Lancashire and
South Cumbria
Integrated Care Board

Public Involvement and Engagement Policy

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Author (inc Job Title):	Neil Greaves, Director of Communications and Engagement
Ratified by: (Name of responsible Committee)	Integrated Care Board
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Target audience:	• All Board, Committee and Sub Committee members and any groups formed to undertake work on behalf of the ICB; • ICB employees; • Agency and other staff working on behalf of the ICB

This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

Document control:		
Date:	**Version Number:**	**Section and Description of Change**
July 2022	V1	Neil Greaves – development of document for approval
14 November 2023	V2.1	Updated based on updated strategy for working in partnership with people and communities and engagement framework.
28 November 2023	V2.2	David Rogers – updated based on revised content from the staff engagement and involvement toolkits Updates from Neil Greaves, director of communications and engagement

CONTENTS

1. POLICY SUMMARY 5
2. INTRODUCTION 5
3. PURPOSE 6
4. PRINCIPLES 6
5. LEGISLATION 7
8. GOVERNANCE AND ASSURANCE 11

1. POLICY SUMMARY

1.1. This policy embeds the principles from to the strategy for working in partnership with people and communities for Lancashire and South Cumbria ICB into a policy for public involvement and engagement for the Lancashire and South Cumbria Integrated Care Board (ICB) and describes how this will be implemented by the NHS in Lancashire and South Cumbria. This also aligns with the NHS England statutory guidance for working in partnership with people and communities.

1.2. This policy sets-out how the ICB will ensure our citizens can expect meaningful involvement, engagement and participation in the development, implementation, review and transformation of healthcare and wellbeing services across the ICS area. It also sets out how we will ensure all information shared is accessible for all individuals and groups.

1.3. This policy is relevant for all ICB staff providing a framework for good involvement and engagement.

2. INTRODUCTION

2.1. Public involvement and engagement is an essential part of ensuring that effective and efficient health and care services are delivered; 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.

2.2. Our vision for Lancashire and South Cumbria is to put people at the centre of health and care. This is based on the understanding that engaged and involved residents make best use of services to support their health and wellbeing and this will help to improve population health and drive down health inequalities in Lancashire and South Cumbria.

2.3. We know that genuine engagement and involvement stems from good communications, openness and transparency. It is evidenced that engaged and involved residents make best use of services to support their health and wellbeing and this will help to drive down health inequalities and deliver better outcomes for health and care services.

2.4. Our commitment to working as a partnership is a real one. Involving local people, reaching diverse communities and empowering change will only be possible by working closely with our partners in the voluntary, community faith and social enterprise sector, local authorities and Healthwatch who already work closely with those who are most vulnerable in society.

2.5. This policy embeds the principles of our partnership approach to working with people and communities for Lancashire and South Cumbria ICB and ambitions to work in partnership in our four place-based partnerships. This policy describes how this will be implemented by the NHS in Lancashire and South Cumbria.

2.6. This policy sets-out how the ICB will ensure our citizens can expect meaningful involvement, engagement and participation in the development, implementation and review of healthcare and wellbeing policies and services across our ICS area. It will also set out how we will ensure all information shared is accessible for all individuals and groups. This policy provides guidance and support for ICB staff in relation to engagement and involvement and how to contact the ICB communications and engagement team for advice and support.

3. PURPOSE

3.1. The purpose of this policy is to set out how the ICB will involve and engage people and communities in decision making; it:

- Sets out principles for working with people and communities;
- Sets out the legislation for involvement and engagement;
- Sets out the spectrum of engagement as a guide of the different levels of engagement which may be enacted to ensure a high standard of involvement and engagement is in place for different pieces of work
- Sets out the toolkit and supporting material for staff which helps support engagement and involvement of public, patients and carers
- Sets out the nine simple steps to start engagement as a guide for staff
- Sets out how the ICB will support members of the public to participate in involvement opportunities.

4. PRINCIPLES

4.1. In Lancashire and South Cumbria, the ICB will align and embed 10 principles set out for our places and across our health and care partnership. These principles are aligned with the national NHS England guidance for working with people and communities which were developed with extensive engagement with a range of groups, stakeholders and partners including Healthwatch England and voluntary, community and social enterprise organisations.

4.2. These principles have been tested and extensive engagement with partners has taken place in Lancashire and South Cumbria to ensure their adoption is supported. Our principles for working with people and communities are:

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

5. LEGISLATION

5.1. The Health and Care Act 2022 sets out what ICBs must do to make arrangements to involve and consult patients and the public in:

- The planning of commissioning arrangements and provision of services.
- The development and consideration of proposals for changes in the way services are provided.
- Decisions to be made by ICB that impact or affect how services are run.

5.2. The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the ground of the following ‘protected characteristics’

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex and sexual orientation

5.3. The public sector equality duty as outlined in section 149 of the Equality Act 2010 requires clinical commissioning groups to have ‘due regard’ to the need to:

- Eliminate discrimination that is unlawful under the Equality Act 2010
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

5.4. The ambition for the ICB is to embed an approach and mechanisms to ensure the NHS in Lancashire and South Cumbria is not only compliant with legislation and guidance in relation to public involvement but exceeds the duty as it is the right thing to do.

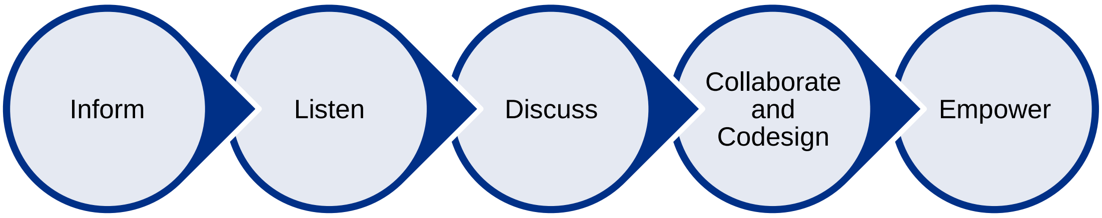
5.5. It is important to add that the NHS has a clear commitment to working with wider system partners intrinsically throughout its approach to public involvement – valuing the role of Healthwatch and voluntary, community, faith and social enterprise organisations in representing the public voice. Wider partners - such as local authorities and NHS Foundation Trusts – have similar obligations to involve the public as part of the national legislation.

6. PUBLIC INVOLVEMENT SPECTRUM

6.1. Public involvement is not about a single methodology; it is a spectrum of activity that involves different methods and approaches. It is important to recognise the need for diverse but complementary ways of reaching, hearing from and involving our people and communities.

6.2. This is often referred to the ladder of engagement and our ambition in Lancashire and South Cumbria is to move our involvement with people into communities, as much as possible, towards the empowerment end of the spectrum. This is not a linear process or a process of steps to be taken when involving people. At different times different types of involvement may be required.

6.3. The language used for the elements of the spectrum often vary between different organisations and this document has aimed to draw from this, along with national guidance, to set out consistent principles for the different types of involvement.



6.4. Inform

6.4.1. We will tell local people about developments in health and care services in a clear and transparent way, in a format that is appropriate to them. We will provide clear information on how people can be involved in our work – ranging from ways to feed in views and experiences, to working in partnership with us.

6.4.2. It is important to note that this spectrum shows the progression of levels of engagement and as a system we will listen and involve before we inform.

6.4.3. We will do this in a range of ways, including through our website, newsletters and briefings (written/online/face to face), cascade through key partners, and via our staff. Our intention is for a high standard of communications activity – targeted, creative and actively reaching audiences with the purpose of creating behaviour change.

6.4.4. We will make it clear how we are held to account, and to whom, how the public can be involved in our decision making, and what impact this involvement has had.

6.5. Listen

6.5.1. We will actively seek people's views in a range of ways; we will listen to what people want to talk to us about – as well as discuss areas that are important to us.

6.5.2. We will do this by providing ways for people to talk to us – face-to-face or online and through trusted partners such as the VCFSE partners and Healthwatch, and we will also collate views that come through enquiry routes and complaints. This will help us understand what is important to people, what is going well and where we need to improve.

6.5.3. We know it is particularly important to listen to the views of those who experience inequity of access to, and outcomes of, care and we will use a range of methods to ensure we hear from these groups and communities. We will also ensure that we tell people who have been involved, or who have shared their views and experiences, what impact this has had to ensure that they feel listened to.

6.6. Discuss

6.6.1. We will discuss how we plan, design and deliver the best possible services with people, and ensure that their experiences, feedback, views and suggestions help shape our work.

6.6.2. We will do this by ensuring that there are opportunities for meaningful dialogue, which may be with groups of people, by involving individuals with lived experience

or through representatives of a wider community in our programmes and projects and use tools including deliberative engagement to provide ongoing ways to discuss key issues for our health and care system.

6.6.3. We will make sure we build relationships with people and communities to have a continuing conversation, and so we know how changes we have made are making a difference and complete a feedback loop.

6.7. Collaborate and codesign

6.7.1. We will agree our collaboration and co-production principles and standards and embed these across our work and partners.

6.7.2. We will make sure that involvement, collaboration and co-production are centred around people and communities, not around our structures and ways of working.

6.7.3. We will also share examples of good co-production across our programmes and projects and embed people with lived experience into programmes and steering groups across the system to encourage more views and feedback to be considered as priority areas of work are developed by partners.

6.7.4. We will support our health and care workforce to work in a co-productive way, including providing awareness and training sessions. This includes supporting our workforce with skills for engaging, listening and involving local people in open and collaborative ways.

6.8. Empower

6.8.1. We will empower people and communities to take control of their own health and wellbeing, in ways that work for them. We will do this by working with people and communities to understand what they need in order to make informed choices about their health and wellbeing and responding to this insight, including co designing information with our people and communities.

6.8.2. We will promote asset-based community development as an approach, particularly in our neighbourhoods, and underpin this with support for Primary Care Networks to engage with communities, including providing opportunities to access resource and support.

6.8.3. Empowering local people at a very local level is an ambition from our partnership work around improving population health and reducing health inequalities. This will be a key area of priority for testing this approach and learning more about the impact we are able to make by empowering local people to make decisions in their communities and about their health and wellbeing.

6.8.4. An objective of working towards empowering individuals and communities involves a process of culture change – a shifting away from traditional approaches. We will agree our collaboration and co-production principles and standards and embed these across our work and partners.

7. DELIVERING EFFECTIVE PUBLIC INVOLVEMENT

7.1. The following commitments outline how partners will work together to ensure we deliver effective public involvement.

7.2. Embedding

7.2.1. As an ICB and working in partnership we will ensure that excellent public involvement is embedded throughout our programmes and projects, at system and at place level. This includes making sure our partners and colleagues see involving the population as "business as usual", that the value of involvement is understood, and that actively improving the experiences of our communities is integral to our ways of working.

7.3. Advising

7.3.1. As an ICB we will provide an expert advice function to our staff across the ICB, to programmes, projects and services, in order that the voices, experiences and views of our population are sought, heard and acted upon in a consistent way. We will do this through the networks of communications, engagement and involvement specialists at system and place level – bringing together partners from the range of partners across the system developing and aligning understanding and principles for involvement and engagement.

7.4. Enabling

7.4.1. Ensuring that partners are able to involve people effectively, whether that be through knowledge of existing methods, supporting to develop bespoke ways of engaging, or by providing agreed frameworks to support activity and process. Collating insight from our people and communities in a systematic way to ensure partners are able to understand people's needs and aspirations without over engaging.

7.4.2. We will do this by bringing patient experience and engagement leads together to share insights and a repository of public involvement insight in collaboration with all partners.

7.5. Aligning

7.5.1. Making sure that, across both System and Place, that public involvement is not in silos; working to share insight and best practice, to join up areas of work where appropriate to do so, and to support staff and partners to consider a journey across services and sectors, rather than an island of experience without interdependencies. This will be through strong networks at system and place.

7.6. Empowering

7.6.1. Public involvement will empower our communities, through showing that we have heard people's voices and taken action as a result, through involving people and communities and recognising the strengths and assets they bring to our system. Through working with people, and in particular those who experience the greatest inequity in access, experience and outcomes to facilitate their voices and experiences to be heard and to shape services, public involvement will support our overall aspiration to reduce health inequalities.

7.7. Demonstrating

7.7.1. We will work with people and communities to effectively demonstrate the impact of their involvement and by doing so, increase community confidence in health and care services. This will also illustrate to system and place partners the benefit of good involvement, and how this leads to improved outcomes for people increased health and wellbeing in general and more effective and responsive services and interventions.

7.8. Evaluating

7.8.1. We will consistently review how we involve people and assess how well this works for our system and for people and communities. This will form the basis of continually improving our public involvement work, and support ICB priorities.

7.8.2 We have developed an evaluation matrix to assess all engagement and this can be found on the staff intranet. The matrix is simple scoring system that can be applied at all stages of engagement and helps to understand what phase of the process each project is in and allows for demonstrating impact to be monitored and captured working with teams across the ICB.

7.8.3 Considering feedback from an internal audit of public, patient and carer engagement, it is considered best practice to establish a target for engagement programmes of which sets out expectations for the levels of engagement. This needs to consider the reach into diverse communities and health inclusion groups, recognising this requires considerable and valuable time resource and partnership working to effectively involve and engage. This target figure is not advised to be a performance target to determine whether the project was successful or unsuccessful but will provide the levels of expectation on the scale and scope of the work at an early stage and how that has been realised.

8. GOVERNANCE AND ASSURANCE

8.1. A Public Involvement and Engagement Advisory Committee will assure the ICB about how the voice of local people and residents is actively embedded and valued in decision making of the ICB and at all levels of the system, particularly in relation to inequalities and those who are seldom heard.

8.2. The Committee will define best practice in terms of public engagement, involvement and communications and holding other committees and parts of system to account for how local voice is embedded and valued in all aspects of the ICB at different levels of the system including within place-based partnerships.

8.3. The Committee will take a responsibility for the mechanisms and approaches to making sure people in Lancashire and South Cumbria are informed about health services, health and care and how they can improve their health and wellbeing.

8.4. The Committee will ensure the principles for working with people and communities are intrinsically in place across all parts of the organisation and wider integrated care system and therefore exceeding the requirements of national legislation for involvement and engagement.

8.5. The Committee will take a clear role in ensuring the weight of public voice has significant value within the ICB Board, ICB leadership teams and staff. This includes ensuring the ICB is listening and in dialogue with local people and taking appropriate action to improve satisfaction and influence quality improvement of services.

8.6. The Committee will be responsible for the delivering against the ambitions of the ICB in relation to working with people and communities and how it deploys its function for involvement, engagement and communications to deliver best value and greatest level of impact for the population of Lancashire and South Cumbria.

9. Engagement and involvement toolkit and guidance for ICB staff

9.1 To support the implementation of the strategy across the ICB and NHS in Lancashire and South Cumbria, a toolkit of materials have been developed and endorsed by the Public Involvement and Engagement Advisory Committee (PIEAC). The toolkit aims to support teams to embed the ten principles for engagement and involvement in all areas of the organisation and partnership.

The toolkit includes:

- An Engagement, involvement and coproduction framework for the NHS in Lancashire and South Cumbria
- An Engagement, involvement and coproduction quick-start guide for staff
- A demographic insight report – with key insights on the population and health inequalities in Lancashire and South Cumbria
- A diversity and inclusion glossary of terms

The toolkit has been supported and endorsed by the Public Involvement and Engagement Advisory Committee (PIEAC), which is a sub-committee of the Integrated Care Board. The toolkit and associated materials will be reviewed at regular intervals to keep them up-to-date and ensure they are useful for our staff and teams across the ICB and wider partners. The toolkit is available for ICB staff on the intranet and teams are actively being encouraged to use the materials.

The toolkit is available on the ICB staff intranet: https://intranet.lancashireandsouthcumbria.nhs.uk/working-with-people-and-communities/

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

10.1 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.

10.2 The 9 steps represent good practice in engagement and all engagement with people and communities is expected to follow these steps:

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:

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

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

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

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

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. For advice and support in this area please contact the ICB communications and engagement team: mailto:Lscicb.communications@nhs.net

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.

<u>Duration:</u> 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.

<u>Duration:</u> 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.

9. REVIEW

9.1. This policy will be reviewed annually unless an earlier review is required.

10. REFERENCES

- Health and Care Act 2022
- Equality Act 2010