Introduction

Morecambe Bay CCG, on behalf of Bay Health and Care Partners, sought public feedback on its proposed priorities for its emerging five-year plan.

'*Better Care Together; developing our Bay Strategy for the next five years'* was circulated to partners*, and an online survey went 'live' on 21 August. A news release was issued to the media and the strategy and accompanying survey were also promoted via social media channels (Facebook and Twitter). There were 260 unique page views on the Healthier Lancashire and South Cumbria website. No paid-for social media advertising was undertaken.

The views of more than 50 CCG staff were sought on 20 August via a workshop to discuss each of the priorities. Staff views were collated into a single report.

The 'next five years' document also formed a part of the public engagement conducted around the setting up of a Public Assembly. Meetings were held in Barrow, Lancaster and Kendal. The broad themes from the meeting are captured below*. No specific feedback on the challenges and priorities was gathered at the Assemblies; some commentary on the style and language of the document was collated. Attendees were encouraged to complete the online survey.

More than 40 community groups were contacted, alongside elected representatives from both county councils and district councils, including those with a broad health and care remit (such as children's wellbeing, youth justice, scrutiny committees). In addition, more than 100 parish councils were contacted, alongside housing associations from the Health and Wellbeing group for the north west. Information was circulated to 300 recipients of the Cumbria CVS newsletter, as well as via the Better Care Together newsletter.

It is estimated that the consolidated 'reach' of these groups would be in the region of 15,000 adults and young people, though not all recipients would share the narrative with their constituencies.

Mandate

The engagement was proposed to ensure that Bay Health and Care Partners had taken the views of the public and civic society into account when preparing its plan for NHS England.

The proposals under consultation

The five-year strategy document sets out the challenges and priorities for Bay Health and Care Partners. The draft priorities have been broadly grouped into: population health; ICCs and primary care networks; meeting national standards; financial sustainability and further development of the ICS/ICP/ICC infrastructure.

The aim of the engagement was to seek a view on the proposed priorities, as well as raising awareness of the 'local' challenges the Morecambe Bay health and care system faces.

Process

The Communications and Engagement Team supported the promotion of the document via: creation of a bespoke web page (on the HLSC website); document design; circulation by email to key civic and voluntary sector colleagues across the Morecambe Bay footprint. The document was accompanied by a letter from both Chief Executives (Jerry Hawker, for Morecambe Bay CCG and Aaron Cummins, for University Hospitals Morecambe Bay Trust) which was segmented by stakeholder priority. Those identified as a priority stakeholders were offered a meeting. Others were invited to make contact via email.

In order to reach a broader constituency, reflecting the broader BHCP audience group, a wide group of organisations was contacted via email and letter on 20 August with the proposed strategy attached and a direct invitation to complete the survey by 12 September.

Given the truncated timelines applying, leaving less than a month between inception of the narrative document and the completion of this report, in-depth engagement (i.e., face-to-face meetings or events with selected priority groups) has not been undertaken in this phase. The Assemblies have partially substituted for this.

Forty-two responses to the survey were received. Respondents may overlap with Assembly members, however there is no evidence they are the same cohort. Dates of survey responses do not correlate with Assembly dates.

Survey responses:

<u>Challenges</u>

76% of those who replied agreed that the challenges were set out clearly (n = 42)

> Of those who were unsure (3), responses varied from:
>
> "Clearer descriptions of what we mean by population heath - it is not widely understood even in the NHS never mind in the wider population. Need to be clear it is about a shift in how we think of health and public services - more public responsibility."
>
> To
>
> "Language needs a lot of attention. Needs to explain impact for patients in easy language."

Respondents selected the following as the most important challenges to tackle:

> "We are not meeting national standards of care"
>
> Followed by:

> "We need to improve healthy living services and education for children and adults, particularly for smoking, obesity and exercise, mental wellbeing and alcohol and substance misuse."

Workforce, budget and an ageing population featured less prominently as challenges to tackle.

Priorities

Forty-seven percent of respondents selected population health as the most important priority. This was followed by 'deliver more integrated care' at 22%. Financial sustainability was a priority for only 20% of respondents.

More than half of all respondents agree that the priorities would meet the challenges (51%). 44% answered that the priorities 'maybe' would meet the challenges. Of those respondents, who did not feel the priorities would meet the challenge, most went on to make an individual comment:

This included things like 'addressing the obesogenic environment' (environments that encourage people to eat unhealthily and not do enough exercise); 'children and families are not given enough prominence' and 'reopen convalescent homes to address the bed blocking crisis'.

One respondent commented:

> "I have not ranked the challenges in order of importance as none of them are more or less important - the impact on patients and the public is what needs to be measured and assessed. I also haven't ranked the priorities - Population Health is number one and the others are all enablers for that."

When invited to offer any other comments, responses included:

> "How will you measure progress?"

> "Why is the Third Sector not more involved in creating priorities?"

> "Need to reflect the needs of children and young people more – they are our future"

Demographics

The largest number of responses were from the Lancaster area. Five of the 42 respondents did not live in the Morecambe Bay footprint.

70% (30 respondents) are aged 45+. Only one respondent was aged under 35. Of those who declared a disability, six had a physical disability and three had a mental health need.

The majority of respondents (23) were white, female Christians, either married or co-habiting.

Staff workshop outcomes

A morning workshop was held with approx. 40 staff. Staff were invited to comment on the near-final narrative document and feedback on the individual priorities.

Staff feedback mirrored that of the survey responses and Assembly comments. General comments included:

- The document refers a lot to integrated care but needs to explain more what that means, there was a feeling round the table that people generally in the population don't know what we mean by integration. There was concern that that raises expectations about co-location and how feasible co-location actually is.
- In terms of what is missing, there was a comment that we need it to be more about the contract with the public, more about what people reading it can do for themselves and that there needed to be more of an emphasis on educating the public; self-care, ownership of people's own responsibilities for their health.
- It doesn't draw out the shift towards personalised care, that different approach that we are embarking on.
- People don't know what population health means and it needs to be better articulated. It is confusing regarding Public Health vs Population Health.

Comments on the individual priorities included:

<u>Population health</u>

- Population Health is a partnership approach and the population taking responsibility for their own health (not done-to,
  - "You can change this and make a difference and help yourself"
- We should be clear that in delivering this we will need to shift the priorities and we will always being thinking about how we can shift those priorities towards things like those groups that are most at need of health improvement such as people with Learning Disabilities, how we can shift the priorities towards the first 1000 days of life and shift them towards earlier intervention so that we use that as a yard stick almost for any developmental plans and do they help us in shifting this balance.

<u>Integrated Care Communities and Primary Care Networks:</u>

- Need to change language – less jargon (pathway, model of care, frail) and say more about how things will work
- Need to describe what people will see – people not patients
- Telling the story will illustrate why it matters and what needs to change

<u>Meeting National Standards:</u>

- Need to explain this will mean smaller acute/hospitals sites – more in communities and general practice
- Don't *do to* people – it's not about 'we'/NHS doing but the people helping themselves
- Could focus on mental health and wellbeing, cancer, chronic long-term conditions

Developing the infrastructure of ICS, ICP, ICCs & PCNs:

- What are we doing as a system to incentivise the right behaviours and recognise that people run healthcare? Systems don't run healthcare.
- The review of the structure / architecture of the system is an opportunity to do things once which have become duplicated across numbers of CCGs/ICPs.
- CCGs have become hospital focussed but 93% of interactions concerning health take place out of hospital.
- The CCG does not have as much contact with the public as it used to.

Financial sustainability:

- Agreement that the public are aware that current NHS is unaffordable
    - But some people don't care about what things cost because accessing the NHS is their right
- Simple version of what the size of the deficit is would be helpful - £70m is not easy to understand
- Transparency is key

Conclusions and recommendations:

This engagement work takes the views of the public into account in a snapshot fashion. The conclusions and recommendations are distilled from interactions with a small proportion of the population.

- **Population health is a concept that is not well understood by the 'general' public**. In order for the public to both see the benefits and grasp the implications, further educative work is required to highlight the intended 'destination'. This should embed across all of the BHCP communication channels;
- **Human-interest, real-life stories should be collated and used where possible** (i.e. national priorities) in order to illustrate each priority and offer tangible examples of how the service or culture will change as a result of the BHCP's work;
- **The use of simple-to-understand graphics and illustrations would facilitate easy sharing** (via a range of channels) of, i.e. the needs assessment and other drivers of change. Data visualisation and design resource is needed;
- **There is a risk of engagement/consultation reticence**, without momentum and visible achievements.
    - This was also noted as ensuring we **work with existing forums** and interest groups (i.e. carers, patient participation groups, social workers, & others);
    - An **audit of existing** public influence channels, their frequency of use and their roles and outcomes would support building trust, by ensuring that each channel has parity in access to information, feedback and level of influence;

- **Transparent ‘progress’ reports**. Few people understood the roles and functions of the ‘infrastructure’ as it relates to them, or the benefits that are provided by that infrastructure. Explaining the change educates and builds recognition; this also supports reporting under the Improvement Assessment Framework (IAF) successor programme;
- **BHCP is not well understood as a concept / vehicle**. If it is seeking to create trust (through recognition) it will need to ‘live the change’: more frequent and targeted engagement; working visibly with local partners; allowing capacity and time to gather meaningful feedback, and to share that with interested stakeholders. It should also consider ‘co-production’ with external groups;
- **Engaging with the public requires meaningful effort and resources**. Engagement should be routine, planned and consistently applied over time to build trust. This includes, for example, resourcing.

Findings and conclusions were presented to Leadership team on 19 September.

Leadership team response

Following the presentation of the findings, the BHCP leadership team recognised that engagement with the general public is improving but could improve further. BHCP reaffirmed its commitment to continue work to listen to the public and to grow the role the public’s input in improving services. This includes continuing with the Assemblies, listening and responding to questions and comments, and providing transparent information on progress. BHCP will continue to improve the way it engages the public, patients, staff and the wider community in developing and delivering its services.

The engagement document was sent to:

In total, at least 40 ‘community’ groups were sent the engagement narrative, for example: Mind, YMCA, Lancaster Boys and Girls Club, Dementia Alliance, Princes' Trust, Cancer groups, MENCAP parents, LGBTQ groups etc. Housing Associations were contacted via the Chair of the North West branch of the National Housing Federation.

Other stakeholders included: Backing Lancashire, Lancs Wellbeing committee, Cumbria Lancs Joint Health Scrutiny committee, Lancashire Care, Cumbria Children’s Wellbeing, Prevention, Early Years committee, Youth justice boards (Lancs & Cumbria), and at least 100 Parish Councils in the LA postcode area. This group reaches the elected representatives with a locus of health and care in both County councils.

The engagement was also featured to 300 recipients in the CVS newsletter and the Better Care Together newsletter.