West Yorkshire and Harrogate
Health and Care Partnership

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Strategic review of readiness for public involvement in relation to the NHS White paper ambitions

A report by Stand

www.WeAreStand.co.uk

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Contents

Overall findings

West Yorkshire and Harrogate Health and Care Partnership's (the Partnership) commitment to patient, public, stakeholder and staff involvement is exemplary.

It is not just about fulfilling a statutory duty or ticking boxes, the Partnership are proactive in understanding and valuing the benefits of listening to people who access care and the wider public in the commissioning process.

They have set out strong commitments to involve local people in giving them a say in how services are planned, commissioned, delivered, and reviewed and this is vital to ensure services meet the needs of local communities.

To underpin this there are strong relationships in place between involvement partners, and the commitment to continuous improvement, transparency and trust is evident and observable.

The Partnership's Harnessing the Power of Communities Programme, with its ambition to establish the voluntary, community and social enterprise sector (VCSE) as an equal partner within health and care, contributing to shaping and delivering services from the outset and to the improved health and well-being of the population is impressive.

The Partnership has also made public statements that it is the servant of place with key strategies, operational delivery and feedback from local partners demonstrating that this is indeed the case.

Its updated Involvement Framework and underpinning Involvement and Communications Plan clearly describes a proactive and open culture in relation to public involvement and the role it has in transformation and service improvement both at scale Partnership and place levels.

Overall communications and involvement activities are co-ordinated at a local place-based level and the Partnership works with local involvement colleagues to ensure all activity is joined up, timely and appropriate through its at-scale support.

In local places and across the Partnership there is a strong community of engagement practitioners who deliver a range of best practice activities supported by examples of good involvement governance.

From the participation of a range of partners and involvement professionals in this review there is a tangible sense of positivity about the future integrated care system despite concerns around many unknowns in relation to pending NHS legislation at present.

These existing place-based staff and local involvement networks are paramount in making the transition over to a new statutory integrated care system which continues to be the servant of place.

All these elements, along with the ambition to continually be better at involvement at all levels and places, demonstrates a true belief of the positive benefits' public involvement within an open and transformative leadership.

It demonstrates a positive culture for ongoing improvements to be made to further develop involvement as the key strategic and operational function which binds the integrated care system together at all levels. It truly puts the public voice at the heart of decision-making which is critical to improving the health and care of the people of West Yorkshire and Harrogate.

There is a strong foundation to deal with the impending new legislation to minimise risks to the new integrated care system in relation to involvement.

The recommendations contained in this review are designed to build on this foundation, support the continuous drive for involvement excellence and help mitigate the risks in relation to organisational change.

It's important to note that the Partnership requested this review as part of their learning and improving process. This review pre-dates the publication of the Integrated Care Systems: Design Framework (June 2021).

Summary recommendations

Themes:

- Involvement policy, quality, and planning
- Inclusivity and equality
- Partnership working
- Investment and workforce
- Leadership, autonomy, accountability, and transparency
- Communication
- At place and West Yorkshire and Harrogate (ICS).

The recommendations can be read in full in Section 3.

Adopt and embed 'involvement' as the standard term in policy, strategy, and multi-channel communications

The Partnership's progressive approach in the adoption of the term involvement should be fully embedded, recognising that it is a spectrum from active communications at one end, through a wide range of participatory approaches and co-production, to public consultation.

Develop and agree key principles for involvement

The Partnership's updated Involvement Framework and supportive Involvement and Communications Plan include refreshed key principles for the Partnership. These are critical documents as they provide a strategic policy framework for working together at all levels.

Ensure there is a public voice at every level

Carry out a systematic review to establish that public voice is included at every level across the Partnership and that it is representative of the communities being served.

Ensure equality is the first consideration of involvement planning

Put reducing health inequalities at the heart of all involvement activity and ensure there is a joined-up approach across the Partnership by linking business intelligence functions with local place and equality leads.

Adopt a Maternity Voices Partnership (MVP) approach for equality groups or under-represented communities

MVP provides a positive model to resource and support ongoing involvement with key communities. Assess which other communities of interest would benefit from this approach. Other examples include the Cancer Alliance Community Panel, Health and Care Champions and Youth Collective Voice

Develop joint standards and protocols for involvement

To underpin the refreshed key involvement principles within the Involvement Framework, work together to develop joint standards and protocols.

Map good practice in places in order to scale and provide consistency

Capture and consider in particular good governance examples for involving patients, the public and carers at place level so these can be shared.

Continue to develop distributive approaches and serve local place

At scale working ensures that the right support and resources flow to places so they have what they need to deliver involvement locally.

Ensure business continuity for place-based involvement groups and networks

Ensure local places are supported to maintain relationships and links.

Adapt and adopt the spectrum of participation

The updated Involvement Framework includes the spectrum of participation and this should be adapted with underpinning Standard Operating Procedures to provide clarity and consistency for the Partnership.

Develop an insight and patient experience bank/dashboard

Develop a one-stop shop resource bank/dashboard which contains regularly updated insight and feedback around key issues as it becomes available.

Develop a clear forward plan pipeline for projects and programmes

Build on the engagement and consultation timelines work and collaborate to make available a refreshed forward plan which includes information about live activities at place, Partnership and programme level.

Link involvement closely with NHS trusts and social care/public health

Work much more closely with NHS and social care providers who through the delivery of services have day-to-day contact with patients and service users with lived experiences.

Develop and resource a community of involvement practice

Build in existing networks to further develop an active community of involvement practitioners.

Understand the involvement capacity and expertise within organisations at Place level

Involvement colleagues hold the critical links and local relationships which must be maintained if the Partnership is to continue to be a servant of place.

Develop a programme of wider staff awareness and training (non-involvement staff)

Identify and target colleagues at different levels and places who can champion patient and public involvement and be part of the extended community of practice. Develop a programme of training to enable this.

Next steps

All of the recommendations are important to include and it should be noted that many are already underway.

It might not be possible to implement some straight away due to the coproduction way of working evident in Partnership.

The outputs of coproduction activities will be addressed and incorporated into strategy and planning as work continues to move forward.

Introduction

In February 2021 the Department for Health and Social Care (DHSC) published *Integration and Innovation: working together to improve health and social care for all,* its white paper setting out legislative proposals for a Health and Care Bill.

The West Yorkshire and Harrogate Health and Care Partnership (the Partnership) required an independent external review of current involvement work with the aim of assessing strategic readiness to adapt to the direction of travel outlined in the white paper.

To do this effectively it required input from Healthwatch, partnership communications and engagement leads, programme directors and public involvement practitioners, wider public, governors and non-executive directors by means of discussion/focus groups.

The output of the work will inform the future design of the Integrated Care System (ICS) involvement. To note this review pre-dates the publication of the *Integrated Care Systems: Design Framework* (June 2021) which provides more detail around involving communities within Integrated Care Systems.

Methodology

To inform the discussions, a desk review of the white paper in relation to public involvement was carried out. This can be found in Appendix 1.

The review was provided as a written paper and prepared as a slide set to frame what was understood about the known expectations of the white paper in relation to public involvement and therefore inform discussions within the involvement activity.

A desk review of the Partnership's existing Involvement and Communications Strategy was also carried out, this can be found in Appendix 2. This is currently being coproduced with the intention of producing an easy read version, plan on a page, with a publication of early September (as per other editions).

Involvement activity

Stakeholders were targeted via email from West Yorkshire and Harrogate Health and Care Partnership directly, with a link to an Eventbrite page where those interested could register their interest in attending an event. An example of these emails can be found at Appendix 3.

Stakeholders were asked to participate in two ways:

- Taking part in online events
- If they were unable to attend the online events, they had the opportunity to respond to a wider discussion forum or /and online survey (see Appendix 4 for the survey questions)

Feedback was also taken at a meeting with the Race Equality Network 7 May 2021. The notes taken during the session can be found at Appendix 5.

Online focus groups and discussion event

Four events took place in April and May. Three were run as focus groups targeting different groups and the final event was run as a discussion event:

29 April:	Focus group for communication and engagement leads and Healthwatch, including local communication and engagement leads.
10 May:	Focus group for programme leads, Joint Committee of Clinical Commissioning Groups - Public, Patient, Involvement, non-executive directors, lay members and Partnership Board co-opted members.
11 May:	Focus group for patient or citizen representatives who are already involved in and familiar with involvement work of the Partnership.
20 May:	Discussion event was an opportunity for those who were unable to attend the previous events to participate.

A full list of organisations involved in the focus groups and discussion event are listed in Appendix 6.

The discussion events began with an introduction to the exercise, some background information and a briefing regarding the white paper and its impact on West Yorkshire and Harrogate Health and Care System.

A post-event evaluation survey was sent out after each event. The event evaluation report can be found at Appendix 7.

Online survey

Those who were unable to attend the focus groups or discussion event were invited to complete an online survey which contained the same discussion points as the events. The survey ran from 17 May to 31 May 2021. In total 10 surveys were submitted.

A copy of the online survey can be found at Appendix 4.

Analysis and feedback from participants

This report including feedback from the groups and the survey was shared in draft with all participants and a number of small clarifications added to this final report. A number of further issues were highlighted from reflections on the findings and thematic analysis. These are included in the addendum at the end of the report.

Recommendations in full

The recommendations have been developed to address the issues and themes raised through the Involvement Review engagement activities. The summary analysis of this can be found in Section 1 and the full thematic analysis is Appendix 8.

It should be noted that elements in the recommendations are already under way or in development, forming part of draft plans. This recognises the continuous improvement and reflective leaning approaches that are standard within the Partnership's approach to public involvement.

Adopt and embed 'involvement' as the standard term in policy, strategy, and communications.

The Partnership has adopted an updated Involvement Framework, which sets out its approach to involvement across West Yorkshire and Harrogate, with an underpinning communications and involvement plan for the current year.

Involvement has a definition to point to in NHS legislation: a spectrum from active communications at one end, through a wide range of participatory approaches and co-production, to public consultation. By adopting this approach it helps all partners to work to consistent level and see involvement as a spectrum.

Consistency and clarity in this area is very helpful in managing stakeholder expectations. Statute[1] sets out the duty for NHS bodies to involve patients and the public by providing information, by consultation, or in other ways in planning services, developing and considering proposals for changes to services, and making decisions. The terms engagement, involvement, participation and consultation are often used interchangeably, which can cause confusion, especially when public consultation (a formal framework for involvement with stringent legal requirements) is needed.

We can have participation, engagement or involvement without consultation. Consultation can't take place without participation, engagement or involvement.

It's not surprising that the Partnership is progressive in relation to the adoption of involvement as an encompassing term in comparison to the majority of other integrated care systems. The updated Involvement Framework and supportive Involvement and Communications Plan should be widely shared within the Partnership, as has been their practice in the past. It is a critical document to explain the rationale, embed involvement policy and ways of working which will support the continued consistency and high standards for public involvement and its role in helping the Partnership reach its objectives.

[1] S242/13Q/14Z2 NHS Act 2006 as amended

Develop and agree key principles for involvement

The new legislation gives the opportunity for health and care partners to renew involvement strategies through the development of refreshed key principles for involvement that can be adopted by all.

The updated Involvement Framework and supportive Involvement and Communications Plan include refreshed key principles for the Partnership. The latest version will be updated on the Partnership's website. These are critical documents as they provide a strategic policy framework for working together at all levels. The Framework supports horizontal relationships and distributed leadership. It supports the ability to link up similar structures and help create a more collaborative voice.

The principles must be owned and adopted by all boards and partnership groups and underpinned by supportive communications.

Ensure there is a public voice at every level

Carry out a systematic review to establish that public voice is included at every level across the Partnership and that it is representative of the communities being served. Assess and, where necessary, strengthen public, patient and carers' voice at place and system levels. This includes at executive and non-executive level within the ICS Statutory Board and Partnership board through to place. Ensure public voice is included in terms of reference and there is a clear feedback loop on how public voice has influenced decisions. Make clear the links public involvement planning, activity and feedback has with the quality board. once established for the Partnership

Ensure equality is the first consideration of involvement planning

Place reducing health inequalities at the heart of all involvement activity and ensure there is a joined-up approach across the partnership. Better data helps to understand which particular communities of interest should be prioritised for particular involvement activities/projects. This will also inform how resources can be managed to ensure they are available to support this work.

Business intelligence functions should work with local place and equality leads to support better data and understanding starting positions for involvement activities across the Partnership. Further work with the Race Equality Network to build local demographic representation in patient, public and carer involvement activity to ensure it is representative of the make-up of the local community.

Adopt a Maternity Voices Partnership (MVP) approach for equality groups or under-represented communities

MVPs in West Yorkshire and Harrogate provide a positive model to resource and support ongoing involvement with key communities. Similar models are also in use with children and young people (Youth Collective Voice) and learning disabilities (Health and Care Champions).

Review the model and resourcing of MVP and pilot with a key community of interest with the support of place colleagues. Other examples such as the BME Hub at Voluntary Action Leeds is a good example of a real partnership approach to increasing opportunities for under-represented communities to have a say

Assess which other communities of interest would benefit from this approach, for example minority communities, people from poorer communities or groups that have health inequalities are incentivised to get involved and are not disadvantaged.

Carry out a review of incentivisation or reimbursing orgs for their staffs' time. Meaningful incentivisation. Put in action plan. Engage and fund community and voluntary enterprise organisations to support.

Develop joint standards and protocols for involvement

To underpin the refreshed key involvement principles within the Involvement Framework, work together to develop joint standards and protocols.

Already the Partnership is identifying existing good practice in order to consider and adopt for all. Examples include planning frameworks, standard data monitoring information, accessibility standards and tools. For example the Good engagement toolkit Calderdale CCG produced for engaging with young LGBTQ communities

Work together to codesign a toolkit with standard procedures, set out best practice standards for different involvement methodologies and provide clarity about online and offline methods, where appropriate and helpful locally and at a system level.

These should include a clear description of what is a Standard Operating Procedure is at integrated care system (ICS) level and what is at local or place based. This will help build consistency and make it easier for partners to work together.

Map good practice in places in order to scale and provide consistency

Capture and consider in particular, good governance examples for involvement at place level so these can be shared. Work together to consider what could be scaled up, taking the best from all areas, and adopted more widely. This should also include equality and accessibility standards and practices for involving different communities. This would work

well as part of integrated care partnership (ICP) or place level in line with a governance working group.

Continue to develop distributive approaches and serve local place

At scale working ensures that the right support and resources flow to places so they have what they need to deliver involvement locally. This is a two-way reciprocal relationship which has responsibilities for all to work with each other with trust and transparency.

Ensure business continuity for place based involvement groups and networks

The majority of work will continue to be carried out at place by current CCG staff who will transfer to the ICS. Ensure local places are supported to maintain relationships and links. Carry out the mapping of involvement groups at place eg Clinical Commissioning Group (CCG) and local authority supported groups (e.g. citizen panels, PPI groups) and other local networks. Make arrangements to ensure support and key links are in place for support to them after April 1 2022 so as to minimise the inadvertent loss of relationships and contacts which are of paramount importance to local areas.

Adapt and adopt the spectrum of participation

The spectrum of participation is internationally recognised as the best model to help differentiate levels of involvement.

The updated Involvement Framework includes the spectrum of participation and this can be further adapted for health and care partners.

It would provide clarity over what is communications information sharing (passive) through to co-production (proactive participatory), provide clarity on the Partnership's use of terminology (consultation or engagement) and provide guidance around resources and timescales for involvement to be effective. It would be a helpful exercise to adapt each level of participation for the partnership with underpinning Standard Operating Procedures (SOP) for different tools used within each level, allow room for local place needs.

Develop an insight and patient experience bank/dashboard

Build on the engagement mapping reports to develop a one-stop shop resource bank/dashboard/hub which contains regularly updated insight and feedback around key issues. Further work is under way to consider a public experience section of the website and the 'we heard' or 'You said, we did' section to be regularly updated. Build on this to explore a live hub approach.

Gain support from all partners to contribute to as well as resources to develop and maintain. By continuing to ensure there is a collective understanding of what is already known about what is important to patients will allow a deeper understanding to permeate into the collective consciousness of staff and decision makers. This will help them make better more informed decisions both operationally and strategically.

Develop a clear forward plan pipeline for projects and programmes

Build on the engagement and consultation timelines work and collaborate to make available a refreshed forward plan which includes information about live activities at place, Partnership and programme level.

This should include involvement projects pipeline at all sizes and scope, whether at scale, placed based or locality based (or wider at NHS region or national).

In it recognise that things do change as well as new urgent projects are sometimes needed.

This will mitigate different projects overlapping and reduce duplication at partnership and place with the same target audience.

It provides opportunities to join up activities with social care, NHS Trusts and VCSE. Having a strategic overview allows better use and flow of resources and identify areas for investment. It supports the requirement for continuous involvement.

Link involvement closely with NHS trusts and social care/public health

The easiest way to involve people with lived experiences of services is to work much more closely with NHS, public health and social care providers who through the delivery of services have day-to-day contact with patients and service users. Involve these partners in planning the pipeline and support then with place based involvement expertise on shared projects and issues, taking account of the richness each different group bring from varying perspectives

Local places have integrated care relationships across CCGs, trusts and local authorities. To help minimise risk it's recommended that there are links made with an involvement lead for each trust and local authority, who are linked into the development of Community of Involvement Practice

Develop and resource a community of involvement practice

There is already broad networking which takes place every three months, supported by regular updates and meetings. This has a wide membership and good participation which provides an excellent basis for further development. Map the stakeholders and roles within the network to develop further involvement interests and specialisms, for example patient

experience, participatory methods specialisms. It's important to recognise that current CCG engagement and communications staff will become part of the statutory ICS and will require network support as a key ICS staff group with strong links to place.

Continue to use on and offline for more regular opportunities to network, guest speakers, share case studies, learning and development and share forward planning pipeline. Use involvement principles to co-produce a collaborative approach. Continue to provide opportunities for training and development and link to professional bodies such as The Chartered Institute of Public Relations and The Consultation Institute.

Understand the involvement capacity and expertise within organisations at place level

Involvement colleagues hold the critical links and local relationships which must be maintained if the ICS is to continue to be a servant of place.

It's an uncertain time with lots of unknowns from the white paper, so it's essential that staff are involved and supported. In line with those supportive approaches knowing the skills, expertise and experience of practitioners is critical to maintaining business continuity. Carry out refreshed stakeholder mapping and update the stakeholder data base to include an involvement lead within each partner organisation, recognising that not all VCSEs can do this so it would need to be explored how best to do this.

Develop a programme of wider staff awareness and training (non-involvement staff)

Poor involvement experience and outcomes is often a consequence of the lack of planning, time, resources or understanding what is involved to deliver a project to a good standard. Raising awareness of key considerations, where to access support and advice with non-involvement colleagues will help mitigate poor involvement due to lack of knowledge and unrealistic expectations about what is possible and reasonable within the timeframe and resources.

Identify and target colleagues at different levels and places who can champion patient and public involvement and be part of the extended community of practice. Develop a programme of staff and citizen training to enable this.

Assess and collate resources for training and supporting public representatives. There is good practice within the areas that can be shared and adopted.

Key themes gained from review involvement activity

This section brings together the feedback from the review of involvement activity. It has been drawn from the thematic analysis which is contained in full in Appendix 8.

It shows the further analysis which was distilled from the thematic analysis into sub-themes which explore further the key issues raised and provide information and areas for recommendations contained above.

Involvement policy, quality and planning

What good involvement policy and planning looks like

There were recurrent comments across the groups and survey about how involvement must be meaningful and purposeful, relevant, continuous, timely and planned in advance.

People felt that involvement should build upon what is already known and actively seek opinions on the issues that matter to citizens on their own terms.

This also included how involvement should be ongoing and flexible enough to deal with new issues that arose which required rapid responses.

People also strongly felt that for involvement to be meaningful it needed to take place before the decisions are made and that the insights from involvement are to be used in the decision-making process. And that there needs to be continued feedback on how involvement made a difference, even where this might take some time to be implemented.

There was an appetite to enshrine the public voice at ICS or ICP level and include the public in the decision-making process. It was felt there needed to be a distinction between passive and decision-making involvement, and between consultation and engagement as the difference is really important.

What is done well for involvement policy, quality and planning

It was recognised by many participants that the Partnership does involvement well, and involves people at system level, and that there was good involvement at place level as appropriate with lots of opportunities and events for involvement.

There were positive comments from place colleagues about how proactive the Partnership was in gathering views and experiences in planning and provide clear resources and examples to base engagement on.

The ambition to co-design services from the beginning with those with lived experience was also recognised along with meaningful grassroots engagement support delivered by VCSEs. Prior to the COVID-19 pandemic would go into the community to engage.

One participant was keen to stress that payment for people with lived experience sharing their views was important, in terms of how we value peoples time, effort, experiences and worth.

Importantly it was recognised that there had been no top-down enforcement of what involvement has to look like and that colleagues listen without judgement.

There were numerous examples of good practice going on at place level provided in the focus groups including:

- Joint strategy in Calderdale on how to involve
- Use of asset-based community development/engagement – community champions (Calderdale) and community voices (Kirklees)
- Patient Engagement and Advisory Group in Kirklees (VCSE)
- The Big Leeds Chat - leaders from all sections of health and care meet directly with members of the public (Healthwatch, VCSE)
- PPI assurance group works and ensures engagement is proportionate, timely and adequate (NHS Organisation)

What could be done better for involvement policy, quality and planning

There were some remarks about what could be done better, which were around planning time and notice given for involvement opportunities, but recognition that this was sometimes out of the Partnership's control. And while there was a generally proactive stance in asking for people to be involved, it was felt that both Partnership and local places were not as good at responding to requests for reciprocal involvement input.

There were comments about being very clear about why involvement is needed in the first place as good engagement has a focal point and a clear objective. Involvement should be able to influence a decision or design.

By the nature of covering a large geography, there was a perception that sometimes the Partnership and local commissioners could appear distanced leading to a disconnect with NHS providers.

Also the perception that system barriers and working practices get in the way of working together. There were concerns around involvement fatigue where different organisations were talking to the same people on multiple occasions and overlapping on subjects, and this was because there wasn't a general oversight of the involvement work being carried out by all partners. This could be improved by colleagues making best use of the current WY&H HCP engagement and consultation mapping insight report as the starting point.

There was recognition that often councils have better relationships with the public and VCSEs. It would be helpful to have insight shared so all could benefit when planning activity. The mapping report helps with this.

There were a number of areas identified by participants that provide opportunities to work better together as a community of practice.

These included:

- Insight repository of past engagement with a database to allow information to be analysed to find emerging themes – it can guide how to engage and where to focus
- Use of key performance indicators and linking involvement service specifications/patient experience requirements that are in provider contracts
- Joint standards and mirror good examples across different areas

Opportunities for involvement from integration and closer partnership working in relation to involvement policy, quality and planning

People felt that there was a renewed opportunity to work on involvement projects together and really demonstrate impact of involvement and show the difference it makes. This included renewed partnership working with multiple organisations engaging on the same or similar issues and sharing insight and resources between organisations and places. This would increase awareness about involvement exercises taking place across localities among practitioners.

In particular there was an opportunity to look at whole pathways including social and health care provision, making involvement feel more streamlined and cohesive.

People felt the potential to really embed involvement so that decision makers always have public involvement in mind. There was an appetite to look at involvement projects that could be done once at scale, similar to the engagement with the vaccine programme, working at scale freeing up others to get out and about to build relationships. Another good example of scalable best practice is the IRO children's involvement toolkit produced by Leeds City Council and the stroke and assessment treatment unit work.

Again the issue of continuous involvement was seen as paramount and not just when change is imminent.

There were suggestions around the continued need to share best practice (NHS organisation):

- Understanding one type of involvement does not work for all, and will need to be adapted (NHS Organisation, VCSE).
- Prevention agenda should underpin every commissioning decision (Healthwatch).

Risks this brings for public involvement policy, quality and planning

Comments on risks ranged from concerns that people may feel involvement is distant from the community, with things being done at too large a scale, to a worry about more

bureaucracy – people feel more lost in the system and therefore less engaged, therefore important to continue to involve local race equality networks and community groups to make sure the voice of minority communities remains strong There was a concern about overcomplicating things and the need to keep momentum going.

Also that it takes years to change people's mindset around patient involvement meaning that new ways of working won't be embedded overnight.

Risks were raised about losing the experience, knowledge and skills around involvement. Also a major risk was highlighted that nothing changes at all, there is an opportunity for change and the risk is that it is not capitalised.

Inclusivity and equality

What good involvement policy and planning looks like for inclusivity and equality

In relation to inclusivity and equality, there were strong feelings about the importance of using a variety of methods of involvement, channels of communication and multiple opportunities to target all audiences and populations. This includes all communities, ages, faiths, and socio-economic sectors and should represent the communities it serves. This means not just ethnicity and race but socio-economic status, language, and experiences and also not just those who always turn up. Participants felt that there should be a focus on those with health inequalities including digital exclusion and a recognition that one size does not fit all.

There were suggestions that involvement activities with these groups need to be done by outreach – going to the people and not expecting them to come to you. For example, the use of an engagement bus to help reach out, in particular to reach those in rural villages.

What is done well for inclusivity and equality

There was acknowledgement that organisations use different methods of involvement such as newsletters, websites, social media, meetings, and podcasts and that information and opportunities for involvement is made accessible for all communities. Also that opportunities were provided for lived experiences at the decision-making table and various mechanisms for patient and citizen participation and that under-represented voices were actively sought.

There was a recognition that COVID-19 has been difficult, but lots has been done to change involvement rapidly and develop good practice, for example community Covid champions to encourage certain groups to take up the vaccine, involving and co-designing with people with learning disabilities and an example of a communication and equality collaborative being developed.

What could be done better for inclusivity and equality

There were suggestions that more could be done to involve a range of young people from vulnerable groups to give them a voice. Similarly, engagement should be proportionate with the smallest voice being given the greatest opportunity. It was also observed that greater consideration was needed for non-digital engagement. There is support for more public representatives on boards and for development opportunities for representatives to join boards.

Opportunities for involvement from integration and closer partnership working for inclusivity and equality

In relation to inclusivity and equality there is the opportunity to engage more systematically with people with lived experiences of health and care services.

Also, to support young people from education and the social care perspective and to have the patient voice at the centre of decision-making.

There were comments about ensuring organisations serve the community they represent, employing people with lived experiences of services being used. There are very few NHS Directors or senior staff with disabilities. And there is an opportunity to look at how the Fellowship Programme for ethnic minority colleagues could be adopted for a similar approach for people with disabilities.

Working closely with local authority/public health and VCSE would help to link to vulnerable communities eg gypsy traveller community.

Risks does this bring for patient and public involvement for inclusivity and equality

There was a strong message that consideration of equality needed to be front and centre of all involvement planning and activity and that the thread of equality in PPI needed to be more robust.

It was also highlighted that the funding to carry out involvement with protected and deprived communities was different for various CCGs, so patients and carers will see the differences across areas in relation to involvement activities being carried out. There is also a risk of smaller grass roots VCSE not having voices heard at an ICS level as they don't have the capacity to engage. The links from place based relationships were important to ensure small VCSEs kept their voice. There was a concern about the distance between decision makers and the public – West Yorkshire and Harrogate is a large area with disparate communities.

There were concerns that quieter voices may be drowned out and to guard against the assumption that they are represented when they are not. In terms of working at scale there was a worry that feedback might be diluted.

There was recognition of the challenges between equity versus equality and that doing the same across all places may increase inequalities.

Partnership working

What good involvement policy and planning looks like for partnership working

As regards the theme of partnership working there were comments that all organisations needed to work together on the planning and operational deployment of involvement.

This needed to extend from involvement practitioners' relationships but also multi-way conversations between decision makers, commissioners and the public in relation to key issues and involvement. There were comments about how lay involvement can address conflicts of interest.

What is done well for partnership working

There were many comments about the good partnership relationships that are in place, working well with VCSEs and Healthwatch and not duplicating activities.

There were many comments about the value of the community and voluntary sector who do relationship-building well and reach people who statutory organisations wouldn't normally hear from.

People felt that it was very helpful to share good practice between organisations so everyone could learn from each other.

Maternity Voices Partnership was working well and being resourced at place and WY&H level, to be properly supported was raised as a good practice partnership example, and that participants are involved from day one and help to develop plans.

These good relationships should be fostered and further strengthened with other advocate organisations more systematically and there was recognition that long term relationships build trust in both directions.

What could be done better for partnership working

In response to what could be done better the responses focused around building relationships and working together more. There were examples of much great partnership work going on but it was felt this was not consistent across areas and frustrations about this were expressed.

This included continuing to build the connection between involvement work at place and at system level and more co-production of solutions with residents and clinicians working together, as well as joined-up working with local government.

Because there isn't a framework in place it was difficult to have a conversation across multiple areas. There were missed opportunities to build involvement into contracting meaning that organisations were obliged to have involvement plans which were monitored.

Also that Healthwatch is underused and they fit very well in providing collaboration and involvement.

While it was recognised that there was a lot of good practice going on, it was felt there was inconsistency in closing the loop to feed back to participants and stakeholders on how issues have been influenced or changed as a result of involvement.

The issue of sharing key insights and patient experience was raised as an area for development in order for all to have a mutual understanding of the things that are important to people.

There was curiosity about how internal resolution structures might be put in place between the partnership board and the NHS statutory board in case of disagreement.

Opportunities for involvement from integration and closer partnership working for partnership working

Again the opportunities were seen to be significant. The opportunity to work collaboratively and the linking up of similar structures to create a more collaborative West Yorkshire voice. Having a more integrated approach to patient care, removing the silo way of working, and the merging of health and social care to share resources and break down barriers were cited, as well as it was simply helpful to see what is going on with involvement from different partners and systems.

There was a great opportunity to engage with adult social care and get them to understand the benefits of working across boundaries.

Being able to share insight in one place and making it easy to find views on services another opportunity.

As part of sharing good and best practice, practical examples of how medical and clinical services could learn from mental health around patient reported outcome measures were discussed. There were comments about how dialogue between patients and clinicians could be encouraged and for clinicians to own patient involvement so they would be more likely to buy in and there would be a better outcome as a result.

The opportunity to better support VCSEs with funding and guidance was mentioned.

Risks does this bring for patient and public involvement for partnership working

In relation to risks, there was concern about how conflicts of interest would be resolved; the danger that the ICS commissions a service and it is difficult to resolve problems as the provider is sitting at the table.

The differences in the language that partners use was a risk, with consultation meaning different things to local authorities and the NHS.

The general ongoing challenge of cross border working creates problems was discussed.

Investment and workforce

What good Involvement policy and planning looks like for investment and workforce

There was an opportunity to really invest in public involvement, meaning both operational funding support and investment in staff. This also included wide range of learning and mentoring for those involved in delivering involvement.

There was a recognition that volunteers needed to be reimbursed for their time, either financially or with training. However noting that financial rewards are difficult for those without bank accounts.

Also mentioned was the investment in the training and development of people who will be involved in the meetings as well as ensuring that professionals understand what involvement is.

What could be done better for investment and workforce

Again, the need to invest in capturing voice and influence was highlighted.

There were comments about involvement not being given enough of a budget, in particular for small low-cost solutions rather than big service change. Also the question of who pays for different involvement activities.

It was felt that there was an workforce model which had not been invested in for years and that the pandemic has had a disproportionate effect on workforce - they're patients as well and get lost in the system due to labels.

Opportunities for involvement from integration and closer partnership working for investment and workforce

The opportunity is there for more investment into involvement as a priority area and making the link between involvement and better quality and outcomes.

Risks for patient and public involvement in relation to investment and workforce

Conversely one risk highlighted was that there may be insufficient resources to be able to support involvement and the competing demands from individual organisations.

There were concerns around social care integrating as they have separate streams for budgets.

There was recognition that the cost of involvement, if done properly, is costly.

It was recognised that VCSEs and social care are running on fumes, expecting them to collaborate is a bit much without proper support and investment.

Other risks mentioned were around the uncertainty for staffing and continuity of work as well as the potential for extra work, as it takes time to plan and deliver involvement projects.

Leadership, autonomy, accountability and transparency

What good involvement policy and planning looks like for leadership, autonomy, accountability and transparency

Transparency, trust and accountability with the patient voice throughout was seen as essential.

There were comments that there is a leadership culture which encourages engagement and involvement. There is also visible leadership with transparent recruitment in place.

It was felt that the ICS boards should meet in public and be subject to freedom of information (FOI) requests and that there should be representation of public, patients and carers at statutory ICS level and local place level.

What is done well for leadership, autonomy, accountability and transparency

There were examples of the Patient Assurance Group (PAG) in Leeds CCG which is a team of volunteers who scrutinise every involvement exercise and hold everyone accountable, with a similar board also in Bradford and Wakefield. Having checks and balances with independent people to assess involvement planning and outcomes was considered good practice.

What could be done better for leadership, autonomy, accountability and transparency

It was felt that it was unclear who, under the white paper, who will be responsible for listening and responding - many partners are involved. And the need to have true independence and scrutiny of PPI arrangements, again it was not clear how this could be achieved.

It was felt that sometimes there were concerns about sharing gathered insight, particularly VCSEs. It was felt that more could be done about managing conflicts of interests and impartiality and understanding how conflicts are resolved or mediated.

Opportunities for involvement from integration and closer partnership working for leadership, autonomy, accountability and transparency

There were a number of suggestions about opportunities for leadership in relation to involvement. Continuing to develop leadership with influence on different levels, from place to ICS level, and to have a leader who will champion the voice of the people. There was a suggestion for a board level director of patient and public involvement who is independent

of, but representative of organisations and patients and able to take ownership in involvement. In support of this, further robust governance was necessary to ensure there is challenge at the ICS level linking through to place. There are four co-opted members on the current Partnership Board.

Risks does this bring for patient and public involvement for leadership, autonomy, accountability and transparency

The main issue raised around risks in relation to accountability was the plan to remove powers from health overview and scrutiny to refer to the Secretary of State.

It was felt that scrutiny provides accountability and a way for the public to express concerns. Scrutiny can look at services from a point of view of place, organisations can make changes, scrutiny looks at the services as needed, it's an important crossover.

Communication

What good Involvement policy and planning looks like for communication

The need for ongoing clear regular communications so communities know what is happening in their area and can get involved was raised.

Making sure there is a clear line into the decision maker so that the outputs of involvement can be used to influence.

It is key to always start with what is already known and that the involvement activities are meaningful and effective for improving services, as well as being clear about what can be changed as result of engagement.

What is done well for communication

It was commented that there were regular communications which are shared and lots of information is made available.

What could be done better for communication

There were comments that communications are often not written in a public-friendly manner – it is aimed at professionals. Sometimes when lots of information is provided at once it could be broken into bite sized pieces. There was a preference expressed for regular updates via social media.

Opportunities for involvement from integration and closer partnership working for communication

There was a need for more information about integration to keep up-to-date with progress.

Risks does this bring for patient and public involvement for communication

If a communications model was to be developed across the ICS, all organisations would need to sign up and follow it, otherwise it could result in mixed messages.

At place and ICS

What good involvement policy and planning looks like at place and ICS

This would mean a clear commitment to local areas while working at scale, getting the balance of bottom up and top down in terms of planning and resources.

It was strongly felt that engagement with communities works at place level and needs to stay at place level.

What is done well at place and ICS

Local areas felt that the ICS was supportive of those working in places and worked hard to get place based support right.

It was recognised that the size of West Yorkshire and Harrogate helps the NHS and partners to work successfully at a place-based level.

What could be done better at place and ICS

It was recognised that there was a need for coordination at ICS or place level and getting the balance of this right was difficult.

It was important to point out that this is not just place, that neighbourhoods are also important.

Opportunities for involvement from integration and closer partnership working at place and ICS

There is an opportunity to mitigate complicated geographies, for example Kirklees share an acute Trust with Calderdale and Wakefield.

Risks does this bring for patient and public involvement at place and ICS

While there was a commitment to place, there was a concern about how local would groups still exist after the CCG goes.

Appendices

Appendix 1 - Desk review of the white paper.

Desk review of key issues around the NHS Duty to Involve in relation to the Department for Health and Social Care's (DHSC) White Paper Integration and Innovation: *working together to improve health and social care*

Prepared by Stand for West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP)

26th April 2021

Background

This report has been prepared as part of a best practice process in conducting an independent external review of West Yorkshire and Harrogate Health and Care Partnership's current involvement work with the aim of assessing strategic readiness to adapt to the direction of travel outlined in the Department for Health and Social Care's (DHSC) White Paper Integration and Innovation: *working together to improve health and social care* which was published in February 2021.

It contains a desk review of commentary and analysis from a range of organisations that have published information in relation to the white paper and this review has a specific focus on how future legislative proposals for a Health and Care Bill could impact on NHS duties to involve patients and the public.

The purpose of producing this report is to identify key issues contained in the white paper to assist participants taking part in the partnership's focus group and survey activity in formulating their views in how current involvement strategies and plans should develop for the future.

For completeness, the sources identified for the desk review are contained in appendix one.

Introduction to the white paper

A white paper setting out legislative proposals for a Health and Care Bill was published February 2021 Integration and Innovation: working together to improve health and social care for all

The main focus is to speed up integration of health and care and to resolve tensions in NHS policy since Health and Social Care Act 2012.

It builds on engagement carried out by NHS England and NHS Improvement and the Health and Social Care Committee to draw up a set of agreed legislative proposals in 2019 and also NHS England and NHS Improvement subsequent more recent engagement process on Integrating Care with regard to system working published November 2020.

The DHSC emphasises the fact that it has sought to develop the legislative proposals with the whole health and care system in mind to realise the ambition of reducing inequalities and supporting people to live longer, healthier and more independent lives. The purpose of the legislation set out is to create an enabling framework for local partners to build upon existing partnerships at place and system levels, and to align services and decision making in the interests of local people. In addition to closer working at a local and system level, the white paper refers to new, 'proportionate national legislative intervention on public health measures'.

The three factors that frame the government's proposed approach are:

1. The importance of shared purpose within places and systems
2. The recognition of variation – some of it warranted – of form and in the potential balance of responsibilities between places and the systems they are part of
3. The reality of differential accountabilities, including the responsibility of local authorities to their elected members and the need for NHS bodies to be able to account for NHS spend and healthcare delivery and outcomes.

The white paper focuses on two forms of integration: (1) integration within the NHS to remove some of the boundaries to collaboration and to make working together an organising principle; and (2) greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved health outcomes and wellbeing for local people. To achieve these goals, the paper proposes to establish statutory integrated care systems (ICSs) comprising:

- **Statutory ICS NHS Body** – responsible for day-to-day running of the ICS, including developing a plan to meet the health needs of their population, developing a capital plan for NHS provision and securing the provision of health services to meet population needs. It will have a duty to meet the system financial objectives allocated to it by NHS England. The white paper also establishes a set of minimum standards around representation on the unitary board governing the ICS NHS body. The ICS NHS body is set to feature, as a minimum: 'a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally for example community health services (CHS) trusts and mental health trusts, and non-executives.' (Chapter 6, 6.18)
- **Statutory ICS Health and Care Partnership** – a body bringing together NHS, local government and partners that will be responsible for supporting integration and

developing a plan to address the systems' health, public health and social care needs. Representation will be at the discretion of individual systems but members: 'could be drawn from a number of sources including health and wellbeing boards within the system, partner organisations with an interest in health and care (including Healthwatch, voluntary community social enterprise (VCSE) partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers).' (Chapter 6, 6.20)

The proposals for ICSs provide for a core set of requirements for each system that the partners can then supplement with local arrangements. There is recognition of the need to avoid a one-size-fits-all approach and enable flexibility for local areas to determine the best system arrangements for them. Systems will be helped in this regard by proposals to allow various organisations to form joint committees to which functions may be delegated, with the power to make decisions on behalf of the organisations within the ICS.

The government reiterates its intention to bring forward separate proposals on social care later this year.

Key issues regarding patient and public involvement

The current statutory duty to involve that commissioners hold will transfer to the statutory ICS NHS body

Under the duties to involve (S13Q & 14Z2 National Health Service Act 2006 as amended Health and Social Care Act 2012) currently commissioners must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—

a) in the planning of the commissioning arrangements,
b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them [from the perspective of the patient], and
c) in decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Commissioning groups must also [S14Z11] prepare and publish a commissioning plan before the start of each financial year. In developing or revising the plan it must [S14Z13] consult the people who it is responsible for; publish a summary of their views and how it took those views into account in the plan. It must consult each relevant Health and Wellbeing Board and include in the published plan a statement of their final opinion.

The power for Local Authority Health Overview and Scrutiny Committees (HOSC) to refer to the Secretary of State for review will be removed

Currently if HOSCs are dissatisfied with a service change decision made by an NHS body they can refer the matter to the Secretary of State for review (Regulation 23(9), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013).

HOSCs will continue to be a key stakeholder, however the loss of these powers at the end of the scrutiny process will mean that political relationship are paramount and may make a claim for Judicial Review more likely in contentious cases.

To note that anyone with an interest may bring a claim for Judicial Review if they consider that the NHS body has failed to act in accordance with the law. In this legal process a judge will review the facts of the case by examining programme documents and considering written witness statements. The court can quash decisions if a judge finds they have not been made in accordance with the law.

There will be increased power for the secretary of state over the NHS

Under Chapter 5 (5.83), it reads: 'We are therefore proposing to broaden the scope for potential ministerial intervention in reconfigurations, creating a clear line of accountability, by allowing the Secretary of State to intervene at any point of the reconfiguration process.'

Secretary of State is currently only able to intervene in such cases upon receiving a local authority referral and may commission the Independent Reconfiguration Panel to provide recommendations.

The Independent Reconfiguration Panel (IRP) will be replaced by new arrangements

On managing local service reconfigurations, the IRP has (following local authority referral) provided a clear mechanism for resolving disputes. While the process of gathering the required information to make a referral to IRP can be slow and extremely resource intensive, it offers the opportunity to clinicians, managers and the public to set out their cases so, should Secretary of State intervention be required, information about local circumstances and opinions is clear. The current Independent Reconfiguration Panel offers generic advice and support to NHS and other interested bodies on the development of local proposals for service change, and publishes the advice it gives to the Secretary of State on each matter referred to them. These provide a rich resource of lessons learned for systems and programmes planning service reconfigurations.

The commissioners' requirement to formally consult a local authority on a proposal for substantial development or variation will transfer to the statutory ICS NHS body

The 2013 Health Scrutiny Regulations (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013) place on NHS commissioners a statutory duty to formally consult a local authority where the NHS (commissioner or provider) has under consideration any proposal for a substantial development of the health service in the area of that local authority, or for a substantial variation in the provision of such a service.

There will be speedier reconfiguration process to be set out in new statutory guidance

The current NHS England and NHS Improvement two-stage independent assurance process (Planning, assuring and delivering service change for patients, NHS England 2018) is due to be reviewed. The assumption being that the review will bring about that speedier process.

There are no plans to remove health and wellbeing boards

Health and wellbeing boards (HWB) will work with the statutory ICS Health and Care Partnership, but it is not clear if these will continue to be local authority based HWBs or if there will be one Joint Strategic Needs Assessment for the ICS. This is relevant for those ICS footprints that have multiple local authorities involved. Further guidance is expected.

The importance of place but no statutory recognition

The importance of 'place' is often that of a local authority boundary. Much of the integration and improving population health is driven by organisations collaborating at this level, and successful ICSs have concentrated their efforts on supporting the places within their footprint. There is not expected to be a statutory underpinning for 'place' but the white paper sets out a clear expectation that the statutory ICS NHS body delegate 'significantly' to place level as well as to provider collaboratives.

The development of place-based partnerships will be left local determination, building on existing arrangements where these work well. We can expect that involvement duties will be delegated in this way with most of service change involvement happening at place level.

A new duty to collaborate

The white paper sets out that the collaboration proposal is set to replace two existing duties to cooperate in legislation, but there are concerns about doing so unless there is clarity on what exactly organisations are being asked to do through the duty. Suggestions that the government may wish to develop the notion of a 'duty to collaborate on improving health inequalities'. This in effect would mean a duty to collaborate towards a goal rather than collaboration for collaboration's sake.

There is a lack of a reference to addressing health inequalities so suggestions to develop the notion of a 'duty to collaborate on improving health inequalities'.

Concerns around pace and timescales

'On current timeframes, and subject to Parliamentary business and successful passage, our plan is that these proposals for health and care reform will start to be implemented in 2022.' (Chapter 4, 4.6)

There is an assumption across the health and care sector that more specifically this will be from the beginning of the financial year next April 2022.

There has been no formal consultation on the content of the white paper and the only pre-legislative scrutiny has come through a handful of sessions conducted by the Health and Social Care Select Committee.

Appendix one – Sources in relation to the white paper

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
NHS Confederation	In February 2021 the government published Integration and Innovation: Working Together to Improve Health and Social Care for All. The white paper sets out the key elements of a forthcoming health and care bill, the first piece of new primary legislation on health and care in England since the Health and Social Care Act 2012 (HSCA 2012). This report outlines the views of healthcare leaders on the white paper, the implications for the forthcoming health and care bill and a set of recommendations to government as it develops the finer detail of the legislation. **Key points** Our members – spanning acute, mental health and community providers, as well as commissioners, primary care networks and integrated care systems – have strongly welcomed and endorsed the direction of travel set in the white paper. The experience of recent years, and especially the pandemic, has shown the real benefits of collaboration within the NHS and also with other public services. Our members are clear that the complex challenges facing the health and care sector over the coming years will require ever-closer collaboration, risk-sharing and flexibility, which the proposed legislation will facilitate. There is also a widespread view across the NHS that the forthcoming legislation should aim to be as permissive as possible. One of the most welcome features of the white paper is that it recognises the contribution that local leaders will make to address the specific needs of their communities. It is especially welcome, therefore, that the white paper provides scope for local	**No specific notes in relation to Involvement duty** **Scope for local flexibility** One of the most welcome features of the white paper is that it recognises the contribution that local leaders will make to addressing the specific needs of their communities. It is especially welcome, therefore, that the white paper provides scope for local flexibility. **Increased power for the secretary of state over the NHS** The measures in the forthcoming bill should not return to an environment in which there is heavy-handed ministerial involvement in the operation of the NHS. There must be clear and robust checks and balances in place for the circumstances under which the Secretary of State for Health and Social Care can NHS Confederation Legislating on the future of health and care in England intervene in issues such as service reconfigurations and senior appointments within ICSs, which should as far as possible be left to local discretion.

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
	flexibility. We urge the government and those that regulate and oversee the NHS to ensure that the bill, and especially the wider guidance to support its implementation, continues to embrace this principle. There are, however, some concerns shared across our membership in four key areas that the government may wish to address in the bill: **1.** Increased powers for the Secretary of State over the NHS **2.** Governance and accountability **3.** The duty to collaborate **4.** Pace and timescales	Under Chapter 5 (5.83), it reads: 'We are therefore proposing to broaden the scope for potential ministerial intervention in reconfigurations, creating a clear line of accountability, by allowing the Secretary of State to intervene at any point of the reconfiguration process.' On managing local service reconfigurations, the Independent Reconfiguration Panel (following local authority referral) has provided a clear mechanism for resolving disputes. While the process can be slow and extremely resource intensive, it offers the opportunity to clinicians, managers and the public to set out their cases so, should Secretary of State intervention be required, information about local circumstances and opinions is clear. Our members believe that any future resolution process should continue to be based on transparent, local consultation in the first instance, only requiring central intervention where local accountability mechanisms have proved ineffective. If the Secretary of State will be able to intervene earlier in future, we believe there must be a minimum level of supporting information requirements upon which the SoS would base a decision either in support or opposition of a service reconfiguration. Further, this information should be made public by the Secretary of State when confirming their decision.

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
		To support this point, concern about the health and social care secretary's recent intervention in Chorley and South Ribble local reconfiguration before local authority referral or even a public consultation had concluded. Careful consideration must be given to legal process on this issue to avoid the SoS intervening when it is not clear what the views of local communities are and to avoid the power being misused for political reasons. At the heart of any new powers for the Secretary of State must be transparency. There must be clear and robust checks and balances in place for the circumstances under which the Secretary of State can intervene in service reconfigurations and a minimum level of supporting information requirements. These should include: clear processes for local resolution in the first instance; criteria indicating when and how Secretary of State intervention is needed; a requirement for the Secretary of State to consider local clinical advice and any other advice offered by the affected ICS on a service reconfiguration decision, all of which should be in the public domain. Similarly, if new powers are proposed around market intervention, such powers should be deployed only after the

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
		Secretary of State has taken account of local opinion and advice.
NHS Providers	The proposals are expected to speed up the move to integrate health and care at a local level. The new bill is expected to be wide ranging, including new powers for the secretary of state to direct NHS England and plans to put Healthcare Safety Investigation Branch on a statutory footing. NHS Providers will work closely with the government to get the detail of these proposals right. Commenting on the release of the 'White Paper' with legislative proposals for a Health and Care Bill, the chief executive of NHS Providers, Chris Hopson, said: "There is widespread agreement across the NHS on many of the proposals in this paper thanks to the work done by NHS England and NHS Improvement and the Health and Social Care Committee to draw up a set of agreed legislative proposals in 2019, a process to which NHS Providers contributed extensively. We are pleased to see that this work forms the bedrock of what is now being proposed. "These proposals provide an important opportunity to speed up the move to integrate health and care at a local level, replace competition with collaboration and reform an unnecessarily rigid NHS approach to procurement.	**No specific notes in relation to Involvement duty** Confirmation that as expected the statutory basis of trusts and foundation trusts will remain 'broadly unchanged' as the key unit of delivery for acute, mental health, ambulance and community services. Trusts' role as the leaders and co leaders of system working, will continue to evolve in this new context. In general, trust leaders also view the current fragmented commissioning arrangements, competition rules and procurement processes as sub-optimal, and support the aim to align the legislative framework with collaborative ways of working far reaching powers for the secretary of state. This includes greater powers of direction over NHS England, and the potential for the secretary of state to intervene at an earlier stage in local service reconfigurations. We are actively engaged in discussions with the DHSC to understand the intent and practical application of these new proposed powers. **Timing** How quickly these legislative changes can be implemented, given the immediate operational pressures the NHS is currently facing, including COVID-19 hospitalisations, maintaining non-

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
		COVID care and delivering the vaccination programme – which will remain a significant undertaking over the next six months at least. Staff will then need time to recover before the NHS turns its attention to recovering elective care and other services, which again will last many months – if not years. The scope, scale and pace of these changes, in the middle of the pandemic, mean it is more important than ever to engage trusts and their system partners in the policy development and Bill drafting process. The proposed changes are complex and must be carefully worked through with the sector to avoid unintended consequences. The consensus created around NHSE/I's 2019 proposals was helpful in terms of getting overall support from the health and care sector, which is essential for successful implementation. We encourage DHSC to replicate this forum. **Reconfigurations intervention power** The government is proposing to broaden the scope for potential ministerial intervention in reconfigurations, allowing the secretary of state to intervene at any point of the reconfiguration process. Currently, the secretary of state is only able to intervene in service reconfigurations upon referral from a local authority, usually in difficult or complex cases. Under the new proposal, the

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
		secretary of state will be required to seek appropriate advice in advance of their decision, including in relation to value for money, and subsequently publish it in a transparent manner. Guidance will be issued by DHSC on how this process will work as well as removing the current local authority referral process to avoid creating any conflicts of interest. DHSC expects the Independent Reconfiguration Panel, established in 2003 to be replaced by new arrangements. It is not anticipated that this power be used frequently but where there are issues that ministers have concluded need to be pressed to a resolution, this will provide a means of doing so.
The King's Fund	https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained On 11 February 2021, the Department of Health and Social Care published the White Paper Integration and innovation: working together to improve health and social care for all, which sets out legislative proposals for a health and care Bill. The White Paper brings together proposals that build on the recommendations made by NHS England and NHS Improvement in *Integrating care: next steps to building strong and effective integrated care systems across England* with additional ones relating to the Secretary of State's powers over the system and targeted changes to public health, social care, and quality and safety matters. The White Paper groups the proposals under the following themes: working together and supporting integration; stripping out needless bureaucracy; enhancing public confidence and accountability; and additional proposals to	**No specific notes in relation to Involvement duty** Unlike previous reforms, the proposed legislation aims to avoid a one-size-fits-all approach and leaves many decisions to local systems and leaders. This is appropriate given the great variation across England in terms of history, demography and local health challenges. It is not possible to legislate for collaboration and co-ordination of local services. This requires changes to the behaviours, attitudes and relationships of staff and leaders right across the health and care system, including within the national bodies. This makes the implementation plan very important, especially as the legislation leaves

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
	support public health, social care, and quality and safety. In this long read, we describe the main proposals under each theme and the rationale for each. We also provide our initial assessment of the proposals and their implications for the health and care system….	so much to local (and national) discretion. Some of the proposals seek to give ministers far greater powers over NHS England and other arm's length bodies. While it is right to clarify who is accountable for the health service, the government should protect the day-to-day clinical and operational independence of the NHS. Similarly, the proposal to give ministers the power to intervene earlier in local decisions about the opening and closing of NHS services risks politicising local service decisions. The document also recognises the importance of 'place', which is a smaller footprint than that of an ICS, often that of a local authority. Experience suggests that much of the heavy lifting of integration and improving population health is driven by organisations collaborating at this level, and successful ICSs have therefore often concentrated their efforts on developing the places within their footprint. The Department states that it has decided against giving place a statutory underpinning although it is explicit that there will be an expectation that ICS NHS bodies delegate 'significantly' to place level as well as to provider collaboratives. The development of place-based partnerships will therefore be left to local determination, building on existing arrangements where these work well.

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
		In response to concerns that local service reconfigurations can be complex and protracted, the Department proposes legislating to give the Secretary of State the power to intervene in reconfigurations at any point with a view to speeding up decision-making. The current process for contested reconfigurations, including the Independent Reconfiguration Panel, would be removed and replaced with a new process underpinned by statutory guidance. When using this power, the Secretary of State would be required to seek appropriate advice before intervening, and to publish it subsequently. Allowing the Secretary of State to intervene at any stage of a reconfiguration process may increase ministerial involvement in operational issues and risks politicising reconfiguration decisions.
Hill Dickinson	What next for the NHS – the white paper proposals https://www.hilldickinson.com/insights/digital-newsletter/what-next-nhs-%E2%80%93-white-paper-proposals The white paper and general practice: https://www.hilldickinson.com/insights/articles/white-paper-and-general-practice What next for the NHS – the white paper proposals The UK government has published a policy white paper setting out its proposals for reforming the NHS. The paper, Integration and innovation: working together to improve	Useful focus piece: https://www.hilldickinson.com/insights/articles/white-paper-service-reconfiguration-public-involvement-and-scrutiny Key points: Speedier reconfiguration process to be set out in new statutory guidance. HOSCs no power to refer. Expected to use influence in ICS. [No mention of using political power in absence of statutory power] SoS power to intervene without referral

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
	health and social care for all (HTML version) - GOV.UK (www.gov.uk) sets out legislative proposals for a Health and Care Bill. It builds on previous guidance going back to the 2014 NHS England » NHS Five Year Forward View and more recently the 2019 NHS Long Term Plan. 'Working together to integrate care' The headline grabbing focus of the paper is more and better integration of care between primary care, hospitals, community and mental health services, and care homes.	HWBs will work with ICSs. [Not clear if there will continue to be LA HWBs or if there will be one HWB/JSNA for the ICS footprint). Paper doesn't mention patient involvement duties. Doesn't mention plan consultation duties either, so assume they'll transfer to ICSs.
Mills & Reeve	Integrated Care Systems and the NHS White Paper https://www.mills-reeve.com/insights/publications/integrated-care-systems-and-the-nhs-white-paper Rhian Vandrill outlines six of the standout issues as the Government embarks on legislative reform of the NHS and social care as proposed in its recent White Paper. The Government plans to begin implementation of these proposals for health and care reform in 2022. While the proposals have been largely welcomed across the health and care system as supporting better joined-up care for patients, there are a few issues that require further clarification….	**The proposal is for each ICS area to have two ICS boards: an ICS NHS board responsible for the day-to-day running of the ICS and an ICS Health and Care Partnership board responsible for promoting partnership arrangements, and developing a plan to address the health, social care and public health needs of their system.** **New duty to collaborate to deliver: better health and wellbeing for everyone, better quality services and sustainable use of NHS resources.**
The Health Foundation	Webinar: The Health and Care White Paper unbound An analysis of the key proposals 11 March 2021 https://www.health.org.uk/about-the-health-foundation/get-involved/events/webinar-the-health-and-care-white-paper-analysis Webinar slides are here: https://www.health.org.uk/sites/default/files/2021-03/The%20health%20and%20care%20white%20paper%20unbound%20-%20HA.pdf	**No specific notes in relation to Involvement duty**

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
	On 11 February, the UK government published a White Paper on Health and Care setting out the latest steps to reform parts of the NHS in England. This webinar analysed the major changes proposed, in particular, plans to develop a more integrated approach to care and increase the powers of the Secretary of State.	
Bevan Brittan	https://www.bevanbrittan.com/expertise/markets/nhs/#ics Integration and Innovation: the White Paper proposals on improved quality and safety in the NHS https://www.bevanbrittan.com/insights/articles/2021/integration-and-innovation-the-white-paper-proposals-on-improved-quality-and-safety-in-the-nhs/ Related Articles ● 10/03/21 Integration and Innovation: Where is the workforce in the White Paper? ● 04/03/21 Integration and Innovation: the White Paper proposals on improved quality and safety in the NHS ● 23/02/21 Integration and Innovation: the White Paper proposals touching on digital and data driven health and social care ● 18/02/21 Integration and Innovation; the proposals for procurement and competition ● 12/02/21 Legislative proposals for a Health and Care Bill	**No specific notes in relation to Involvement duty**

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
	On 11 February 2021 the Department of Health & Social Care published its legislative proposals for a Health and Care Bill: Integration and Innovation: working together to improve health and social care for all. The proposals build on the NHS's recommendations in the 2019 Long Term Plan, shaped by the recommendations of NHS England, reflecting the travel towards Integrated Care Systems (ICSs) and informed by experience since Covid-19. Proposals in the White Paper 1. For every part of England to be covered by an integrated care system ("ICS") 2. To reduce bureaucracy (in relation to the arrangement and commissioning of healthcare services) 3. A streamlined framework for national oversight, merging NHS England and NHS Improvement 4. Appropriate oversight of social care and public health functions 5. Further regulatory proposals for safety and quality The triple aim duty on health bodies includes better quality of health services for all individuals. The White Paper therefore introduces a number of measures aimed at improving patient safety and quality including legislative proposals for the Healthcare Safety Investigations Branch (HSIB), new medical registries run by the Medicines and Healthcare products Regulatory Agency (MHRA) and a statutory Medical Examiners role…	
Browne Jcobson	insights into the NHS White Paper – integration and innovation: working together to improve health and social care for all https://www.brownejacobson.com/health/training-and-resources/nhs-white-paper-integration-and-innovation	**No specific notes in relation to Involvement duty**
BMA	Member briefing: https://www.bma.org.uk/media/3814/bma-member-briefing-gov-nhs-reform-feb-2021.pdf	**No specific notes in relation to Involvement duty**

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
	The NHS 'Integration and innovation: working together to improve health and social care for all' white paper was released on 11th February 2021. It's aim is to: • establish Integrated Care Systems • promote collaboration across healthcare, public health and social care • ensure that all NHS organisations have regard to better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. • set a capital spending limit on Foundation Trusts • ensure that joint committees could be formed • allow flexibility in commissioning & collaborative commissioning • allow joint appointments between NHS bodies, local authorities and combined authorities • build in successful data sharing • allow patient choice. Member briefing: Government health White Paper The UK Government has now formally published its white paper on NHS reform - Integration and Innovation: working together to improve health and social care for all – which sets out a range of proposals that would see dramatic changes for the NHS in England. This briefing provides a summary of those changes, the BMA's initial analysis of them, and outlines how the BMA is working to influence the proposed legislation on behalf of members. The BMA issued a press response to the publication of the White Paper, highlighting the unfortunate timing of the proposals and saying clinicians must be front and centre in plans for NHS reform.	In that any future system must have strong clinical leadership, engagement and involvement at its heart. While it is therefore positive that representatives from NHS Trusts and general practice are required on ICS NHS bodies, there remains a risk that the proposals outlined could reduce clinical involvement in decision making (eg with the loss of formal clinical eadership enshrined in GP-led CCGs) In addition, the Secretary of State will also be granted increased powers to intervene in local service The BMA has long advocated for clear lines of political accountability for the NHS at Secretary of State level • However, alongside this it is also vital that the day-to-day running of the NHS is free from excessive political control reconfigurations. Currently, the Secretary of State can only become involved if plans are referred to their office. The Government sees this as a hindrance to the effective resolution of issues with such plans, as referrals tend to come only very late in the process. This reform would essentially allow them to proactively intervene in service reconfigurations much earlier than currently possible. However, the white paper does include a specific requirement on the Secretary of State to seek

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
		appropriate advice prior to making their decision on any reconfiguration, and to publish that advice transparently
County Councils Network	**Health and Care White Paper: CCN response** https://www.countycouncilsnetwork.org.uk/health-and-care-white-paper-ccn-response/ Today the government will publish its Health and Care White Paper, which will outline reforms to both the health service and adult social care in a bid to closer integrate local healthcare. Below, the County Councils Network responds. Cllr David Fothergill, health and social care spokesperson for the County Councils Network, said: "There is much to welcome in these proposed reforms. We have consistently argued for close engagement and parity of esteem between health and care professionals and between the NHS and councils. Local government must be an equal partner in Integrated Care Systems and these bodies should be closely aligned to social care authorities' boundaries to reduce complexity and enhance local collaboration. "We also recognise the need for greater transparency in social care, but any new performance and inspection regime must be co-designed with local government. Today's white paper proposes some initial reforms to adult social care assurance and reporting whilst indicating a broader set of reforms will be set out later this year. "This broader approach to reform is essential: our report with Newton released this week proposes an optimised model of social care and shows what could be	**No specific notes in relation to Involvement duty** Reference to social care report on link. https://www.countycouncilsnetwork.org.uk/new-report-thousands-of-people-could-live-more-independently-if-councils-continue-to-deliver-social-care/

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
	possible through well integrated, locally-led services. This must be underpinned by long-term funding reform for social care."	
Lexology	Health and Care White Paper: Social Care Implications https://www.lexology.com/library/detail.aspx?g=958adc7c-2a55-46d7-b6f7-da86f3ffcf5d The Government yesterday published a White Paper setting out its legislative proposals for a Health and Care Bill - which we have reported generally on here: Health and Care White Paper: Integration and Innovation, Patrick Parkin (burges-salmon.com) This update looks at the specific implications for Social Care. Whilst the main focus of the paper is on the healthcare system, the Government intends to bring forward separate proposals on social care reform later this year. As the paper notes "No one piece of legislation can fix all the challenges facing health and social care – nor should it try – but it will play an important role in meeting the longer-term health and social care challenges we face as a society"…	**No specific notes in relation to Involvement duty**
Local Government Association (LGA)	We are concerned about the proposal to create a power for the Secretary of State for Health and Social Care to require NHSE to discharge public health functions will undermine local leadership of prevention and promoting wellbeing. We will seek clear assurance from Government that this will not adversely impact on local government's public health responsibilities. Establish health and Care Partnerships to ensure there is a partnership of equals that can set out plans for improving population	**No specific notes in relation to Involvement duty** We will continue to work with Government to ensure there is clarity regarding the respective roles and responsibilities of the proposed ICS NHS Statutory Bodies and the ICS Health and Care Partnerships, including how they: relate to health and wellbeing boards and integrated activity at local level; and support local leaders in developing arrangements

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
	health and delivering better and more integrated care and health services.	that work best for local areas. Any future accountability mechanisms will need to build on and enhance existing local democratic accountability, not bypass or undermine it. It is imperative that local government remains directly accountable to our residents.
National voices	https://www.nationalvoices.org.uk/blogs/thoughts-white-paper-detailing-new-legislative-changes-nhs While welcoming the focus the government's White Paper could bring on integration, National Voices CEO Charlotte August warns 'the track record of achieving better, more equitable, outcomes for people on the basis of mergers and restructures of national bodies is pitiful'.	**No specific notes in relation to Involvement duty** The NHS can't do it all alone. It needs the support, but also challenge from charities, social enterprises and even (deep breath) the private sector. Any assumptions that only if you have the blue logo can you improve outcomes for people is clearly for the birds. People using services aren't interested in red tape challenges. They want services to be run well, and that includes being administered well. The misery of bad admin is something we are doing insight work on, and it is clear that in many cases the NHS should invest more, not less in its administrative processes and staff. So we want to see much more detail on how Integrated Care Systems in particular will be challenged and supported to work with, rather than on behalf of, the people who need health and care services to do better. We hope the White Paper doesn't confuse accountability with further centralisation (also for example with regard to inspecting councils …) – and one thing we have learned in the last 12 months is that better

ORGANISATION	TITLE, LINKS AND KEY MESSAGES	NOTES IN RELATION TO INVOLVEMENT
		decisions were made closer to the issues, rather than in wood-panelled rooms in Whitehall. In summary, for us the key question clearly is 'how will all this make a difference for people who need health and care to do much better?' We stand ready to interrogate the detailed provisions of this White Paper and then Bill to make this much clearer.

Appendix 2 – Desk review of the Partnership's existing Involvement and Communications Strategy

It's clear that West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) value relationships at all levels and work very hard to build and maintain them.

Overall communications and engagement activity is co-ordinated at a local place-based level (Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield). The Partnership's core team works with local colleagues as well as the programme priority leads to ensure all activity is joined up, timely and appropriate and to avoid duplication.

There's a strong commitment to transparency and meaningful engagement in its work and it shares weekly updates, engagement plans and engagement reports of findings and target work at those voices which are under-represented.

The key principle of the way in which the Partnership works is to build on existing communication and engagement work already in place at a local level and not to develop mechanisms and channels solely for the purpose of the Partnership.

The focus is on informing, sharing, listening and responding and to ensure there is a coordinated approach and that they are not 'getting in the way' of valuable local work.

The West Yorkshire and Harrogate Communications and Engagement Strategy underpins the principles by which the engagement and consultation will operate and highlights the commitment to good practice in delivery.

The Partnership supports networking every three months, with weekly updates to local communication and engagement leads in each place.

There is evidence of exemplar strategic planning and reporting with the production of programme engagement and consultation timelines as well as engagement and consultation mapping reports which set out and share insight gathered. There is good use of accessible formats and the partnership delivers this in line with target audience needs, for example BSL, audio, community languages and easy read.

These are shared with the communication and engagement network, and the Joint Committee Patient and Public Assurance Group.

All engagement feedback is available on their website and pending engagement activity is logged.

Appendix 3 – Email inviting participation

SUBJECT: Independent review of the Partnership's public involvement work

Good afternoon everyone

I hope you are all very well

You are invited to take part in an independent review of the integrated care system (ICS) public involvement work.

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP, also known as an ICS) has commissioned an independent, external review of current involvement work with the aim of assessing strategic readiness to adapt to direction of travel set out in the Government's Health and Care White Paper.

The review recognises that the Partnership is not starting from scratch. It aims to recognise good involvement practices that we can build on, to gaps we can address, and to identify opportunities that we can leverage in the future.

The output of the work will inform the future design of WH&H HCP involvement approaches, whilst keeping firmly in view that the majority of involvement work takes place locally and will continue.

The review links to the work of the Partnership's 'Future Design and Transition Group' and the 'Chairs and Leaders Reference Group'. The final report will be presented at both meetings, as well as the System Leadership Executive Group.

You are invited to attend the group for Programme leads, Joint Committee of Clinical Commissioning Groups Public, Patient, Involvement members; non-executive directors, lay members, Partnership Board co-opted members. **This will be held on Teams on Monday 10 May 09.30-11.30**

There are limited places available and we'd very much appreciate your time and input. To register your interest, please follow the link below.

https://www.eventbrite.co.uk/e/150702028825

If you are a programme lead and have a lay member on your programme board / projects, please share this invite.

Thank you so much and do hope you can attend

With very best wishes

Appendix 4 – Survey questions

Help shape how West Yorkshire and Harrogate Health and Care Partnership involves people.

Introduction

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, charities and the community, voluntary & social enterprise sector to improve the health and wellbeing of local people living in its six local places:

- Bradford district and Craven
- Calderdale
- Harrogate
- Kirklees
- Leeds
- Wakefield

Since the Partnership began in 2016, it has worked hard to build the relationships needed to deliver better health and care locally and across West Yorkshire and Harrogate so it can support people to improve their lives with them.

Background

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) has commissioned an independent, external review of current patient, public and stakeholder involvement work with the aim of assessing strategic readiness to adapt to direction of travel set out in the Government's Health and Care White Paper.

The review recognises that the Partnership is not starting from scratch. It aims to recognise good involvement practices that it can build on, gaps it can address, and to identify opportunities that it can leverage in the future.

The output of the work will inform the future design of WH&H HCP's involvement approaches.

Some information about you

1. Before we start, please indicate the areas in West Yorkshire and Harrogate that you are involved in (tick all that apply):

    - ☐ Bradford district and Craven
    - ☐ Calderdale
    - ☐ Harrogate
    - ☐ Kirklees
    - ☐ Leeds
    - ☐ Wakefield

- ☐ All areas
- ☐ Other (please specify)

2. Please tell us some information about yourself*

   Name: _____
   Email: _____

3. What is the organisation you work for or represent?

4. What is your role?

5. Please tick if you would like be kept informed about this work as it progresses. *
   - ☐ Yes
   - ☐ No

Data Protection statement

The contact details collected by Stand Associates will be provided to West Yorkshire and Harrogate Partnership who may contact you. These organisations will never share your contact details for marketing purposes.

<u>Start the survey</u>

What does good involvement look like?

You may hear or read terms like Involvement, Engagement, Participation, Consultation, Communication, and Citizen Voice. These are just some of the phrases used to describe the different ways of involving people.

For West Yorkshire and Harrogate Health and Care Partnership it is very important to speak with people and listen to what the public, residents and patients have to say. They want to make sure they get this right, and involve people in the right ways.

It's important to note that most public involvement takes place at a local level, in partnership with local place colleagues – this won't change.

6. In an ideal world, what would good involvement look like to you? (please explain your answer)

Thinking about how we involve people

We would like to know what you think West Yorkshire and Harrogate Health and Care Partnership does well when they involve people and what you think they could do better.

7. Thinking about WH&H HCP, what do they **do well** when they engage with people? (please give examples)

8. Thinking about WH&H HCP, what could they **do better** when they engage with people? (please give examples)

Thinking about the future

We would like to know what you think about involvement in relation to the future and the white paper.

You can read about the white paper setting out legislative proposals for a Health and Care Bill was published February 2021 Integration and Innovation: working together to improve health and social care for all

You can also find more about West Yorkshire and Harrogate Health and Care Partnership

9. Thinking about moving towards a more integrated way of working between health and care systems, **what opportunities does this bring** for public and patient involvement? (please give examples)

10. Thinking about moving towards a more integrated way of working between health and care systems, **what risks does this bring** for patient and public involvement? (please give examples)

Thank you for providing your views.

Appendix 5 - Feedback notes: Race equality network 7th May 2021

Subject: Race equality network - PPI discussion

1. The variety of PPI representation needed should represent the local demographic makeup of the community for example people from deprived backgrounds, variety of ethnicities such as East European etc

2. One approach/framework across the partnership to ensure we have effective PPI will not work – it needs to be a targeted approach tailored to reach local people across place that are seldom heard from. We often hear from the same people when we ask for PPI so taking some positive action here would be more meaningful

3. There is a need to define the role of an individual asked to be a PPI representative – who's needs/voice are they representing? Criteria for this would be helpful

4. A governance process and criteria for equitable reimbursement is required

5. Defining consultation and engagement as different asks is really important

6. We need to ensure PPI is not tokenism and ensure it is meaningful for the people involved and impactful/effective for improving services

7. We need to ensure there is a joint up approach to PPI across the whole partnership

8. We need to use data on the makeup of local demographics to identify what the targeted approach to PPI needs to be. Teams across places and at WY&H level needs support from analysts to help interpret the intel too

9. Comms back to PPI representatives on the impact of their involvement leading to service change/improvement is key – in simple and easy ways for people to understand

10. Links with the VCSE are key to ensure we reach grassroots communities

11. We have numerous people within our partnership who have been PPI representatives – we could build some of this insight to use in a targeted approach

Appendix 6 - Full list of organisations involved

The table below gives details of the registration and attendee numbers, and the list of organisations represented at the events.

Event	Registrations	Attendees	Organisations represented
29 April	15	12	Healthwatch Bradford Airedale NHS FT Leeds Community Healthcare NHS Trust NHS Bradford District and Craven CCG NHS Calderdale CCG NHS Kirklees CCG NHS Leeds Clinical Commissioning Group (CCG) NHS Wakefield CCG South West Yorkshire Foundation Partnership Mental Health Trust
10 May	13	10	NHS Leeds CCG NHS Bradford District and Craven CCG NHS Kirklees CCG NHS Wakefield CCG and WY Joint Comm. CCGs West Yorkshire & Harrogate Health & Care Partnership Board West Yorkshire & Harrogate Health & Care Partnership Local Maternity System West Yorkshire & Harrogate Health & Care Partnership MHLDA Collaborative West Yorkshire & Harrogate Health & Care Partnership ICS
11 May	13	11	Healthwatch Bradford & District Healthwatch North Yorkshire Locala NHS Kirklees CCG PEAG NHS Leeds CCG NHS Wakefield CCG None South West Yorkshire Partnership Foundation Trust VAC Women's Health Network/ Mind in Bradford
20 May	34	14	Advancement of Community Empowerment (CIC)

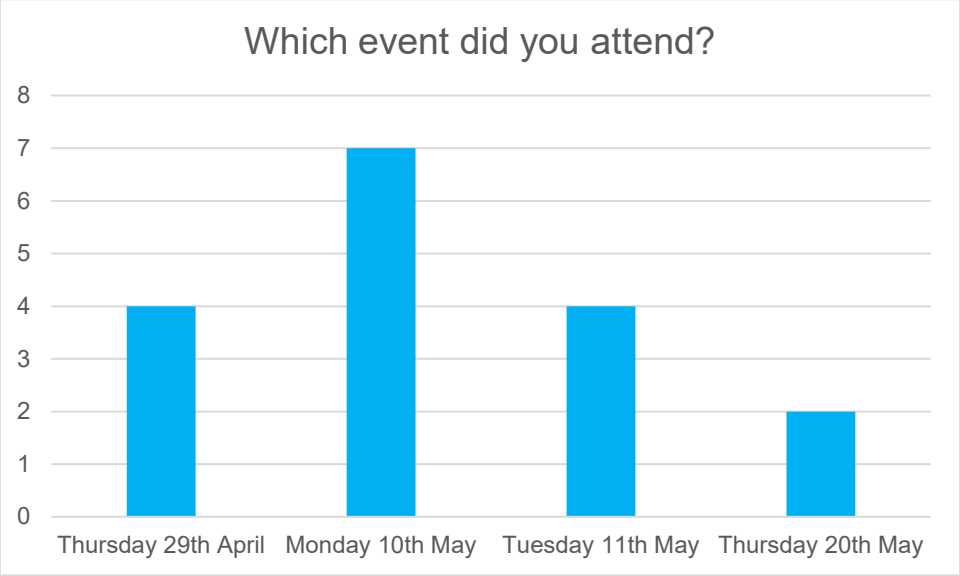
Event	Registrations	Attendees	Organisations represented
			Bradford District Care NHS Foundation Trust Calderdale MBC Family Voice Calderdale Healthwatch Kirklees Healthwatch Leeds Leeds Academic Health Partnership Leeds Community Healthcare NHS Trust South West Yorkshire Partnership Foundation West Yorkshire and Harrogate Health and Care Partnership West Yorkshire and Harrogate Health and Care Partnership Local Maternity System

Appendix 7 - Post-event evaluation survey report

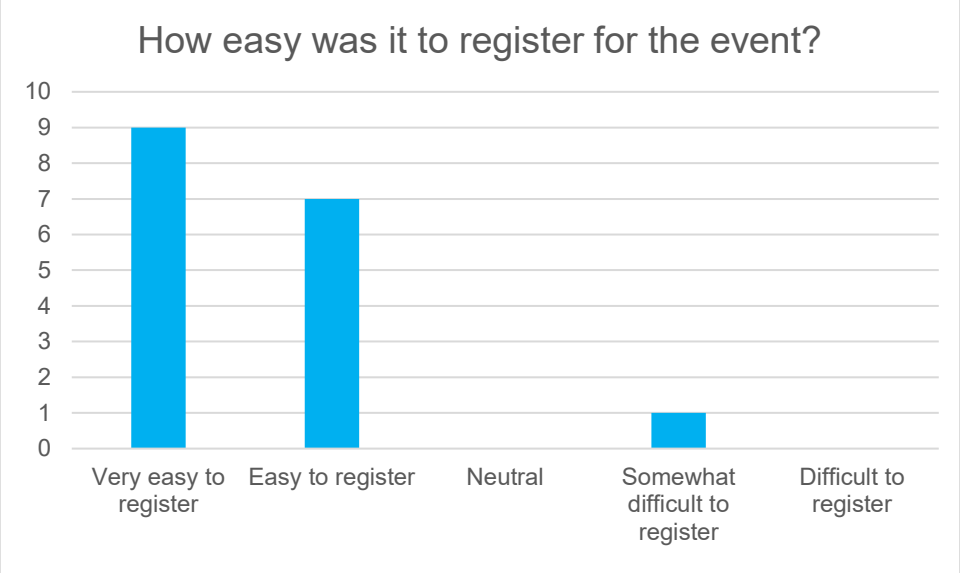
Following each focus group and the discussion event, a link to a Survey Monkey survey was circulated to all event participants. The survey asked for their experiences before the event (registering and joining) as well as during the event.

In total 17 surveys were submitted by attendees.

Q1. Which event did you attend?

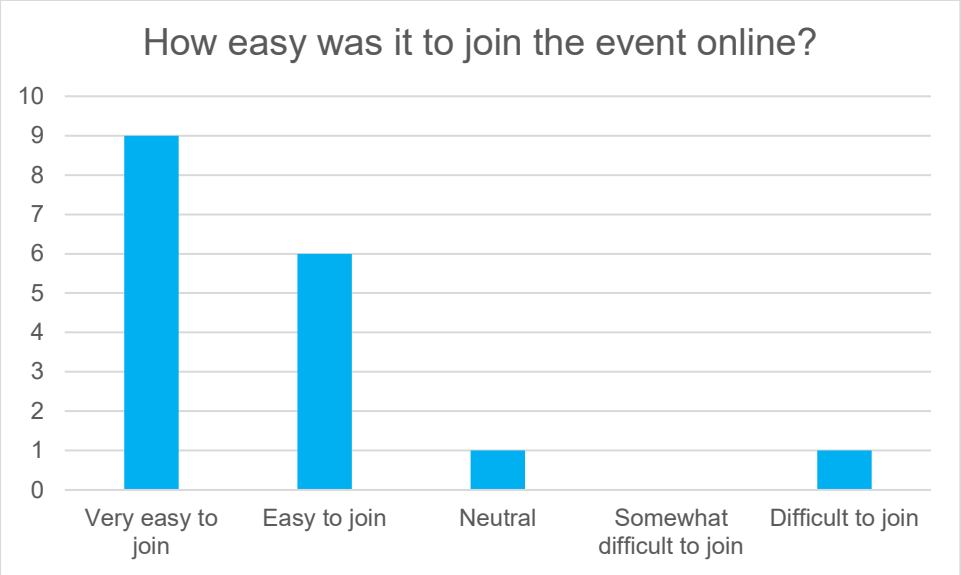


Q2. How easy was it to register for the event?



Improvement: We are aware of some participants who found it difficult to register on Eventbrite and so Stand registered on their behalf and sent the confirmation details through to them.

Q3. How easy was it to join the event online?



Improvement: some participants didn't receive the joining information. For the later events, we sent the joining details on two occasions via a calendar invite containing the joining details.

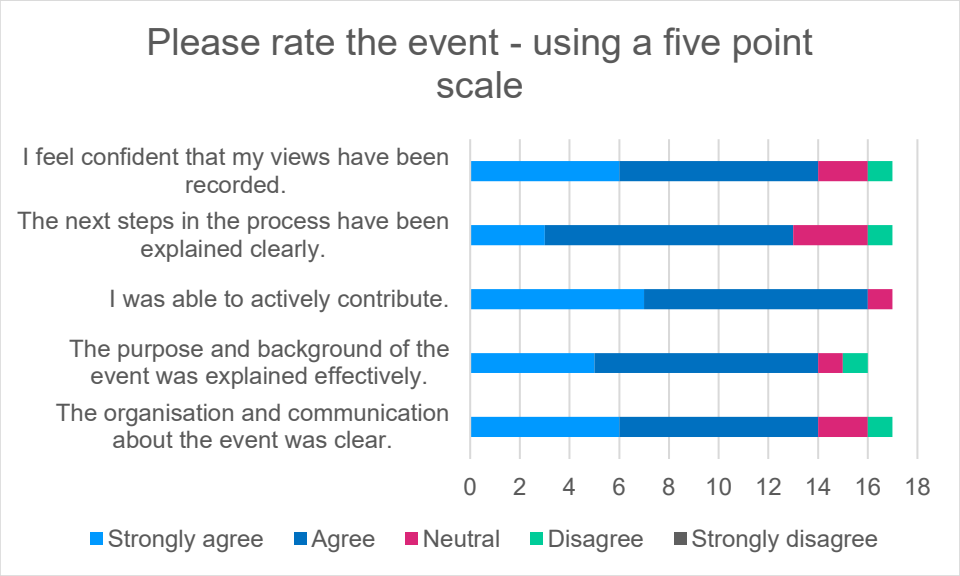
Q4. Please tell us how we could improve registration or joining the event online here:

Eight comments were received, the majority of which referred to sending out the joining instructions. Recommendations from participants included using an automated way of sending joining instructions (e.g. using Eventbrite), sending the instructions as soon as they register, or sending a calendar invite.

One participant stated that it wasn't clear who should be attending the session, and another mentioned that in their session the facilitator was not there to start the session on time.

Improvements: use the full functionality of Eventbrite - including automated email reminders, calendar invites and ability to access joining instructions by logging in.

Q5. Participants were asked to rate 5 statements using a five point scale (5 = strongly agree, 1 = strongly disagree).



I feel confident that my views have been recorded - 82% strongly agreed or agreed

The next steps in the process have been explained clearly - 76% strongly agreed or agreed

I was able to actively contribute - 94% strongly agreed or agreed

The purpose and background of the event was explained effectively - 88% strongly agreed or agreed.

The organisation and communication about the event was clear - 83%

Q6. Overall - please tell us if you have any other feedback about the event. You may also have comments that you would like to reiterate or raise following the event. Please let us know here.

Six comments were received:

- Interesting that most queries were responded to but the first one from the BAME person wasn't power dynamics and bias?
- It was a really informative discussion. However, it was more about the concerns implied by the white paper - which were all useful to hear - rather than a review of ICS public engagement. I may have misunderstood the purpose. Nonetheless, some very good points raised and the fact the meeting took place is excellent.
- Facilitators were great, the white paper was well explained, good amount of background info given and breakdown at the beginning of the session was very helpful. I thought the questions asked were good ones - open but prompted specific examples
- I would be good to see a summary of findings from all four sessions.

- Most of the questions and discussion were quite high-level and about the principles of what we want good PPI to look like across WY&H. Whilst this is fine it didn't seem to quite get into the question of 'what do we do where?' and the big tension we have as a system between place and system until the very end. And less focus on how we make this a success
- All participants made very welcome. Relaxed atmosphere. Ample opportunities to contribute. Clear prompts to encourage contribution by all participants. Very professional facilitation. Thank you!!

Appendix 8 - Full thematic analysis of the survey and groups

Survey

In an ideal world, what would good involvement look like to you? (N=8)

Respondents were asked in an ideal world, what would good involvement look like. These comments were grouped into the following themes:

Engagement and Involvement

Engagement and involvement were discussed by three representatives from NHS Organisations, two representatives from Healthwatch and one VCSE representative:

- Engagement must be meaningful and purposeful, relevant, timely and planned in advance (Healthwatch, NHS Organisation). Involvement should be ongoing involvement, with the opportunity for rapid response (2 NHS organisations and Healthwatch).
- Ensure involvement takes place before the decisions are made (VCSE) and that the insights from involvement are used in the decision-making process (NHS Organisation).
- Actively listen to what the public say or want and make the public essential to decision-making (Healthwatch).
- Feeding back how involvement made a difference (NHS Organisation).

Inclusivity and equality

Inclusivity and equality were discussed by five representatives from NHS Organisations, one representative from Healthwatch an one representative from a VCSE:

- Using varied methods of communication and multiple opportunities to target all audiences and populations (3 NHS Organisations, VCSE, Healthwatch).
- Include all communities, ages, faiths, and socio-economic sectors (4 NHS Organisations).
- Accessible (NHS Organisation).
- Focus on those with health inequalities (NHS Organisation).

Investment

Investment was discussed by a representative from an NHS Organisation:

- Financially supported (NHS Organisation),

- Learning and mentoring for those involved (NHS Organisation),

Partnership Working

Partnership working was addressed by a representative from Healthwatch:

- Multi-way conversations between decision makers, commissioners, and the public (Healthwatch).

Thinking about WY&H HCP, what do they do well when they engage with people? (N=8)

Respondents were asked to think about the Partnership and what it does well when it engages with people. These comments were grouped into the following themes:

Engagement and Involvement

Engagement and involvement were discussed by three representatives from an NHS Organisation, one representative from Healthwatch and a VCSE representative:

- Partnership feedback following engagement (NHS Organisation, Healthwatch).
- They include gathered views and experiences in planning and provide clear examples to base engagement on (Healthwatch, NHS Organisation respectively).
- They provide lots of opportunities and events for involvement (VCSE).
- The Partnership involves people at system level, and other levels when appropriate (NHS Organisation).
- There has been no top-down enforcement of what engagement has to look like and they listen without judgement (Healthwatch, NHS Organisation respectively).

Inclusivity and Equality

Inclusivity and equality were discussed by a representative from Healthwatch, an NHS Organisation and a VCSE:

- They do well by using different methods of involvement such as newsletters, websites, social media, meetings, and podcasts (Healthwatch, NHS Organisation, VCSE).
- They make information and engagement accessible for all communities (NHS Organisation).
- They provide the opportunity for lived experiences at the decision-making table (Healthwatch).

- They engage with the public and other interested parties and actively seeking out underrepresented voices (NHS Organisation).

Leadership and autonomy

Leadership and autonomy were discussed by a representative from an NHS Organisation:

- There is a leadership culture that encourages engagement (NHS Organisation).
- There is visible leadership with transparent recruitment (NHS Organisation).

Partnership Working

Partnership working was addressed by a representative from an NHS Organisation:

- They work well with VCSEs and Healthwatch (NHS Organisation).

Thinking about WY&H HCP, what could they do better when they engage with people? (N=8)

Respondents were asked to think about the Partnership and what they could do better when they engage with people. These comments were grouped into the following themes:

Communication

Communication was discussed by a representative from an NHS Organisation and a representative from a VCSE.

- A lot of communication is not written in a patient friendly manner – it is aimed at professionals (VCSE).
- They provide too much information at once - need bite size pieces (NHS Organisation).
- The Partnership needs to be clear about what can be changed as result of engagement (NHS Organisation).

Engagement and Involvement

Engagement and involvement were discussed by two representatives from Healthwatch and two representatives from NHS Organisations:

- They're good at asking for involvement, but not good at responding to it (Healthwatch).
- The Partnership appears distanced and there is a lack a connection with providers and communities – they do not know what the providers and communities' roles are (NHS Organisation).

- More notice for engagement - finding things out too late or after the fact (NHS Organisation and Healthwatch).

Inclusivity and Equality

Inclusivity and equality were commented on by one representative from Healthwatch and an NHS Organisation:

- The Partnership should ensure they involve a range of young people from vulnerable groups giving them a voice (NHS Organisation).
- Similarly, engagement should be proportionate - smallest voice should be given the greatest opportunity (Healthwatch).
- Greater consideration is needed for non-digital engagement (Healthwatch).

Partnership Working

Partnership working was commented on by a representative from Healthwatch and a representative from an NHS Organisation:

- More connection between engagement at place and system levels (NHS Organisation).
- More co-production of solutions - residents and clinicians working together, as well as joined-up working with local government (NHS Organisation)
- Development around patient experience and insight sharing (Healthwatch).

Thinking about moving towards a more integrated way of working between health and care systems, what opportunities does this bring for public and patient involvement? (N=7)

Respondents were asked to think about moving towards a more integrated way of working between health and care systems and the opportunities this will bring for public and patient involvement. These comments were grouped into the following themes:

Inclusivity and Equality

Inclusivity and equality were addressed by two representatives from NHS Organisations:

- The opportunity to engage with people with lived experience (NHS Organisation).
- Also, to support young people from education and social care perspective (NHS Organisation).
- Have patient voice at centre of decision-making (NHS Organisation).

Communication

Communication was addressed by a representative from an NHS Organisation:

- Tell people what is going on with integration - not many people know (NHS Organisation).

Engagement and Involvement

Engagement and involvement were discussed by a representative from an NHS Organisation, Healthwatch, five NHS Organisations and a VCSE:

- The opportunity to demonstrate impact of engagement to show difference it made (NHS Organisation).
- Work on engagement together - multiple organisations engaging on the same or similar things and sharing insight and resources between organisations and areas (4 NHS Organisations, Healthwatch respectively).
- Look at whole pathways including social and medical support (NHS Organisation).
- It will feel more streamlined and cohesive (VCSE).

Thinking about moving towards a more integrated way of working between health and care systems, what risks does this bring for patient and public involvement? (N=7)

Respondents were asked to think about moving towards a more integrated way of working between health and care systems and the risks it can bring for patient and public involvement. These comments were grouped into the following themes:

Engagement and Involvement

Engagement and Involvement were addressed by two representatives from NHS Organisations and a VCSE:

- People may feel involvement is distant from the community – things are done at too large a scale (2 NHS Organisations).
- More bureaucracy – people feel more lost in the system and therefore less engaged (VCSE).

Inclusivity and Equality

Inclusivity and equality were discussed by a representative from Healthwatch and an NHS Organisation:

- Quieter voices may be drowned out - may be assumed to be represented when they are not (NHS Organisation).
- Dilution of feedback - coming to majority view over large area (Healthwatch).

Accountability

Accountability was commented on by a representative from Healthwatch and an NHS Organisation:

- It is unclear who is responsible for listening and responding - many partners are involved (NHS Organisation and Healthwatch).

Investment

Investment was discussed by a representative from an NHS Organisation:

- There may be insufficient resources to be able to support this alongside organisational specific demands (NHS Organisation).

Partnership Working

Partnership working was discussed by a representative from an NHS Organisation:

- Partners use a different language - consultation means different thing to Local Authorities and the NHS (NHS Organisation).

Focus Groups

In an ideal world, what would good involvement look like to you?

During the focus groups, participants were asked to discuss what good involvement would look like in an ideal world. Participants provided the following feedback:

Engagement and Involvement

Engagement and involvement were commented on by representatives from Healthwatch, NHS Organisations and VCSEs:

- Continuous and ongoing engagement (Healthwatch, NHS Organisation, VCSE). With Involvement commencing at the start of the process (NHS Organisation). Community engagement shouldn't be an afterthought (NHS Organisation). Preparation is paramount (NHS Organisation).
- Ask for opinions and understand people (NHS Organisation). Starting with the barriers that matter to people – time, money etc. (NHS Organisation).
- Enshrine patient voice at ICS or ICP level and include the public in the decision-making process (2 NHS organisations).

- Distinction between passive and decision-making involvement, and between consultation and engagement as the difference is really important (NHS Organisation, VCSE respectively).
- Feeding back and explain the results of involvement (NHS Organisation, VCSE).
- Involvement must be genuine, made to happen, and monitored (NHS organisation, VCSE) and should not be a tick-box exercise (NHS organisation)
- Engage with people on their terms (VCSE).

Inclusivity and equality

Inclusivity and equality were discussed by representatives from Healthwatch, a Local Authority, NHS Organisations and VCSEs:

- The use of a wide range of channels and methods to not miss out groups (2 NHS Organisations, VCSE). One size does not fit all (Local Authority).
- Groups must be representative of communities, not just ethnicity and race but class, language, and experiences - not just those who always turn up. (2 NHS Organisations, 2 VCSEs).
- Acknowledge how different communities prefer involvement (NHS Organisation).
- Accessible information for everyone, inclusivity is a foundation stone (NHS Organisation.
- Needs to be done by outreach – going to the people and not expecting them to come to you (NHS Organisation, VCSE, Healthwatch, Local Authority). For example, the use of an engagement bus to help reach out, in particular to reach those in villages (Healthwatch, VCSE).
- Voices and needs of those that are represented are defined clearly – a criteria would be helpful (VCSE).

Communication

Communication was discussed by representatives from NHS Organisations and a VCSE:

- Communication seems to be aimed at high flyers (NHS Organisation).
- Clear communication – communities need to know what is happening in their area (NHS Organisation, VCSE).
- There must be a clear line to the decision maker (NHS Organisation).
- Start with what they already know, they are not very good at that (NHS Organisation).
- Ensure PPI is meaningful and effective for improving services (VCSE).

Partnership Working

Partnership working was discussed by representatives from NHS Organisations and a VCSE:

- Organisations should work together on involvement (NHS Organisation, VCSE).
- Involvement has to happen at all levels - PCNs, CCG, at place, with patients and the public (2 NHS Organisations).
- Lay involvement to address conflict of interest (NHS Organisation).

Accountability

Accountability was commented on by representatives from Healthwatch and NHS Organisations:

- Transparency, trust and accountability (NHS Organisation, Healthwatch).
- There needs to be a patient voice throughout (NHS Organisation).

Investment

Investment was addressed by representatives from Healthwatch, a Local Authority, NHS Organisation and a VCSE:

- People need to be reimbursed for their time, either financially or with training (Healthwatch, Local Authority, NHS Organisation, VCSE). However, financial rewards are difficult for those without bank accounts (Healthwatch).
- Invest in the training and development of people that will be involved in the meetings (Local Authority, NHS Organisation).

Workforce

Workforces was commented on by a representative from an NHS Organisation:

- Ensure colleagues understand what involvement is (NHS Organisation)

Thinking about WY&H HCP, what do they do well when they engage with people?

During the focus groups, participants were asked to discuss what the Partnership does well. Participants provided the following feedback:

Engagement and Involvement

Engagement and involvement were commented on by representatives from NHS Organisations and a VCSE:

- Joint strategy in Calderdale on how to involve (NHS Organisation).
- Engagement is good at place and ICS Level (NHS Organisation).

- Asset based engagement – community champions and community voice (VCSE).
- Meaningful grassroots engagement – people open up more than with a faceless CCG (VCSE). Prior to the COVID-19 pandemic they would go into the community to engage (VCSE).
- Patient Engagement and Advisory Group in Kirklees (VCSE).
- The Big Leeds Chat - leaders from all sections of health and care meet directly with members of the public (Healthwatch, VCSE).
- They have the ambition to co-design services from the beginning with those with lived experience (NHS Organisation).
- PPI assurance group works and ensures engagement is proportionate, timely and adequate (NHS Organisation).

Partnership Working

Partnership working was addressed by representatives from NHS Organisations:

- Partners working together and not duplicating services (NHS Organisation).
- Using GPs – working together to increase reach (NHS Organisation).
- It is helpful to share best practices between organisations (NHS Organisation).
- Great partnership with Healthwatch – could be strengthened with other advocate organisations more systematically (NHS Organisation).
- Chaplaincy department have been helpful during COVID - have learned a lot (NHS Organisation).
- Maternity Voices Partnership works well – involved from day one and helped develop plans (NHS Organisation).
- Voluntary sector in Leeds do relationship building well - reach people we wouldn't normally hear from (NHS Organisation).
- Long term relationships can build trust in both directions (NHS Organisation).

Inclusivity and Equality

Inclusivity and equality were discussed by representatives from NHS Organisations:

- COVID has been difficult, lots has been done to change things rapidly (NHS Organisation).
- Communities having influence - involving people with lived experience to identify and overcome barriers (NHS Organisation).
- Community connectors to encourage certain groups to take up the vaccine (NHS Organisation).

- Involving and co-designing with people with learning disabilities (NHS Organisation).
- Communication and equality collaborative being developed (NHS Organisation).

Accountability

Accountability was commented on by representatives from NHS Organisations:

- Patient Assurance Group (PAG) in Leeds CCG – a team of volunteers scrutinise every involvement exercise and hold everyone accountable, with a similar board also in Bradford (NHS Organisation).
- Checks and balance – they have independent people to assess engagement (NHS Organisation).

Locality – at place

Locality – at place was discussed by representatives from Healthwatch and NHS Organisations:

- Engagement works at place level – needs to stay at place level (NHS Organisation).
- The size of West Yorkshire and Harrogate helps them work successfully at a place-based level (Healthwatch, NHS Organisation).

Quality

Quality was addressed by representatives from an NHS Organisation:

- They can't lose the experience and knowledge they already have (NHS Organisation).

Thinking about WY&H HCP, what could they do better when they engage with people?

During the focus groups, participants were asked to discuss what they think the Partnership could do better when they engage with people. Participants provided the following feedback:

Engagement and Involvement

Engagement and involvement were discussed by representatives from NHS Organisations and a VCSE:

- Insight repository of past engagement with a database to allow information to be analysed to find emerging themes – it can guide how to engage and where to focus (NHS Organisation, VCSE).
- Key performance indicators are missing – commissioners don't share involvement service specs and don't specify data collection details (NHS Organisation).

- Consultation fatigue – caused by different groups talking to the same people on multiple occasions (NHS Organisation).
- They want people to only flag up what they want to hear, not what people want, and it's not heard with the same ears (NHS Organisation).
- An issue is they don't have sight of what the work partners are doing (NHS Organisation).
- Continuous engagement – councils have better relationships with the public and VCSEs (NHS Organisation).
- Look at why involvement is needed in the first place, good engagement has a focal point (NHS Organisation).

Partnership Working

Partnership working was commented on by representatives from NHS Organisations and a VCSE:

- Working together – Other organisations need this so why not work together, there's lots of good involvement in patches, but they don't share when they come together (VCSE, NHS Organisation respectively).
- People's Voice group allows opportunities to be identified to work together (NHS Organisation).
- Leeds are good at telling and listening, but not good at closing the loop (NHS Organisation).
- Likely that local authorities will be opposed to the proposals – there is no structure for resolving political and managerial tension (NHS Organisation).
- Internal resolution structures put in place between partnership board and ICS (NHS Organisation).
- They could work the contracting process better (NHS Organisation).

Investment

Investment was addressed by representatives from NHS Organisations:

- Need to invest in capturing voice and influence (NHS Organisation).
- Involvement not given enough of a budget – small low-cost solutions rather than big service change (NHS Organisation).
- Question who pays for certain work (NHS Organisation)?

Communication

Communication was discussed by representatives from Healthwatch and an NHS Organisation:

- Be specific about why you need public involvement and bring involvement in when necessary (NHS Organisation).
- Regular updates via social media (Healthwatch).

Quality

Quality was discussed by a representative from an NHS Organisation and a member of the public.

- Joint standards and mirror good examples across the patch (NHS Organisation, member of the public).
- Come up against system barriers and working practices that get in the way (NHS Organisation).

Inclusivity and equality

Inclusivity and equality were addressed by a representative from an NHS Organisation:

- They need more patient representatives on board (NHS Organisation).

Locality – at place

Locality - at place was discussed by a representative from an NHS Organisation:

- Needs coordination at ICS or place level (NHS Organisation).

Transparency

Transparency was discussed by a representative from an NHS Organisation:

- Protectiveness over gathered insight, particularly VCSEs (NHS Organisation).

Thinking about moving towards a more integrated way of working between health and care systems, what opportunities does this bring for public and patient involvement?

During the focus groups, participants were asked to discuss what opportunities the move towards a more integrated way of working between health and care systems will bring for public and patient involvement. Participants provided the following feedback:

Engagement and Involvement

Engagement and involvement were discussed by representatives from a Local Authority, NHS Organisations, a VCSE and a member of the Public:

- Prioritise engagement that needs to be done once, meaning they would be freed up to get out and build relationships (NHS Organisation).
- Continuous engagement, not just when change is imminent (member of the public)
- More engagement – similar to the engagement with the vaccines, working at scale (VCSE).
- Not just having the same people at the table, reviewing who to give a voice, for example getting elected (NHS Organisation).
- Awareness of involvement exercises (Local Authority, NHS Organisation).
- Practical governance – being on the ground and going to patient networks (NHS Organisation).
- In absorbing the CCG, the ICS will adopt the best practices from IRO consultation, engagement and involvement (NHS Organisation).

<u>Partnership Working</u>

Partnership working was commented on by representatives from Healthwatch, a Local Authority and NHS Organisations:

- Work collaboratively – linking up similar structures and create a more collaborative West Yorkshire voice, and sharing insight in one place to find views on services (NHS Organisation, Local Authority respectively). A more integrated approach to patient care, removing the silo way of working, and the merging of health and social care to share resources and break down barriers (NHS Organisation and Healthwatch).
- Medical and clinical to learn from Mental Health around patient reported outcome measures (Healthwatch).
- Helpful to see what is going on in different partners and systems (NHS Organisation).
- VCSEs could be included to help with guidance and funding (NHS Organisation).
- Encourage dialogue between patients and clinicians, they're more likely to buy in and the result will be a better outcome (NHS Organisation).

<u>Leadership and autonomy</u>

Leadership and autonomy were discussed by representatives from NHS Organisations:

- Needs a leader with influence on different levels, from place to ICS level, a leader that will champion the voice of the people (NHS Organisation).
- Needs robust governance to ensure there is challenge at ICS level (NHS Organisation).
- A director of PPI who is independent but representative of organisations and patients and able to take ownership (NHS organisation).

- Opportunity for HWBB to be less council controlled and more generalised (NHS Organisation).

Quality

Quality was discussed by representatives from NHS Organisations and a VCSE:

- Need to share best practice (NHS organisation).
- Understanding one type of involvement does not work for all, and will need to be adapted (NHS Organisation, VCSE).
- Prevention agenda should underpin every commissioning decision (Healthwatch).
- The potential is there, decision makers should always have patient involvement in mind (NHS organisation).

Communication

Communication was discussed by a representative from an NHS Organisation:

- Use publications, both online and print, to make people aware (NHS Organisation).

Inclusivity and Equality

Inclusivity and equality were addressed by a representative from an NHS Organisation:

- Ensuring organisations serve the community they represent, employing people with lived experience. There are very few NHS Directors with disabilities (NHS Organisation).

Investment

Investment was addressed by a representative from an NHS Organisation:

- Investment and resources (NHS Organisation).

Thinking about moving towards a more integrated way of working between health and care systems, what risks does this bring for patient and public involvement?

During the focus groups, participants were asked to discuss risk with a move towards a more integrated way of working between health and care systems and what this will bring for public and patient involvement. Participants provided the following feedback:

Inclusivity and Equality

Inclusivity and equality were addressed by representatives from NHS Organisations and a VCSE:

- Equity vs equality – doing the same across all places may increase inequalities (NHS Organisation). Tackling inequalities could lead to better off areas having resources taken away (NHS Organisation).
- Equality needs to be part of the conversation (NHS Organisation).
- Inequalities in funding for various CCGs – patients will see the differences across areas (Healthwatch).
- The distance between decision makers and the public – West Yorkshire and Harrogate is a large area with disparate communities (NHS Organisation).
- Risk of smaller VCSEs not having voices heard (VCSE).

<u>Engagement and Involvement</u>

Engagement and involvement were commented on by representatives from a Local Authority and NHS Organisations:

- If decision-making feels remote, will local people want to get involved (NHS Organisation)?
- Can use engagement to push through initiatives (NHS Organisation)?
- Make sure the ICS use down up involvement, involvement too far up will cause detachment (Local Authority).
- It takes years to change people's mindset around patient involvement, it won't be solved overnight (NHS Organisation).

<u>Partnership Working</u>

Partnership working was discussed by representatives from Healthwatch and NHS Organisations:

- Engage with adult social care and get them to understand this opportunity (NHS Organisation).
- Cross border working creates problems (Healthwatch).
- Danger the ICS commissions a service and it is difficult to resolve problems as the provider is sat at the table (NHS Organisation).

<u>Investment</u>

Investment was addressed by representatives from NHS Organisations:

- Concerns around social care integrating as they have separate streams for budgets (NHS Organisation).
- The cost of involvement, if done properly it is costly (NHS Organisation).

Quality

Quality was discussed by representatives from NHS Organisations:

- Overcomplicating things, there's a need to keep the momentum moving (NHS Organisation).
- Nothing changes – there is an opportunity for change and the risk is they don't capitalise on it (NHS Organisation).

Workforce

Workforce was addressed by representatives from NHS Organisations:

- Uncertainty around staffing and continuity of work (NHS Organisation).
- Potential for extra work, it takes time to hold focus groups (NHS Organisation).

Bureaucracy

Bureaucracy was discussed by a representative from an NHS Organisation:

- Politics becoming too involved with health and social care, could be seen as using the public to delay (NHS Organisation).

Communication

Communication was addressed by a representative from an NHS Organisation:

- If model is used across the ICS, make sure all organisations are signed up and actually do it, otherwise it could result in mixed messages (NHS Organisation).

Leadership and Autonomy

Leadership and autonomy were addressed by a representative from an NHS Organisation:

- Need to have true independence and scrutiny of PPI arrangements (NHS Organisation).

Locality – at place

Locality – at place was addressed by a representative from Healthwatch:

- Not just place, neighbourhoods are also important (Healthwatch).

Questions/comments from the presentation

During the focus groups, participants were given the opportunity to comment on the presentation. Participants provided the following feedback:

Inclusivity and equality

Inclusivity and equality were discussed by representatives from a Local Authority, NHS Organisations and VCSEs:

- Lack of mention of carers, they need to be involved (Local Authority, NHS Organisation).
- No mention of health inequalities – poor health is the outcome of inequality, they are integral to each other (Local Authority).
- Unclear how it is embedded at all levels - must ensure diverse representation (NHS Organisation).
- Amplify those with lived experience to have the power to make change (NHS Organisation).
- The thread of equality in PPI needs to be more robust (NHS Organisation).
- They need to ensure they have grassroots organisations onboard (NHS Organisation, VCSE). Some grassroots organisations don't have the capacity to engage so their voice may be lost (VCSE).

Engagement and Involvement

Engagement and involvement were addressed by representatives from NHS Organisations and VCSEs:

- How do we engage, what is the right balance to achieve involvement (VCSE)?
- Healthwatch is underused – they fit very well in providing collaboration and involvement (NHS Organisation).
- What will this mean for parent carer forum's involvement (VSCO)?
- Need representation of public and patients at statutory ICS level and local place level (NHS Organisation).

Locality – at place

Locality – at place was commented on by representatives from Healthwatch, a Local Authority, NHS organisations and a VCSE:

- Commitment to place – will groups still exist after the CCG goes? (NHS Organisation, VCSE).

- Complicated geography – Kirklees share an acute Trust with Calderdale and Wakefield (Local Authority).
- How do you replicate good practice across the whole area? (Healthwatch)

Partnership Working

Partnership working was discussed by a representative from an NHS Organisation and a VCSE:

- There is no framework in place, so it is difficult to have a conversation (NHS Organisation).
- There is a duty to collaborate, but legislation would be difficult (VCSE)
- More could be done on managing conflicts of interests or impartiality (NHS Organisation and Local Authority). How are conflicts resolved or mediated? (NHS Organisation).

Accountability

Accountability was commented on by representatives from a Local Authority.

- Scrutiny not mentioned - provides accountability and a way for public to express concerns (2 Local Authorities).
- Scrutiny can look at services from a point of view of place – organisations can make changes, scrutiny looks at the services as needed, it's an important crossover (Local Authority).

Workforce

Workforce was discussed by a representative from a Local Authority and an NHS Organisation:

- Inadequate workforce model neglected for years is the main driving problem (Local Authority).
- Pandemic has disproportionate effect on workforce - they're patients as well and get lost in the system due to labels (NHS organisation).

Bureaucracy

Bureaucracy was addressed by a representative from the Local Authority:

- Barrier to joint commissioning, procurement for healthcare is removed but procurement for social care stays in regulations (Local Authority).

Investment

Investment was addressed by a representative from a VCSE:

- VCSEs and social care are running on fumes, expecting them to collaborate is a bit much at this stage (VCSE).

Leadership and autonomy

Leadership and autonomy were discussed by representatives from local authorities:

- The power for councils to refer to the Secretary of State is important (2 Local Authorities).

Transparency

Transparency was addressed by a representative from the Local Authority and a VCSE:

- Will ICS boards meet in public and be subject to FOI requests (Local Authority, VCSE)?

Addendum

The following issues were raised in response to the feedback being shared in draft report:

- Consideration of involvement throughout the entire procurement cycle
- Adding carers into all public, patient and carer voice/involvement as a standard term
- Continue to use existing volunteer assets such as Leeds CCG Volunteer Programme and PPGs (Patient Participation Groups in GP Practices).
- Recognition that involvement has a definition to point to in NHS legislation: a spectrum from active communications at one end, through a wide range of participatory approaches and co-production, to public consultation.
- Look at other partnership approaches such as BME Hub at Voluntary Action Leeds is a example of a real partnership approach to increasing opportunities for under-represented communities to have a say.
- Carry out a review of incentivisation or reimbursing orgs for their staffs' time for meaningful incentivisation.
- The development of an insight bank is valued and could be held somewhere neutral e.g. VSE umbrella support organisation, or on a partnership webpage. Great example at Listening Library from North Halifax Partnership.
- Needs to be more opportunities for bottom up planning as well as top down, current is mainly top down the partnership/organisations decide on the agenda for engagement for the year. If local people notice an issue in the health system, they have to wait for commissioners/organisations to decide they want to engage on this before they have the opportunity to share their views.

Other examples of good practice were provided by Kirklees CCG

Patient reference groups (PRGs)-Patient reference groups (PRGs) have been set up by most local GP surgeries. By joining a group, you'll be able to find out more about the work of your

practice and help them to improve their services. For information on whether your GP practice has a group and how to join, please contact the practice directly.

Patient reference group network-The Patient reference group network (PRGN) provides an opportunity for practice representatives to come together to discuss issues that matter to them and provide input into the commissioning process..

Community Voices (mentioned already in report) are individuals working in the voluntary and community sector who are trained to engage with the local population on our behalf. Working with these assets strengthens and increases the feedback we receive, particularly from seldom heard groups.

Your health, your say network- Local residents who want to get more involved in the development of new and existing services and to share their experiences can join our engagement database. We contact people on this database when an opportunity arises for them to get involved.

Events -The CCGs hold regular joint engagement events which are open to members of the public and representatives of voluntary and community sector organisations.

Kirklees Equality Health Panel -The panel provides an opportunity for people from protected groups and their representatives to share views, information and feedback with the CCGs and providers to support us to improve services, promote equality and achieve our equality objectives

Voluntary and community sector -We also work with community organisations on specific engagement projects and encourage them to share important health messages.

Patient engagement assurance group (mentioned already in report as well). This group helps to make sure that the CCG involves patients, carers and members of the public when they plan, develop and purchase (commission) health services, or in some cases, discontinue services.