Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

NHS

People and communities at the heart of what we do:
a strategic framework

The Bristol, North Somerset and South Gloucestershire Integrated Care Board

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1. Introduction

The Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) exists to improve the health, wealth and wellbeing of the 1 million people living in our area. Together, we are committed to putting people at the heart of everything we do.

We recognise that our diverse communities hold many of the assets and answers to improving wellbeing and contributing to healthy, happy places. As our Integrated Care Board (ICB) becomes established, putting Integrated Care Systems on a statutory footing, we are committed to building relationships with people that recognises their role as equal partners – whether in individual care, designing a service or shaping the broader context in which we can all thrive.

As a new Integrated Care Board, we will harness our collective ability to listen deeply to the people of Bristol, North Somerset and South Gloucestershire. While the Covid-19 pandemic has shone a spotlight on longstanding inequalities, it has also demonstrated the incredible assets within our communities. There is great progress to build on - among statutory partners and in broader collaboration with lived experience, community groups and the local voluntary, community and social enterprise (VCSE) sector.

One of our first priorities will be working together to understand the views and aspirations of the population we serve in a systematic way, so that citizen voice and experience shapes decision-making at every level. We will build on the existing citizen involvement eco-system within our ICS, bringing insight and experience together with population health data to improve people's lives and outcomes.

This strategic framework sets out how we will do this in our first year of operation. Together, we are committed to:

- Turning an understanding of our population into action.
- Ensuring our decision-making is informed by citizen insight and lived experience.
- Making co-production everyone's business and embedding best practice.

This framework will be supported by robust activity plans in line with the Integrated Care Board's strategy development for 2022/23.

"We help people and communities improve local health and social care services by sharing in conversations about things that matter to them"

Staff member, University Hospitals Bristol and Weston, Engagement Lead

"I guess the pandemic has changed the overall picture, has changed everything, and it will take some time to get to where we were before"

BNSSG Healthier Together Citizens' Panel Member, April 2022

2. Legislation and Equality Statement

Integrated Care Boards have a legal duty to involve the people we serve in decision-making around the services we provide. These legal duties are currently held by the Clinical Commissioning Group (CCG) and will transfer into the newly formed organisation with its establishment on July 1st 2022. Further details of these legal duties are outlined in the appendix to this document.

Our wider system partners, including local authorities and NHS Trusts, have similar obligations to involve the public. This gives further impetus to a whole-system approach to putting people at the heart of all we do.

The principles of respect, dignity and compassion for our population set out in the NHS Constitution, underpin our work. We strive to shape healthcare for our population based on the principles of equality.

In line with the Equality Act 2010 and the Public Sector Equality duty, we do not discriminate unfairly on the grounds of age, race, pregnancy and maternity, marriage and civil partnership, gender reassignment, disability, sexual orientation, sex, religion or belief, caring responsibility for dependents, social or economic status or criminal record. We are also committed to following the principles of the Accessible Information Standard, to ensure that we consistently identify and meet individual information and communication support needs.

We use Equality Impact Assessments (EIAs) in the development of our engagement plans and the Public Health England Health Equity Assessment Tool (HEAT), so that we can identify the barriers to participation for individuals and groups and proactively address them in our involvement approaches. This may mean providing additional support for seldom heard groups, in order to ensure equity of engagement. All information will be made accessible in preferred formats.

> "One size does not fit all, each community or group has different needs. E.g. older groups needing more information through the television or traditional medias or faith leaders. You've also got the younger generations who look at social media more than the television"

Participant, Ethnic minority communities Covid-19 Listening Event

3. About Bristol, North Somerset and South Gloucestershire

Just over 1 million people live in Bristol, North Somerset and South Gloucestershire. A thriving city, bustling coastal towns and rural communities make our area an increasingly popular place to live and work. The population is growing, with a 20% overall increase expected by 2041. The fastest growing population group is people over the age of 65.

The population in BNSSG is ethnically diverse and culturally rich. According to the 2011 census, at least 91 different languages are spoken in Bristol alone, and we are expecting to see an increase in this diversity in the 2021 census results.

Alongside some of the wealthiest areas in the South West of England, there are significant pockets of deprivation in our area. Around one in ten people live in a deprived location. There is a 15-year gap in life expectancy between the most and least deprived areas of BNSSG.

"I was diagnosed with multiple sclerosis 12 years ago. Health wise as I deteriorate, I am concerned with how much more difficult it is to get help and how long it takes. The library service is very important to me...a large amount of my time is listening to audio books. I suffer from massive problems with fatigue, and these have proved as excellent way to help rest but also feel a little less isolated because the voices are so beautiful to listen to."

BNSSG Healthier Together Citizens' Panel Member, January 2019

5%
of BNSSG residents say they 'regularly' do not take their prescriptions as advised.

This is significantly higher for ethnic minority groups
42%,

those living in Inner City & East Bristol
40%

those who are unemployed
27%

and those aged between 25-44 years
14%

4. Our Integrated Care System

The Integrated Care System in Bristol North Somerset and South Gloucestershire (also known as the Healthier Together Partnership) is formed of 10 partner organisations, covering three Local Authority footprints.

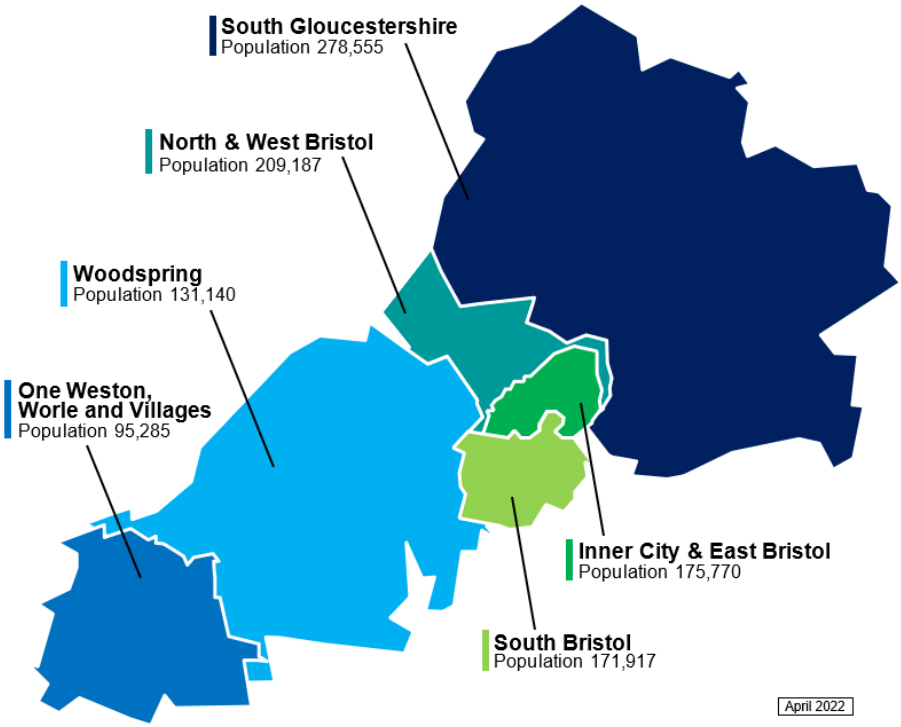
The ICS is formed of a statutory Integrated Care Board (ICB, as of July 1st 2022) and a wider Integrated Care Partnership – evolving from the existing Healthier Together Partnership Board which has been in place since 2018.

There are six established place-based partnerships in BNSSG (known as Locality Partnerships), all of which have taken part in a joint programme with the Design Council this year to embed effective co-production in their ways of working. Locality Partnerships bring together General Practice, community services, mental health, social care and the voluntary sector - with citizens and communities recognised as equal partners.

As outlined in our Memorandum of Understanding (MoU), all ICS partners are committed to the 'subsidiarity principle'. This states that decisions should be taken as close as possible to the communities affected by them. Our ambition is that over time, the vast majority of health and care service design and delivery will take place at this locality level in partnership with people and communities.

"I am very concerned with air pollution which is very bad in Bristol. I am a member of a local group called St George Breathing Better which looks at how we can individually and collectively look to improve the quality of air in our community"

BNSSG Healthier Together Citizens' Panel Member, January 2019



5. What does this document do?

This document is a strategic framework for embedding citizen voice and involvement in the BNSSG ICB, building on our Partnership's progress to date.

It describes how the ICB will work alongside the Integrated Care Partnership (ICP) to ensure that people are at the heart of all we do in our health and care system. It sets out some of the principles and approaches we will use to guide us as our partnership evolves, and ways in which we will assess our progress and maturity.

This document reflects the guidance provided by NHS England and NHS Improvement to Integrated Care Boards and other NHS organisations. It also draws on the core principles of our ICS Memorandum of Understanding, which was approved by all 10 partner organisation boards in Autumn 2021 and contains our system Communications and Engagement framework.

Specific involvement activity will evolve alongside the organisation's broader strategy development process in 2022/23.

6. What do we mean by 'people and communities at the heart of what we do?'

Working effectively with people and communities encompasses a broad range of activities. The spectrum is summarised in the graphic below (see figure 1).

"Solutions to the vast variety of reasons why people are digitally excluded will come from the people themselves"

Digital health inclusion event, September 2020

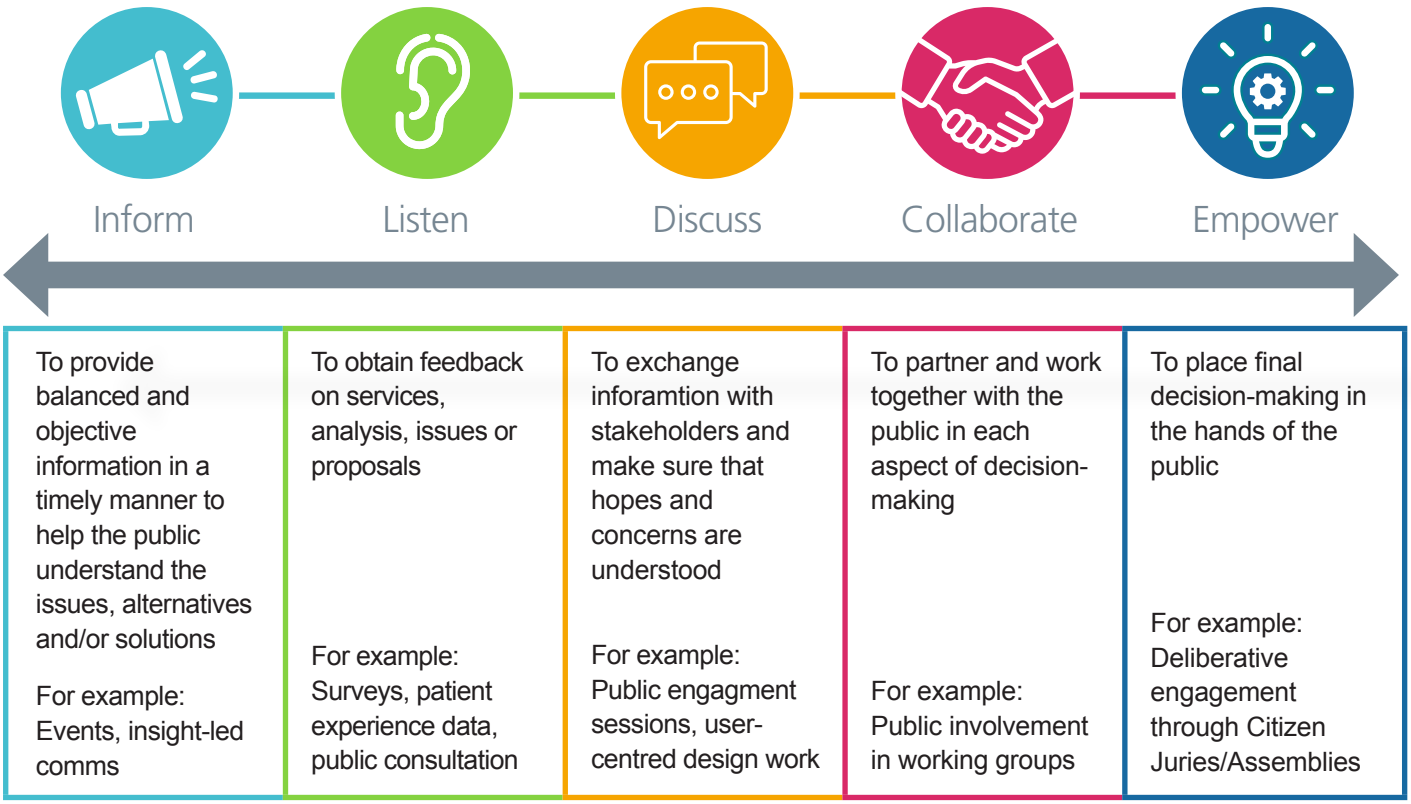


Figure 1: The Spectrum of Involvement (Source: Point of Care foundation – with examples provided by BNSSG ICB)

There is no 'one size fits all' approach to effective involvement. We will continue to innovate and listen to our population on what works and provide a range of ways for people to have their say and ensuring they are supported to do so where necessary.

There is a huge amount of progress to build on within our Partnership to date. Involvement activity over recent years has included public surveys, online listening events, community-led engagement, Citizens' Panels and Assemblies, joint working groups on public consultation, Experience-based co-design projects, Lived Experience input to clinical service redesign, drop-in sessions and commissioned research. This breadth recognises the diversity of both need and interest that exists within our population; and our commitment to ensuring that citizen involvement is shaping decision-making and change.

6.1 Effective use of insights

The population we serve is diverse and varied. By using insights effectively, we cement our commitment to understanding what matters most to people and to direct our services and resources to where they are most needed.

As a Partnership, we have had a representative Citizens' Panel made up of around 1,000 people in place since 2019. Regular engagements of the Panel have allowed us to track population views on a range of issues – from how in control people feel of their health and wellbeing, to how likely people are to access remote GP appointments. This insight – which has shaped delivery of the Covid-19 vaccination roll-out and development of our digital strategy among other key areas – can be segmented by age group, location and other factors. So, for example, we know there is more to do to ensure that people with long term conditions feel able to access remote appointments with confidence.

Alongside the Citizens' Panel, we have other mechanisms for gathering and using insight across our Partnership. Effective use of insight allows us to 'start with people' when embarking on projects, as well as identify areas where further understanding, listening or engagement is needed – particularly when we bring insights together with population health data and equality impact assessment and findings from our Health Equity Assessment Tool.

6.2 The role of Lived Experience

Experts by experience play a pivotal and distinct role within our broader work with people and communities. For example, recent major changes to stroke services in BNSSG were shaped by people with lived experience of stroke and disability from the outset. Lived Experience input has also been vital in developing new approaches to mental health support in our area.

Aligned with research published by the Fulfilling Lives programme, we believe that by working in true partnership with the voices of lived experience we are able to create change by:

- Raising awareness of the experiences of individuals who face multiple disadvantage.
- Gathering evidence and providing insights.
- Influencing the design and delivery of policy and services.

All three of these areas were demonstrated in our recent work with the Design Council (see page 16). It is also critical that the process of being involved in this work has a positive impact on the health and wellbeing of lived experience representatives.

> "Good health education and support might encourage me to be responsible for my health"
>
> **BNSSG Healthier Together Citizens' Panel Member, April 2022**

6.3 Co-production

"The term co-production refers to a way of working, whereby everybody works together on an equal basis to create a service or come to a decision which works for them all."
Think Local Act Personal (TLAP)

Embedding effective co-production across our system is key to our aims. While there is no universally agreed definition of co-production, it involves service providers and users coming together as equal partners to problem solve and make decisions. To ensure this equality of partnership, true co-production should take place at the outset of a process, and where major decisions can be taken jointly. Critically, good co-production starts with people, their assets and their aspirations.

Co-production can include:

- **Co-commissioning** – where those commissioning a service work with people who and local communities in the prioritisation, planning and purchase of those services.
- **Co-design** – where people and communities shape how a project or service should look and feel.
- **Co-delivery** – where service providers work with people and communities to deliver services; working together to improve the way in which a service is provided and taking actions to improve outcomes.
- **Co-evaluation** – where people and communities play a role in assessing how public services are being delivered and the benefits they are providing to those who use them.

11%
of BNSSG residents report that they have had an appointment that they considered to be a waste of time:

"Did not seem interested in me, did not listen to me, did not believe me"

BNSSG Healthier Together Citizens' Panel Member, June 2019

6.4 User Experience (UX)

We are increasingly adopting User Experience (UX) approaches, particularly in relation to health and care service change or development. UX looks closely at how people use a service or product at every stage, and then designs the outcome with that in mind.

Adopting UX makes it much more likely that changes will 'stick', because you have tested how people will use something prior to launch. It also works to improve access, because people can find what they need and how to use it quickly and easily.

A recent example of this is some UX development we completed on the North Somerset Local Offer, which has improved access to information, advice and guidance for children and young people with special educational needs and disabilities (SEND) and their parents and carers. UX will be an increasingly important way of working with people and communities, particularly as we develop more digital resources and services.

7. Building on our progress to date

A wealth of good practice in citizen involvement, co-production and community engagement takes place across our Partnership every day – from service user involvement in mental health service evaluation, to Youth Parliaments, older people's forums and patient participation groups shaping decision-making.

As a new Integrated Care Board, we will be building on this foundation, which includes:

- BNSSG CCG's 'Green star' for working with people and communities – the highest rating that can be awarded by NHS England, achieved consistently since the organisation's formation in 2018.
- A system-wide Citizens' Panel of over 1,000 people - the insights from which have shaped the design and delivery of the Covid-19 vaccination programme, the BNSSG digital strategy and changes to our 111 service among other key programmes of work.
- Development by the CCG of a "Working with people and communities charter",launched in January 2021, which shaped our approach to working with people and communities and preceded the development of this strategic framework.
- Award-winning public consultations on major service change such as the Healthy Weston programme and Stroke Services transformation - with lived experience representatives shaping key decisions including clinical model design and consultation roll-out.
- A system-led response to Covid-19 - working with elected members across our area to share key public health messages, promote vaccination opportunities and communicate available support.
- North Somerset Together Network – an informal partnership of VCSE organisations and community groups facilitated by North Somerset Council, initially introduced in response to the pandemic but continuing to work together to address issues such as tackling food insecurity and digital exclusion.

- The introduction of a ‘reducing inequalities grant’ scheme for community groups as part of the Covid-19 vaccination programme – empowering people and communities to make the changes that work for them.
- Bristol Adult Social Care Equalities forum – the establishment of a forum to address issues for disability groups, ethnic minority communities and other equalities groups around accessing adult social care and social work
- A major piece of user-research and user-centred design to guide changes to urgent and emergency care, and the BNSSG 111 service. This work won a national industry award for best use of insight in 2021.
- The launch of free online training in partnership with the charity Zero Suicide Alliance, calling on 10,000 BNSSG citizens to complete the training and play their part in saving lives.
- The response to Sir Stephen Bubb’s independent Autism review, “Building Rights”, which resulted in a series of system-wide activities to support autistic people and people with learning disabilities
- A Covid-19 ‘listening events’ series run throughout the first wave of the pandemic, inviting views on key topics such as digital inclusion, race and ethnicity and disability.
- An audit of our Emergency Departments by people with autism, resulting in a series of improvements for this group.
- A partnership between Healthwatch South Gloucestershire and people with lived experience to support people with learning disabilities and their families or carers attending a GP appointment for their annual health check.
- Work commissioned by South Gloucestershire Council’s Public Health Division to understand how the Covid-19 pandemic has affected local residents, which has been used to shape service development to improve the health and wellbeing of local residents.

8. Making it happen

8.1 Turning an understanding of our population into action

- **Citizen voice and involvement in ICS decision-making**

Setting out how citizen voice can be effectively heard, understood and acted on at all levels of ICS governance will be a key priority as we develop strategies and ways of working for 2022/23. The Integrated Care Board has already adopted NHS England and Improvement's '10 principles for working with people and communities' and these are embedded in the new ICB constitution.

The Integrated Care Board will work alongside the Integrated Care Partnership (ICP), which draws its membership from a wide range of partners including elected members, Healthwatch and representatives from the VCSE sector. The ICP will be Chaired by the Chairs of our area's Health and Wellbeing Boards on a rotating basis.

We will be carrying out a fresh public engagement exercise as an ICS in 2022. This engagement will inform both the ICB's strategy development and the ICP's Integrated Care Strategy, which will also have regard to the plans developed by our area's Health and Wellbeing Boards. Outputs from the public engagement will include recommendations for incorporating meaningful citizen involvement in the way the ICS is run.

A key role of the ICS is to reduce the health inequalities faced by some groups. As part of this, an Independent Advisory Group (IAG) on Race and Ethnicity has been established. This group reports directly into the ICB's Board, offering an independent perspective on how our health and care system can address avoidable differences in outcomes across our population.

- **Working with Population Health Management (PHM)**

PHM approaches identify people who are at higher risk of a poor health outcome. By understanding this, we can then design interventions that make a difference. A good example of PHM in practice is summarised in a recent inner city Bristol project to improve the outcomes of people at high-risk of developing heart disease.

Bringing PHM approaches together with best practice engagement can be hugely powerful, as evidenced in the local COVID-19 vaccination roll-out (See case study on page 14). The BNSSG Population Health Management Academy will provide training and support to colleagues across the system. The academy will create a community of practice in our area, so that people are better able to:

- Review the information we have and connect with people closest to the issues.
- Work in partnership with clinicians and communities themselves to come up with solutions and design interventions that make a difference.
- Share ideas and the latest thinking from both national and international evidence.
- Document, evaluate, reflect and learn from the work we have done in order to continuously improve.

8.2 Ensuring our decision-making is informed by citizen insight and lived experience

- **Developing a shared understanding of people's experiences**

We have a wealth of insight and feedback to draw on as we seek to improve people's health and wellbeing, as well as experiences, treatment and services. A key priority for our first year of statutory operation is to develop a single, shared intelligence hub that brings all of this together in one place. This will mean:

- Key decisions are informed by the most up-to-date information on what matters most to people.
- Trends are spotted, with any concerns and issues acted on.
- People's views and experiences are understood as a whole.

The final point is a critical one. We need to understand people's diverse needs and aspirations in order to improve lives and reduce inequalities.

- **Embedding User Experience (UX) approaches**

UX approaches seek to gain a deep understanding of the people who will be using a product or service and develop solutions alongside them. BNSSG CCG recently completed the discovery phase for embedding a system-wide approach to UX and User-Centred Design. The next phases of this work will take place across 2022/23.

UX has recently been applied to the design of our NHS 111 services. As a result, a pilot programme was developed which has reduced 111 referrals to minor injuries units by 70%, helping more people to get the right care first time. This work recently won an industry award for "Best Healthcare Project" in the 2021 Marketing Research and Insight Excellence awards.

8.3 Making co-production everyone's business and embedding best practice

- **Developing a system co-production framework**

Around 40 people – including service users, VCSE representatives and health and social care staff - have taken part in the first cohort our Design Council partnership training in 2021/22. This is the first step in creating a culture of co-production in BNSSG, in which people have the tools and confidence to work in equal partnership with citizens.

We will develop a system-wide framework for effective co-production in 2022/23, building on best practice and working in partnership with Lived Experience and community groups. As part of this, we will develop a toolkit of resources, so that these approaches can be spread more widely – and everyone in our area is empowered to 'start with people'.

"We need community meetings where the NHS comes to us"

St Paul's Community Family Health Day, May 2022

- **Creating and sustaining a vibrant ICS network**

There is great citizen involvement work taking place in our system every day – whether that's working with children and families affected by learning disability to improve local provision; or supporting mutual aid groups established through the pandemic. To harness our collective capability, we have already begun to establish an ICS involvement network for practitioners to share learning and best practice.

As part of this, we will map existing citizen involvement mechanisms within partner organisations, to develop a picture of the whole eco-system in BNSSG. This strengths-based approach will allow us to build on what works reduce duplication for the public we serve. In doing this we will be able to identify any gaps and community support needs, including from seldom heard groups.

Our six Locality Partnerships will be key, given their role in the system. We will also work with local VCSE sector groups at a pan-BNSSG level to better understand communities of interest. Local Authorities in our area have strong links and networks with businesses that we will seek to build on through our collaboration as an Integrated Care Board.

"The NHS needs to be more visible in our communities"

St Paul's Community Family Health Day, May 2022

Summary of commitments for Year 1

Turning understanding into action	Citizen voice in ICS decision-making	Working with PHM
Decision making informed by citizen insight	Shared intelligence hub	Embed User Experience (UX) approaches
Co-production and embedding best practice	System co-production framework	Creating an ICS engagement network

9. Putting people and our diverse communities at the heart of all we do: some examples

9.1 Turning an understanding of our population into action: improving our diverse communities' vaccine uptake

In February 2021, our vaccine uptake data showed vaccination rates in minority ethnic communities diverging from White British uptake. Prior to the vaccination programme, 90% white British citizens in BNSSG said they would have the Covid-19 vaccine vs. 71% for minority ethnic citizens. To address this, we collaborated with communities to deliver a series of Covid-19 vaccination clinics in trusted community and religious settings. The clinics were and guided by communities themselves – using existing mechanisms and structures.

This approach has become the model for our Covid-19 outreach. Since March 2021 we have held 264 Covid-19 clinics in community settings and given over 36,700 Covid-19 vaccinations as part of our 'maximising uptake' outreach programme. The gap in vaccination uptake has narrowed among all minority ethnic communities. We have also gained a better understanding of the complex concerns and barriers that exist for communities and put in place ways of working that can build trust. We learned that confidence and trust plays a significantly bigger role in Minority Ethnic citizens' reasons for taking up the vaccine (18%), when compared to White citizens (11%).

We continue to build on this way of working and to explore how true collaboration with communities and system partners could become more sustainable. In December 2021, our Vaccination Programme used national inequalities funding to create Reducing Inequalities Grants for our area. This awarded nine community organisations grants of up to £10k to fund initiatives that encourage Covid-19 vaccination uptake and address health inequalities in their community.

Huda Hajinur, Nurse Practitioner and Community Engagement Manager:

"The community all came together and participated, and with that came empowerment and a sense of control which influenced a positive change."

Robert Hayward, Consultant in Public Health, South Gloucestershire Council :

"[The Covid-19 vaccination programme] has helped me imagine a way of multi-agency working that returns to the first principles of what is possible, rather than working in silos."

Carol Slater, Head of Service, Public Health:

"This programme has had an extraordinary impact, enabling thousands of local people who have never had a vaccine before to protect themselves and others. It has changed the face of how the NHS works with the community and partners and engendered a sense of trust."

9.2 Ensuring our decision-making is informed by citizen insight and lived experience: Lived experience representatives at the heart of major service change

In 2019/20, 1,561 people were admitted to hospital with a stroke in Bristol, North Somerset and South Gloucestershire, and 1 in 50 of our residents live with its long-term impacts. In 2021 we undertook a public consultation on major changes to stroke services, following an extensive period of service redesign involving senior clinicians, people with lived experience and health and care staff.

People with lived experience of stroke were involved at every stage of the process, including in the clinical design work and shaping the consultation plans.

A co-produced Equality Impact Assessment (EIA) for the engagement strategy led to the creation of a range of accessible consultation materials, including specific resources for people affected by aphasia (a language disorder often resulting from a stroke). Over 1,800 people responded to the consultation, with broad and robust representation from key groups identified within the EIA, including 234 people with long-term conditions or disabilities, 290 carers and 151 individuals from an ethnic minority. Public feedback was analysed at a total level, and by these critical sub-groups to inform the final decision.

Stephen Hill,
Co-Director for Patient and Public Involvement for the Stroke Health Integration Team and lived experience representative.

"I know from my own experience of stroke, and through regular talks with other stroke survivors, that far too many local people have had varying experiences of services depending on where and when their stroke hit.

The changes agreed will remove that variation, aligning all local services to give everyone access to specialist care at each stage of stroke – from initial treatment to ongoing therapy – enabling more people to survive and live independently after stroke.

"I am pleased to have been involved in shaping and designing these services alongside other stroke survivors and look forward to supporting local organisations as services are put in place."

9.3 Making co-production everyone's business and embedding best practice across our system: Embedding design thinking in our locality work.

Between September-December 2021, our six Locality Partnerships worked in partnership with the Design Council to embed design thinking at the heart of their work, using community mental health as the area of focus.

Each of the Locality Partnerships participated in an intensive four-month online training programme, working in small co-production teams to apply tried-and-tested tools in developing their local community mental health service offers. These teams brought together a diverse mix of 30 people, including those with lived experience of mental ill-health, representatives of voluntary community and social enterprise organisations and health and social care staff. Through collaboration, each team shaped approaches to support their local populations, including the development of Integrated Personalised Care Teams and online peer support services.

Through this work, the teams have built a strong partnership network to enable more effective working in the future. 100% of those taking part agreed that taking a design-led approach gave clarity to the challenge they were trying to solve, 62% shared a design-led approach to problem solving with their senior management and 77% shared this with partner organisations. The learning is now being captured in toolkits that will spread the approaches within the wider Integrated Care System.

"I had never considered design as a critical part of service delivery before, but having used the various tools and techniques taught to us through the course of the programme, I now see how crucial well thought through design can be to the success of your work. We were able to develop and present a model which addresses the challenges posed in our intial problem, but also is clear and concise enough to be deliverable."

Participant

"We had insightful conversations with social prescribers, VCSE lead and lived experience reps which helped to further develop ideas."

Participant, Woodspring

"The power of not jumping to a solution, and taking a step back to assess the real problem."

Participant, Bristol Inner City & East

10. Monitoring and evaluation

As outlined within our communications and engagement framework within the ICS Memorandum of Understanding, we are committed to ensuring that all our activity is underpinned by robust evaluation.

We are currently working with academic evaluation partners to support impact measurement and improved understanding of communications interventions in our work within Urgent Care and the COVID-19 vaccination programme.

The specific set of activities which will follow in the implementation of this strategy will all be subject to a rigorous set of evaluation standards to ensure that we understand impact, explore how it can be optimised and apply this learning to future activities. Our evaluation will include feedback from people and communities themselves on the experience of engaging with us and what could be improved.

We will report our progress in the form of a 'balanced scorecard' in annual reviews and in the Integrated Care Board's statutory open meetings.

11. Appendix 1 - How was this strategy developed?

This strategic framework builds on work done by the CCG in developing the BNSSG Working with people and communities charter published in January 2021. This document was initially co-produced with members of the BNSSG Patient and Public Involvement Forum (PPIF), which is a committee of the CCG's Governing Body, chaired by the lay member for patient and public involvement, with membership drawn from a range of representatives from voluntary sector organisations, equalities groups and Healthwatch. Further feedback on the draft policy was given by members of the public, people with lived experience, carers, VCSE representatives and other key stakeholders. Responses were invited and received via online and paper surveys, emails and letters and verbal responses via meetings and one-on-one discussions. Learnings from this engagement process were summarised, reflected in the final version of the charter and shared back within a final report.

In order to establish a system-wide strategic framework for working with people and communities, we have also undertaken an extensive period of engagement with key stakeholders across our system partnership, including representatives of VCSE organisations, place-based partners and our local Healthwatch team. 28 system engagement leads from across the system joined an online discussion session on 1st March 2022, which was chaired by the Non-Executive Director of one of our hospital trusts. The session was co-delivered by a representative of the PPIF, a senior communications and engagement lead from our system partnership and the ICB's Insights and Public engagement team. In breakout groups, using online bulletin boards to capture feedback, key elements of the strategy were developed in partnership with our system engagement leads.

At this initial system-wide network meeting, it was agreed to form a smaller working group of representatives from system partners to work through the detail of the strategy and develop a final draft. Through a combination of individual 121 conversations and group discussions, we gathered over 100 individual pieces of feedback to help to develop the final version, as well as gathering key areas for focus for the development of our eventual action plan. The Consultation Institute provided further guidance and support in the finalisation of this strategy.

The final draft strategy was shared and discussed at our Partnership Board, which includes senior representatives of all of the partner organisations from across our Integrated Care Partnership, and representatives from Public Health, Healthwatch and NHS England. Final sign off was provided by the BNSSG ICB Chair (designate) and the BNSSG ICB Chief Executive (designate).

12. Appendix 2 - Relevant Legal Duties

Overview

The main duties on NHS bodies to make arrangements to involve the public are set out under:

- **Section 13Q** (for NHS England) of the NHS Act 2006, as amended by the Health and Social Care Act 2012;
- **Section 14Z2** of the NHS Act 2006, as amended by the Health and Social Care Act 2012 (for NHS CCGs) and which has now been superseded by **Section 14Z45 of the Health and Care Act 2022 for ICBs**; and **14Z35 of the National Health Services Act 2006** duty to reduce health inequalities
- **Section 242 of the National Health Service Act 2006** liaison and scrutiny by Local Authority led Health Overview Scrutiny Committees (HOSC)

Together these Sections of the law around the duty to involve the public set out what Integrated Care Boards and hospital trusts 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 that impact or affect how services are run.

Statutory duties, such as the involvement duties set out above, are not the only circumstances in which a duty to consult may arise. Under common law, a duty to consult may also arise where there has been a promise to consult, where there has been an established practice of consultation, or, in exceptional cases, it would be conspicuously unfair not to consult. There will also be circumstances in which working with people and communities would be beneficial even if doing so is not legal requirement. Therefore, whether or not the involvement duties apply is not the only consideration when deciding whether and how to work with people and communities.

Section 3a of the NHS Constitution for England 2012 gives the following right to the public: *"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."*

Individuals, carers and representatives

These public involvement duties have applied to commissioners and providers for many years and are largely unchanged. However, a significant change proposed in the Health and Care Act 2021 is that the description of people to be involved has been extended from 'individuals to whom the services are being or may be provided' to also include 'their carers and representatives (if any)'. While it is already common practice to involve carers and their representatives – and to do so is in line with previous statutory guidance on the public involvement duties – this change makes it a legal requirement for arrangements for public involvement to secure the involvement of carers and representatives (if any), as well as service users themselves.

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

Health inequalities

NHS England and ICBs are also under a separate statutory duty to have regard to the need to reduce health inequalities of access to health services and the outcomes achieved (sections 13G and 14T of the NHS Act 2006, respectively). By working with people affected by health inequalities, services can understand barriers to access and can work together to design improvements.

Public Services (Social Value) Act 2012

This requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. There are several benefits to local communities in embedding social value in commissioning, including improved service delivery, health creation and an increase in the resilience of communities. Working with a range of VCSE organisations on new approaches to engaging diverse communities in service planning is an example of how NHS organisations can bring social value to their commissioning. This links to the role of the NHS as anchor institutions, using their assets to promote the health and wellbeing of their local communities and harnessing their spending power to address health inequalities and invest in health.[1]

[1] **Anchor institutions and how they can affect people's health, The King's Fund, September 2021.**

13. Appendix 3 NHS England and NHS Improvement Guidance

"Ten Principles for how we should work with people and communities"

The guidance is built around ten principles to help health and care organisations develop their ways of working with people and communities.

They build on the principles set out in the 2017 guidance for commissioners and the 2021 implementation guidance for ICSs on working with people and communities.

NHS England and NHS Improvement will provide resources and training to help health and care organisations put these principles into place.

1. Ensure people and communities have an active role in decision-making and governance
2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions
3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if changes is working
4. Build relationships based on trust, especially with marginalised groups and those affected by inequalities
5. Work with Healthwatch and voluntary, community and social enterprise sector as key partners
6. Provide clear and accessible public information
7. Use community-centred approaches that empower people and communities making connections to what works already
8. Use co-production, insight and engagement methods so that people and communities can actively participate in health and care services
9. Tackle system priorities and services reconfiguration in partnership with people and communities
10. Learn from what works and build on the assets of all partners - networks, relationships and activity in local places

14. Appendix 4 – Detailed review of the BNSSG strategy in the context of national guidance

	Principle	Comment	Actions / Next steps
1	Ensure people and communities have an active role in decision-making and governance.	Outlined throughout the document, but specific reference to governance process in section 9.1 – Citizen voice and involvement in ICS decision-making.	As outlined in the strategy, a key priority for the ICP and ICB is to define how citizen voice can be effectively heard and acted on at all levels of ICS governance.
2	Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions.	A key theme throughout the document, but specific reference made to this within section 9.3 which talks about the need to embed best practice across the system. Additional reference made within case studies, providing examples of how this has been done in practice within BNSSG.	As a follow-up to this document, toolkits will be developed to ensure that system practitioners are able to follow best practice in terms of working with people and communities at the early stages of planning and to ensure that there is clear feedback at the end of this engagement process around how the engagement has influenced activities and decisions. This will be supported by ongoing training sessions.
3	Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working.	Commitment to measure impact of engagement in Equality Statement. Commitment in section 9.3 to bringing together citizen's voice and experience with population health management data to understand the needs, aspirations and experience of health care is identified as a priority in the Introduction.	Creation of an evaluation process which will be embedded in the approach to coproduction and engagement across all ICB commissioning activity. This will include the usage of a balanced score card as set out in section 11.
4	Build relationships with excluded groups, especially those affected by inequalities.	Equality statement sets our intention. The introduction sets a further intention to acknowledge barriers to participation, build relationships and adapt our approaches to what people want and need. Section 9 goes into greater detail around the approach to building relationships with excluded groups, including the establishment of an Independent Advisory Group (IAG) on Race and Ethnicity and the mapping of the citizen involvement ecosystem within BNSSG to identify gaps and support needs. Examples of current work are set out in Section 8 – progress to date.	Develop and offer training for colleagues and partners at all levels of the ICB and ICS on how to work with excluded groups and those affected by health inequalities as a core programme starting at induction.
5	Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.	Examples of working with the voluntary, community and social enterprise sectors are mentioned throughout the document. The membership of the Integrated Care Partnership includes Healthwatch and representatives from the VCSE sector.	Development of programme to support patient leaders and representatives (at all levels of the ICB).
6	Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.	The Equality Statement sets out our intention to provide clear and accessible access to all.	Creation of an accessibility check list for information and events of all types/ scale. To include details for booking interpreters, translations and BSL signers
7	Use community development approaches that empower people and communities, making connections to social action.	Set out in section 9 – the intention to take an assets-based approach, recognising the strengths of people, places and partners.	Develop relationships with Community Development workers in Local Authorities and work with Community Influencers to reach into communities
8	Use co-production, insight and engagement to achieve accountable health and care services.	Many references to using coproduction, insight and engagement throughout the document.	To continue to publish feedback reports together with how they have been used to influence decision making. Ensure transparency by continuing to publish minutes of decision-making meetings in accessible formats.
9	Co-produce and redesign services and tackle system priorities in partnership with people and communities.	Explanation of coproduction and codesign and our commitment to this approach is given in section 7 and 7.3 and contextualised against the spectrum of involvement. Section - Our Integrated Care system - states the ambition that health and care service design and delivery will take place at locality level in partnership with people and communities. The principle of subsidiarity is highlighted.	Develop a fair and value-based recruitment process for lived experience and representation from VCFSE sector. Embed a coproduction culture and ethos for working to deliver system priority outcomes. Develop and support Locality Partnerships to work with people and communities at place level under the principle of subsidiarity.
10	Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.	This is discussed in section 9.3 in terms of understanding the citizen involvement eco-system and building an engagement network.	Develop a detailed action plan against this section to understand and map the assets that support health, care and wellbeing across BNSSG.