Engagement, involvement and coproduction framework for the NHS in Lancashire and South Cumbria

> "Public Involvement is an essential part of making sure that health and care services are delivered effectively. By reaching, listening to, involving and empowering our people and communities, we can ensure that they are at the heart of decision making. The NHS in Lancashire and South Cumbria is committed to putting our population's needs at the heart of all we do."

Working in partnership with people and communities strategy: A strategic approach to public involvement for Lancashire and South Cumbria ICB

Lancashire and South Cumbria Integrated Commissioning Board (ICB)'s working in partnership with people and communities' strategy embeds public involvement and engagement into the heart of decision-making and commissioning processes.

Improving the health and wellbeing of our population, tackling health inequalities, and making services accessible and effective, means we need to understand our communities, the problems they face, and the barriers they must overcome.

To move forward together we must:

- meet people where they live and work
- build trust and relationships
- listen to them directly and through representatives and advocates
- engage through and with partners

There is no short-cut to leaving the confines of the office or the computer screen and going out into the community to bring community voices in, and not just invite their voices to be heard. Decision-makers too, need to see and hear from patients and the public directly, and to be seen and heard, whether that is through patient stories, at events or in focus group sessions, or in other ways.

Good engagement needs to be a genuine two-way process which:

- gives people an opportunity to influence decisions about the services available to them and their loved ones, now and in the future
- takes into account whether or not services currently meet their needs
- maximises the benefits to their physical and mental health and wellbeing.

ICBs and all provider partners operating within the NHS have a statutory duty to involve and consult the public.

Both as individual organisations and as part of a wider collaborative, NHS partners must:

- assess the need for public involvement and plan and carry out involvement activity
- engage with service users and our population at all stages of the planning and delivery of services
- clearly document at all stages how involvement activity has informed decision-making and the rationale for decisions

- have systems to assure themselves that they are meeting their legal duty to involve and report on how they meet it in their annual reports.

All NHS partners, as part of an Integrated Care Partnership (ICP), must consider the effects their decisions make on the health and wellbeing of people and the quality of services to all, including its effects on inequalities (both personal and in respect of health benefits), and on the sustainable use of NHS resources.

ICBs and partners must seek patient and public involvement as early as possible in the development, redesign, or transformation of services.

Involving people and communities is not always easy and can take time, but when undertaken well it provides opportunities to improve patient safety, patient experience and health outcomes, and can support people to live healthier lives.

Principles of engagement

NHS England recommends ten principles of engagement. These principles have been reviewed and adopted by Lancashire and South Cumbria ICB. The ten principles of engagement for Lancashire and South Cumbria ICB are:

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.
3. Understand your community’s needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
4. Build relationships with excluded groups, especially those affected by inequalities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCFSE) sector as key partners.
6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
7. Use community development approaches that empower people and communities, making connections to social action.
8. Use co-production, insight and engagement to achieve accountable health and care services.
9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
10. Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.

Meaningful engagement and involvement is required by all parts and levels of the NHS, whether system, place, or neighbourhood. Insight and feedback gathered through engagement and involvement should be shared wherever possible.

Levels of engagement

There are five levels of engagement, which identify the type of engagement provided. These are:

INFORM	• Telling people about developments. • Raising awareness of services.

LISTEN	• Using insight from what people tell us.
	  • e.g. complaints and Healthwatch reports.
	  • e.g. surveys

DISCUSS	• Actively seeking to discuss plans with dedicated groups of people, seeking their views and using their feedback to shape work. • e.g. focus groups
COLLABORATE AND CO-DESIGN	• Including groups in the design process so their ideas are an integral part of the planning and development of work. • Allowing groups to be involved in the implementation of plans.
EMPOWER	• Working with people and communities to help them with asset-based community development where they have control of health and wellbeing in their communities.

Putting the ten principles into practice

This engagement framework aims to put the ten principles of engagement into practice: making them the everyday business of the NHS in Lancashire and South Cumbria.

Engaging and involving patients and the public has two main elements; making sure people can express their needs, concerns and frustrations and the impact this has on their physical and mental health; and understanding access to services, how well these work for people, and what needs to change to make these better so they can get on with their lives.

The Gunning Principles, supported in case law as applicable to public consultations, apply equally as guiding principles for undertaking any patient or public engagement or involvement activity. Failure to follow these principles risks a Judicial Review and failure to meet the Public Sector Equality Duty. These principles are:

1. That engagement or consultations should take place when proposals are still at a formative stage (decisions should not already be made)
2. Sufficient reasons for proposals to permit ‘intelligent consideration’ – people need to have enough information to make an intelligent choice and input into the process. Equality assessments are needed to inform this, at the beginning.
3. Adequate time for consideration and response – appropriate timing and environment; enough time for people to make an informed decision and provide feedback; enough time to analyse results and make the final decision
4. Must be conscientiously taken into account – need to demonstrate how decision-makers have taken responses into account.

Getting engagement right and making a difference

There are several key factors that will make any engagement or involvement activity successful. These are:

- Planning
- Timing
- Audience
- Resources
- Reporting and evaluation

These key factors overlap with each other; get one wrong and it can affect the whole process.

Planning – adequate time needs to be allowed for good quality engagement. This means:

- Understanding what the engagement is for and how this fits into the decision-making process (if all decisions have been made already, engagement is futile)
- Understanding who the engagement will impact upon
- Making arrangements that suit the people being engaged, as well as the people doing the engaging
- Having the resources and materials needed, including time to prepare

- Building in time for analysis and reporting and feeding back to contributors.

All this needs building into the process of engagement and is closely intertwined with timing.

Timing – engagement should start as early as possible- ideally before any decisions are made. All workstreams at system, place or neighbourhood level need to factor this into their plans.

Community liaison and involvement, co-production or empowerment engagement should happen at a time and place that suits the community, whenever or wherever this may be.

Sufficient time for good planning is vital. This includes time to prepare resources in all required formats, and to arrange engagement sessions. If using established meetings and forums, make sure their schedule works for organisational timescales.

Audiences need time to access and digest the information, consider a response and/or be able to plan to attend a session, whether it is online or face-to-face, in line with the Gunning Principles.

Time to allow a thorough assessment of the feedback and information received must be built into the process, as well as time to create a report of findings for the decision-making body/committee and to provide a 'you said, we did' response to contributors and/or the wider public.

Audience - not all pieces of engagement and involvement need to reach everyone. Some will be aimed at a specific audience. Once an audience is agreed stakeholders should be identified; these are the people, patients, potential patients, staff, and others who will be impacted directly or indirectly by a service or situation. All engagement should be as inclusive as possible.

Reaching the right audience is fundamental for good engagement. Building strong relationships with community groups, voluntary sector organisations and key stakeholders through transparency, consistency and trust will make sure you reach the right audience.

Consider those who will be most adversely affected by any change, or lack thereof. Vulnerable people and groups often may have one or more of the ten protected characteristics; there are other communities or groups that may need to be engaged with such as socio-economic groups, homeless people, carers, asylum seekers and refugees.

It is best practice to undertake an equality and health inequalities impact and risk assessment (EHIIRA). Reference to the Demographic Insight Report for Lancashire and South Cumbria, developed by Midlands and Lancashire Commissioning Support Unit Equality and Inclusion team for an overview of the demographic and protected characteristic profiles in each place and across the system. The report helps to identify and understand the needs of different groups and potential barriers to accessing services.

Engaging with a fully representative sample of patients and communities is important, whether by targeted engagement or existing forums - this will make sure meaningful insight is captured. It is just as important to understand who you are not hearing from as it is to know who you are. Some groups and communities will only get involved once a relationship and trust has been established; others require greater effort and input each and every time you engage. How well and how consistently this is done depends on the resources used.

Resources – Engagement is everybody's responsibility, not just the handful of people who may have it in their job title. We need to remember and not pay lip service to the notion that the patient is the centre of the NHS, even when we do not have a patient-facing role.

Partnership working allows for greater flex of resource and allows organisations to ‘piggy-back’ on existing positive relationships groups and individuals may have with stakeholders. There will be occasions when it is important for an NHS representative to be present to see and hear from patients and the public directly – it demonstrates commitment, interest and sincerity.

Sufficient budget should be allowed for the purchase of resources e.g. leaflets, advertising, room bookings etc. When using written materials the current standard is to avoid the use of jargon and corporate-speak; aim for a 10-year-old literacy level, and use Arial font for readability. Ideally, all public-facing materials will be co-produced with public and patient representatives.

Resources also includes the use of venues. Where possible, make use of community venues on public transport routes which are wheelchair-accessible and have hearing loops. Avoid asking groups and individuals to come to NHS buildings unless they are easily accessible.

Reporting and evaluation – ultimately, the results of engagement should feed directly into the decision-making process and have a tangible impact on outcomes. If this is rushed or not given sufficient weight then the engagement, however thorough, may end up being meaningless.

Where action and assurance are transparent and clearly communicated to patients, the public and contributors to engagement, we see greater willingness to engage and work in partnership. Governance around engagement is provided by the Patient Involvement and Engagement Advisory Committee (PIEAC) which provides assurance to the ICB Board on engagement and involvement. Contributors should always receive feedback, either directly or through publicly-available information, which lets them know what decisions have been made and why- often referred to as ‘you said, we did’. Patient and public engagement may not always provide the benefits those who contributed to it may wish for, but good-faith efforts are seen and appreciated by contributors.

Engagement, involvement and coproduction quick-start guide for staff

The 9-step guide to engagement for NHS staff across Lancashire and South Cumbria

This is a step-by-step guide to planning and delivering an engagement programme which should be considered with the ICB strategy for working in partnership with people and communities. Paying attention to each step should result in meaningful insight to inform your project's direction and help to embed best practice for engagement, involvement and coproduction.

Step 1: Plan your engagement programme

Think about:

- the service areas/issues that are likely to require public engagement over the next six to 12 months or more
- the immediate area(s) of activity that require engagement (for example, specific service areas such as vascular services or MSK).

Step 2: Engagement objectives

What is the purpose of the engagement exercise? For example:

- Understanding how best to improve the service, make it more accessible, reduce waste, meet unmet demand and/or enhance patient experience?
- Understanding the impact of proposals on patients and their families?

Be clear on what the engagement is expected to provide. Most importantly, identify which decisions the engagement needs to support.

Step 3: Decide who to engage with

- Determine who will be impacted, directly or indirectly, by the potential service change, now or in the future.
- Ensure participants are drawn from diverse backgrounds. An equality impact assessment should be completed as part of the process to understand the impact on individuals, groups and communities.
- The reach should be reasonable, representative and proportionate. The greater the impact, in respect of what, how, who and where, the wider your engagement needs to be.
- Think about which partners and organisations are best connected or best placed to engage with the communities which have been identified.

Step 4: When to engage

The timescales for any engagement should include the planning and preparation, the promotion and delivery of the engagement, and the analysis and findings from the results.

Things to consider:

a) Patient representative on decision making boards or steering groups

Invite patients, carers or members of the public to join forums where decisions are made, so they can communicate and engage directly with the project team including lead clinicians and provide lived-experience perspectives.

Duration: as soon as is practical at the start of the project

b) Patient advisory group

This consists of patients, carers and members of the public with an interest in the development of a particular service. The group meets on a regular basis with the project lead and clinical lead. Alternatively, it may function as a virtual group which feeds in via email or online surveys.

Duration: Ideally throughout the project from the case for change stage

c) Pre-consultation engagement

This involves gathering or consolidating patient experience; supporting the formulation of options; identifying gaps in service or delivery; checking understanding of the patient and/or public perspective.

Duration: minimum of 4 weeks, often much longer

d) Involvement/co-production

Health professionals, patients and carers work together to change, develop or design a service that provides the right clinical, social and personal outcomes for patients, carers, clinicians and staff.

Co-production takes time (months rather than weeks) and commitment from all involved.

Duration: 6 weeks to 6 months

e) Wider consultation/engagement

Depending on urgency and timescales, this stage of engagement can follow all of the above, or be the only engagement undertaken.

Where pre-consultation/ co-production has not been possible a consultation/engagement exercise should take place. This should still be reasonable, representative and proportionate; it needs to hold up to the scrutiny of health overview and scrutiny committees and, where necessary, the Secretary of State.

Duration: Minimum of 4 to 12 weeks

Step 5: How to engage, involve or coproduce

You are likely to use more than one engagement or involvement method in each engagement exercise. Questionnaires and surveys tend to have the widest reach and are good for quantitative information and satisfaction levels however do not provide the opportunity for qualitative feedback and open discussion. Focus groups, workshops and deliberative events are different ways to get qualitative feedback and ideas, and to promote discussion and debate. Listening events and public meetings are useful ways of informing both local and wider audiences and to sample local opinion and reaction. Whichever engagement method is used it needs to be carefully planned.

It is important that ant engagement or involvement approaches should be planned with the intention to genuinely listen and value the contributions from local people, patients, staff and communities.

Step 6: Planning, preparation, and promotion

Consider resources available, skills, budgets, and who is doing what – a communications and engagement plan. Materials (questionnaires, papers, website content, FAQs, invitations, visuals etc.) need to be prepared and should be shared and/or tested beforehand to check accessibility. Venues and other support services may need booking.

You will need to take into account the analysis and evaluation required following the engagement. Qualitative/written survey responses will need theming and analysing – the more questions asked, the more time needed for analysis. Focus groups discussions/debates need analysing and matching with other feedback.

Consider promotion (via advertising, web pages, social media, partners and contacts) to give people time to make arrangements, read materials and attend/respond. An event/focus group session should continue even if only one person turns up.

Duration: Minimum of 2 to 8 weeks or more

Step 7: Doing the engagement

Engagement specialists can lead and advise, but others must be actively involved. Some engagement activities are resource intensive – focus group sessions will need facilitators and scribes; workshops and events will need lead facilitator, technical support staff, presenters. Attendance of senior decision-makers at many engagement events is welcomed and their absence noted.

With a series of engagement activities, continuous monitoring and evaluation is key; waiting until the end is too late. Surveys should be monitored for response rates, locality, emerging themes. Where an event is open to the public, thought needs to be given to the potential attendance of people with disabilities, wheelchair users, and those with hearing or sight impairments.

Duration: **Minimum of 4 weeks – 12 weeks (potentially longer for co-production, collaboration, and co-design)**

Step 8: Analysis, evaluation, and reporting

A record must be kept of responses and feedback received (and retained for five years).

A report should be prepared outlining the analysis of engagement insight. It should make clear:

1. Dates and timescales of the engagement
2. What engagement has taken place
3. A breakdown of the participants
4. Themes and findings of the responses, feedback and discussions held
5. Recommendations and/or issues for discussion/consideration by the organisation
6. Next steps.

The findings and recommendations should be reflected in a service report and/or in the board/working group identifying what will or will not change because of the engagement findings. This too, should be recorded.

Duration: **Minimum of 2 weeks**

Step 9: Reporting on the outcomes of engagement

We must tell people what happened because of their participation in engagement:

- What changed because of their engagement and involvement?
- What could not change, and why?

This often takes the form of a ‘You said, we did’ document which keeps people informed and builds trust, and supports the values adopted by the Integrated Care Board.

Feedback on the results of engagement should be shared on websites and, where possible, shared with those who have contributed directly.

Duration: **Depends on decision making, but unlikely to be less than 4 weeks.**