

Our working with people and communities charter



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Introduction

Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) recognises the importance of working in partnership with people and communities and the impact it can have.

As an organisation we believe that the best solutions come from working with those who are closest to the services or issue, and we are committed to:

1. Ensuring that people and communities are at the heart of what we do
2. Building a two-way dialogue and partnership with residents of Bristol, North Somerset and South Gloucestershire to co-produce and shape services
3. Applying the principles of value-based healthcare.

Working in partnership with people and communities like this will help us to fulfil our goals, values and overall vision of: “*Healthy, fulfilled lives for everyone*”.

What does this document do?

This charter sets-out how BNSSG CCG will work with people and communities to give all residents the opportunity to contribute to the development, implementation, and review of health, care and wellbeing policies and services in a way that is accessible and meaningful them.

We define meaningful as complying with the principles and commitments set out below. The principles and commitments of this charter will also ensure that all the work we do is made known to everyone who may want to contribute and is fully accessible to them if they wish to take part.

What do we mean by ‘working with people and communities’?

This charter recognises that how we work with people and communities has and will continue to evolve. This document is a reflection of this evolution and looks to ensure that the belief that ‘the best solutions come from working with those closest to the service or issue’ is embedded in all our work.

Sometimes people will use terms like involvement, engagement or participation to describe the different ways that we work with people and communities. These can be valuable and meaningful ways of working with people but it is our ambition to go beyond this and develop two-way dialogue and partnership by 'working with people and communities'.

This charter recognises that the way we work with people and communities will take different forms and different times, proportionate to the need. However to make the most of every opportunity, we are committed to ensuring that the principles of co-production are considered at all stages of our work and that wherever possible we work in partnership with people and communities to shape the services that we commission and deliver.

For more information on the different ways we work with people please refer to Appendix 1.2. We will also provide detailed information on the ways we work with people in the supporting resources, designed to support all CCG staff to apply the principles and commitments outlined in this charter.

Our statutory and legal duties

The National Health Service and BNSSG CCG see the role of listening to and taking into account the experiences and views of all people who use NHS services as central to the way we work.

This isn't just a commitment, it is also a legal duty, set-out in the Health and Social Care Act 2012, which states that residents have the *'right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions affecting the operation of those services (including monitoring and review of services)'*.

This act and other legal duties are referenced in more detail in Appendix 1.1.

Working with people and communities: Our principles

The way we work with people and communities will be based on the following principles:



Figure 1 summarising the six principles of working with people and communities, as outlined in the text below

- **Accessibility and inclusion** – ensuring that all who wish to contribute to discussions around policies and services are given the opportunity to do so; proactively addressing the barriers for individuals and groups and ensuring all information is accessible in preferred formats.
- **Embrace diversity and respect and value the knowledge of all individuals** – all opinions, feelings and thoughts should be equally valued, regardless of culture, background, experience and knowledge; taking positive action to ensure the views from underrepresented individuals, groups and/or marginalised communities are included.
- **Clarity, transparency and integrity** – building trust from the outset between all stakeholders; ensuring that all individuals and groups are clear on the purpose, process and outcomes of involvement and engagement (in particular how their input and feedback will influence decision making).
- **Timely and realistic** – ensuring that all our work is timely, realistic and planned around a clear timetable, giving all individuals and groups enough time to properly consider and respond.
- **Two-way dialogue and feedback e.g. 'You said...we did'** – ensuring that the benefits are clear for all by closing the feedback loop; providing clear and consistent feedback and reporting on the outcomes of any work we have completed in partnership with people and communities. This will include how the CCG has acknowledged and acted upon the implications. If the CCG is not able to respond or act upon feedback received we will always explain why we have not been able to do so.

Our commitments when working with people and communities

We commit to make sure that the following steps are taken when working with people and communities.

Step One: Planning and starting projects with people and communities:

1. We will work with people and communities at every stage in the commissioning cycle (from strategic planning to commissioning services and including monitoring and evaluation).
2. Every appropriate charter and service development, change or review the CCG has responsibility for must be informed by meaningful and accessible ways of working with people and communities.
3. All CCG staff are aware of their responsibilities and how they can obtain support when working with people and communities.
4. Where possible, we will use patient experience, feedback and other data sources at the start of the process to inform the planning and development of our work, including the identification of who will be impacted and where we need to focus our work.
5. We use equality impact assessments to identify any groups or organisations we especially need to hear from, and demonstrate how we will work with them.

Step Two: During a project, when working with people and communities:

1. All our work involving people and communities will be planned around a clear and realistic timetable that is appropriate for the type of work, enables all individuals and groups to take part, and that wherever possible allows for co-production. We will include a clear explanation of how this timetable was selected and what influenced this decision.
2. We define how we will work with people and communities, including what the process will be, why this way has been chosen and who made this decision.
3. It is clear how the decision-making process will be influenced by working with people and communities, including how their input, partnership and feedback will influence the decisions to be made.
4. There is a clear explanation of what can or cannot be changed as a result of working with people and communities and why.
5. All parts of the way we work with people and communities on a specific project are fully publicised and fully accessible (wherever the relevant guidelines and regulations permit us to).
6. We provide support to people and communities to take part in all our activities and work, taking positive action to remove the barriers preventing people getting involved.

7. We respect the privacy and confidentiality of all individuals involved in our work. We will ensure that we comply with data protection legislation and provide participants with appropriate details about how we will use their information.

Step Three: After projects where we have worked with people and communities:

1. We review the process during and at its end to make sure we capture key learnings, identify what could be improved, and act upon these learnings in the future.
2. We monitor and review the different people and communities that have been involved in our work, reporting back to the extent to which we succeeded at engaging with specific groups or communities
3. We summarise the outcome of our work with people and communities and demonstrate how the work informed and guided decision making. This will include what we have heard, what we have learned and how we have acknowledged or acted upon feedback.
4. On occasion there will be situations where final decisions need to be based on financial, clinical or safety needs. Consequently we may not be able to fully respond to, and act upon, all the feedback received when working with people and communities. There will be different reasons for this and we will always explain if and why we have not been able to do so.

Case studies demonstrating the different ways we will work with people and communities

As outlined earlier in the charter, the different ways we work with people and communities will take different forms at different times. The following case studies are just a few examples of how we will apply these principles and commitments to our work and additional case studies will be available with the supporting resources:

What?

The contract to deliver GP services at a medical centre came to an end, with the contract being returned to a CCG as the partners believe they can longer sustain the service.

How people and communities were involved?

In response to this the regional CCG ran a phase of public engagement, via in-person meetings and an online survey to collect peoples' feedback and concerns on proposed the change.

What was the outcome?

The CCG carefully considered the views of patients in coming to the decision to help patients re-register at a neighbouring practice. This included monitoring the impact of peoples travel time and ensuring they are adequately supported.

What?

There was a need to improve community mental health services to provide more proactive, person-centred services to support people experiencing emotional distress or a mental health crisis.

How people and communities were involved?

The regional CCG co-designed the new service with local patient representatives, clinicians and other stakeholders via a series of workshops and design sessions.

What was the outcome?

This co-design process identified a requirement for a crisis and recovery centre that should be based within the community e.g. in a town or city centre. People and local communities were also involved in the procurement decision making process to select the new provider for the centre.

What?

A local partnership was formed to support people aged 50 or over who are experiencing or at risk of social isolation and loneliness.

How people and communities were involved?

The partnership embraced the principles of co-production and began with understanding the voices and perspectives of older people, by working with community volunteers to facilitate pop-up feedback sessions in community venues. These insights then shaped the focus and shared priorities of a 'innovation fund' where a panel of older people decided which community projects to fund.

What was the outcome?

This co-produced process helped to empower local people and many of the community projects developed into co-produced peer-support services, building on the resource of local people and communities.

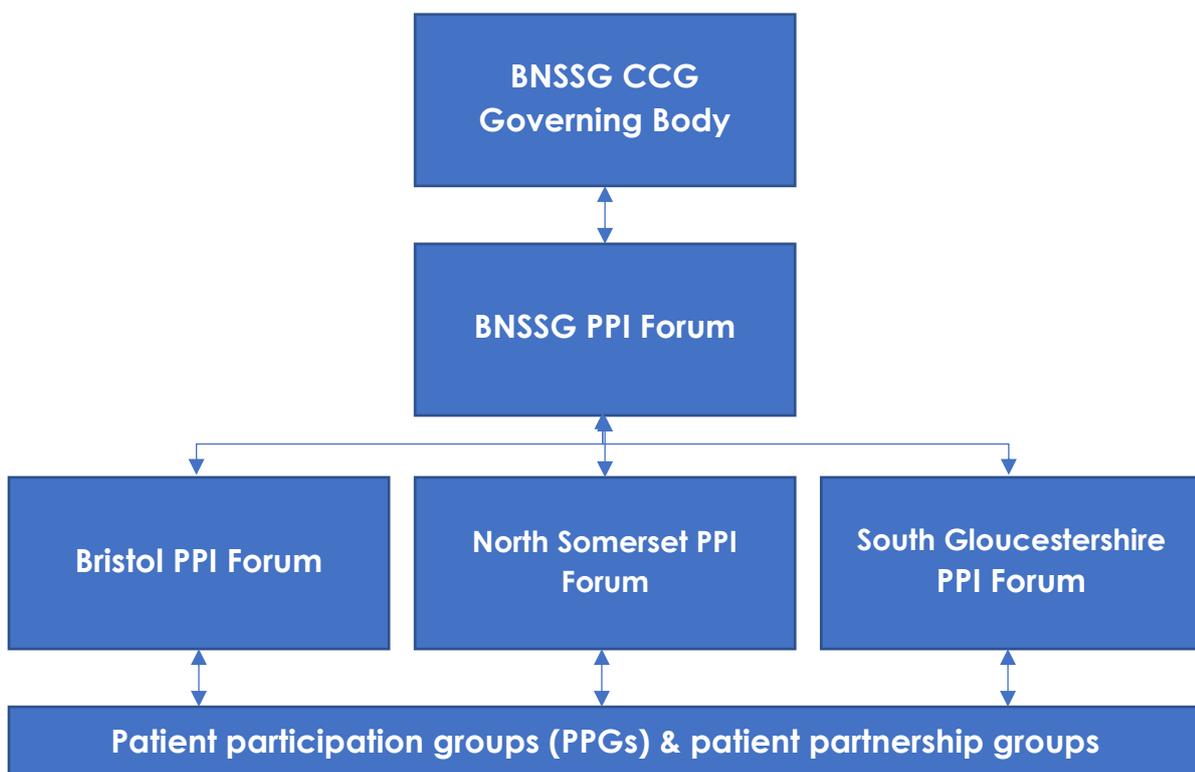
How we will implement and monitor this charter

This charter helps to operationalise our belief that the best solutions come from those closest to the service or issue.

We will act upon this charter through the development of resources, toolkits, training and mentoring for all stakeholders, including CCG staff and the people and communities that we work with.

This action and the charter will be monitored by the CCGs Patient and Public Involvement Forum (PIIF) and patient participation groups (PPG) and patient reference groups. This charter will be reviewed annually. The action plan will be reviewed on a bi-annual basis.

The role of the patient and public involvement forum, primary care based public participation groups and patient partnership groups (e.g. Parent and Carer Forums and Sirona's Peoples Council) is outlined below:



- The CCG Governing Body is made up of GPs, clinical representatives and five independent members. The role of the Governing Body is to gain assurance that we operate effectively and ensure that the CCG is discharging its duties effectively and functioning effectively.
- The BNSSG PPIF is a non-statutory sub-committee of the CCG Governing body and the chairperson is the independent member with responsibility for patient and public involvement.
- The BNSSG PPIF is made up mostly of representatives from the public and voluntary organisations and includes representatives from Healthwatch Bristol, North Somerset and South Gloucestershire, the chairperson of each of the three area PPIFs, representatives from local authorities, and representatives from anchor organisations reflecting BNSSG CCG strategic priorities including mental health, children and young people, older people, accessibility, equality and inclusion.
- The role of the BNSSG PPIF is to provide strategic leadership for patient and public involvement and equality and inclusion in the CCG. The BNSSG PPIF monitors that the CCG is meeting its statutory duties for these two areas and reports back to the CCG Governing Body. BNSSG PPIF meets every two months, rotating localities and venues across the BNSSG area. The BNSSG PPIF feeds into and is informed by the three area PPIF groups.

- The PPIF area groups reflect and represent our three areas: Bristol, North Somerset and South Gloucestershire. These groups support the BNSSG PPIF by acting on local area patient and public involvement needs, as well as strategic patient and public involvement needs as informed by the BNSSG PPIF. The chairperson of each area group feeds into and is informed by the BNSSG PPIF.
- As a CCG we have a key role in supporting and developing patient participation groups and patient reference groups:
 - Patient participation groups (PPGs) are independent groups who work with their local GP practices to act as a forum to monitor how the practice is run and share suggestions and ideas for improvements.
 - Patient reference groups are similar to PPGs and are independent groups who work with local service providers, such as community services or mental health services, to feed into how services are designed and delivered.
 - As PPGs and patient reference groups develop, our ambition is for the chairperson of each of these groups to feed into and be informed by the three area PPIF groups.

Appendix:

1.1. Legal Duties and National Charter Guidelines

Section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012 sets out what clinical commissioning groups 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 the clinical commissioning group that impact or affect how services are run.

Section 3a of the NHS Constitution for England 2012 gives the following right to citizens and service users: *“You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.”*

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
- Sexual orientation

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

1.2. Different ways of working with people and communities

There are a number of different ways of working with people and communities. The 'ladder of participation' below describes the different levels of how we might work with people:

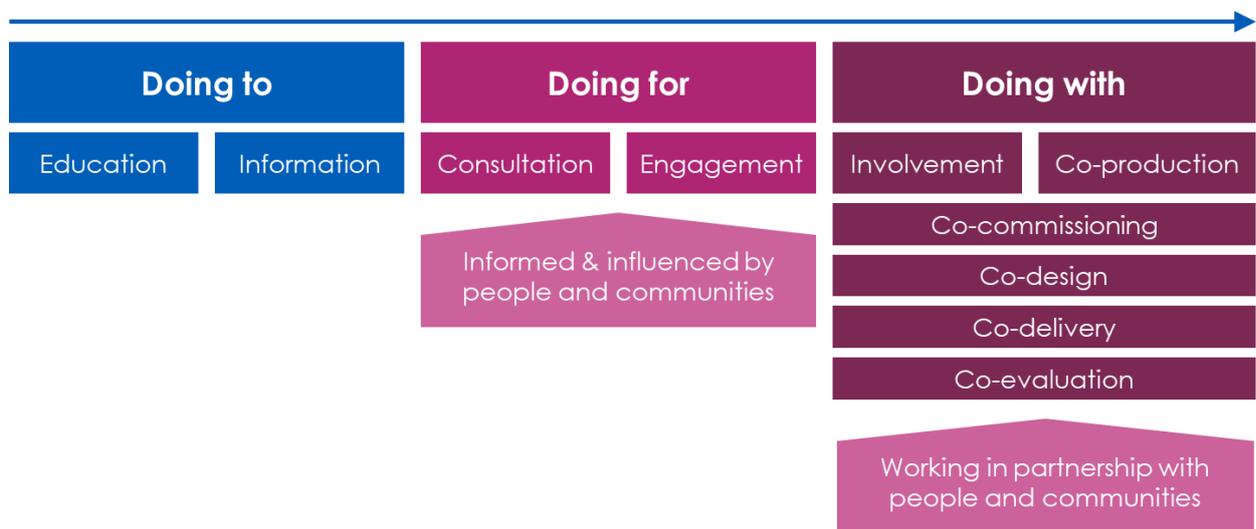


Figure 2 describing the different ways of working with people and communities, as summarised by the descriptions below.

These different levels are outlined in further detail below, under headings described by the New Economics Foundation.

Doing to: “Here recipients are not invited to participate in the design or delivery of the service; they are simply educated or informed about the service and supposed to agree that it will do them good and let the service happen to them.”

Doing for: “Here services are often designed by professionals with peoples best interests in mind, but people are only invited to be heard; they are not given the power to make sure their ideas or opinions shape decision making. “

Doing with: “Here people and communities have more power and influence over decision making. People and professionals share decision making power through equal and reciprocal relationships that respect and value each other’s experiences and contributions.”

1.3. Jargon buster

Please see below for the following definitions of the key terms used in this charter:

Commissioning - The process of planning services for a group of people who live in a particular area. It does not always mean paying for services, but making sure that the services people need are available in that area.

Commissioning cycle – the diagram below helps to identify ways in which patients and the public can engage and participate in the different stages of the commissioning cycle:

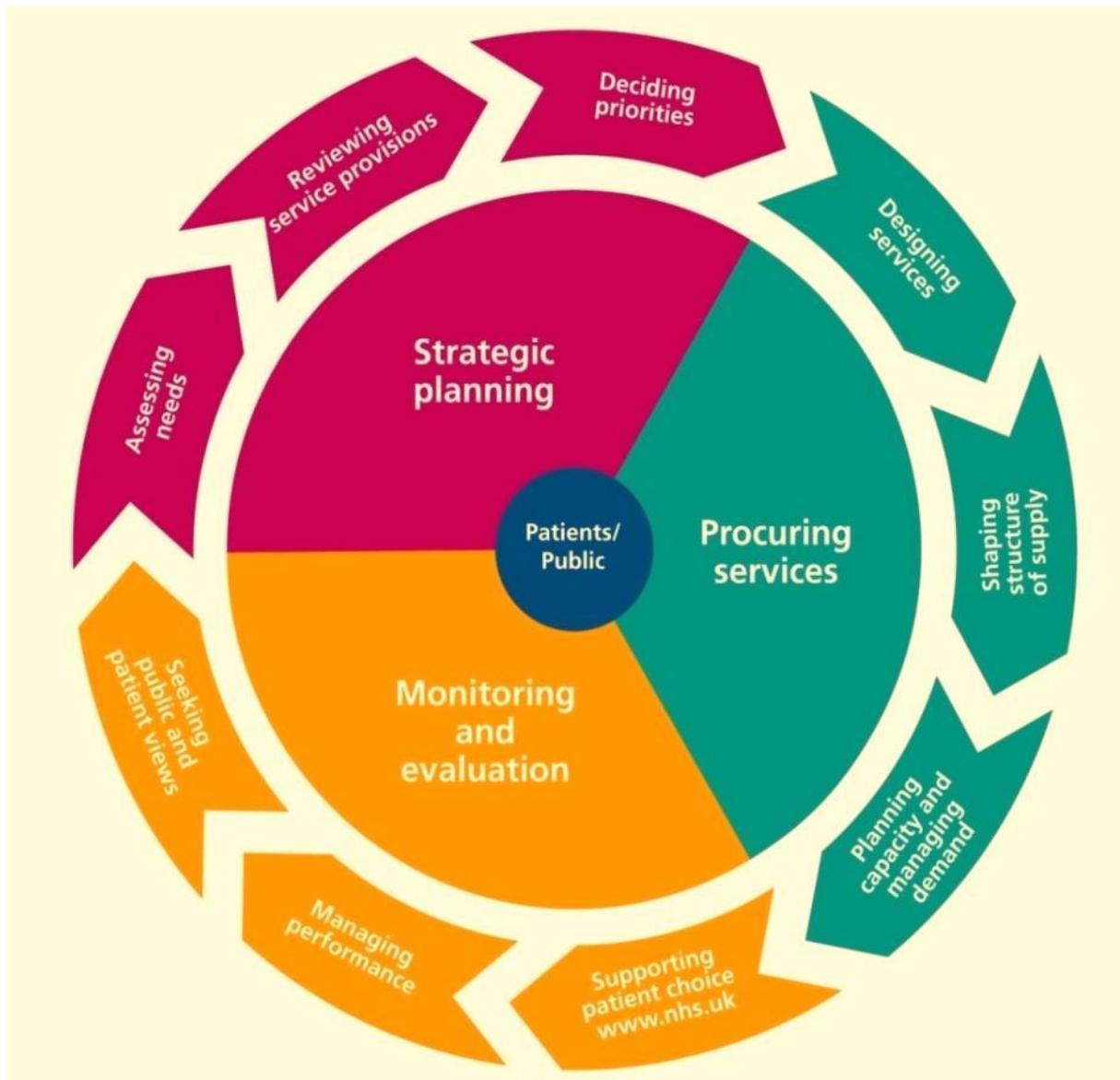


Figure 3 outlining the commissioning cycle, with some example commissioning activities outlined below

Examples of commissioning activities include:

- **Planning:** The development of a CCG charter for the commissioning of diabetes services
- **Proposals for change:** Development of options for the reshaping of A&E services in a particular area
- **Operational decisions:** Making changes to the services or the location of services e.g. the closure of a fracture clinic

Clinical commissioning group (CCG) - A group of GP practices in a particular area that plans and designs health services. Each CCG is given a budget from NHS England to spend on a wide range of services that include hospital care, rehabilitation and community-based.

Statutory – Information and guidance from the Government explaining how specific laws such as the Health and Social Care Act 2012 should be put into practice and what they mean for people.

Non-statutory – If something is non-statutory, it is not required by law and such information, guidance or decisions are based on customs or precedents.

Value-based healthcare - Value-based healthcare is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person.

Involvement - **The involvement of people who use services in the way that those services are designed, delivered and run.** It may be an opportunity to use your experiences to make a particular service work better, and to be involved in decisions about things that affect you. User involvement takes different forms in different organisations, from voicing your opinion to getting actively involved in the way a service is run.

Engagement - Where you have the opportunity to express your own views to professionals and say what you need, as well as being properly supported through the process.

Participation - Taking part in decisions about things that affect you and other people. This may be about your own day-to-day life, such as what to eat or how to spend your time, or about how a service or organisation is run. It is more than consultation: you should not just be asked your view, but should be able to have an influence over the final decision.

Consultation - An invitation to express your views and opinions about a particular service or proposed change, before any final decisions are taken. Your local council, NHS and organisations that provide services may consult you before making a change that will affect you. You may be able to give your views in writing or in discussion at a meeting.

Co-design - When you are involved in designing and planning services, based on your experiences and ideas. You may expect to work with professionals to design how a new service could work, or to share your experiences in order to help a service improve.

Co-production - When you as an individual are involved as an equal partner in designing, developing and delivering the support and services you receive.

Co-production means people and professionals working together to pool the expertise and strengths of each other and use evidence to deliver more effective and sustainable ways to deliver services. It also means sharing power and working together as equals - it could be by sharing power to decide how money is spent, how services are commissioned or an equal voice in designing a service.