

# West Yorkshire communication and engagement workshops on White Paper proposals and Independent Review of Involvement

## Report of feedback from colleagues and involved citizens

### Background

Following publication of the [Independent Involvement Review Report](#) the Partnership continued this work by asking colleagues and informed citizens who had hopefully been part of the original review workshops and survey to sense check the recommendations. This was undertaken in the form of two workshops. One for communication and engagement colleagues from partner organisations on 22 July and one for citizens already involved with partner organisations 9 September. There were approximately 100 participants

### Summary of themes from both workshops, all breakout sessions

Take the best of what we have and share. However, sometimes difference is good i.e. because of demographics.

Colleagues can work / lead on Partnership projects but this might only be expertise and advice as this is how it works at place sometimes (other managers should learn about engagement). Also, colleagues represent place on different projects i.e. Healthwatch/ICS model.

All “lay member”, “patient representation” involvement needs mapping and coordinating. Some people were concerned that relationships and groups i.e. Patient Reference Groups (PRGs) would be lost in the transition period.

Patient experience is also important, and to improve it where necessary. Without collecting this insight we will not know what needs to improve. People liked the idea of a patient experience repository – maybe as part of a website. But also, other shared resources, documents and templates on a shared platform.

It was evident that citizens were concerned about the changes to the NHS.

Don't get drawn into using corporate language – always focus on accessibility – coproduce materials where possible.

Inequalities is a key factor in involvement. Value difference, all our communities are different. There was concern about how plans will work for all. Social inclusion / equality (not just about ethnicity) should be a golden thread that runs through everything, it is everyone's business. One size does not fit all.

Collaboration is essential and we should use good examples already there – SEND, MVP etc. Involve: staff, universities, VCSE in work, networks, resource. Build capacity to engage, also on relationships in the voluntary, community and social enterprise sector who help with this.

Digital / virtual engagement has worked well during the pandemic but when possible we do need to continue to engage with communities.

Involve people as early as possible, not once the main decisions have been made.

Involvement is everybody's business – this should be supported with training and resources.

There was concern about who would decide on priorities.

Ask our communities what good involvement looks like (possibly as part of Constitution). But colleagues feel across West Yorkshire there is much good involvement and a good culture – don't change for the sake of change. Let the new "way" evolve.

A Slido poll was undertaken at both workshops. Some of the results are shown below.

**Do you think the review gives a correct overview of the current picture of public involvement at a WY&H and local level?**

Colleagues (out of 20)

Yes 100%

Citizens (out of 23)

Yes 65%

No 35%

**Is there something missing you expected to see?**

Colleagues

- More about keeping VCSE grassroots heard
- More focus on health inequalities
- I don't think so (2)
- Actual benchmarking
- Recommendation about the culture that facilitates joined up working
- Keen to keep inclusiveness on the agenda and track progress About staffing/ structures
- Would be helpful to reflect limited capacity

Citizens

- No (4)
- A commitment to achieving objectives whatever they may be - structures.
- No detail
- More clarity around coproduction
- Pals not directly involved
- More emphasis on patient involvement
- Clarity
- A definition of involvement
- Difficult to know because of the poor connectivity
- 1. According to Marketing gurus you picked the wrong time 2. There was no agenda beforehand 3. I know this is a critical issue but there has been little communication about it.

Below is feedback from the break-out sessions where participants were able to discuss issues and the recommendations in more detail.

### **All groups**

#### **How do we connect better, form better networks, support each other and share good practice?**

- Regional, national – can't all go to everything. Don't duplicate purpose of meetings.
- Healthwatch model – one area represent all at one meeting (partnership), one on another e.g. System Oversight and Assurance Group (SOAG) etc.
- Strong feeling that we should let it evolve – “not broken so don't mend”.
- Need better connections between similar networks across different places e.g. Black Minority, Ethnic (BME) hub may work well in Leeds and not so much in another place, Kirklees may have a great carers network, another place maybe not... How do we link up and support each other to keep improving?
- Some concern that voices from grassroots level may get lost at Integrated Care System (ICS) level.
- Regional, national – can't all go to everything. Don't duplicate purpose of meetings.
- Healthwatch model – one area represent rep on one meeting (partnership), one on another (SOAG) etc
- Strong feeling that we should let it evolve – “not broken so don't mend”.
- Need better connections between similar networks across different places e.g. BME hub may work well in Leeds and not so much in another place, Kirklees may have a great carers network, another place maybe not... How do we link up and support each other to keep improving?
- Some concern that voices from grassroots level may get lost at ICS level.

#### **What would a good communication and involvement model look and feel like for our Integrated Care System (ICS)?**

- We will still be partnership as we are now, we work well. Clinical Commissioning Groups (CCGs) will be different and become part of the Partnership. The council will be separate, and provider will be separate – they will drift off as they think it's our work.
- Don't lose good work we have already, how do we share
- We have a system (wider Integrated Care Partnership) – it works, why change it. Partnership will be the body – colleagues at place.
- Not sure how will work will flow down, up.
- Starts with place – place model fist – not top down but bottom up
- Conversations in safe spaces
- People often have consultation fatigue – not enough feedback what happened
- Need to link our information up / opportunities and make it better for people
- We need a hub (not NHS platform futures) – where information can be stored/can access files and share
- Consistency of approach across places e.g. core principles of involvement and refine for each place. For example, some consistency to remuneration for people sharing their time / expertise / experience, or application of equality impact assessments, regardless of where involvement is taking place. Work from a core framework and co-produce detail at place for the right approach.
- Time – agreement that time to collaborate, time to prepare properly, time to share experiences / best practice is in short supply – NHS Future Collaborations platform was mentioned as a useful place to ask for examples / input on work areas.
- Sharing insight / ideas – like the dashboard idea, as current West Yorkshire approach – some way to check what we already know and who else is working on / has worked on a certain topic / issue. Maybe some kind of digital directory – accessible online/social media.

- Principles on what makes a good leader in relation to involvement. How many leaders have lived experience of inequality / disability etc.? There is a perception of leaders being quite far removed from real life grassroots experiences. Leadership is so important in securing effective involvement.
- What does good involvement look like? Who are we asking? What do people at grassroots level think it looks like? Who gets to decide? Collaborate / co-produce – what if we don't like what they say?
- Continue place based work & do not lose focus / trust of the local mechanisms created
- Build on local successful programmes i.e. increasing vaccination uptake and build on the legacy
- All key stakeholders to be kept included
- Not lose focus of current staff knowledge / expertise across the WY&H footprint
- Work underpinning engagement matters. Recognise health inequality – not just reduce it but end it
- Can see that we are passionate about engagement, about our work
- Positive – get in there, get involved – but it takes investment
- Repository work in Leeds
- Analysis tool – Healthwatch Kirklees and Calderdale
- Build on local successful programmes i.e. increasing vaccination uptake and build on the legacy
- Share good practice.

#### **Involvement policy, quality and planning**

- No comments were received from the citizen group
- All have principles at place – we need to think about how we incorporate these (what is the same, what is different)
- How we report to NHS England is onerous, but it does work and has a benchmark – so have key performance indicators (KPIs)
- Opportunity – be an enabler of sharing good practice. Quarterly reviews NHS England – Partnership will be part of it and pick up learning from different areas to share
- Save time – shouldn't duplicate time
- Ability to adapt learning because of local demographics
- Structure – West Yorkshire level work but some piece had a place lead – teamwork matrix
- Colleagues work at place but also have times when one colleague could lead for West Yorkshire because of capacity or expertise.
- Even at place other colleagues e.g. the service improvement manager, lead on engagement we just give expertise.

#### **How do we connect better, form better networks, support each other and share good practice?**

- How to have a voice? Participant wrote a paper last summer (2020). Happy to share
- Working in partnership and collaboratively with communities / stakeholders
- Needs to be accessible – the recommendations are not
- Zoom has helped – more people can join in – can see their name
- Don't change feedback into corporate language
- Covid hesitancy, picked up information about other health concerns, diabetes, testicular cancer – now we've got everyone talking – work needs to happen with groups who are connected to those receiving service – don't be too formal.
- Intelligence can get lost – develop a principle
- Mencap – learn from people with learning disability, if it works for them it will work for most
- Look at the learning from the pandemic – equalities, illnesses, neglected but positives too.

## Inclusivity, equality and communication

- The main discussion was about technology – user involvement
- Digital champions are a good idea
- People can help to sense-check information – the language / access
- Teams is not as accessible as Zoom
- There can be a disconnect between the technology trusts use – with little explanation for the general public / co-production is key
- Don't bring people in at a later stage when input isn't as practical – would save money
- Many people use technology as part of their work – the public use it for social things / the skills aren't often as good
- Although technology is good – we also need to promote people still engaging with their communities – going out and seeing people. People going out in their community is a lifeline. But the reasons to go out are getting fewer and fewer
- The role of the voluntary sector is so important in reaching group / people and making information accessible
- There is often not enough in place to encourage people (deaf / heard of hearing) to get involved, seen as a health and safety risk
- International standard on accessibility – access to a compute / smart phone
- Consistent / robust equality monitoring
- They are not seldom heard – give opportunities to express their opinions
- Acknowledge the profile of community serving – shouldn't have to do 'special' engagement
- H.I is not new – pandemic has highlighted and the leadership 'talk' has been frustrating – address the counterbalance 'them and us'
- Create the culture - profile of people in the room
- Golden thread everyone's business – social inclusion
- Self-appointed 'community leaders with white beard's – not everything to fall up on / tick a box
- Mental health patients – take till 11.30am to come round from medication be considerate and plan appropriately
- Not just about ethnicity! Health and accessible info – learning disabilities (LD) / easy read
- Through covid – Bradford has worked hard to get networks right – community champions/ used properly and continue to engage with – cultures, background, voices heard
- As comms people – many of us struggled with the Slido – expectations of others and not all online
- From Calderdale / Kirklees point of view if there is a proposed change, they do health impact assessments with broadest people – who to target/how to reach – specialisms / safeguarding / quality – all things considered use community voices trained and paid – to reach those affected by change – so important to work with the voluntary, community and social enterprise (VCSE) sector
- As a partnership – one size doesn't fit all – even at place footfall very different – do we need one version of this? At place we know the profile / data
- Data can be a barrier – often sits with the local authority (LA). Health and Care but is only social care NOT the council and working better together could help e.g. popular bus routes
- Engage with staff – they are people and residents
- Don't need special people in special roles to be inclusive – don't always look at the person from an ethnic minority background
- The Maternity Voices Partnerships (MVP) model was mentioned – maybe worth looking at what it is that works well and how replicable is that.

### **Partnership working** (most people took this to mean the ICS)

- Is the new ICS in danger of becoming a 'talking shop'?
- More community involvement in the development of the ICS, bottoms up approach. Not engaging when views / changes have been already formed.
- Is the ICS another layer of bureaucracy and will we lose the local commissioning focus?
- Work needs to build on/or continue locally.
- The consensus of the group was all legislation discussion should be led by patient involvement
- The ICS needs to listen and learn from the diverse patients
- Are patients simply being asked to endorse the ICS approach, rather than listening and demonstrating the scope of influence?
- We can work better by trusting our communities / voluntary community sector / Patient Reference Groups and asking them to lead and / or get involved in healthcare
- The ICS and new structure should invite criticisms, that is how they can grow and flourish
- Health inequalities needs to be a key driver in all we do, losing the focus in the transition may compound the existing health inequalities.
- Greater understanding is needed of the new legislations and the process
- Communication is key, that needs to be tailored accordingly
- All agreed that two-way trust is crucial.
- Priorities need to be agreed, how to implement them flexibly and creatively.

### **Investment and workforce, leadership, autonomy, accountability and transparency**

- Involvement should be a standard part of everyone's role. All staff should have a commitment to involvement within their job descriptions and it should be discussed in appraisals, etc.
- All staff should receive basic training and have an understanding of what involvement is, why it's important and that it is all our responsibilities – too often there is a sense that involvement is something that happens over there, every now and again, and is something that is carried out by involvement specialists.
- It's important that involvement takes into account people's / patient's day-to-day experiences outside of organised involvement activities. These experiences shape wider views of services and the system and help to highlight gaps / barriers and also good practice.
- Concerns that the complexity of the governance issues may distract from us getting it right on the front line – important to keep a focus on all parts of the structure / system and work to ensure patient's / people's voices continue to be heard as the system develops.
- The front line is where people experience their care – so important that all staff, including clinicians and line managers are supported to buy into culture change which pays attention to patient experience.
- The way we currently collect patient experience feedback is very much tied to each service (site-related). Healthwatch Leeds are moving away from looking at experience of care from a service perspective and moving to consider it from a patient perspective – the whole patient journey.
- Sharing good practice is so important, and that should also happen at the front line – involving people / patients – nominations from them – recognition of what good service / care looks like.
- Challenges relating to silo-working – traditionally working as CCG / local authority / Trust / etc. Working towards better integration will be fundamental to making the system more effective.
- The opportunities available are really exciting, but the majority of the workforce are established in these ways of working and will need to learn and buy into a more collaborative approach for it to work. Excited about the principle of collaboration, but good line management will be key, as will holding onto good, experienced staff.

- There are already good examples of better collaborative approaches e.g. in children's and special education needs and disability (SEND) services – involvement and co-production with families and children taking place.
- Collaborate – who can add value? For example, involving universities – different faculties provide different skills – data analysis, etc. Potential to involve dissertation year students in supporting specific engagements. Involvement is everyone's business – who else can support?
- Need to ensure the VCSE sector are included when thinking about involvement capacity and expertise, and when thinking about raising awareness and planning training to champion involvement. Inclusive communities of practice.
- Ensure that public involvement includes staff – staff are members of the public and vice versa. Staff need to be fully involved in, for example, the Left Shift conversations.
- Training – who is providing the training and raising our awareness and championing involvement – asset based community development (ABCD) model? People who have lived experience?

### **At place and ICS**

- Local groups can and do hear lot of intelligence – it's useful for the wider picture but also through involvement they can share information onwards back into the communities. This way of working can also support communities in different ways, even if just to share information on how they can get involved, how can support others (peer support groups and setting up).
- Think about capacity in the community sector and there already is or could be
- Grassroots involvement – this works. You need to go where people are and go back to the old way of working of approaching and linking up with existing groups who can then enable you to 'go in'. It's a tried and tested way and valuable especially for when working with diverse groups and communities.
- Networks are passionate to be involved and information on what's happening is useful – this gives reassurance, see where we fit in and how we can support the wider picture. Need to consider funding though or support for it which will create and give continuity to what is happening and the support within the community sector.
- Networking would be useful. Online does make it easier and many people can make use of it.
- General comment but links to one of the recommendations: Managers of ICS should visit groups, get first-hand information, be visible and explain what ICS is.
- The work needs to be informed by what people are saying.
- We are holding local discussions on areas of work, some of which are very local and specific, but some that might lend themselves to scale up. We need good communication and relationships to decide/agree/be aware of what is beneficial to scale up across the ICS.
- Understanding of work across the place and ICS
- Strength in scaling up but also learning from where involvement was done differently. Use the difference to learn. Different can be good.
- Celebrating, supporting each other when done great/different pieces of work.
- Shared workspace, if not already thought of, e.g. like the NHS Futures is. For engagement but also perhaps for communications.
- It feels that, at the moment, there are different approaches in different places in terms of how partners work together on pieces of work. Some have more positive experience than others.
- Some work may be needed to join things up at local / place level before we can move consistently to ICS level. Look at building foundations at place to make sure it works at ICS.
- Consider what mechanisms are being used at place level to bring engagement together that can be learnt from across the ICS.
- Co-ordinate approaches and learning

- Local example of involving people shared at our Comms and Engagement Network meetings.
- Reduce duplication but don't reduce investment. We need investment in involvement, whatever form that might be in. Not reduced but improved.
- "inclusive" "ambitious" "pragmatic"
- Networking and opportunities of working across the system
- What are our opportunities at local and ICS levels around involvement? ICS could facilitate this so that we know what is happening and what can be shared.
- We have the local expertise but need to bring it together at wider level.

### **Practicalities / Systems**

- What's going to happen to Practice Participation Groups? Need the impact of what people are telling us from GPs to go to Board level how will this be done?
- How will ICS maintain inclusivity when looking at feedback received? Some groups partake some don't – need to hear from disadvantaged groups. Embrace diversity and be inclusive. Also, systems don't talk to each other i.e. System One, EMIS (technology systems) etc.
- Echo diversity
- Primary care is getting lots of bad press at the moment. However, it is underfunded and impacted by Covid
- How will ICS manage the budget across wider area? Everyone has their own priorities. How will it be divided up and take into account health inequalities and differences in each area and how will services get representative amount of money to ensure cradle to grave services are catered for?
- Practice Participation Groups are not representative.
- Need to decide exactly what engagement is needed as there are so many differing purposes
- Most public only participate when they have a concern or a complaint
- Try subcontracting the engagement and feed back to Healthwatch
- Who decides the priorities?
- Liked the idea of a repository on website of national and WY insight.
- It would be great to have somewhere where all of this sat – have the ability to drill down to local level.
- It would be good to have uniformity of reports, documents to capture insight
- Develop a clear forward plan pipeline for projects and programmes to include activities at place, Partnership and programme level
- Continue place based work & do not lose focus / trust of the local mechanisms created
- Quarterly insight report could be created from the 'Core ICS Team '
- Work closer with Patient Experience colleagues
- Public involvement is 'broader than your world' – patient involvement is not the same 10 people

### **Public voice / lived experience**

Comments largely focused on the specifics of the "how" – tactical comms methods:

- A dedicated involvement website and / or email system that facilitates and enables interaction and feedback.
- How do we properly involve the digitally excluded and those who while they may have access to technology, aren't comfortable using it for this purpose?
- Put notices and information into the public domain via news media.
- Put notices and posters etc in public spaces (libraries, town halls, doctors' surgeries etc), door drops – leafleting.

- Think about accessibility – languages; tap into mosques and community leaders, appoint involvement ambassadors.
- Make sure that people know why they're being invited to engage – what's in it for them. Are there any tangible benefits (not necessarily financial).
- Get support from Voluntary, Community and Social Enterprise (VCSE) organisations.
- Regular updates on progress.
- Trust management could use screens in waiting and staff areas to push out involvement messages and encourage participation.
- Communicate with intent and with the end in mind.
- Be clearer about the impact of changes on place and emphasise the benefits – people may have to travel further, but better care makes that worthwhile.
- Explain how funding will work and how the changes to the way services and the system are funded will benefit people.
- Covid has forced the pace of integration with the VCSE sector and this is an opportunity to capitalise on these maturing relationships with proper funding and recognition.
- What's going to happen to Practice Participation Groups? Need the impact of what people are telling us from GPs to go to Board level how will this be done?
- Open stream board meeting
- Defined roles in board to assure engagement – i.e. designated Patient and Public Involvement (PPI)
- Tick box on board papers – enables someone to challenge if engagement has taken place and to what degree
- Someone like that on each Programme not just Board
- Lay members involved in programmes to go to Board when appropriate to assure Board of engagement, raise profile and challenge
- Also, a citizen panel – diverse. Equality panel to assure (separate or within) represent geography too.

#### **General comments**

- These statements were clumsily worded and consequently difficult to understand – if we want people to properly consider the concept, we need to use clearer language.
- The Health and Social Care Bill is a real concern, people are worried about the NHS, worried about how to pay for their care. Is there going to be an NHS? Concerned re privatisation and arguing over who pays what
- If we do get involved, we can help through the back door
- Many felt that the new Government proposals were not an open and transparent process, the agenda is dictated to rather than in its development stage
- Final point was made in relation to the recent developments re Social Care – how to deal with social care reform will be a test of the ICS.

#### **Feedback about the Independent Review of ICS Involvement Report**

- Agree with the main points of the report but disappointed no case study or example of good practice for patient engagement in health and well-being. For example, Community Partnerships - some work well and provide services and deliver projects to the public and would have been good to see an example of how ICS can build on this e.g. dementia awareness and social prescribing activities. Also, report should say more about financial support and potential resources available to VCSE etc. Would have liked to see a potential governance model - ICS board at top and how VCS patient groups would fit into governance. Finally, in Bradford we

have / had patient representative groups like patient network and peoples board who communicate key messages with their own networks and something similar is needed for ICS.

- Again, we heard about terminology being difficult and the need for simple language
- How this change will affect the Patient Network only the powers that be can decide but it would be a sad reflection on past work for this to be disbanded.

#### **Actions to add to our plans**

- Reassure people / communicate that the changes are a change within the NHS not a weakening or watering down of its core set up
- Make the recommendations from the review understandable
- Involvement is key to work on inequalities and vice versa
- Maintain groups and networks that exist locally
- It is essential that we communicate well with those involved in our organisations and work
- Think about ways for these people to network
- Managers from ICS may want to think about visiting local groups (or virtual meetings)

#### **Evaluation of the citizen event**

13 people from the 65 attendees completed the evaluation survey which was sent out afterwards. Equality and diversity data told us that we have an even spread of participants across West Yorkshire, there were slightly more male than female and the majority were over 60 years of age.

Themes were:

- Able to understand – Yes (6). No, presentations were complicated and too long, too much info on slides (7)
- Not enough time for questions (8) (one joined late, did not have information to know what to ask)
- Yes, questions answered (3)
- Not enough time in break out groups (4). However, “able to get my point of view across during the breakout sessions”
- When asked how we should share information we were told: email information prior to event (3) – “presumed we had more knowledge than we had” and email information (presentations) out after event or link to website (2) “Given precise website references to the presentations and the supporting 'evidence'”
- Virtual experience – satisfied (5), dissatisfied (8) (technology failure, breakout session failed, poorly managed)

Other comments:

- Difficult to meet everyone’s needs but appreciate that you tried
- Confusion – title when joining the event was different to what we thought we’d signed up for. People thought the event was about the White Paper changes rather than the Involvement Review.
- What was the objective of the workshop? Side-tracked by people’s concerns for the future of the NHS. Clearer description of what the event was about (3)
- Share learning from Leeds 3 PPVP roles.
- Planning needs to take into account the variety of people who will be involved, as what their knowledge of the topics maybe.
- Not everyone is aware of how the NHS and its policies are run and administered

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