proposals can be subject to judicial review or be referred by the local Health Overview Scrutiny Committee (HOSC) to the Secretary of State for Health and Social Care, particularly if they have not been sufficiently involved. In undertaking service change, systems must comply with their legislative duties to engage the public, consult their HOSC where required and have regard to the need to reduce health inequalities, and to have due regard to the Equality Act and the Public Sector Equality Duty. In carrying out these duties, consistent and meaningful involvement from people and communities is fundamental.

One of the most important early steps to take is to build long-term relationships and invest resources in developing partnership approaches with key community and political leaders, including politicians, faith leaders and VCSE sector organisations. Clinical Senates also bring a public perspective to significant service reconfiguration. They bring together clinicians, patients and other partners to assist commissioners and providers to make the best decisions about healthcare for the populations they represent. Clinical Senates will assure the contents of a service change's Pre-Consultation Business Case (PCBC), including approving the involvement of patients and the public in any clinical modelling that has been undertaken.

[19] Insight on effective NHS service change from the Independent Reconfiguration Panel, February 2020.

Every effort should be made to include local Healthwatch organisations in the decision-making process at an early stage, where they may offer support and advice as to the best way to engage with the groups affected by the change, as well as sharing existing relevant insight. Where a proposal is likely to have an impact across a wide geographical area, it will be necessary to work with all the individual Healthwatch organisations to ensure that all areas are appropriately represented.

Every system that plans to change how its services are delivered should undertake an Integrated Impact Assessment (IIA) to understand pre-existing access to and understanding of the services available. This assessment can support commissioners to identify and reach diverse communities that may be affected by these changes. Local Healthwatch and VCSE sector organisations can support commissioners to engage these communities, and to develop meaningful long-term relationships with them in the design and delivery of reconfigured services.

Inevitably, some transformation proposals will be so contentious that any amount of good planning, relationship building, and mitigation will not prevent significant local opposition. In these circumstances, systems should consider the following core principles:

- maintaining a civil discourse: All partners should work hard to maintain a civil discourse throughout the process and avoid disengaging from dialogue or publicly criticising other partners
- ongoing and continuous dialogue with communities: Engagement even from the early planning stages, before formal service change proposals are made, can support understanding about the process and rationale for decisions, including how people have been included and their views considered. This needs visible leadership from Board level
- learn from previous proposals: Communities often have longer memories than the professionals who may change roles and move. Understanding the local history of change that communities have experienced helps to learn and build trust with people
- scope of proposals: All engagement must have a clearly defined scope and the ability to have some influence. For example, it is not appropriate to consult on options that are not genuinely under consideration or are unviable or unrealistic
- length of consultation: When planning a public consultation, consideration should be given to the amount of time necessary – a longer consultation is not always best. Government advice is that consultations should last for a proportionate amount of time. Shorter consultations backed by significant evidence of engagement beforehand may be most effective. Long and unpopular consultation processes, however well meaning, can negatively impact on the long-term relationship with communities and partner organisations. However, in all circumstances you should ensure that the consultation is long enough so that interested parties have the time to respond. This may include giving them time to consult within their membership. Through demographic monitoring, you may also need to factor in time to undertake additional engagement with communities that have not previously been adequately involved. The length and timing of the consultation and other engagement activities can be affected by pre-election periods, during which consultation should generally not be launched

- access to information: As part of the consultation process you should ensure that people have access to the information that they need. This should be accessible, timely and easy to understand with potential benefits and drawbacks clearly set out. This will allow them to give an informed opinion that may take account of significant factors about which they may not have been aware previously. Alternative formats (such as easy read documents) must be ready at the same time. Good practice indicates that public-facing versions of business cases, such as the plan for public consultation, will help communities to understand proposals more easily. Certain documents, such as the Pre-Consultation Business Case, and the Decision-making Business Case, will be publicly available and systems should ensure these are clear, succinct and easy for everyone to access
- continuing dialogue throughout consultation: The consultation process should not close all other communication with stakeholders. You should consider whether it is it is appropriate to share information openly and to maintain an ongoing dialogue
- addressing issues raised by all groups: Significant service change will often arouse a lot of public interest, including from campaign groups. Any public consultation needs to ensure that all opinions provided as part of the consultation are heard, but also must consider that there may be a range of views. Responses to public consultation should address significant issues raised by all groups and show how they have been considered. This underlines the importance of involving all groups affected by the change but who may be less likely to take part in public consultations
- public-facing decision-making: Once consultation has completed, and responses have been independently consolidated and considered, a decision regarding the agreed way forward should be made in public and communicated clearly.

Finally, it should be emphasised that systems that have ongoing, meaningful involvement of people and communities, are more likely to develop proposals where issues, barriers, opportunities and solutions have been thought through together. This gives them a firm basis before going out for wider consultation.

Case Study: Community hospital change

The NHS in Gloucestershire used a Citizens' Jury to decide the location of a new community hospital instead of having two hospitals. The change had been proposed and firmly rejected more than 10 years previously by a very vocal and well-organised opposition.

Communicating to the public that it was not possible to deliver high quality care across two sites comprised of older buildings was seen as challenging as the local population have experienced high-quality care in both hospitals over time and may not understand the benefit that a new site would bring to the quality of their care.

To involve the public in the change process and gather strong public evidence, the team needed to recognise the strength of local feelings and emotions rooted in the area.

The presence of local staff at involvement events who understood the history of the two hospitals helped to acknowledge the significance of the change for local identity. Their presence helped support residents to provide views about quality of care. They also reported that showing the experience of new community hospitals elsewhere in the county helped highlight the increased quality of care that could be delivered at a new site. This approach helped the public navigate the tension between local access to services and quality of care.

A combination of traditional and deliberative involvement informed decision-making and design at each stage. Qualitative evidence gathered through public events and discussions helped answer the question, 'what good looks like' at the pre-consultation business case stage. It highlighted issues around access and the potential impact of inequalities that the team would need to consider in more depth in the design of options.

The site selection stage of options development used an independent Citizens' Jury to make a recommendation from three possible locations. A Citizen's Jury is an involvement method where a small group of the public are selected to deliberate over a policy issue and asked to make a recommendation based on evidence presented. The Jury has no decision-making power as it is not a legal entity, and instead makes a recommendation to the local NHS as accountable decision-makers. Neither the Trust nor the CCG had a preferred option out of three possible locations – all were understood to have the potential to deliver high quality care. The local population did have preferred options – it was a highly contentious local decision.

The jury was run by an independent company that recruited a mix of residents through public advertisement where residents applied to take part. This ensured a geographical spread across the area and as well as selecting people who were genuinely interested to take the recommendation-making responsibility.

The system accepted the Citizens' Jury recommendation because they trusted the process that had created more neutral, clinically framed public evidence.

Health Overview and Scrutiny

Where changes are proposed which are a substantial development of the health service in the local area, or a substantial variation in the provision of the service, commissioners and providers of NHS services (including NHS England, ICBs, trusts and private providers) are under a duty to consult all relevant local authority Health Overview and Scrutiny Committees (HOSCs) on the change. Ordinarily, the commissioners (ICBs or NHS England) will carry out this exercise on behalf of providers.

HOSCs contribute constructively, in the interests of their communities, to plans. Councillors can highlight potential risks which might not otherwise be apparent – their unique perspective and insight, derived from their role in the local community, provides vital intelligence for policymakers and a particular credibility in giving voice to public concerns. They will expect to see how NHS commissioners and providers have engaged people in developing plans and that equalities issues have been considered. Where relationships are positive, the management of proposals for substantial variations or other major changes will be easier.

Where there are concerns about proposals for reconfiguration then local authorities can formally refer them to the Secretary of State, for example if the HOSC does not view the proposal as in the interests of the health service of its area or that consultation with the HOSC on the proposal was inadequate. Early and transparent engagement can minimise the likelihood of referrals to the Secretary of State and any damage to the relationship between the NHS, local authorities and communities.

Judicial Review

If a person with sufficient interest in the matter disagrees with either the proposals or the Secretary of State's decision in relation to a referral, they can seek the court's permission to bring a Judicial Review (JR). It is important to note that under a JR the court will not typically scrutinise the merits of a decision made by a public body, or substitute its own decision. Rather, the court will scrutinise the process by which the public body has come to this decision, and may 'quash' the decision if it finds it to be unlawful. This scrutiny may include whether legal duties regarding public involvement and equality have been met. Strong, consistent and continuous involvement of the public, and good records to demonstrate that this has been done in compliance with legal duties, will reduce the risk of an application for JR materialising, being granted permission by the courts, or ultimately succeeding.

B4. Integrated Care Systems' responsibilities

ICSs have been set up to improve outcomes in population health and healthcare, and to support and promote partnership working to address broader health inequalities. The underlying principles to achieve these aims are collaboration between partners within and outside the NHS, and that decisions are taken as close as possible to the people they affect. ICSs are encouraged to identify the best way to improve the physical and mental health of their populations, address health inequalities, and provide joined-up, efficient and effective services. ICSs should build on existing work with people and communities. For example, the approaches and networks of the Clinical Commissioning Group (CCG) predecessors and other partners within the ICS.

There is separate guidance for ICPs, place-based partnerships and provider collaboratives which includes how they should work with people and communities. They can use the 10 principles in Chapter 4 to develop their approaches, ideally collaboratively with all partners, for working with people and communities.

Specific opportunities and minimum expectations for each are detailed below.

Integrated Care Boards

ICBs have a legal obligation to include in their constitutions:

- provision about the arrangements to be made by them for discharging their public involvement duty, and
- a statement of the principles to be followed by them in implementing those arrangements (paragraph 14 of Schedule 1B to the National Health Service Act 2006).

In addition they should:

- have a process for updating and reviewing progress on its strategy for working with people and communities (see Annex B5)
- adopt clear and transparent mechanisms for developing joint forward plans with people and communities, and include in these details of how they will meet their statutory duties on public involvement, research and innovation
- work with partners across the ICS to develop arrangements for ensuring that ICPs and place-based partnerships have representation from local people and communities in priority-setting and decision-making forums

- give workforce the time, resources and support to deliver on working with people and communities.

Where a process to involve people has already started by one of its legacy CCGs, ICBs will need to be assured that this meets the legal duty for which they are now responsible. Where good arrangements are already in place, ICBs should continue and build on the work already underway.

Under section 14Z59 of the National Health Service Act 2006, NHS England has a duty to assess the performance of ICBs on various duties, including those under section 14Z45 for public involvement. This will be included in the new System Oversight Framework, building on the approach that took place for CCGs where a specific indicator was included in their oversight framework. The process will include providing evidence of the how the ICB meets the 10 principles in this guidance and the difference that working with people and communities has made. It will look for evidence of meaningful involvement taking place consistently across the ICB's places and neighbourhoods.

NHS England will work with partners including ICBs to design the new indicator and will issue specific guidance for ICBs as part of the overall system oversight framework in 2022/23.

Integrated Care Partnerships

ICPs should:

- be open and transparent, agreeing arrangements for accountability, including meeting in public and providing accessible information about their plans and strategies
- build on the expertise, governance arrangements and engagement forums that already exist, such as Health and Wellbeing Boards, and so avoid duplication and ensure joined-up decision-making
- develop a structured and meaningful approach to how they work with people which brings accountability. This could include engagement on its strategy, co-producing sections with people with relevant lived experience, and collecting quantitative and qualitative evidence
- include membership from the VCSE sector, Healthwatch and people with lived experience who can bring expertise on how the ICP can engage its population and provide scrutiny that it takes place effectively.

Working with people and communities at place level

It is at place level that many engagement activities will happen. It contains health and care services that people use frequently, including those provided by councils and the VCSE sector, and so is a level that people can often recognise more easily than a system. It is also to places that some commissioning will be delegated by ICBs and NHS England.

Place-based partnerships

Place-based partnerships should:

- have clear and transparent mechanisms for ensuring strategies and changes are developed with people with lived experience of health and care services and wider communities
- Work with their coterminous Health and Wellbeing Boards to identify priorities to improve the health of their communities
- build on existing approaches and networks for engaging and co-producing with people and communities, including those run by providers and the former CCGs
- support PCNs and neighbourhood teams to work with people and communities using community-centred approaches to strengthen health improvement and treatment. This might mean working with existing neighbourhood provision such as from the local authority or housing associations, networking Practice Participation Groups so they share insight and learning across the PCN, and leveraging the links that GPs and primary care staff already have into their communities. Resourcing this work at neighbourhood level can support place and system level engagement.

Provider collaboratives

Provider collaboratives should:

- share and build on the good practice that exists in their member organisations, such as co-production approaches and partnerships with experts by experience
- draw on the community connections of foundation trust governors, and use insight and feedback from patient surveys, complaints data and partners like Healthwatch
- each provider organisation within the collaborative will need to meet its own legal duties on public involvement where programmes result in changes that impact how patients receive services
- explore community-centred approaches to enable both better decision-making and new approaches to outreach for communities of both geography and experience (for instance, people with the same condition).

System Quality Groups

ICSs have responsibilities for quality to ensure services are consistently safe, effective and provides a personalised experience. Working with people and communities forms part of how systems can achieve these aims.

All ICSs must have a System Quality Group (SQG) to engage and share intelligence and improvement for quality. These groups provide an important strategic forum within ICSs at which partners can share and triangulate intelligence, insight and learning on quality matters across the ICS and identify actions for improvement.

Guidance on SQGs is available here. Part of their scope is to improve the safety of NHS care and people's experience of care through co-design and co-production. This includes involving people with relevant lived experience as equal partners in the full range of SQG activities, including co-designing improvements. Membership must include at least two patient safety partners (see below) and two members with lived experience or from local Healthwatch. It is possible that the patient safety partners may also have lived experience and work for Healthwatch. The groups are therefore an important source of insight into what matters to patients and a forum which works with people to make quality improvements.

The guidance also covers place-based quality groups which are expected to include two people with lived experience. It is also expected that people with lived experience are on any task and finish groups reporting to SQGs. Examples established to date include maternity, children and young people, and safeguarding.

Patient Safety Partners

The NHS Patient Safety Strategy recognises the importance of involving patients, their families and carers and the public in improving the safety of NHS care. One way this is achieved is through the new role of Patient Safety Partners (PSPs) which is required in all NHS organisations. PSPs are patients, carers, family members or other people who work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation.

PSPs' roles include involvement in patient safety improvement projects, membership of safety and quality committees and participation in investigation oversight groups. They therefore offer unique insight into safety from a patient perspective and as potential partners in quality improvement projects. Further guidance is available here.

B5. Strategies and reports

There are statutory requirements for organisations in ICSs to produce strategies and plans for health and care. These are the minimum requirements for who must be involved:

Joint strategic needs assessment

What does it do?
A comprehensive analysis of the current and future needs and assets of their area relevant to health, social care and public health.

Who prepares it?
Local authority (through the Health and Wellbeing Board) and local ICBs.

Who must be involved?
Local Healthwatch, local people, district councils (where applicable) and any other appropriate person.

Joint local health and wellbeing strategy

What does it do?
Plans the delivery of integrated local services based upon those needs and assets to collectively address the underlying determinants of health and wellbeing.

Who prepares it?
Local authority (through the Health and Wellbeing Board) and local ICBs.

Who must be involved?
Local Healthwatch, local people.

Integrated care strategy

What does it do?
Sets out how the assessed needs in an area are to be met by the ICB, NHS England and relevant local authorities.

Who prepares it?
ICP

Who must be involved?
Local Healthwatch, local people.

Joint forward plan

What does it do?
Sets out how the ICB and its partner NHS trusts and NHS foundation trusts will discharge its duties over the next five years, including in relation to public involvement and reducing inequalities.

Who prepares it?
ICBs and partner NHS trusts and NHS foundation trusts.

Who must be involved?
Local people, Health and Wellbeing Boards and any other appropriate person.

Other reports and strategies which should demonstrate how organisations are working with people and communities are included below.

Annual reports

ICBs and NHS England have a duty to produce Annual Reports that must show how their public involvement duties have been met (sections 14Z58 and 13U of the National Health Service Act 2006 respectively). The reports must also explain how they discharged a variety of their duties, including their duties in relation to improvement in quality of services, research, reducing inequalities, the triple aim and public involvement.

Organisations can take different approaches to how they do this – they can incorporate it in their main annual report or produce a separate one dedicated to public involvement. However the following should typically be included:

- governance and assurance information: an overview of the structures and processes that support working with people and communities, and how these work at different levels of the organisations, including place-based partnerships and primary care networks
- how the strategy on working with people and communities has been put into practice: how the role of the public in governance structures have been achieved, how it has worked with people in priority setting and decision-making, and examples of approaches used to work with people and communities
- the key involvement activities that have taken place: what the changes have been for service delivery and health outcomes, how activities were designed to reach specific groups and the voices of those experiencing health inequalities were heard
- patient insight and data: how intelligence about people's needs and experiences was gathered and how this informed decision-making and quality governance
- information presented in an accessible and appealing way for a public audience. This applies to the main annual report and to any separate one covering involvement
- the evidence that equality and inclusion principles were considered when with working with diverse communities.

The information accessible and appealing, considering the needs of the diverse groups of people in the area. NHS England is producing new guidance in 2022/23 which explains these requirements in detail, and updates Annual reporting on the legal duty to involve patients and the public from 2016.

ICB strategies on working with people and communities

Although not a statutory requirement, each ICB has prepared a strategy for working with people and communities. The strategy should describe the ICB's:

- principles and approaches to working with people and communities
- approach to working with partners so people and communities are involved in priority-setting and decision-making forums across the ICS
- arrangements for gathering intelligence about the experience and aspirations of people who use care and support, and its approach to using these insights to inform decision-making and quality governance.

The strategy helps promote consistency of approaches across systems. It is an important element in how ICBs demonstrate to people they intend to work with them, and one which will develop over time. NHS England's assurance of ICBs' public involvement duties will include how the strategy is monitored and reviewed, and how further iterations are developed with people and communities.

Provider Quality Accounts

A Quality Account is a report published annually about the quality of services offered by an NHS healthcare provider, including trusts. It reports on patient safety, the effectiveness of treatment and patient feedback, so is an important way to demonstrate how providers are acting on insight to improve continuously its services.

Drafts must be shared with NHS England and relevant ICBs, local Healthwatch and HOSCs, with any comments included in the final version. Healthwatch and HOSCs are best placed to provide meaningful comment when there has been continuous engagement with them by the provider on their priorities.

Producing a Quality Account should not be a one-off exercise, but rather a year-round process of engagement with the public, including with foundation trust governors and members, local Healthwatch and patient groups. Providers may organise specific engagement on their Quality Accounts to agree with people the actions that it will take improve the services it delivers.

Quality Accounts must be published by the trust. The language and layout should be accessible and appealing to the public to improve accountability.

Case study: Co-producing a Patient and Public Involvement Strategy

East of England Ambulance Service NHS Trust (EEAST) needed to develop a Patient and Public Involvement Strategy to provide clear direction to how it works with its communities. It was decided that the strategy should be approached as a co-production project and to effectively start from a blank page.

The Trust understood the importance of co-production to produce the strategy but had not previously had much experience working in this way, especially for such a large project. Co-production was a move away from the traditional consultation process, and collectively led by the people who would be affected by the strategy. The Trust reached out to Healthwatch Suffolk, who then delivered comprehensive co-production training, with these sessions explaining the culture of co-production, the underpinning principles, and the benefits of using co-production for such a project.

With support from their Healthwatch partners, the strategy was developed through a series of 16 co-production workshops, with 70 attendances by patients, community representatives, volunteers, and specialist groups. Each session took an open approach but included key questions which were used to build foundations for the strategy. Co-production sessions were as inclusive as possible and were offered at a variety of times to suit the needs of individuals and community groups.

All the feedback received was collated and a thematic review was then undertaken, which identified five key themes (Ethos, involvement and engagement, accessibility, networking and communication). In true co-production style, further sessions were organised to feedback and sense check in relation to the themes identified, concluding with strategy writing workshops with the patients and the public, to decide on the language used within strategy.

The strategy is currently into the process of being officially launched, although both the strategy on a page and easy read version are available on the Trust's public website.

B6. Resources and learning

NHS England offers a range of learning and resources to help put this guidance into practice. More information is available on the Start with People network.

The following are some other resources and guides on different ways of working effectively with people, including groups with specific needs.

Benefits of working with people and communities

Building trusted relationships with partners and communities, resources for NHS leaders, NHS Leadership Academy, 2022

Community Power: The Evidence New Local, 2022

Community engagement: improving health and wellbeing and reducing health inequalities National Institute of Health and Care Excellence, 2016

Understanding integration: how to listen to and learn from people and communities King's Fund, 2021

Community-centred approaches

Community-centred public health: taking a whole system approach, Public Health England, 2020

Health and wellbeing: a guide to community-centred approaches, Public Health England, 2015.

Asset-Based Community Development for Local Authorities, NESTA, 2020

Evidence for strengths and asset-based outcomes, Social Care Institute of Excellence, 2019

Supporting different groups to take part

West Yorkshire Health and Care Partnership has collated resources on trauma informed approaches

Integrated health and social care for people experiencing homelessness National Institute of Health and Care Excellence, 2022

Seldom Heard - Engaging young people in health services research and service design, Challenging Behaviours Foundation

Engaging young people in health services research and service design The Association of Young People's Health, 2022

Valuing the Views of Children with a Learning Disability Challenging Behaviour Foundation and Mencap, 2021

Involvement in health and care research

The National Institute of Health and Care Research (NIHR) has several resources to support involvement in research including:

- UK Standards for Public Involvement which support the research community to work effectively with people and communities
- People in Research website which links people and communities to opportunities to shape research
- Include Ethnicity framework to help the research community become more inclusive.

WIRRAL PLACE BASED PARTNERSHIP BOARD

12th JANUARY 2023

REPORT TITLE:	**PLACE REVIEW MEETINGS**
REPORT OF:	**PLACE DIRECTOR (WIRRAL), NHS CHESHIRE AND MERSEYSIDE**

REPORT SUMMARY

Each of the nine Places in Cheshire and Merseyside will have quarterly review meetings with NHS Cheshire and Merseyside. The first of these review meetings for Wirral took place on 24th October 2022. This report provides an update on this meeting for the Place Based Partnership Board.

This matter affects all Wards within the Borough.

RECOMMENDATION/S

It is recommended that the Wirral Place Based Partnership Board:

(1) Notes the presentation that was given at the Place Review Meeting on 24th October 2022.
(2) Notes the feedback from NHS Cheshire and Merseyside following the Place Review Meeting.
(3) Requests an update on the actions taken in response to this feedback.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 The Wirral Place Based Partnership Board is the principal meeting through which NHS Cheshire and Merseyside will undertake its business in the borough with partners. The Place Review Meetings are a mechanism through which each Place, in this case Wirral, can discuss key issues regarding how NHS Cheshire and Merseyside is working in each Place with partners and explore development priorities and options to support ongoing development. The Wirral Place Based Partnership Board should therefore engage in, receive feedback from and take action following these meetings.

2.0 OTHER OPTIONS CONSIDERED

2.1 The Place Review Meeting approach was developed by a working group from across Cheshire and Merseyside Integrated Care System. A range of approaches were considered and it was agreed that a programme of quarterly review meetings should be put in place, arranged by the Place Director with system partners.

3.0 BACKGROUND INFORMATION

3.1 Each of the nine Places in Cheshire and Merseyside will have quarterly review meetings with NHS Cheshire and Merseyside. The first of these review meetings for Wirral took place on 24th October 2022. In addition to the Place Director, the Chief Executive, Assistant Chief Executive, Director of Performance and Planning and Associate Director of Programme Delivery and Assurance attended from NHS Cheshire and Merseyside. Wirral system partners were represented by the Chief Executive, Wirral Community Health and Care NHS Foundation Trust, the Chief Strategy Officer, Wirral University Teaching Hospitals NHS Foundation Trust and a representative of the Primary Care Networks in Wirral.

3.2 The review meetings provide an opportunity to discuss key issues how NHS Cheshire and Merseyside is working in each Place with partners and to explore development priorities and options to support ongoing development, based upon a self-assessment return. The Place visits will also include an exploration of key system delivery issues. The focus of the October meeting was on the Wirral Place plans for winter.

3.3 The meeting on 24th October 2022 commenced with a presentation from the Place Director, which covered system actions around urgent care and the outcome of the Place Maturity self-assessment. These slides are included in Appendix 1 of this report.

3.4 Each place was asked to complete the Place Maturity Framework self-assessment, which was also supported by an online survey link to gather an evidenced understanding of key stakeholder perspectives. The members of

the Wirral Place Based Partnership Board were asked to complete this survey.

3.5 There were four domains against which each Place was been asked to provide a self-assessment and supporting evidence, these are:

- Ambition and Vision – (i) clarity of purpose and vision, (ii) objectives and priorities and (iii) population health management to address health inequalities.

- Leadership and Culture – (i) Place based leadership, (ii) partnership working, (iii) culture, organisational development, values and behaviours and (iv) responding to the voice of our communities and public and patient engagement.

- Design and delivery – (i) financial framework, (ii) planning and delivery of integrated services, (iii) Enabler; Digital and (iv) Enabler: Estates and assets.

- Governance – evidence of Place Based Partnership Board and supporting groups.

Each Place was asked to assess their level of maturity against each domain. There are four levels of maturity – emerging, evolving, established and thriving – each with criteria to measure against. Each Place was also asked to provide a summary of the key evidence which supports the rating given and areas for further development.

3.6 The feedback from the meeting held on 24th October 2022 was received on 5th December 2022. The key points are:

- **Urgent Care and Non-Criteria to Reside (NCTR)** - request for more detail on the work in the Wirral system stratifying NCTR and the outputs of this work.

- **Domiciliary care and care home provision** – request to share the work undertaken on the strategic mapping of the care home marketplace including risk analysis. Suggestion that, as a system, Wirral needs to make a declaration and commitment around the number of care hours/packages that the system intends to buy, providing assurance to the domiciliary care market. Consideration should also be given to setting a target that can be tracked and managed.

- **Winter Plan** - Further consideration on how the Wirral share of the national allocation to support the adult social care workforce will be spent, with a suggestion to think about 'disruptive innovation'.

- **Place Based Partnership Board (PBPB) Development** – the Wirral PBPB clearly recognises its current position in terms of maturity and would benefit from a defined development programme. NHS Cheshire and

Merseyside can support the PBPB with a routine standard set of reports for both finance and performance to enable reporting on impact and delivery at a local level.

- **Additional Roles Reimbursement Scheme (ARRS) -** encouragement to consider the opportunities here and continue to engage and develop relationships. NHS Cheshire and Merseyside can support primary care networks with their transformation journey but needs to clear on the development need so that they can understand how they can best support.

- **Social Care Contract** – A request to keep NHS Cheshire and Merseyside up to date on Wirral Council's decisions on the social worker contracts with NHS providers.

A response will be prepared to this feedback.

3.7 The next review meeting is due on 13th January 2023. The Place Director has invited members of the Place Based Partnership Board to attend this meeting.

4.0 FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from this report.

5.0 LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from this report.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There are no direct resource implications arising from this report.

7.0 RELEVANT RISKS

7.1 NHS Cheshire and Merseyside is developing a risk framework for application in each of the nine Places. The Wirral Place Based Partnership Board will also be receiving a report on this at a future meeting.

8.0 ENGAGEMENT/CONSULTATION

8.1 The members of the Place Based Partnership Board were engaged in the completion of a survey that supported assessment against the Place Maturity Framework. Members of the Place Based Partnership Board will also be invited to future Place Review meetings.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council and NHS Cheshire and Merseyside have a legal requirement to make sure their policies, and the way they carry out their work, do not discriminate against anyone. No Equality Impact Assessment is required for this report.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 Wirral Council and NHS Cheshire and Merseyside are committed to carrying out their work in an environmentally responsible manner. There are no environmental and climate implications from this report.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 Community Wealth Building in Wirral focusses on partnerships and collaboration. These partnerships are led by Wirral Council with external partners and stakeholders, including residents. NHS Cheshire and Merseyside will support the Council in community wealth building by ensuring health and care organisations in the borough have a focus on reducing health inequalities and contribute to the development of a resilient and inclusive economy for Wirral.

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APPENDICES

Appendix 1 Wirral Place Review Meeting Slides

BACKGROUND PAPERS

Strategic Aims of Integrated Care Systems, accessed at: NHS England » What are integrated care systems?

NHS Cheshire and Merseyside priorities, accessed at: Our priorities - NHS Cheshire and Merseyside

SUBJECT HISTORY (last 3 years)

Council Meeting	Date

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APPENDIX 1 WIRRAL PLACE REVIEW MEETING SLIDES

NHS
Cheshire and Merseyside

Wirral Place Review Meeting
24th October 2022

Areas for discussion

NHS
Cheshire and Merseyside

- **Urgent Care**
  - Action plan for reduction in NCTR (non-criteria to reside).
  - Place wide report on urgent care system to include use of social care indicators.
  - Developed winter plans including your approach to delivery and oversight through winter period.
- **Place Maturity self-assessment**
  - Key outputs
  - Identification of areas of support the Central Team could provide.
  - Impact of delegation/governance changes.

NHS
Cheshire and Merseyside

Urgent Care

Urgent Care – No Criteria To Reside (NCR)

- ~220 at WUTH against 95% recording level.
- Daily tracking of people by Pathway and readiness for discharge.
- Internal report to check accuracy including those subject to ongoing care within hospital.
- System Discharge Cell and Discharge Director.
- Exploring ‘lift and shift’ of Pathway 1 waiters to residential care beds.
- Separate Integrated Discharge Team support function targeting NCR.
- End of Life Personal Care (Fast Track) expansion by end of year.
- Overall Winter Plan aims to support reduction in NCR - need assurance on delivery and impact.

Urgent Care – System Indicators Overview (1)

- Daily operational performance reporting to Chief Operating Officers.
- Currently refining our Urgent and Emergency Care (UEC) triggers and tolerances.
- Tracking whether the system is meeting the targets and whether there is any change to common cause variation.
- Example of breakdown of metrics circulated prior to Place Review Meeting.
- Activity levels remain high and system flow blockages are being felt strongest in the acute and mental health inpatient facilities.
- General practice also reporting high demand for services.
- Home First and Virtual Wards are new services with less than one month data.
- Capacity in care homes is good but placing and matching is problematic. Domiciliary care availability is below pre-pandemic levels.

Urgent Care – System Indicators Overview (2)

Data as of 17th October 2022

- ED 4 Hour Performance YTD: 76.67% All types & 50.91% Type 1 (7 from 9 in C&M)
- NEL: Marginal reduction compared to last year.
- NCR 220~ / G&A Occupancy ~98%/ Mental Health ~100%
- Ambulance: See and Treat/Hear and Treat @ C&M Average
- Ambulance Turnaround Times >60: Ave 5 per day.
- Type 3/Walk In Centre Activity - Rising activity trend since April 2022 and last year.
- UCR : 220 per month.
- D2A LOS >32 days v 21 day LOS target (Pathway main challenge but 27 down to 11 waiting now).
- Care Market Hours per month circa 30% less than pre covid (3,300/2,300).
- Care Home Capacity: ~340 but less admittable on the day.

Urgent Care– Winter Plan (1)

- Developed by system partners in Wirral through Chief Operating Officers Group, Strategy and Transformation Group and A&E Delivery Board (AEDB).
- Operational delivery alongside change programmes (see accompanying information).
- Minimum ~£6.5m investment, mapped and agreed with Wirral Place Finance Investment and Resources Group.
- Key initiatives include: Virtual Wards, HomeFirst, Care Market Sufficiency, 71+22 D2A, Pathway 1 Step Down Beds, Frailty and Respiratory @ Front Door & EOL Personal Care.

Urgent Care – Winter Plan (2)

- AEDB yet to sign off plan – meeting 25/10/22.
- Key risk of hospital occupancy vs ability of schemes to deliver reduced G&A utilisation.
- Delivery and oversight covered in supporting information, headlines:
  - Daily operational reporting.
  - Minimum weekly and up to daily Chief Operating Officer oversight of UEC and WP delivery.
  - Escalation to Place Director/Wirral System CEOs Group if required.
  - Fortnightly Strategy and Transformational Group oversight of new investments and review of existing initiatives.
  - AEDB monthly.

NHS
Cheshire and Merseyside

Place Maturity Self Assessment

Wirral University Teaching Hospital NHS Foundation Trust | Primary Care Partnership WIRRAL | Wirral Community Health and Care NHS Foundation Trust | Cheshire and Wirral Partnership NHS Foundation Trust | Cheshire and Merseyside | WIRRAL

Category	Summary	Development Need	NHS C&M Support
Ambition and Vision	• Established. • Ambition and vision developed by partners. • Clear links to Wirral Plan 2026.	• Ensure ambition communicated and understood. • Alignment with new strategies, plans and objectives. • Reporting of impact to Place Based Partnership Board.	• Affirmation of importance of "place". • Communication and engagement support. • Engagement in HCP Strategy and any NHS plans. • Place based finance and performance reports to demonstrate impact.
Leadership and Culture	• Established place leadership and partnership working. • Evolving culture (new people involved and new governance - need to revisit).	• Values and behaviours and ways of working. • Conclude MoU with VCFSE. • Wider primary care and provider engagement. • Developed communications and engagement approach.	• Development programme for PBPB. • Support for MoU. • Support for wider engagement of primary care and providers. • Place focused support for communications and engagement activities.

Category	Summary	Development Need	NHS C&M Support
Design and Delivery	• Established. • Finance, planning and delivery of services, estates (including sustainability) local working arrangements being built upon.	• Connectivity to new place governance arrangements. • Alignment with new strategies, plans and objectives. • Alignment with NHS C&M/ICS programmes.	• Continue to develop place governance. • Clarity on alignment of place and wider system programmes. • Scheme of delegation for Place Director. • Clear resource allocation to Place Director. • Place reporting mechanisms.
Governance	• Developed with partners. • Established overall, with some elements evolving. • Wirral Council and historic CCG relationship transposed into new arrangements. • Provider collaboration evolving from strong position.	• Finalised Terms of Reference for PBPB and supporting groups. • Continue to develop shared/aligned governance across system. • Clarity on delegation to place for (a) Council – NHS C&M and (b) NHS C&M – Place.	• Ensure congruence of place governance with NHS C&M requirements. • Formal approval of place governance arrangements. • Clarity on delegation to place.

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WIRRAL PLACE BASED PARTNERSHIP BOARD

Thursday 12 January 2023

REPORT TITLE:	**2022/23 POOLED FUND FINANCE REPORT TO MONTH 7, SEPTEMBER 2022**
REPORT OF:	**ASSOCIATE DIRECTOR OF FINANCE, CHESHIRE & MERSEYSIDE INTEGRATED CARE BOARD – WIRRAL PLACE**

REPORT SUMMARY

This paper provides a description of the arrangements that have been put in place to support effective integrated commissioning. It sets out the key issues in respect of:

a) budget and variations to the expenditure areas for agreement and inclusion within the 2022/23 shared ("pooled") fund; and
b) risk and gain share arrangements.

In 2022/23 Wirral Health and Care partners have chosen to jointly pool £248.97m to enable a range of responsive services for vulnerable Wirral residents as well as a significant component of Better Care Funding to protect frontline social care delivery.

This paper provides an update to the pooled fund budget, a summary forecast position as at Month 7 to 31st March 2023 and the financial risk exposure of each partner organisation.

The report also provides an update on the preparation of the framework partnership agreement under section 75 of the National Health Services Act 2006 relating to the commissioning of health and social care services, which will be subject to approval and final sign off by Cheshire and Merseyside Integrated Care Board (ICB).

RECOMMENDATION/S

The Wirral Place Based Partnership Board is recommended to:

1) Note the forecast position for the Pool at Month 7 is currently a £5.7m overspend position. This is due to CCG / ICB Wirral Place pool commissioned services overspend of £5.9m offset by an underspend on Local Authority Health and Care commissioned services of £0.2m. The ICB Wirral Place holds the financial risks on the £5.9m overspend.

2) Note that the shared risk arrangements are limited to the Better Care Fund only, which is reporting a forecast break-even position.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 Wirral Health and Care partners have the responsibility to maintain pooled funds and report on the expenditure under the framework partnership agreement under section 75 of the National Health Services Act 2006 ("the section 75 agreement) relating to the commissioning of health and social care services.

2.0 OTHER OPTIONS CONSIDERED

2.1 No other options have been considered as necessary.

3.0 BACKGROUND INFORMATION

3.1 Consistent with this the pooled fund and integrated commissioning and service delivery arrangements are intended to enable a focus on the best outcomes for the Wirral population.

3.2 The following key features of integration have been outlined as essential to success:

- Pooling resources, intelligence and planning capacity.
- Delivering the Right Care in the Right Place at the Right Time.
- Managing demand and reducing the cost of care.
- Clear accountability and governance arrangements.
- Resilience and flexibility to emerging issues in service delivery.

3.3 The pooled fund arrangements are already well established in Wirral and enable a range of responsive services to vulnerable Wirral residents as well as a significant component of Better Care Fund ("BCF") funding to protect front line social care delivery.

3.4 Continuing to expand the scope and scale of pooled arrangements for 2022/23 would be an important statement, that Wirral has a strong foundation for integrated commissioning at place level.

Establishment and Authorisation of the Section 75 Agreement.

3.5 The Section 75 agreement must be updated to set out the detail of budget areas that are being pooled in 2022/23 and the associated governance. There is a mandatory legal requirement to have a Section 75 agreement in place between the Council and the Cheshire and Merseyside Integrated Care Board in place to draw down the elements of the pool relating to the BCF. In this context a section 75 agreement is being progressed and a further report will be brought to this board seeking the necessary authorisation to proceed to its finalisation.

4.0 FINANCIAL IMPLICATIONS

2022/23 Pooled Fund for Wirral Place

4.1 As at Month 7 the revised Pooled Fund budget for 2022/23 of £251.05m is set out in Table 1 below.

Table 1

	Final 21/22 £m	at M6 22/23 £m	Revised 22/23 £m
CCG / ICB Place Pool	134.30	138.13	140.21
Health & Care	49.60	50.70	50.70
Children and Young People	1.70	1.70	1.70
Better Care Fund	55.78	58.44	58.44
Grand Total	241.38	248.97	251.05

4.2 The pooled fund has increased this month by £2.08m from £248.97m to £251.05m. This is due to: -

- £2.08m non recurrent virement to Prescribing received from other places within the ICB for neutralising monoclonal antibodies (nMABS) whereby Wirral place is the host for this funding.

The change control process set out in the draft 2022/23 S75 agreement will be initiated so that this change can be formalised by both parties.

4.3 A full breakdown of the 2022/23 Pooled Fund is illustrated in Appendix 1 of this report.

4.4 As at month 7 the reported forecast position of the pooled fund is a £5.7m overspend and a summary position in Table 2 is provided below.

Table 2

	Summary	2022 / 23 Budget	Forecast Outturn	Variance
A	**ICB Wirral Place Pool**	£140.2m	£146.1m	£5.9m
B	**Health & Care**	£50.7m	£50.5m	-£0.2m
C	**Children and Young People**	£1.7m	£1.7m	£0.0m
D	**Better Care Fund**	£58.4m	£58.4m	£0.0m
	Grand Total	**£251.0m**	**£256.7m**	**£5.7m**

4.5 The overspend of £5.7m is due to the CCG / ICB Wirral place pool commissioned services. This element of financial risk lies with the ICB and predominantly continues to be operational pressures in CHC and Mental Health packages of care both activity and price, and therefore the ICB will meet the costs of this overspend. (see R2 and section 7).

4.6 The Wirral Place financial recovery plan summary tables and scenario analysis for best, likely and worst cases will be revised and updated for the month 7 reported position. Monitoring against the trajectories set out with action plans continues with the regular checkpoint reviews which are scheduled for the remainder of the financial year.

4.7 A forecast break even position is reported for the Better Care Fund element. However, there is a potential pressure of £172k, due to the extension of the D2A beds in to Q3. However it is hoped that this will be fully mitigated as the year progresses.

5.0 LEGAL IMPLICATIONS

5.1 A section 75 agreement for the pooled fund is the contractual agreement which sets out the terms of the arrangements between the Council and the ICB. Such an agreement is required in order to draw down resources under the BCF and to enable the pooling of wider funding elements which are in the scope of the arrangement. Each year, the Council's legal services are fully engaged in the development of the Section 75 agreement.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 Currently there is no significant impact on resources, ICT, staffing, and assets as a result of the integration agenda. As greater integration occurs there are likely to be efficiency savings through economies of scale with appropriate sharing of posts and assets etc.

7.0 RELEVANT RISKS

7.1 The 2021/22 reporting arrangements will continue into 2022/23 until further ICB guidance, and as such there will be three main financial risks identified to impact the pooled budget: -

- R1 – Local Authority budget overspend;
- R2 – CCG / ICB budget overspend; and
- R3 – Efficiency savings are not achieved.

7.2 It is proposed to retain the more focused risk-sharing arrangements of 2020/21 for 2022/23. This approach removed the generic approach to risk share arrangements by targeting the 50% risk share arrangement onto the Better Care Fund, with host organisations retaining full financial risk on other areas pooled, as illustrated in Appendix 2

7.3 The Better Care Fund is currently showing a break-even position, so there is no risk share impact to report. The reported overspend relates specifically to R2.

8.0 ENGAGEMENT / CONSULTATION

8.1 There is no requirement for engagement or consultation within this report.

9.0 EQUALITY IMPLICATIONS

9.1 No implications have been identified because it is not anticipated that the integration of commissioning functions will have an impact on equality. Rather, potential impacts on equality will come from commissioning decisions for which EIAs will need to be produced at the development stage.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no environment and climate implications directly arising from this report.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 There are no community wealth implications directly arising from this report.

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APPENDICES

Appendix 1 – Section 75 Pooled Fund Budget 2022/23

BACKGROUND PAPERS

Draft Section 75 agreement 2022/23
JHCCEG Finance Report M7

SUBJECT HISTORY (last 3 years)

Council Meeting	Date

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APPENDIX 1 - Proposed Section 75 Pooled Budget 2022/23 – Wirral Place – Finance position M7

A

ICB - Wirral Place	2022/23 Budget change	2022 / 23 Budget	Forecast Outturn	Variance	Notes
Commissioned out of Hospital	£0.0m	£66.7m	£72.3m	£5.6m	CHC Fully funded, MH and PHBs, also HDP run off impact c£2.2m. Assumes full qipp delivery
Prescribing	£2.3m	£71.3m	£71.5m	£0.1m	Based on Aug prescribing actuals, NCSO pressures emerging offset with DOACs Framework benefits
Primary Care	-£0.0m	£8.2m	£8.3m	£0.1m	
QIPP	£0.0m	-£6.1m	-£6.1m	£0.0m	
Total	**£2.3m**	**£140.2m**	**£146.1m**	**£5.9m**	**= over performance**

B

Health & Care	2022/23 Budget change	2022 / 23 Budget	Forecast Outturn	Variance	Notes
Learning Disabilities		£46.7m	£47.2m	£0.5m	
Mental Health		£14.4m	£13.8m	-£0.6m	
Children with Disabilities		£1.1m	£1.0m	-£0.1m	
Client Charges		-£3.6m	-£3.5m	£0.1m	
Joint-Funded Income		-£7.9m	-£8.0m	-£0.1m	
Total	**£0.0m**	**£50.7m**	**£50.5m**	**-£0.2m**	**= under performance**

C

Children and Young People	2022/23 Budget change	2022 / 23 Budget	Forecast Outturn	Variance	Notes
Care Packages	£0.0m	£1.7m	£1.7m	£0.0m	
Total	**£0.0m**	**£1.7m**	**£1.7m**	**£0.0m**	

D

Better Care Fund	2022/23 Budget change	2022 / 23 Budget	Forecast Outturn	Variance	Notes
Integrated Services	£1.3m	£27.0m	£27.0m	£0.0m	note Q1 CCG funded 30 beds, Q2 50/50
Adult Social Care Services		£24.0m	£24.0m	£0.0m	
CCG Services		£2.0m	£2.0m	£0.0m	
Public Health		£0.2m	£0.2m	£0.0m	
DFG		£4.7m	£4.7m	£0.0m	
Other	-£1.2m	£0.6m	£0.6m	£0.0m	
Total	**£0.2m**	**£58.4m**	**£58.4m**	**£0.0m**	

WIRRAL PLACE BASED PARTNERSHIP BOARD

Thursday, 12 January 2023

REPORT TITLE:	**WIRRAL PLACE BASED PARTNERSHIP WORK PROGRAMME**
REPORT OF:	**HEAD OF LEGAL SERVICES (MONITORING OFFICER)**

REPORT SUMMARY

The report details the annual work programme of items for consideration by the Wirral Place Based Partnership Board. The Board is comprised of members from multiple organisations and the report enables all partners to contribute items for consideration at future meetings.

RECOMMENDATION/S

The Wirral Place Based Partnership Board is recommended to note and comment on the proposed Wirral Place Based Partnership Board work programme for the remainder of the 2022/23 municipal year.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 To ensure Members of the Wirral Place Based Partnership Board have the opportunity to contribute to the delivery of the annual work programme.

2.0 OTHER OPTIONS CONSIDERED

2.1 A number of workplan formats were explored with the current framework open to amendment to match the requirements of the Committee.

3.0 BACKGROUND INFORMATION

3.1 The work programme should align with the priorities of the Council and its partners. The programme will be informed by the Wirral Plan 2021-2026 as well as the priorities of partner organisations.

3.2 Once elected, the Chair of the Board will work with the Place Director and other members of the Board to set the agenda for the remainder of the 2022-23 Municipal Year.

4.0 FINANCIAL IMPLICATIONS

4.1 This report is for information and planning purposes only, therefore there are no direct financial implications arising. However, there may be financial implications arising as a result of work programme items.

5.0 LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from this report. However, there may be legal implications arising as a result of work programme items.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There are no direct implications to Staffing, ICT or Assets.

7.0 RELEVANT RISKS

7.1 The Committee's ability to undertake its responsibility to provide strategic direction to the operation of the Council, make decisions on policies, co-ordinate spend, and maintain a strategic overview of outcomes, performance, risk management and budgets may be compromised if it does not have the opportunity to plan and regularly review its work across the municipal year.

8.0 ENGAGEMENT/CONSULTATION

8.1 Not applicable.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

This report is for information to Members and there are no direct equality implications.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 This report is for information to Members and there are no direct environment and climate implications.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 This report is for information to Members and there are no direct community wealth implications.

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APPENDICES

Appendix 1: Wirral Place Based Partnership Board Work Programme

BACKGROUND PAPERS

Wirral Council Constitution
Health and Care Act 2022

SUBJECT HISTORY (last 3 years)

Council Meeting	Date

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WIRRAL PLACE BASED PARTNERSHIP BOARD/JOINT STRATEGIC COMMISSIONING BOARD

WORK PROGRAMME 2022/2023

Suggested Agenda February 2023

Item	Lead Departmental Officer
Wirral Place Based Partnership Board Terms of Reference Review and Review of process of election of chair and vice chair	Mike Chantler
Wirral Placed Based Partnership Board Supporting Groups Terms of Reference Review	Mike Chantler
Healthwatch Update	Karen Prior/Kirsteen Sheppard
Sport and Physical Activity Strategy Update	Sarah Robertson
Dementia Strategy Quarterly Update	Abigail Cowan
Financial Recovery Plan	Martin McDowell
Adult Social Care Discharge Fund	Simon Banks
Pooled Fund	Martin McDowell
NHS Operational Planning Guidance 2023/2024 (tentative depending on national guidance release date)	Simon Banks
Work Programme	Mike Jones

ADDITIONAL AGENDA ITEMS – WAITING TO BE SCHEDULED

Item	Approximate timescale	Lead Departmental Officer
Place Review Meeting Update	March	Simon Banks
Winter Plan Reflections	TBC	TBC
Cheshire and Merseyside Wide Provider Collaboratives	TBC – after March	Tony Mayer/Linda Buckley
Wirral Provider Partnership Development	March 23	Karen Howell/ Ali Hughes
Health and Care Partnership	After going to Health and	Simon Banks

Strategy Update	Wellbeing Board (possibly after 23 March)	

STANDING ITEMS AND MONITORING REPORTS

Item	Reporting Frequency	Lead Departmental Officer
Work Programme Update	Each scheduled Committee	Daniel Sharples
Pooled Fund	Each scheduled Committee	Sara Morris / Martin McDowell, Louise Morris
Healthwatch Update	Quarterly	Karen Prior
Dementia Strategy Update	Quarterly - May, August, November, February	Abigail Cowan