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Working in Partnership with People and Communities

Statutory Guidance for Integrated Care
Boards, NHS Trusts, NHS Foundation
Trusts and NHS England

Draft for consultation

Version 1, 9 May 2022

About this document

- This is a draft for public consultation of new statutory guidance. Contributions made during the consultation will inform the final draft
- The guidance will exist both as an interactive PDF and on the NHS England website. It will primarily be accessed via webpages meaning that the main sections can be followed through to the later ones when the reader requires extra detail
- The final version will include links to find out the detail of the case studies included in this draft
- It has been developed by NHS England and NHS Improvement with the following partners: Care Quality Commission, Centre for Governance and Scrutiny, Department of Health and Social Care, Healthwatch England, Local Government Association, National Voices, NHS Confederation, NHS Providers, The Health Creation Alliance and the Integrated Care Systems in Dorset, North East and North Cumbria, Sussex and West Yorkshire
- The final version will be jointly branded (following Ministerial approval) with DHSC.

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Executive summary

This guidance sets out how health and care systems should build positive and enduring partnerships with communities to improve services and outcomes for people.

This is statutory guidance for Integrated Care Boards, NHS trusts and foundation trusts, and will be adopted as policy by NHS England, and supports them to meet their public involvement legal duties. It is relevant to other health and care organisations, including local government, on how to work effectively in partnership with their communities.

The guidance is in two sections:

1. Section A covers the essentials. It sets out how the guidance should be used, the benefits of working with people and communities including improved health outcomes, better decision-making and addressing health inequalities. It also contains the principles that health and care organisations should apply and the leadership needed to realise these benefits
2. Section B gives the detail. It describes the approaches to take for different contexts and how different organisations can work together to create genuine and authentic relationships with local communities. It also covers requirements for organisations for involving people in their governance.

It is structured around 10 principles for working with people and communities:

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 change is working
4. Build relationships based on trust, especially with marginalised groups and those affected by inequalities
5. Work with Healthwatch and the 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 service 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.

By applying these principles organisations will develop strong relationships with their communities, enabling them to work together to design and deliver services that effectively meet people's needs.

Section A: Working in Partnership with People and Communities

1. Introduction

The new health and care legislation will mobilise partners within Integrated Care Systems (ICSs) to work together to improve health outcomes.¹ However, these new partnerships between the NHS, local authorities and other organisations will only build better and more sustainable approaches if they are informed by the needs, experiences and aspirations of the people and diverse communities they serve.

This new guidance sets the ambition and expectations for how Integrated Care Boards (ICBs), NHS trusts and foundation trusts should work in partnership with people and communities in this new collaborative environment. It will also be adopted as policy by NHS England and will be useful for local authorities and other partners. It provides practical advice and signposts to further information including training and resources. It also shares learning from areas where partnerships are already making the vision a reality and makes clear the difference working in partnership with people and communities will make.

The response to COVID-19 saw communities mobilise themselves to support family, friends and neighbours including those self-isolating and encourage vaccine take-up, developing approaches that fitted local circumstances and needs². Communities worked alongside health and care partners to find innovative solutions to new challenges³. The learning from this should be transferred to help meet other challenges that health and care services face by listening to people and working with them to decide what will work best locally. The pandemic has also had a disproportionate impact on certain population groups. Part of how we can address health inequalities is to begin by listening to diverse communities and working with their knowledge, commitment and resources to improve health outcomes and wellbeing.

¹ [Health and Care Act 2022](#)

² [The community response to coronavirus \(COVID-19\)](#), UK Health Security Agency, June 2020; [Learning from the community response to COVID-19; how the NHS can support communities to keep people well](#), The Health Creation Alliance, April 2021.

³ [Unlocking the digital front door - keys to inclusive healthcare | National Voices](#) May 2021

Terminology

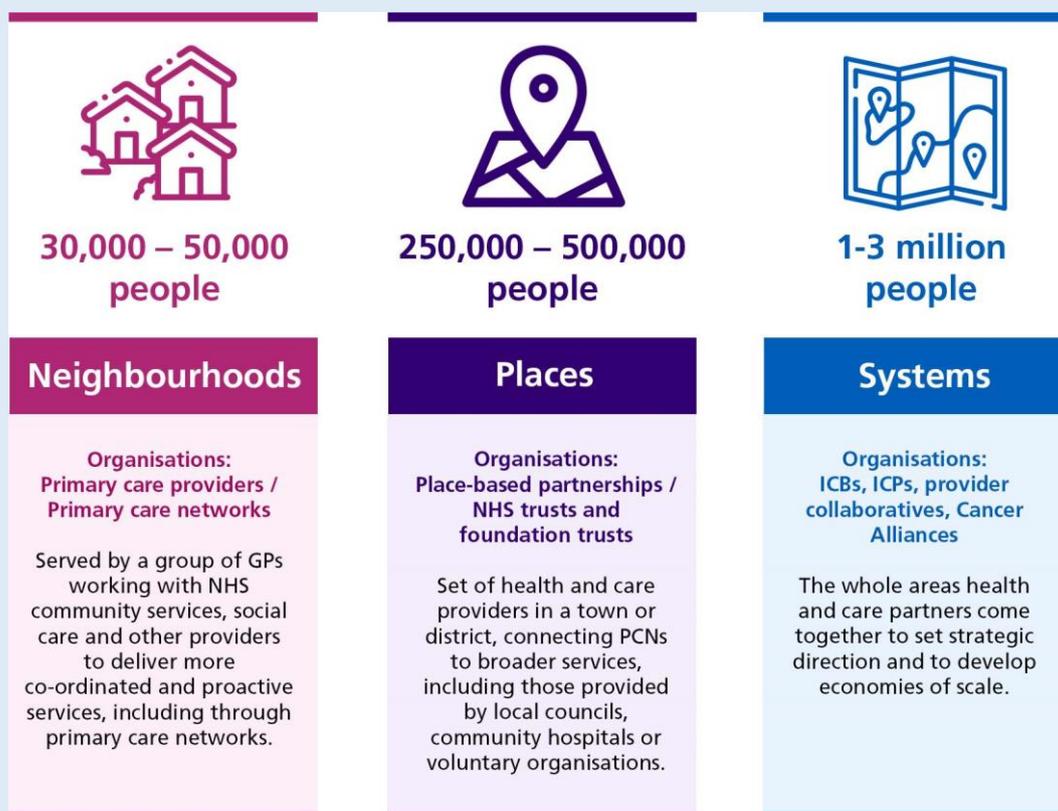
In this guidance we talk about ‘working in partnership with people and communities’. We use this phrase to cover a variety of approaches such as engagement, participation, involvement, co-production and consultation. These terms often overlap, mean different things to different people, and sometimes have a technical or legal definition too.

By ‘people’ we mean everyone of all ages, their representatives, relatives, and unpaid carers. This is inclusive of whether or not they use or access health and care services and support. ‘Communities’ are groups of people that are interconnected, by where they live, how they identify or share interests. They can exist at all levels, from neighbourhood to national.

‘Community-centred approaches’ recognise that many of the factors that create health and wellbeing are at community level, including social connections, having a voice in local decisions, and addressing health inequalities.

We refer to ‘health and care systems’ as all organisations working to improve physical and mental health outcomes from national to local levels. We use the term ‘trusts’ to refer to NHS trusts and NHS foundation trusts.

Integrated Care Systems have three tiers which are broadly defined as:



See the Glossary for definitions of other terms used in this guidance.

2. Objectives and setting the ambition

Partnership working between public sector bodies and local communities has been essential to the pandemic response. It has shown the contributions that people make to their own health and how community life supports health and wellbeing, sense of belonging and control.⁴

The disproportionate impact of the pandemic has highlighted the need for joint solutions. This collaboration will need to continue and accelerate as services recover in order to meet the needs of local populations and deliver the Long-Term Plan.⁵

People and communities have the experience, skills and insight to transform how health and care is designed and delivered. Working with them as equal partners helps them take more control over their health. It is an essential part of securing a sustainable recovery for the NHS following the pandemic.

The ambition is for health and care systems to build positive and enduring relationships with communities to improve services, support and outcomes for people.

This means a health and care system that:

- listens more and broadcasts less
- undertakes engagement which is ongoing and iterative and not only done in isolation when proposing to change services
- is focussed on what matters to communities, including people from marginalised groups and those who experience the worst health inequalities
- supports approaches around existing networks, community groups and other places where people come together
- develops plans and strategies that are fully informed by people and communities
- provides clear feedback about how people's views lead to improvement
- empowers communities to develop their own solutions to improving the health of all.

This creates systems where people have a greater say in how health and care services are run and the actions needed to reduce health inequalities. It enables communities to set

⁴ [The community response to coronavirus \(COVID-19\)](#), UK Health Security Agency, June 2020

⁵ [Third Phase of the NHS response to COVID-19](#), NHS England, July 2020

the agenda for local change, and for systems to create the conditions for that power-sharing to occur.

It means that systems can make better decisions with people about service changes and how money is spent. It reduces risks of legal challenges and improves operational effectiveness, CQC inspection outcomes, safety, quality, experience and performance. It gives people a strong voice in transforming healthcare, in service improvements, in research and the development and adoption of proven innovations. It involves people in shaping a future that meets their needs and aspirations.

This needs leaders who really listen and are equipped to work alongside the communities they serve; and ensuring their organisations actively engage people from the start, including in decision-making. Putting people in control is good for their health.⁶

It requires taking community-centred approaches that empower people to take more control over their health and areas. It recognises that working in genuine partnership with local government, the voluntary, community and social enterprise (VCSE), leads to better decisions that have greater benefit for local people.

⁶ [Health Equity in England: The Marmot Review 10 Years On](#), Institute of Health Equity, February 2020.

3. Audience and status

Who does this apply to?

This is statutory guidance issued by:

- NHS England for ICBs under section 14Z51 in relation to their public involvement duty (section 14Z45 of the National Health Service Act 2006 as amended)
- the Secretary of State for Health and Social Care for NHS trusts and NHS foundation trusts in relation to their 'public involvement' duty under section 242(1G) of the National Health Service Act 2006.

It replaces the 2017 [statutory guidance for commissioners](#), the 2008 guidance for trusts and the 2021 [Implementation Guidance for ICSs](#).

NHS England has its own 'public involvement' duty (section 13Q of the National Health Service Act 2006). It is NHS England's policy to have regard to this guidance in the same way that ICBs and trusts are required to as statutory guidance.

It supports the duties on ICBs and NHS England to produce Annual Reports that must show how their public involvement duties have been met (sections 14Z58(2)(a) and 13U(2)(c) of the National Health Service Act 2006).

NHS England is required under section 14Z59 to conduct a performance assessment of ICBs that must (amongst other things) include how well the ICB has discharged its public involvement duty.

NHS England	Status: Policy	Public involvement duty: Section 13Q, NHS Act 2006
Integrated Care Board	Status: Statutory guidance	Public involvement duty: Section 14Z44, Health and Care Bill 2021
NHS trust and foundation trust	Status: Statutory guidance	Public Involvement duty: Section 242, NHS Act 2006
Integrated Care System partners	Status: Good practice	Public Involvement duty: N/A

As statutory guidance, this means that ICBs and trusts must ‘have regard’ to this guidance. They must consciously consider the guidance and, where appropriate, be able to explain any substantial departure from it.

There is no ‘one size fits all’ approach and this guidance is not a ‘tick list’ to be worked through. Rather it describes fundamental principles and approaches, it signals a change in leadership practice. Organisations are best placed to decide how to work with people and communities – depending upon the circumstances and the nature of the services and decision-making process. Therefore, whilst the guidance is ambitious in its intent, it is not intended to place additional legal obligations on organisations and does not mandate that organisations may only discharge their duties in a particular way. Chapter 9 provides detail of what these legal duties mean and how they can be met.

Other relevant legal duties are:

- *Equalities:* The Public Sector Equality Duty (PSED), section 149 of the Equality Act 2010
- *Health inequalities:* The Health and Social Care Act 2012
- *Triple aim duty:* The Health and Care Act 2022
- *Social value:* Public Services (Social Value) Act 2012.

Chapter 10 explains how working with people and communities can help meet these duties.

Who else is it relevant to?

The guidance is relevant to the entire health and care system:

- Within **Integrated Care Partnerships (ICPs)** it can be used to inform their strategies, during the development of which they must involve people
- For **place-based partnerships** it can guide how they involve people in decision-making processes and engage them on plans for change
- For **provider collaboratives, clinical networks and cancer alliances**, it supports working with people on improving whole care pathways across multiple places and systems
- For health and care partners involved in **research**, the guidance supports working with communities to identify research needs (both locally and across care pathways), and to be involved in shaping research studies that align with what matters to communities.
- At neighbourhood level, it can help **Primary Care Networks** work with their local communities to understand local needs and reduce health inequalities.

It will be of interest to partners within health and care systems as good practice, including local authorities, VCSE sector organisations, health overview and scrutiny committees (HOSCs), local Healthwatch, Health and Wellbeing Boards, and community and patient groups. It will also be relevant to people interested in how their NHS should work with them.

This guidance complements separate guidance on involving people in their own health and care.⁷

⁷ Add link once published.

4. Why work in partnership with people and communities?

The benefits of partnership

Improved health outcomes

Working in partnership with people and communities creates a much better chance of ensuring services meet people's needs, improving their experience and outcomes. People have the knowledge, skills, experiences and connections to support their health and wellbeing. Partnership working contributes to defining 'shared outcomes' that meet the needs of their communities.⁸ This is particularly relevant in the context of population health management and reducing health inequalities.

Value for money

Services that are designed with people and therefore effectively meet their needs are a better use of NHS resources. They improve health outcomes and reduce the need for further, additional care or treatment because a service did not meet people's needs first time.

Better decision-making

We view the world through our own lens and that brings its own judgements and biases. Business cases and decision-making are improved when insight from local people is used alongside financial and clinical information to inform the case for change. Their insight can add practical weight and context to statistical data, and fill gaps through local intelligence and knowledge.

Improved quality

Partnership approaches mean that services can be designed and delivered more appropriately, because they are personalised to meet the needs and preferences of local people. Without insight from people who use, or may not use, services, it is impossible to raise the overall quality of services. It also improves safety, by ensuring people have a voice to raise problems which can be addressed early and consistently.

Accountability and transparency

The [NHS Constitution](#) states: 'The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff.'

⁸ [Health and social care integration: joining up care for people, places and populations](#), DHSC, February 2022

Organisations should be able to explain to people how decisions are made in relation to any proposal – and how their views have been taken onboard. Transparent decision-making, with people and communities involved in governance, helps make the NHS accountable to communities.

Participating for health

Being involved can reduce isolation, increase confidence and improve motivation towards wellbeing. Individuals' involvement in their own care can lead to involvement at a service level and to more formal volunteering roles and employment in health and care sectors.⁹ It is well recognised that doing something for others and having a meaningful role in your local community supports wellbeing. Getting involved can be health creating – being part of a community and being in control is good for our health.

Meeting legal duties

Although this should not be the primary motivation, failure to meet the relevant legal duties risks legal challenge, with the substantial costs and delays that entails, and damage to relationships and trust and confidence between organisations, people and communities.

Case study: Building a consistent approach to involvement across North West London ICS

In December 2019, North West London ICS launched the EPIC (Engage- Participate-Involve-Collaborate) programme to try to address some of the challenges around how it works with residents. A key strand of the programme was co-production of a future, best practice approach to resident involvement in the CCG and future ICS. Despite some very good practice, the public were not involved in shaping the ICS's work and many of communities were not being effectively engaged. The ICS's approach now includes:

- **'Collaborative spaces'** – open meetings where health and care professionals come together with people to discuss health and care issues
- **outreach** with all our communities including **targeted involvement** of groups we have not successfully involved in the past
- **Lay partners** to sit on key programmes/workstreams as appropriate

This approach is assured via North West London's [Involvement Charter](#).

Reducing health inequalities

Joint solutions

Tackling the causes and consequences of health inequalities is a central priority for health and care systems, one that has been given new momentum by the disproportionate impact

⁹ There is [separate guidance](#) on involving people in their own health and care and how to meet these legal duties.

of the COVID-19 pandemic on those people and communities who already face the worst inequalities.¹⁰

Health inequalities can be reduced by jointly identifying solutions, developed in partnership with people using community-centred approaches. Understanding the experiences and perspectives of those who face barriers to care and support, and have different outcomes, will help to develop opportunities for improvement and investment. By building trust and mutual understanding with marginalised communities, then we will start to address unequal access to services and health outcomes.

Focussing engagement on excluded groups will help tackle the inverse care law, whereby those with the most need for services are the least likely to receive them and least likely to feel safe to participate. By building engagement approaches that include people who are currently not well supported by existing services, systems can design models of care that meet the needs of all their communities and address inequalities. This includes recognising that some communities may require different approaches to meet their needs.

Collaborative approaches

The NHS cannot do this alone. Health inequalities are caused by more than healthcare, for example poverty, employment and housing, and relate to barriers that the NHS by itself cannot overcome. ICS collaboration brings an opportunity to capture a holistic picture of inequalities and work with people and communities on joined up solutions. Local authorities and other partners are well placed to understand the social determinants of health and how they can be addressed together.

There is also an opportunity to share power and strengthen relationships with people that experience inequalities. They can be involved in agreeing ambitions, shared outcomes and plans to improve health outcomes through commissioning and service delivery. For example, they could work with the groups identified through [national frameworks](#) to make decisions collaboratively on how to address their specific health and care needs. This helps ensure intended objectives are relevant, achievable, and based on the skills and experiences of the people they are intended to help. This means proactively seeking their participation and using community-centred approaches that enable diverse communities to take more control.

It is important to recognise that boosting the power of communities to take decisions and to influence and help set an agenda for change has a strong health creating effect. If the NHS can support people and communities to take more control, they will be helping to improve health and address inequalities.

¹⁰ [COVID-19: review of disparities in risks and outcomes](#), Public Health England, June 2020.

Case study: working with people in Morecambe Bay to reduce health inequalities

This project was designed to explore what access issues and inequalities were being experienced by a range of health inclusion and other key groups. It started with the Primary Care Networks (PCNs) using population health management approach to identify groups of patients that may experience health inequalities. Co-create then facilitated an asset mapping process with each PCN group to identify local people and organisations that could potentially support with the work. Next, engagement took place with groups of patients and local people including young people, adults with learning disabilities and their carers and workers from migrant communities. A workshop supported people to plan how they would share what they had found and what they planned to do next with the communities they had focused on.

The PCNs have changed their services based on what they found through this work. For example, for people with learning disabilities, annual learning disability health checks are being reassessed to improve uptake and providing care in a way that makes patients feel comfortable, cared for and listened to.

Overall, participants report feeling more confident around how to engage with their local communities, and how the process can be applied to other groups experiencing health inequalities to inform other improvement initiatives.

It was undertaken by Morecambe Bay CCG, North Cumbria ICS, Morecambe Bay PCNs, Co-create and other local partners.

Case study: Transformation of non-surgical service for adults with Gender Dysphoria

The current contract for the non-surgical gender identity service in the South West is due to end in March 2023. NHS England and NHS Improvement's regional team has taken the opportunity to co-design a service specification able to meet the needs of the population for years to come.

Initially, commissioners engaged with Trans and non-Binary (T+) people through a VCSE sector organisation that is well known and trusted by this community. This gathered a wealth of rich information from 645 T+ people and opened the eyes of commissioners to the wide range of health inequalities they experience, some of which can best be tackled through partnership working with other organisations, who then joined the engagement work.

The insights from this were used for a co-design event using a SPRINT methodology. Partners from police, housing, secondary care, primary care, the VCSE sector and commissioners working with members of the T+ community to co-design a more holistic, integrated and joined-up model of wraparound care for T+ adults.

The information gathered at the event was sufficiently rich and detailed that a new prospectus was written. This prospectus is now being used to stimulate the market and raise awareness among possible providers of the sheer range of health inequalities that T+ people are more likely to experience than non-T+ people, which can be addressed in the next service that is commissioned. It helps give a message to T+ people that they have been heard, and something is being done about it.

Building a culture of partnership

Communities and staff will look to system leaders to role model a culture of partnership, to demonstrate that their views are taken seriously and that power is shared so they can play a genuine part in decision-making. Leadership can be a joint endeavour, with leaders from systems and from within communities working together.

Collaborative and inclusive leadership means seeing participation as everybody's business and fundamental to meeting shared objectives. It means making sure that professionals and communities can work, learn, and improve together. It means creating the culture to enable staff to innovate and collaborate in new ways and giving them permission and autonomy to try things out, to learn and to celebrate success. This requires a commitment for the resources, training and support to do so effectively, and allowing people time to build trust and relationships. One way of doing this effectively is using community-centred approaches that enable diverse communities to develop their skills, take more control of their health and realise their own potential.

5. Ten principles for working with people and communities

These principles will help health and care organisations develop their ways of working with people and communities, depending on local circumstances and population health needs.

They are designed to be a golden thread running throughout systems, whether activity takes place within neighbourhoods, in places, across system geographies or nationally.

They build on the key actions and principles set out in the 2017 [guidance for commissioners](#) and the previous 10 principles set out in the 2021 [implementation guidance](#) for ICSs on working with people and communities.

They will form the basis of NHS England's assessment of how well ICBs meet their legal duties (see 12.1 below). However, they can be used by all organisations to develop effective ways of working in partnership.

1. Ensure people and communities have an active role in decision-making and governance

- Build the voices of people and communities into governance structures so that people are part of decision-making processes
- Recognise the collective responsibility at board level for upholding legal duties, bringing in lay perspectives but avoiding creating isolated, independent voices
- Make sure that boards and communities are assured that appropriate involvement with relevant groups has taken place (including those facing the worst health inequalities); and that this has an impact on decisions.
- Ensure that effective involvement is taking place at the appropriate level, including system, place and neighbourhood, and that there is a consistency and coordination of approaches
- Support people with the skills, knowledge and confidence to contribute effectively to decision-making and governance
- Make sure that senior leaders role model inclusive and collaborative ways of working.

2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions

- Take time to plan and budget for participation and start involving people as early as possible so that it informs options for change and subsequent decision-making
- Involve people and communities on a continual basis, as part of meaningful partnerships, rather than taking a stop-start approach when decisions are required. As a result, there will be much greater, ongoing awareness of the issues, barriers, assets and opportunities
- Be clear about the opportunity to influence decisions; what taking part can achieve; and what is out of scope
- Record and celebrate people's contributions and give feedback on the results of involvement, including changes, decisions made and what has not changed and why
- Keep people informed of changes that take place sometime after their involvement and maintain two-way dialogue so people are kept updated and can continue to contribute
- Take time to understand what works and what could be improved.

3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working

- Use data about the experiences and aspirations of people who use (and do not use) health services, care and support and have clear approaches to using this information and insight to inform decision-making and quality governance
- Work with what is already known by partner organisations, from national and local data sources, and from previous engagement activities including those related to the wider determinants of health
- Share data with communities and seek their insight about what lies behind the trends and findings. Their narrative can help inform about the solutions to the problems that the data identifies
- Understand what other engagement might be taking place on a related topic and take partnership approaches where possible, benefiting from your combined assets and avoiding 'consultation fatigue' amongst communities by working together in an ongoing dialogue that is not limited by organisation boundaries
- Build on existing networks, forums and community activities to reach out to people rather than expecting them to come to you. Be curious and eager to listen; don't assume you know what people will say or what matters to them.

4. Build relationships based on trust, especially with marginalised groups and those affected by inequalities

- Proactively seek participation from people who experience health inequalities and poor health outcomes, connecting with trusted community leaders, organisations and networks to support this
- Consider how to include people who do not use services, whether because they do not meet their needs or are inaccessible and reach out to build trust and conversations about what really matters to them
- Work with people and communities from the outset, taking time to build trust, listen and understand what their priorities are being realistic about what is in scope and where they can set the agenda for change
- Tailor your approach to engagement to include people in accessible and inclusive ways so you include those who have not taken part before. This includes recognising that some communities will not feel comfortable discussing their issues and needs within wider meetings, so may need separate, targeted activities. They may need additional support to take part including reimbursements for their time
- When reporting on engagement activity, explain the needs and solutions for different communities rather than simply aggregating all data and feedback together. This also supports equality impact assessments.

5. Work with Healthwatch and the voluntary, community and social enterprise sector as key partners

- Build strong partnerships with Healthwatch and the VCSE sector to bring their knowledge and reach into local communities. Work with them to facilitate involvement from different groups and develop engagement activities
- Understand the various types of VCSE sector organisations in your area, their different features and how the NHS can connect with them.
- When commissioning other organisations to work with communities, ensure that decision-makers remain personally involved and hear directly what people have to say.

6. Provide clear and accessible public information

- Develop information about plans that is easy to understand, recognising that everyone has different needs and testing information where possible. Where accessible formats such as easy read are used, these should be ready at the same time as other materials
- Providers of NHS care must meet their requirements under the [Accessible Information Standard](#) for the information and communication needs of people in their own care. The same principles should be applied for public information so that it is clear and easy to understand

- Be open and transparent in the way you work, being clear about where decisions are made and the evidence base that informs them, along with resource limitations and other relevant constraints. Where information must be kept confidential, explain why
- Make sure you describe how communities' priorities can influence decision-making, including how people have influenced research priorities or planning for future health care ambitions, how people's views are considered, and that you regularly feedback to those who shared their views and others about the impact this has made
- Provide feedback in an inclusive and accessible way that suits how people want or are able to receive it
- Make sure information on opportunities to get involved is clear and accessible and encourage a wide range of people to take part.

7. Use community-centred approaches that empower people and communities, making connections to what works already

- Support and build on existing community assets, such as activities and venues which already bring people together such as faith communities, schools, community centres, employers and local businesses, allotments etc...and community-centred services like link workers, community champions and peer support volunteers
- Build trust and meaningful relationships in a way that people feel comfortable sharing ideas about opportunities, solutions and barriers. Design, deliver and evaluate solutions together that are built around existing community infrastructure
- Recognise existing volunteering and social action that supports health and wellbeing and create the sustainable conditions for them to grow (for example, by providing places to meet, small grants or community development support).

8. Use co-production, insight and engagement methods so that people and communities can actively participate in health and care services

- Choose the method to working with people and communities depending on the specific circumstances, ensuring it is relevant, fair and proportionate. The most extensive method possible should be used that suitable for the situation. Use blended methods where appropriate
- Design activities to take place at a time and in a way that encourages participation and consider the support people may need to take part, including reimbursements for their time
- Recognise that people are busy and have other priorities such as work and caring responsibilities and ensure that there are different ways to get involved with varying levels of commitment

- Include approaches such as co-production where professionals share power and have an equal partnership with people to plan, design and evaluate together
- Where decisions are genuinely co-produced, then people with lived experience work as equal partners alongside health and care professionals (those with learnt experience), and jointly agree issues and develop solutions.

9. Tackle system priorities and service reconfiguration in partnership with people and communities

- People who use health and care services have knowledge and experience that can be used to help make services better including through involvement in research. They can put forward cost-effective and sustainable ideas that clinicians and managers have not thought of, leading to changes that better meet the needs of the local population
- People who use health and care services understand unmet need. This might be different from professional views of unmet need and should inform planning for future healthcare development
- Communities often have longer memories than the professionals who may change roles and move. Understanding the local history of change that communities have experienced helps to learn and build trust with people
- When people better understand the need for change, and have been involved in developing the options, they are more likely to advocate the positive outcomes and involve others in the process.

10. Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.

- Collaborate with partners across your system to build on their skills, knowledge, connections and networks
- Reduce duplication by understanding what is already known and what has already been asked, before designing the approach to engagement.
- Learn from approaches taken elsewhere in the country and how they can be adapted and applied locally
- Plan together across systems so that partnership work with people and communities is co-ordinated, making the most of partners' skills, experiences and networks.

Section B: Turning the Principles into Action

6. Different ways of working with people and communities

This chapter sets out a variety of approaches to working with people and communities however there is no 'one size fits all'. The options for doing so will vary depending on the context and objectives, and there needs to be flexibility depending on the aims and scale of the programme. A blended approach can also work well, with different approaches and methods used at different stages of a project to build a more detailed picture of what matters to people and what improvements can be made.

Some of the main ways to work with people are set out below. They each offer different levels of involvement, from sharing information through to more extensive methods such as co-design and co-production where there is a greater opportunity for people to have influence. As a general principle, partnership should be achieved by using the most extensive method as is feasible and suitable in any given situation. In other words, consultation should not be used if co-design and co-production are feasible, and so on.

Starting with people means going to the neighbourhoods and networks where they already are and begin by listening to them about their priorities. From this we can design approaches that should ensure relevant communities can take part, recognising that different methods work better for different groups.



Examples of activities to work with people include:

Inform:

- letters, leaflets, posters, and emails, including text and infographics
- online and social media, including use of animations and videos
- information on notice boards in local community facilities and shops.

Consult:

- formal public consultations to gather views and ensure they are considered appropriately, including webinars, public meetings and surveys.

Engage:

- focus groups or interviews
- citizens' panels and deliberative engagement
- patient forums, sounding boards and advisory groups
- membership on decision-making committees and boards.

Co-design

- co-design sessions with people with lived and learnt experience.
- service redevelopment tools such as Experience Based Co-Design.
- people with lived experience as members of programme boards.

Co-produce

- community development approaches including asset mapping, appreciative inquiry and community conversations.
- partnership of equals between people and professionals working together to reach a collective outcome.

For all the approaches used, there are three pitfalls to avoid:

1. **Tick box exercises.** *Involvement is not an obstacle to overcome on the way to achieving a predetermined outcome. Any perception that it is tokenistic or that a strategy or service change has not been informed by insight from the public, will not only undermine trust, it is unlikely to be supported at local, regional or national level.*
2. **Unrealistic timescales.** *Service design and service changes should be planned to achievable timescales that allow for early, ongoing and effective public involvement, including careful consideration and discussion of the views expressed by people and communities. Public involvement should not be shortened to meet deadlines.*
3. **Limiting public dialogue to service change proposals.** *While consultations necessarily focus on the proposals being consulted on, involvement should not only take place when a system wants to make changes – it should be part of how every system operates, with insights from community conversations informing and driving policy decisions. Systems should be in regular dialogue with people and communities; enabling them to also influence the agenda.*

Existing sources of feedback and insight

The starting point for any involvement activity is to consider existing sources of insight about the needs and experiences of different groups of people. A review of existing information can save time and money and point staff towards gaps in insight; whilst also avoiding asking people to repeat themselves. This helps to ensure that involvement is focused, meaningful and avoids duplication. This may be information held by partner organisations, including that collected during previous activities. Involving these partners in the planning process helps identify what is already known and where the gaps are; including whether the insight from particular communities was previously missed. Consider whether the context of this previous work has changed significantly and when it took place to understand whether it is still relevant.

One source of insight into population health needs are the intelligence functions that ICSSs are building. These are system-wide, multi-disciplinary collaborations which provide data and analytical support to help understand their local contexts. A key purpose of the intelligence function will be to support a population health management approach to care, including by developing a detailed understanding of the local population's health and care needs, such as granular intelligence on inequalities across different population groups. intelligence functions should work with patient experience and engagement colleagues to ensure that qualitative and quantitative insights about the population are informing the interpretation of other analyses and are given equal weight in decision-making.

Examples of insight and feedback sources:

- National [patient surveys](#)
- [Friends and Families Test](#)
- Local surveys and engagement by the NHS and local authorities, social media and review websites
- Local [Healthwatch reports](#) and [Healthwatch England national reports](#)
- Intelligence from the VCSE sector and local authorities
- Care Quality Commission (CQC) reviews, surveys and reports
- Patient Participation Groups (PPGs)
- Complaints and compliments
- [Patient Experience Library](#)
- Patient Safety Specialists
- Patient experience discussions at System Quality Groups
- Staff feedback including their own views
- Previous engagement activities including those by partner organisations
- [Local Health Profiles](#)
- ICS intelligence functions

Case study: System Insight Group and Patient and Public Insight Library at Derby and Derbyshire ICS

During the early stages of COVID-19, partner organisations within the Derby and Derbyshire ICS wanted to gather insights on how people were experiencing the pandemic and how it affected their lives. Residents in Derby and Derbyshire began to get inundated with separate requests to share their experiences and fill in surveys.

To avoid duplication, these efforts needed to be co-ordinated, so the ICS set up a System Insight Group, bringing together patient and public experience and engagement leads from NHS trusts, the local authorities and the VCSE sector. Its vision is to develop a culture of making insight-led decisions across the ICS. Insight could be from evidence, research, reflections, conversations, observations, and from any number of different sources. The aim of the System Insight Group was to link the types of insight together.

The System Insight Group has developed a Patient and Public Insight Library set up on the NHS Future platform. New insight is being added to the library on a regular basis, and any member of staff can join. The aim is to assist decision-makers to find current insight in the system, with the aim of avoiding duplication and consultation fatigue.

The group has also produced a report on Remote Access to Health and Care during the pandemic. The report pulled together a large proportion of insight and summarised the key themes. The report is being used by ICS partners when making decisions about the recovery of services, meaning that additional engagement will only be needed if it fills a gap in insight within the report. A digital inclusion checklist was developed using the report and will be promoted to all service providers to ensure good practice in remote access implementation programmes.

Patient Participation Groups

It is a contractual requirement for every GP practice to have a Patient Participation Group (PPG). The form a PPG takes is not specified and this provides flexibility for practices to work in partnership with people and communities in ways that best support the practice populations. While the PPG is one of the main ways primary care have engaged with people and communities, it should not be the only approach if it does not reach diverse groups, people with the worst health inequalities or people not accessing the services. These groups are more likely to be hesitant about getting involved in traditional PPG models. However, PPGs do not need to be limited to the meeting style group which has tended to evolve across the country. It is also helpful to consider if the form of the present PPG supports people to take part or if other approaches are also needed to widen the people who get involved. This [animation](#) on widening participation in primary care has some useful principles to use as a starting point to think through how practices currently hear the voice of their community and where the gaps are.

Co-production

Co-production is a way to involve people by sharing power with them. [The Coalition for Personalised Care](#) defines co-production as:

‘a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.’

Co-production can be used strategically, to design services, make quality improvements, design and undertake research and innovation, and develop participatory budgets. At an individual level, it is the cornerstone of person-centred care such as personal health budgets. As well as being well suited to place and neighbourhood levels, it can also be applied at national and system levels.

The starting principle is that people with ‘lived experience’ are often best placed to advise on what support and services will make a positive difference to their lives. When done well, co-production helps to ground discussions in reality and to maintain a person-centred perspective.

Where partnerships are genuinely equal, professionals are comfortable with not having the answers and with sharing resources, responsibility and power. [The Coalition for Personalised Care](#) sets out the values and practical steps to make this ambition a reality.

This includes:

- senior leaders supporting co-production through culture and behaviour
- identifying areas of work where co-production can have a genuine impact and involving people at the earliest stages
- investing in training and development so that people with lived experience and people working in the system know what co-production is and how to make it happen.

NHS England has published [resources](#) on co-production and its use in quality improvement.

Case study: Building people's skills and knowledge to take part in co-production

The Peer Leadership Development Programme was launched in 2014 by NHS England with the purpose of enabling people with lived experience to develop their knowledge, skills and confidence to co-produce. Over 200 peer leaders have now been trained.

The programme provides people with an opportunity to learn about how the health and care system works, about local and national policy and about how to share good information. It also teaches about change management theory and communication styles and preferences, and how people can use their personal story to create a narrative for change. This programme enables people with lived experience to access up-to-date information and support, in the same way that people working in the health and care system do. This ultimately enables people with lived experience to co-produce on a level playing field.

Case study: Co-producing a new model of community mental health support

In Somerset, the NHS, local authority and VCSE sector partners have worked with people with lived experience of mental illness to co-produce community mental health services. The involvement of experts by experience as equal partners has been embedded across the programme from the beginning, and the lived experience perspective they represent has influenced key decisions about the service. They co-designed the Open Mental Health model, whereby 24/7 support is available to adults in Somerset who are experiencing mental health issues. Provision is offered through an alliance of provider organisations from the VCSE sector, NHS and social care working in partnership. Experts by experience have an ongoing role as partners in the governance, continuous development and evaluation of the service.

There is more about Open Mental Health on the Rethink Mental Illness [website](#).

Case study: The difference made to the NHS England Musculoskeletal Services (MSK) programme by the Musculoskeletal Lived Experience Group (MSK LEG)

The first COVID-19 pandemic lockdown had a devastating effect on the provision of Musculoskeletal Services (MSK) services. Face-to-face consultations became a rarity, replaced by telephone and video consultations. MSK clinicians had to quickly learn new skills to assess and treat patients in these unfamiliar formats. The number of patients treated by MSK clinicians was significantly reduced as therapists were re-deployed to care for COVID patients.

It was quickly clear that going forward MSK services would need to be remodelled, not only to cope with pandemic times, but also to move into the future. The pandemic created challenges but also opportunities for new and better MSK services.

For such large-scale re-modelling to be successful it was evident that all partners would need to play a part in the development process including, perhaps most importantly, people using the services and their carers. Without their involvement it could easily result in services that people didn't want or were not sufficiently accessible to them.

In June 2020, a MSK Recovery Group was established with lived experience partners alongside healthcare professionals. The intention was to work together collaboratively to assist with restoring and improving MSK services in the wake of the pandemic lockdowns. It evolved into MSK Lived Experience Group (MSK LEG). Each member of the new MSK LEG has experience of a relevant MSK condition and were rigorously interviewed and appointed after an open and accessible selection process.

MSK LEG have already co-produced its own terms of reference and engaged in providing feedback on various MSK pieces of work. The group have helped shape the evolution of the #BestMSKHealth Collaborative programme and some members have presented alongside the National Clinical Director and various MSK clinicians to a range of audiences at events. The MSK LEG team has been developed from strong principles of co-production and has already made a difference to the recovery and advancement of MSK services throughout the UK.

Community-centred approaches

Community-centred approaches build on existing assets to support communities in taking more control over their lives and their areas. The diagram below shows the different types of assets that can contribute to creating health. These approaches (which include community development, asset and strength-based approaches) help identify the issues that matter to local people and support them in tackling them, working with the relevant public sector organisations.

The skills, knowledge and commitment of individual community members.

The resources and facilities within the public, private and VCSE sectors.



Adapted from: [Health matters: community-centred approaches for health and wellbeing - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

Recognising assets helps value community strengths and helps to ensure that everyone has access to them. This is an important aspect of how to tackle health inequalities by creating closer links between communities and health and care services. It builds on the positives and ensures that health action is co-produced equally between communities and services. The COVID-19 pandemic has brought all this into even sharper focus, highlighting the contribution of volunteers, community groups and individuals. Through system-working, there is an opportunity to strengthen community resilience in recovery and beyond.

Identifying community assets also reduces the possibility that new interventions inadvertently override what already works well or are not fully used because people still defer to preferred and trusted community initiatives.

Of all the levels of the ICS, it is to their neighbourhood that people tend to relate most closely and where links between communities and services can be strongest. Neighbourhoods contain a wide range of professionals which work closely with their communities including community nurses, GPs, pharmacists, community and mental health teams, Social Prescribing Link Workers, and VCSE sector organisations. There are also community-led services, such as peer support workers and community champions whose roles are designed to address local needs and health inequalities.

Communities organise themselves in many ways and understanding where and how they do this is crucial to reaching and hearing diverse voices. An integral part of building a system-wide approach to involvement is to start at neighbourhood level with understanding what matters to people's health and the assets they have. It means that engagement approaches should start with where people are already and build upwards to make the links to place and system levels.

Community-centred approaches help understand the specific local context where people live their lives and so design more integrated and preventative services with interventions tailored to local needs. These can be co-delivered by communities, employing local people and making the best use of the assets in each neighbourhood. This boosts the power of communities to take decisions and set an agenda for change which has a strong health creating effect.

While for many people their community is at the level of neighbourhood, they may also belong to wider communities. For example, as a member of a national support group for a rare condition, where peers help each other to understand treatment options.

Case study: Northern Cancer Alliances' work with communities in the recovery of urgent cancer referrals

The COVID-19 pandemic had a dramatic effect on the rate of cancer referrals across England. At the start of the pandemic the Northern Cancer Alliance saw referral rates across the region drop to 40.9% of pre-pandemic levels (April 2020). The Alliance decided to build on the national Help Us to Help You campaign with locally produced material. This local campaign focussed on health inequalities by focussing on specific tumour groups and communities where recovery levels were slowest.

Key to all aspects of the Northern Cancer Alliance work plan is the effective involvement of the public. The Alliance value to '*always involve the right people at the right time*' was a fundamental aspect of the design and delivery of the campaign. With a focus on health inequalities, the Cancer Alliance brought together the Alliance Lay Representatives, people with lived experience, the [Be Cancer Aware](#) team and community groups to co-produce the campaign.

The campaign produced short films made by people with lived experience of cancer, people with a learning disability and people from minority ethnic groups in different languages. There was also [patient information](#) and [campaign webpages](#) produced by the Northern Cancer Alliance Lay Representatives.

To reach as many people as possible, the campaign worked with community assets, for example, by distributing leaflets, posters and [magazines](#) via food banks and other venues in the most deprived areas across the region. This element of the campaign was supported by local community organisations who already had links to wider groups of people and the Alliance Cancer Community Awareness Workers.

7. Key considerations for all approaches

While the approaches to working with people and communities depend on the specific context, there are some universal considerations that apply. These help meet the legal duties and ensure that people are supported to take part safely.

Fair and proportionate approaches

Whichever approach is taken, it needs to be fair and proportionate. Judgement is needed and it is not an area where definitive advice can be offered without knowledge of the specific circumstances. Where staff need to make a particularly complex or potentially contentious judgement, they may wish to consider seeking legal advice.

The courts have established guiding principles for what constitutes a fair consultation exercise, known as the Gunning principles:

- consultation must take place when the proposal is still at a formative stage
- sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response
- adequate time must be given for consideration and response
- the produce of consultation must be conscientiously taken into account.

For more information, see section 10.4. These four principles relate to formal consultation but can be informative for other approaches.

The approach should also be proportionate. NHS organisations need to meet their duties to involve the public alongside their duties to act effectively, efficiently and economically and make sustainable use of NHS resources. Staff will need to consider the impact of proposals on the different groups of people who may be affected. Generally, the greater the extent of changes and number of people affected, the greater the level of activity that is likely to be necessary. However, the nature and extent of public involvement required will always depend on the specific circumstances.

Decisions in urgent situations

In an urgent situation, it may be necessary to consider the duty to involve the public alongside the public interest in maintaining continuity of care and protecting the health, safety or welfare of patients or staff.

It will only be reasonable to justify carrying out a limited (or no) public involvement exercise on grounds of urgency when the lack of time was genuinely caused by an urgent development or where there is a genuine risk to the health, safety or welfare of patients or staff. It does not permit commissioners or providers to leave public involvement until the last moment without enough time to carry out a fair and proportionate exercise, when the public could and should have been involved earlier or to a greater extent. Where urgent changes are made on a temporary basis, the legal duties still apply if organisations subsequently consider whether to make them permanent. This equally applies when changes were introduced because of the COVID-19 pandemic; public involvement should be undertaken if there are plans to make them permanent.

Of course, organisations that have in place ongoing mechanisms of working with people and communities will be in a much better position to undertake rapid engagement as an interim measure.

Equality considerations

Public authorities including ICBs, trusts and NHS England are required to comply with the public sector equality duty of the Equality Act 2010. When it comes to proposals for changes to services, carrying out an equality and health inequality impact assessment can help identify people who experience the greatest health inequalities, and those people with [protected characteristics](#) under the Equality Act 2010 who may be affected by a particular plan or decision. The [Health Equity Assessment Tool](#) can also help identify what action needs to be taken to reduce health inequalities and promote equality and inclusion.

These can be used alongside the [Equality Delivery System](#) for the NHS, a framework to help local NHS organisations, in discussion with local partners including local communities, to review and improve their performance for people with protected characteristics.

Approaches to working with people should be designed to include these groups and planned to ensure that they are fair and equitable. In practical terms this means recognising that not every type of involvement works for everyone and so you may have to carry out a range of activities to reach diverse groups and communities. For example, using accessible venues, making reasonable adjustments or specific effort to ensure disabled people, autistic people and people with a learning disability can participate. It can also mean considering involvement payments to encourage participation from groups that are typically under-represented. Experiences during COVID-19 have shown how the move

towards digital engagement has made it easier for some groups to participate whilst also excluding others where face-to-face approaches work better.

Auditing and monitoring the participation of equalities protected groups, for example in events and formal governance roles, should be undertaken. This will help identify any gaps in engagement requiring attention; and supports staff to promote the involvement of people who are more reflective of the population in question.

Whilst the Equality Act refers specifically to the protected characteristics, there are also other communities such as [inclusion health](#) groups that should be considered and included within engagement.

Inclusion Health Groups

These groups often experience the worst health inequalities through being at risk or living with extremely poor health because of poverty, marginalisation, multi-morbidity and social exclusion, and further impacted by discrimination and stigmatisation. These are any socially excluded population including, but not limited to:

- Gypsies, Roma, Travellers, Showpeople and Boaters
- people experiencing homelessness and rough sleeping
- people experiencing alcohol and drugs dependence
- young carers
- vulnerable migrants and refugees
- sex workers
- victims of modern slavery
- people in contact with the criminal justice system

It is essential to understand the barriers that the system inadvertently creates to their involvement. Approaches should be developed in partnership with trusted organisations and people with lived experience and seek to ensure that involvement means that people's voices are heard. These may be national organisations where there is not the local expertise of working with specific groups. Approaches must be trauma informed (see box below), culturally aware and provide a psychologically informed environment for people to take part safely.

PCNs can use a [self-assessment tool](#) to assess their engagement with inclusion health groups.

Case study: Making sure vulnerable groups are not left behind

To support the COVID-19 vaccine rollout, Bury Council and CCG worked with its PCNs, Healthwatch and VCSE sector organisations to make sure vulnerable groups did not get left behind. They focussed on proactive outreach to groups which the vaccine data, equality impact assessment and community insight showed were at risk of low update. This included Gypsy, Roma, Travellers, people experiencing homelessness and people with disabilities.

The partners worked together to engage these groups to see what the potential problems were, making use of their existing links with the communities. For example, the local authority team that works with Gypsy, Roma and Travelling people visited traveller sites to discuss what the issues were.

The response to COVID-19 and delivery of the vaccination programme has been a single endeavour between the council and NHS in partnership with the wider system, for example by working together to identify locations for vaccination centres and pop-up clinics that would meet their different communities' needs.

More information is here: <https://www.local.gov.uk/case-studies/bury-council-making-sure-vulnerable-groups-are-not-left-behind>

The impact of wider experiences

Approaches to involvement should be designed to take account of the contexts that people live their lives in and should recognise that everyone experiences health services differently. It should start from a position of building trust, safety, and shared understanding.

This means recognising and reflecting the wider lived experiences of the people we work with and how this can affect how they participate. We should also involve people and communities in a way that considers social determinants of health (such as their local neighbourhoods, access to greenspace, opportunities for being more active and access to healthy food) as well as physical and mental wellbeing.

It is also important to consider that previous involvement experiences, both good and bad, can affect how someone wants to be involved. For example, a bad hospital appointment where someone feels like they have not been listened to, could influence how they respond to engagement. These things may not seem directly relevant to the conversation you want to have but will be highly relevant to those you are wanting to engage.

There is a responsibility to keep people who get involved safe. Being asked repeatedly to go back over bad or even traumatic experiences so professionals can learn how to improve services, will cause distress and increase lack of trust. One way to keep people safe is not to create isolated positions of 'lay representation' which can burden people with the responsibility of bringing a public perspective to a large group of professionals. Instead it can be better to work with groups who can continue to support each other outside of meetings and help each other to take part effectively. Depending on the context, it may be necessary to arrange therapeutic support at activities and afterwards.

Trauma informed approaches

Working with people and communities should start from a position of building trust, physical and psychological safety, and shared understanding. It acknowledges what may be difficult. Trauma informed approaches are often partnership based, working with people and organisations that are trusted, well informed and specifically trained. VCSE sector organisations can have a particular role to work with people who have often experienced significant trauma in their life or who have been excluded by society. Working with community leaders, experts by experience and others who already hold people's trust is often a more appropriate way of reaching people than involving them directly. Recognising people's previous and current negative experiences are a key part of this, alongside building shared understanding and authentic relationships.

West Yorkshire Health and Care Partnership has collated [resources](#) on trauma informed approaches.

Case study: Improving engagement through online communities

With the move to online working during the pandemic, [Shine Cancer Support](#) found that this enabled them to reach people who would not necessarily have engaged with their services or community previously as physical barriers no longer existed. For example, attending in-person retreats was not possible for some due to their treatment, their physical health, or the travel time. But during the pandemic Shine developed several online programmes with shorter sessions over several weeks that enabled people from across the country and at different stages of their treatment able to attend at the same time. Through these programmes people developed strong peer support, shared information and participated in a community that could support them. This has been particularly important for young adults with incurable cancer who are increasing in number but less likely to find someone physically nearby who shares a similar experience. They have been brought together virtually through the [Shine Circles](#) programme and they usually continue their support and sharing via WhatsApp groups after the programme ends. These and other online support groups show how people get information and support for their health and from communities that exist at different levels.

Supporting people to take part

It is important to have a consistent approach to recruiting, training and supporting the range of people who get involved in different roles. This helps ensure they have the knowledge, skills and confidence to contribute effectively, and that opportunities are equally accessible to people on low incomes and those with health and social care needs or disabilities.

The level of support needed will partly depend on the role and method. Roles with ongoing involvement or which include decision-making activities as part of co-production approaches may require specific training, for example to help people to understand their own lived experience in the wider context and have the skills and confidence to influence professionals. This could also include having pre-meetings to help people explore the issues and check their understanding, as well as follow-up debriefs.

It is good practice for organisations to have a written policy giving details about their approach to reimbursing and paying people. A policy helps to clarify the situation for everyone and avoids people being treated differently on different occasions. There are advantages to developing a consistent approach across organisations within an ICS so that people can easily understand whether and how they will be reimbursed. Any policy on payments will need to be compliant with [HMRC rules](#).

Consider the resources required to take part, including the cost to an individual of travelling to a meeting or attending online, especially where they may have limited income or no recourse to public funds. Payments can support participation from more diverse groups and helps recognise the value that organisations place on people contributing their experiences, knowledge and skills. Organisations paying people for their time as part of involvement activities have a responsibility to ensure that people who receive benefits are supported with independent welfare rights advice.

Beyond financial means, there are many ways to recognise people's contributions including receiving an acknowledgement in writing, support to develop skills and experience, and seeing the improvements made because of their input. Ask people which of these other forms of recognition would support them to take part.

It is important to recognise that there can be a cost to partner organisations such as the VCSE sector or Healthwatch. This can be in terms of staff time to provide insight or to take part in advisory groups as well as arranging for communities to participate in engagement activities.

There are also practical considerations to ensure different people can take part by making activities accessible, such as when and where they take place, making reasonable adjustments so everyone can take part, provision of British Sign Language and community language interpretation, and providing accessible information. This links to the recognition that a range of approaches are likely to be needed to involve relevant groups, and that we should go to where they are already rather than expect them to come to us.

NHS England has a patient and public voice partners [policy](#) that sets out how we support people to be involved in our work. It sets out the different types of roles people can do and includes support and training. There is also [policy](#) on reimbursements and payments.

8. Collaboration between the NHS and other partners

This section sets out how different organisations can collaborate on how they work with people and communities. Collaboration is about building relationships with partner organisations and local communities, that treats all partners equitably with a valid and useful contribution to make to the health and care system. The partners highlighted here can help systems to work with people and communities in terms of contributing views, sharing insights and providing outreach. It is not an exhaustive list and systems should map the different partners in their areas to understand how they can work with them.

Local authorities or the VCSE sector may already have well-established mechanisms for including people in decision-making and, where possible, NHS organisations should use the insights from these and work through existing forums and activities, rather than setting up new ones.

There is also an opportunity to coordinate working with people and communities. For example, an ICB and a trust can work together on engagement over changes to hospital services for which they both have legal duties to involve. Their approach could include working with existing forums run by the local authority or commissioning Healthwatch and the VCSE sector to engage the communities they already have links with. Joining up conversations across sectors and coming together to involve people about what matters to them can lead to significant improvements in how people are able to access services and improve their health and wellbeing.

Local authorities and councillors

Local authorities are important partners in working with people and communities. Their membership of ICSs brings their experience of working with people to design and deliver services that meet local needs and build community assets.

The membership of the ICB must include at least one member jointly nominated by the local authorities within the area of the ICB. The ICB, and each responsible local authority wholly or partly within the ICB's area, must establish an Integrated Care Partnership (ICP). All local authorities have a role in delivering better health and care and influencing people's health outcomes due to the environment they live in. As such they are all important partners in working with people and communities. Partnerships should exist with councils at all levels and beyond the formal membership of the ICB and ICP.

Local authorities commission and provide children and adult social care, public health, housing and many other services that contribute to health and wellbeing. Therefore, local authorities are key partners in designing and commissioning person-centred services. They often employ community development workers with experience of community-centred approaches. They are also significant funders of local VCSE sector organisations providing care and support to communities.

Councillors are elected to represent their local communities at ward level. They have detailed knowledge of the communities they serve, including their concerns around health services and the wider determinants of health. They have links to community resources and networks, including neighbourhood forums, and a reach into their communities.

Local authorities are responsible for health and wellbeing boards – inclusive place-based forums in which political, clinical, professional and community leaders agree shared priorities to improve the health and wellbeing of their communities. The boards also produce joint strategic needs assessments, an invaluable source of information on an area's demographics and the profiles of local communities. The boards are required to publish joint health and wellbeing strategies that identify the priorities for improving health and wellbeing and the actions needed to achieve this. ICBs and their partner trusts must involve the boards in producing the new forward plan for each ICS (see section 12.2).

Unitary and county councils have powers and duties in respect of Health Overview and Scrutiny. This role is usually carried out by a Health and Overview Scrutiny Committee (HOSC) of the local authority for its local area or a joint HOSC appointed by two or more local authorities to cover a larger area. Working with scrutiny can help systems take a wider perspective and develop effective partnership working.

Where changes are proposed which are a substantial development of the health service in the local area, or a substantial variation in the provision of the service, responsible bodies, commissioners and providers of NHS services (including NHS England, ICBs, trusts and private providers) are under a duty to consult HOSC on the change. Ordinarily, the commissioners (ICBs or NHS England) will carry out this exercise on behalf of providers. More information on health scrutiny's role is contained in chapter 9.

Case study: Vibrant Communities Partnership Board

Bournemouth, Christchurch and Poole (BCP) Council have a strong track record of working with communities, but acknowledges that to be better, it must involve VCSE sector into decision-making positions within the council.

The vast majority of public sector organisations work using traditional, deficit-based approaches. This means they are set up to focus on perceived issues or weaknesses of a particular community that, it is believed, require a professional approach to solving. While there are some reasons why this approach may be useful, it can inadvertently take power and responsibility away from the community.

In order to reverse deficit-based public service, BCP Council has developed the 'vibrant communities' approach which focuses on developing strength-based ways of working within individual communities and within council services.

To do this, the Council set up the Vibrant Communities Partnership Board, which is a partnership between the council, the local VCSE sector and the NHS and other partners. The broad overall objective is to deliver strength-based approaches and interventions that focus on the inherent assets of people, communities and organisations. The Board has two co-chairs, one elected by the council and the other by the voluntary sector, so a mixture of community and council priorities are covered and to empower non-public sector partners by devolving responsibility.

The Board avoids discussing strategic priorities of Board members, but instead focuses solely on operational needs of the community. This is deliberate as a key objective of the Board was to avoid it becoming a smaller 'health and wellbeing Board'.

Healthwatch

Healthwatch is the independent body responsible for understanding the needs, experiences and concerns of people who use health and social care services, and to ensure their views are put at the heart of their care.

Its activities include:

- promoting the involvement of local people in health and care services
- enabling people to monitor standards of care and how services can be improved
- obtaining their views and experiences of services.

At a national level, Healthwatch England provides leadership and support to local Healthwatch organisations. Its other statutory functions include escalating concerns raised by local Healthwatch to the CQC, and to provide advice to Secretary of State for Health and Social Care, NHS England and English local authorities, especially where they hold the view that the quality of services provided are not adequate.

Providers of health and social care services are under a duty to allow entry by local Healthwatch. This power to 'enter and view' services, offers a way for Healthwatch to undertake their activities and allows them to identify what is working well with services and where they could be improved. Healthwatch can use this evidence to make recommendations and inform changes both for individual services and across the system. There are requirements for the service providers to respond to a Healthwatch report and its recommendations within a set timeframe.

Through their role in obtaining views of local people about their needs and experiences of care, local Healthwatch can provide insight about the breadth of health and care, particularly picking up on issues which go beyond a single service such as integration and the impact on people. ICSs should build on the existing statutory activities of local Healthwatch in their geographies, working with the organisations to resource the co-ordination and analysis of user experience data. This will complement insight collected by commissioners and providers.

Systems can also work with local Healthwatch to involve local people. One of their functions is to support the involvement of local people in the commissioning, provision and scrutiny of care services. Their scrutiny function means they can make recommendations of service improvements to commissioners, providers, Healthwatch England and the CQC. These functions help them have knowledge of how to work effectively with local communities and how services can be improved to meet local needs.

Local Healthwatch must be involved in developing joint strategic needs assessments, integrated care strategies and forward plans (see section 12.2). Healthwatch organisations may provide views, reports and recommendations on decisions and decision-making processes based on the evidence available. This includes the option to refer issues to overview and scrutiny where they feel it is appropriate (see section 9.1).

Local Healthwatch organisations have a place on their local Health and Wellbeing Boards, so they can present people's views in strategic discussions. They can have strong relationships with local authorities, working with both service delivery and elected members.

Many ICSs already have some system-level arrangements in place with their local Healthwatch. Arrangements for how Healthwatch can work at both system and place level will vary depending on the geography of the system and different local authority commissioning arrangements. ICSs should consider how they can invest in these partnerships in order that Healthwatch has the resource to take on their roles effectively, including commissioning them to undertake engagement or fulfil the roles at system level.

While Healthwatch have different roles from VCSE sector organisations, their shared values mean they should be seen as complementary rather than competing (and many Healthwatch are hosted by VCSE sector organisations). Strong relationships with both will help ICSs hear the voices of people at all levels.

Case study: Bringing local people's voices to the ICS – Healthwatch in North East London

To ensure that local people's experiences are at the heart of the North East London ICS, the eight local Healthwatch are working together. By combining their knowledge of their local areas, the experiences that people share with them and the different barriers they face, they have been able to identify trends, variations and differences in health and care - helping to tackle and reduce inequalities.

Together the local Healthwatch have been working with the ICS on its engagement strategy and the principles it will follow. They meet regularly with the ICS as a forum for dialogue and a space to highlight local issues. They are actively involved in their place-based partnerships and will participate in ICS governance.

They have been commissioned by the ICS to deliver community insights through a single database across North East London, particularly in relation to COVID-19. The eight local Healthwatch combined their data, using a system already in use by some local Healthwatch to provide ICS level insight. The [Community Insights Repository](#) collates feedback for providers from different sources, such as NHS Choices, Care Opinion, Google reviews, website feedback, surveys and complaints.

For local Healthwatch, there have been significant benefits too. They now have more evidence to base their work on; they're more quickly able to identify critical issues people are experiencing and have better relationships with communities facing health inequalities.

Healthwatch activities for the ICS are funded through the ICS engagement budget.

More information here: <https://network.healthwatch.co.uk/blog/2021-11-25/improving-access-to-health-services-north-east-london>

The voluntary, community and social enterprise sector

Organisations within the VCSE sector have many different roles. They are often providers of services (both commissioned and funded through voluntary or charitable income) to the most disadvantaged communities and consequently can have an excellent understanding of the health and care issues faced by those communities. The sector has a key role in tackling the wider determinants of health by reaching people who experience health inequalities and removing barriers to accessing services. At both national and local levels, the VCSE sector has an important contribution to make in shaping and providing health and care services, and in developing and implementing plans to tackle wider determinants of health.

VCSE sector organisations can bring their knowledge of how to work with people and communities:

- they are often trusted, accessible and skilled at outreach and engagement
- they have routes into and established relationships with different groups, especially those that experience health inequalities
- being well placed to provide expertise in directly working with people and communities in service planning and delivery, including experience of community-centred approaches
- they have knowledge of the needs and strengths of those they work with and can support them to be more directly involved in health and care strategies and plans.

Within ICSs, VCSE sector partnerships should be embedded in how they operate.¹¹ All ICBs should have a formal agreement to work with the VCSE sector in governance and decision-making, building on their existing involvement in place and neighbourhood level forums, and where they have well-established relationships with other NHS organisations and partnerships such as Cancer Alliances. This agreement should consider the role of infrastructure organisations including the new VCSE Alliances or leadership groups that can bring strategic voice to governance of ICSs.

Depending on the engagement taking place, it may mean working with national VCSE sector organisations. For example, if redesigning the pathway for a rare condition, there may not be relevant groups at place or system levels, but a national organisation could advise on what approaches to take and help contact people.

Beyond the larger VCSE sector partners, it is also important to work with informal groups and networks such as user-led organisations, peer support groups and advocacy organisations. Many people who are excluded or stigmatised by society are often involved in their own community group or user-led organisation.

VCSE sector capacity and infrastructure will vary between areas, as will the resource required for organisations to support health and care services in this way. Costs to the organisations should be recognised, whether in terms of staff time or direct costs of carrying out engagement with communities. Financial planning can build the sector's resilience so that they are able to help tackle health challenges. Commissioning the sector to undertake engagement with the groups they work with supports investment in community assets and can secure wider benefits by strengthening local organisations.

The COVID-19 response saw organisations across the VCSE sector support people and communities. Through ICSs there is an opportunity to deepen partnerships with VCSE sector organisations and amplify the voices of the communities they work with in decisions about health and care.¹²

¹¹ See the 2021 [ICS implementation guidance](#) on partnerships with the VCSE sector.

¹² For more information see [Creating Partnerships for Success](#), NCVO, January 2020, and [How health and care systems can work better with the VCSE sector](#), NHS Confederation, August 2020.

Case study: Embedding the VCSE sector in the planning and design of systems in Humber Coast and Vale ICS

There has been close working between the health and care system and the VCSE sector for over 18 months which have built strong foundations so that the sector is a key strategic partner in the planning, design and delivery of health and care services.

A well-established VCSE leadership programme has meant that the system has got a mechanism to speak to the sector and the leaders around the table to understand their place. From the outset the approach has always been to make the connections with the partnership and ensure the sector is embedded. This has led to investment in the sector and its involvement in the partnership's governance and strategic planning. It has resulted in the system embracing the value of the VCSE sector and is proactively involving it at the earliest opportunity.

This early engagement with the VCSE sector has many benefits and being part of the design of services rather than 'just' delivery, allows for wider perspectives and different ideas being formed through co-design. Our work with the Cancer Alliance has seen the sector shaping proposals around early cancer detection and having a greater reach into targeted communities, which can be delivered by the VCSE. As a result of this increased understanding of the capabilities of the sector, the proportion of the budget allocated for the VCSE is more in line to that for the statutory services, meaning it is seen much more of an equal partnership, rather than an add on.

Social Prescribing Link Workers

Social Prescribing Link Workers (SPLWs) support people with practical, social or emotional needs that affect their health and wellbeing. As part of Primary Care Networks, SPLWs work with people to co-produce a simple Personalised Care and Support Plan (PCSP) which includes personalised, non-medical solutions to meet people's needs. This could include connecting people to a range of activities, groups and services in their local community, including supporting people to access statutory services, volunteering activities and peer support.

Through their role, SPLWs develop detailed knowledge of their neighbourhood, both in terms of the health and wellbeing needs of residents, and the community assets available that can support them. Their local knowledge means that SPLWs may have specific expertise in community-centred approaches and can help facilitate co-production. SPLWs can help identify whose voices need to be heard, and support and facilitate access to engagement opportunities for diverse groups. They can also help identify local community organisations and map existing insight, particularly in relation to health inequalities. In some cases, specialist SPLWs work with specific inclusion health groups and so can act as intermediaries to reach them.

Case study: Co-designing a new green social prescribing project to improve people's mental health and wellbeing and reduce health inequalities

In South Yorkshire and Bassetlaw ICS, a green social prescribing project has started to test how connecting with nature, green spaces and the outdoors can improve people's mental health and wellbeing and reduce health inequalities across the community. The project is also looking at how green space can be accessible to everyone, focusing on people negatively affected by the pandemic, including people from ethnic minority communities.

Co-design, which included working with VCSE sector organisations, community groups and people with lived experience was at the centre of the development of new green social prescribing activities to make sure that they are what people want and need and are accessible.

The project team engaged with local communities in a variety of ways, helping people to get involved in the project in the way that worked best for them. This included working with local voluntary and community organisations, attending local green activities and groups to talk to people, workshops, questionnaires, and offering individual meetings and calls.

The project team and community worked in partnership to reach a set of criteria for new services, such as agreeing that referral pathways to social prescribing projects needed to be expanded to help people less likely to go to the NHS for support connect to social prescribing through trusted community connectors and groups. The group also agreed that working through trusted community leaders would help some ethnic minority communities connect with activities and suggested that promoting case studies featuring people from ethnic minority backgrounds and using communication channels favoured by local communities would increase visibility of support on offer.

People with lived experience of mental ill-health sat on panels to assess grant applications for new green projects and made joint decisions about funding. Working together has helped to form trusting relationships between green spaces and social prescribing services and communities, and funded projects are what people want them to be; accessible, inclusive, and safe to use.

Volunteer and peer roles

These roles provide advice, information and support or organise activities around health and wellbeing. They are often part of community-centred services, designed to meet specific local needs and assets. Examples include community champions, research champions, care navigators, health walk leaders and breastfeeding support peers. These are active community members who draw on their local knowledge, skills and experiences to promote health and wellbeing. Alongside health promotion and improving connections between services and communities, they can support involvement through an in-depth understanding of the different communities' they work with. Like SPLWs, they can have

detailed knowledge of health needs and inequalities, and how engagement approaches can be designed to include diverse groups.

Trusts' non-executive directors and governors

All NHS trusts and NHS foundation trusts have non-executive directors (NEDs) on their Boards. In addition, NHS foundation trusts have a range of governors who represent staff, patients, unpaid carers and service users, and the public, and are elected by the 'constituencies' they serve (including staff members and local people who have chosen to join their trust as a member).

NEDs are appointed for their wider board experience and independence. They have a key role in accountability and bringing a more objective viewpoint to deliberations. NEDs can also support Boards and systems to think strategically about how they connect with local people, having often worked in different sectors, and can be active in and well-connected to the local community.

Public governors provide an important link to local communities, which works in two ways: to help a trust understand the views of the public, and to help a trust engage with them. They can act as a conduit between patients, the public and trust leadership. However, councils of governors are not restricted to representing members or the interests of a narrow section of the public served by the foundation trust – that is, patients and the public local to the trust or those from governors' own electorates. Instead, governors are expected to take account of the interests of the 'public at large'. This includes the population of the ICS that the trust belongs to. The membership system also provides foundation trusts with a ready pool of people who can be more directly engaged in decision-making, with established routes for communication.

Health and care staff

In many areas, the local authority and the organisations which make up the local NHS are together one of, or the biggest local employer – which gives them a significant (and in some cases unique) position within the community. NHS organisations can have a positive impact locally as 'anchor institutions' – contributing to people's sense of local identity, and what defines and makes them proud of where they are from. This also enables organisations to have significant impact on the health and wellbeing of the immediate community they serve, for example by reducing congestion and pollution by adopting green transport initiatives for staff.

In thinking about working in partnership with local people, organisations should take care to include their employees as part of this group. Staff members will also be users, or potential users, of services, as well as unpaid carers and supporters of family members, friends and neighbours. They will have views of their own about what could improve the health and wellbeing of local people, and about how services could be improved – so it is

important to consider how these can be captured. Unions, professional bodies and staff networks can also bring their members' perspectives.

In addition, staff (particularly in patient-facing clinical and non-clinical roles, such as receptionists and porters) can be communicators to the public, through informal conversations with people using services. 'Word of mouth' remains the most powerful communication tool, especially when those speaking directly to local people are in the most trusted of all professions (nurses and doctors), so it is essential that staff understand initiatives and the rationale behind them. If staff have been actively involved, they are more likely to become ambassadors for local change processes and encourage other local people to get involved and have their say. Staff can have an important role here given that they are more likely to live in the local area and can be powerful influencers within their communities.

Other health system partners

Other public bodies and organisations may also be active locally in improving health and care. These might include health and care research collaboratives and local social enterprise and entrepreneur networks as well as Academic Health Science Networks who work to improve health and generate economic growth. ICBs have a duty to 'facilitate or otherwise promote research' and to 'promote innovation', and duties around reporting these activities. There is an expectation that communities are involved in these activities¹³. People and communities should be directly involved in identifying unmet health needs and shaping the future research, innovations and health services for their communities. Local and regional research and innovation partnerships often have strong networks with local communities and are a good source of insight into people's current experience of care as well as aspirations for the future of healthcare.

¹³ [Shared commitment to improve public involvement in research – UKRI](#)

9. Service reconfiguration and public consultation

NB: This section is subject to change as the legislation is finalised. It will be reviewed and updated considering this and the forthcoming revised guidance on health overview and scrutiny.

Applying the principles to major service change

Changing how services are planned and delivered will happen for several reasons including to improve the quality of services and patient experience, and to address prevailing inequalities in health outcomes in a community.¹⁴

A community-centred approach can consider the whole system and involve local people at early stage in co-designing what the future health and care system for their area looks like. It means building on the conversations that systems should already be having with people about what a health community might look like and using their existing approaches as a starting point for producing service change proposals.

Service change proposals can be subject to judicial review or be referred by the local Health Overview Scrutiny Committee (HOSC) to the Secretary of State for Health and Social Care. In undertaking service change, systems should be mindful of their legislative duties to engage the public, consult their HOSC, have regard to the need to reduce health inequalities, and to have due regard to the Equality Act and the Public Sector Equality Duty. In carrying out these duties, consistent and meaningful involvement and engagement with patients, the public, service users and communities is fundamental.

One of the most important early steps to take is to build long-term relationships and invest resources in developing partnership approaches with key community and political leaders, including politicians, faith leaders and VCSE sector organisations. Clinical Senates also bring a public perspective to significant service reconfiguration. They bring together clinicians, patients and other partners to assist commissioners and providers to make the best decisions about healthcare for the populations they represent. Clinical Senates will assure the contents of a service change's Pre-Consultation Business Case (PCBC), including approving the involvement of patients and the public in any clinical modelling that has been undertaken.

¹⁴ There is separate NHS England [guidance](#) on the entire process for substantial service change.

Every effort should be made to include local Healthwatch organisations in the decision-making process at an early stage, where they may offer support and advice as to the best way to engage with the groups affected by the change, as well as sharing existing relevant insight. Where a proposal is likely to have an impact across a wide geographical area, it will be necessary to work with all the individual Healthwatch organisations to ensure that all areas are appropriately represented.

Every system that plans to change how its services are delivered should undertake an Integrated Impact Assessment (IIA) to understand pre-existing access to and understanding of the services available. This assessment can support commissioners to identify and reach seldom heard communities that may be affected by these changes. Local organisations can support commissioners to engage these communities, and to develop meaningful long-term relationships with them in the design and delivery of reconfigured services.

Inevitably, some transformation proposals will be so contentious that any amount of good planning, relationship building, and mitigation will not prevent significant local opposition. In these circumstances, systems should consider the following core principles:

- maintaining a civil discourse: All partners should work hard to maintain a civil discourse throughout the process and avoid disengaging from dialogue or publicly criticising other partners
- ongoing and continuous dialogue with communities: Engagement even from the early planning stages, before formal service change proposals are made, can support understanding about the process and rationale for decisions, including how people have been included and their views considered. This needs visible leadership from Board level
- scope of proposals: All engagement must have a clearly defined scope and the ability to have some influence. For example, it is not appropriate to consult on options that are not genuinely under consideration or are unviable or unrealistic
- length of consultation: When planning a public consultation, consideration should be given to the amount of time necessary – a longer consultation is not always best. [Government advice](#) is that consultations last for a proportionate amount of time. Shorter consultations backed by significant evidence of engagement beforehand may be most effective. Long and unpopular consultation processes, however well meaning, can negatively impact on the long-term relationship with communities and partner organisations. However, in all circumstances you should ensure that the consultation is long enough so that interested parties have the time to respond. This may include giving them time to consult within their membership. Through demographic monitoring, you may also need to factor in time to undertake additional engagement with communities that haven't previously been adequately involved.
- access to information: As part of the consultation process you should ensure that people have access to the information that they need. This should be accessible, timely and easy to understand with potential benefits and drawbacks clearly set out. This will allow them to give an informed opinion that may take account of significant factors about which they may not have been aware previously. Alternative formats (such as easy read documents) must be ready at the same time. Good practice indicates that

public-facing versions of business cases, such as the plan for public consultation, will help communities to understand proposals more easily. Certain documents, such as the Pre-Consultation Business Case, and the Decision-Making Business Case, will be publicly available and systems should ensure these are clear, succinct, and easy for everyone to access.

- continuing dialogue throughout consultation: The consultation process should not close all other communication with stakeholders. You should consider whether it is appropriate to share information openly and to maintain an ongoing dialogue.
- addressing issues raised by all groups: Significant service change will often arouse a lot of public interest, including from campaign groups. Any public consultation needs to ensure that all opinions provided as part of the consultation are heard, but also must consider that there may be a range of views. Responses to public consultation should address significant issues raised by all groups and show how they have been considered. This underlines the importance of involving all groups affected by the change but who may be less likely to take part in public consultations.
- public-facing decision making: Once consultation has completed, and responses have been independently consolidated and considered, a decision regarding the agreed way forward should be made in public and communicated meaningfully and clearly.

Finally, it should be emphasised that systems that have ongoing, meaningful involvement of people and communities, are more likely to develop proposals where issues, barriers, opportunities and solutions have been thought through together. This gives them a firm basis before going out for wider consultation.

Case Study: Community hospital change

The NHS in Gloucestershire used a Citizens' Jury to decide the location of a new community hospital instead of having two hospitals. The change had been proposed and firmly rejected more than 10 years previously by a very vocal and well-organised opposition.

Communicating to the public that it was not possible to deliver high quality care across two sites comprised of older buildings was seen as challenging as the local population have experienced high-quality care in both hospitals over time and may not understand the benefit that a new site would bring to the quality of their care.

To involve the public in the change process and gather strong public evidence, the team needed to recognise the strength of local feelings and emotions rooted in the area.

The presence of local staff at involvement events who understood the history of the two hospitals helped recognise the significance of the change for local identity. Their presence helped support residents to provide views about quality of care. They also reported that showing the experience of new community hospitals elsewhere in the county helped highlight the increased quality of care that could be delivered at a new site. This approach helped the public navigate the tension between local access to services and quality of care.

A combination of traditional and deliberative involvement informed decision-making and design at each stage. Qualitative evidence gathered through public events and discussions helped answer the question, ‘what good looks like’ at the pre-consultation business case stage. It highlighted issues around access, ensuring continuity of history and the potential impact of inequalities that the team would need to consider in more depth in the design of options.

The site selection stage of options development used an independent Citizens’ Jury to make a recommendation from three possible locations. A Citizen’s Jury is an involvement method where a small group of the public are selected to deliberate over a policy issue and asked to make a recommendation based on evidence presented. The Jury has no decision-making power as it is not a legal entity, and instead makes a recommendation to the local NHS as accountable decision-makers. Neither the Trust nor the CCG had a preferred option out of three possible locations – all were understood to have the potential to deliver high quality care. The local population did have preferred options – it was a highly contentious local decision.

The jury was run by an independent company that recruited a mix of residents through public advertisement where residents applied to take part. This ensured a geographical spread across the area and as well as selecting people who were genuinely interested to take the recommendation-making responsibility.

The system accepted the Citizens’ Jury recommendation because they trusted the process that had created more neutral, clinically framed public evidence.

Health Overview and Scrutiny

Health Overview and Scrutiny Committees (HOSCs) contribute constructively, in the interests of their communities, to plans. Councillors can highlight potential risks which might not otherwise be apparent – their unique perspective and insight, derived from their role in the local community, provides vital intelligence for policymakers and a particular credibility in giving voice to public concerns. They will expect to see how ICSs have engaged people in developing plans and that equalities issues have been considered. Where relationships are positive, the management of proposals for substantial variations or other major changes will be easier.

The Secretary of State for Health and Care can review proposals if there is significant concern from HOSCs, for example if it does not view the proposal as in the interests of the health service of its area or that consultation on the proposal was inadequate. Early and transparent engagement can minimise the likelihood of referrals to the Secretary of State and any damage to the relationship between the NHS, local authorities¹⁵ and communities.

Once a referral decision has been made, if the HOSC – or any individual – disagrees with the decision, the proposals can be referred to Judicial Review (JR). It is important to note

¹⁵ There is separate [guidance](#) for local authorities on health scrutiny.

that a JR will not scrutinise the decision made by the system, but the process by which the system has come to this decision. This will include whether legal duties regarding engagement have been met, and to what extent they have been meaningfully met. Strong, consistent and continuous engagement with the public, documented and recorded extensively, will reduce the risk of systems failing a JR.

10. Relevant legal duties

This guidance encourages the involvement of people and communities as an ongoing approach, providing opportunities for people to raise the issues and ideas that matter to them, and make decisions with them about their health and care services. However, as well as best practice, there are also specific legal duties for commissioners and providers of health and care services.

Involvement duties on commissioners and providers

To reinforce the importance and positive impact of working with people and communities, NHS England, ICBs and trusts all have legal duties to make arrangements to involve the public in their decision-making about NHS services. A requirement to involve the public is also included as a service condition in the [NHS Standard Contract](#) for providers.

The legal duties require arrangements to secure that people are ‘involved’. This can be achieved by consulting people, providing people with information, or in other ways. This gives organisations a considerable degree of discretion as to how people are involved, subject to the below requirements.

Neither the legal duties, nor this statutory guidance, seek to prescribe exactly how to involve people in any given case. Indeed, what is necessary will always depend upon the circumstances.

However, whatever the form of involvement, it must be sufficient to secure people’s involvement in the issue in question. Therefore, NHS England, ICBs and trusts must ensure that involvement is tailored to the issue in question and the urgency with which any decisions need to be taken. In this context, urgency means a genuinely urgent development or risk to the health, safety or welfare of patients or staff, that means a decision needs to be taken promptly.

Public bodies are required to act rationally and this applies to the arrangements they make to involve people. Public bodies can demonstrate that they are acting rationally by keeping good records of decisions taken about when and how to involve the public.

The main duties on NHS bodies to make arrangements to involve the public are set out under section 13Q of the National Health Services Act for NHS England, section 14Z45 of the Health and Care Act 2022 for ICBs, and section 242 (for NHS trusts and NHS foundation trusts) of the National Health Service Act 2006.

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.

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 in the Health and Care Act 2022 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 legislation does not include a definition of carers or representatives. However relevant carers¹⁶ and representatives should be identified by reference to the individuals who use, or may use, the services in question. It is up to local organisations to identify who to involve – depending upon the circumstances, nature of the services and decision-making process in question – but relevant carers and representatives could include individual patients' advocates or family members who help organise their care, as well as councillors and community leaders, VCSE sector organisations, local Healthwatch and other organisations able to represent the interests of the individuals who use, or may use, the services in question. A stakeholder analysis can help determine which groups are relevant representatives depending on the context.

¹⁶ NHS England defines a carer as 'anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.... This is inclusive of both adult and young carers.' [Who is considered a carer?](#)

A process for assessing whether the legal duty to involve applies

NHS England has developed a three-step process for assessing whether the legal duty to involve applies. ICBs and trusts may use their own process or adopt this one. They must document whether the legal duty applies and be able to demonstrate how this has been assessed and that the duties are properly followed.

Step 1: Does the activity relate to services the organisation is responsible for commissioning or that the provider is responsible for delivering?

If **yes** – go to step 2

If **no**, the legal duty to involve does not apply

Examples:

- A decision about the relocation of a community diabetes service commissioned by an ICB and delivered by a trust does
- A decision about the relocation of an ICB's or trust's administrative offices does not

Step 2: What type of activity is it? The duty applies to three types of activity.

1. Planning Commissioners are required to always have arrangements in place to involve the public in the planning of commissioning arrangements; trusts must have them in place in the planning of provision of these services. If the activity relates to planning, then the legal duty applies regardless of the impact it may have at step 3.

2. Proposals for change This activity includes not only the consideration of proposals to changes to how services are commissioned or delivered, but also the development of such proposals. If the activity relates to proposals for change, go to [step 3](#).

3. Operational decisions This activity relates to decisions made by the commissioner or trust that change or affect the way a service operates. If the activity relates to operational decisions, go to [step 3](#).

Examples:

Planning

- The development of an ICB policy for the commissioning of diabetes services

Proposals for change

- Development of options for the reconfiguration of urgent and emergency care and the subsequent consideration of any developed options or model.

Operational decisions

- Making changes to the opening hours or location of a service
- The closure of a clinic for operational reasons.

While the legislation distinguishes between these different types of activity, as can be seen by the examples, they often overlap and sometimes a plan, proposal or decision can fall into more than one category. Where the duty sits with commissioners and providers also overlaps and the duty can apply to both. In these cases there is an opportunity for commissioners and trusts to work jointly with people and communities and meet their legal duties without duplicating effort and activities.

Step 3: Would there be an impact on service delivery or the range of services?

An impact on services can arise in two ways:

- 1. An impact on the way services are delivered to individuals, for example the transfer of a service to another location; and/or*
- 2. The range of health services available to individuals, for example the closure of a service of limited clinical benefit to fund investment in other services.*

The impact on services should be considered from the perspective of patients and not necessarily limited to the clinical services being commissioned or provided. Accessibility, transport links and ambulance availability are all examples of matters that could be significant in considering impact. An Equality Impact Assessment can help identify which groups are likely to be affected.

If yes – the legal duty to involve applies

If no, the legal duty to involve does not apply

Examples:

Impact on services

• The closure of a GP practice would mean patients having to find a new practice to seek treatment. This would impact upon the way in which services are delivered to patients. The degree of the impact will depend on how far individuals will have to travel to access another GP practice as well as any specific care that may have been provided at the practice. In such circumstances it is likely that the legal duty to involve applies.

No impact on services

• The retirement of a GP from a practice may mean that patients with a preferred choice of doctor will need to be seen by a different GP. However, this would not typically affect the range of services or the manner of their delivery, in which case the legal duty to involve is unlikely to apply.

• The award of a new contract to a podiatry provider, with no change in the specification of such a contract, would not ordinarily be expected to result in changes to the way that services are delivered to patients or the range of services available. In such circumstances it is unlikely the legal duty to involve will apply.

The Gunning Principles

Commissioners and trusts must ensure that their arrangements to involve people are fair. The courts have established guiding principles for what constitutes a fair consultation exercise, known as the Gunning principles. These four principles relate to formal public consultation processes and do not create a binding legal precedent for how other ways of involving the public should be carried out. However, they will still be informative when making arrangements to involve the public, whatever the form of those arrangements.

- 1. Consultation must take place when the proposal is still at a formative stage.**
Meaningful consultation cannot take place about a decision that has already been made. There is no requirement, and it would be misleading, to consult on options which are not genuinely under consideration, or are undeliverable – but it may be necessary to provide some information about realistic alternatives.
- 2. Sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response.**
Those being consulted should be provided with sufficient information to enable them to understand what the proposal is and the reasons why it is being considered. They should be made aware of the criteria against which proposals have been or will be judged. This may involve providing information about realistic alternatives and the reasons why they are not also being considered. The level of detail provided will depend on the circumstances such as the complexity and impact of the proposal.
- 3. Adequate time must be given for consideration and response.**
People must have enough time to properly consider and respond to the consultation. What is adequate will depend upon the circumstances and is not prescribed by law. However, a time period may be inadequate if it is during a holiday period or only allows a short time for the public to consider complex proposals.
- 4. The product of consultation must be conscientiously taken into account.**
Decision makers must be able to show that they have given consideration to what they have heard during the consultation and that they have borne this in mind when the ultimate decision is taken.

The triple aim duty

NHS England, ICBs, NHS trusts and NHS foundation trusts are subject to the new ‘triple aim’ duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively). This requires these bodies to have regard to the ‘triple aim’ of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. Effective working with people and communities will be essential to understand local populations and deliver this triple aim.

The triple aim duty and participation

Working with people and communities will help to meet the triple aim duty by:

Health inequalities

Improve understanding of the experiences, perspectives and needs of people and **communities that experience the worst health inequalities**, including inclusion health groups, and working together, beyond clinical boundaries, to develop solutions.

Data and insight

Accessing **data and insight**, including qualitative data from communities and the VCSE sector, to build knowledge of the communities we serve, and the impact of wider determinants of health.



Better population health and wellbeing

1

Assets

Understanding the **assets** in our communities that will help to improve population health and wellbeing and to strengthen understanding of community needs and perspectives.

Designing services

Designing services in partnership with people so they meet their needs and preferences and reflect experience.



Better quality of services for individuals

2

Approaches and solutions

Jointly develop **improvement approaches and solutions** to concerns about quality, including patient safety and experience.

Prioritising resources

Prioritising resources to where they have the greatest impact, based on the needs, knowledge and experience of communities.



Improved efficiency and sustainability

3

Understanding barriers

Understanding the barriers to access which impact on the efficiency and sustainability of services and working together on solutions to address them.

Effective working with people and communities will also inform and support organisations in meeting other legal duties (for example, the public sector equality duty and duties in relation to the improvement in quality of services and reducing inequalities).

The Equality Act 2010

The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of protected characteristics. These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

As well as these prohibitions against unlawful discrimination the Equality Act 2010 requires public sector organisations to have 'due regard' to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- and foster good relations between people who share a protected characteristic and those who do not.

This is known as the 'public sector equality duty' (section 149 of the Equality Act 2010).

Working with people with characteristics protected under the Act means understanding how decisions or policies can affect them and whether they will be disproportionately affected.

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 14Z35 of the National Health Services 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.¹⁷

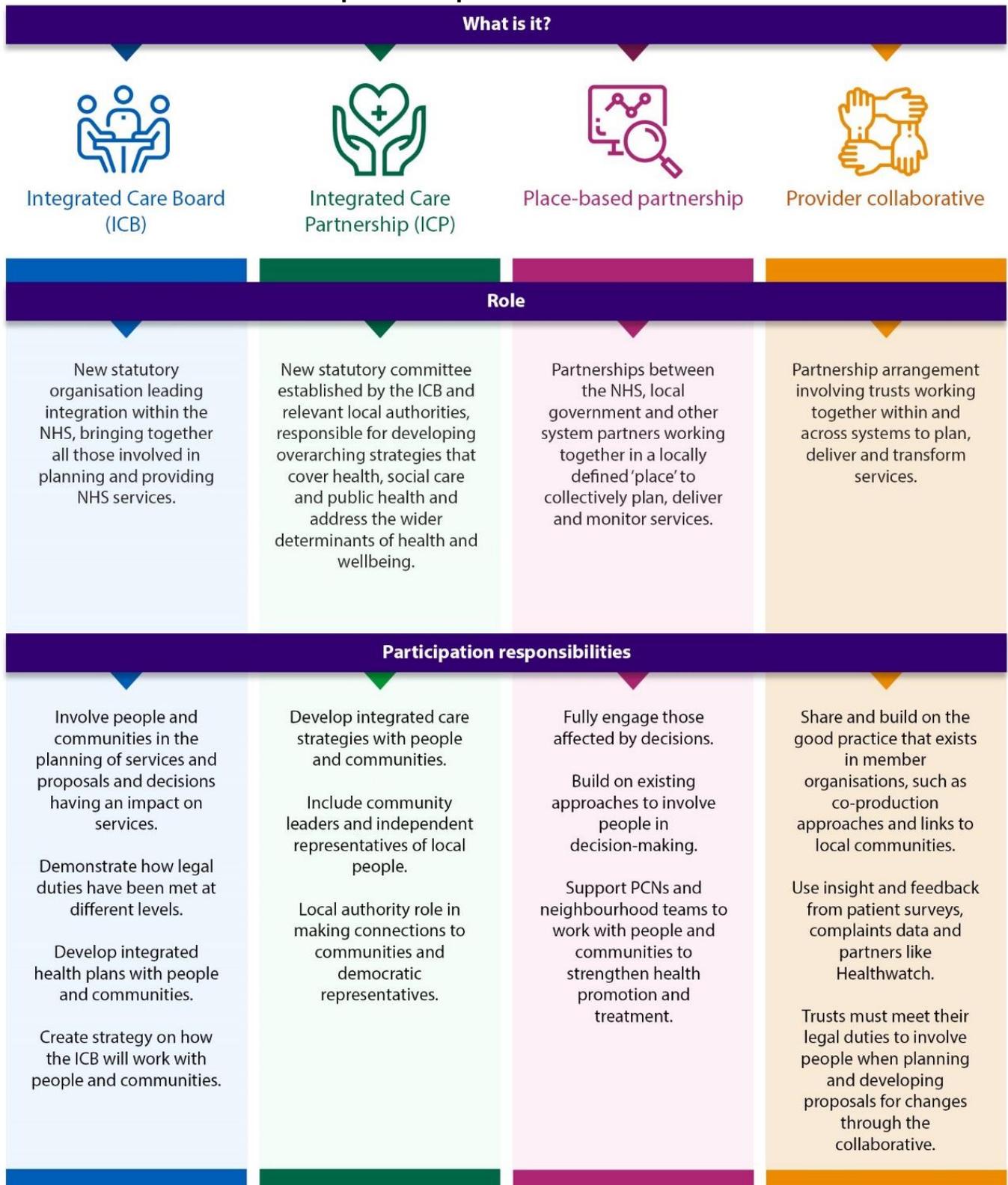
¹⁷ [Anchor institutions and how they can affect people's health](#), The King's Fund, September 2021.

11. Integrated Care Systems' responsibilities

The new ICSs have been set up to improve outcomes in population health and healthcare and support partnership working to address broader health inequalities. The underlying principles to achieve these aims are collaboration between partners within and outside the NHS, and that decisions are taken as close as possible to the people they affect. ICSs are encouraged to identify the best way to improve the health and wellbeing of their populations, address health inequalities, and provide joined-up, efficient and effective services. As new organisations and partnerships, ICSs should build on existing work with people and communities, for example by their Clinical Commissioning Group (CCG) predecessors and other ICS partners.

ICS organisations and partnerships have specific responsibilities towards participation:

Participation responsibilities in ICSs



There is [separate guidance](#) for ICPs, place-based partnerships and provider collaboratives which includes how they should work with people and communities. They can also use the 10 principles in chapter 5 to develop their arrangements for working with people and communities.

Specific opportunities and minimum expectations for each are detailed below.

Integrated Care Boards

ICBs should:

- include in their governance handbook a statement on how they intend to work with people and communities
- have a process for updating and reviewing progress on its strategy for working with people and communities
- adopt clear and transparent mechanisms for developing forward plans with people and communities
- work with partners across the ICS to develop arrangements for ensuring that ICPs and place-based partnerships have representation from local people and communities in priority-setting and decision-making forums. The local authority membership of the ICB can also help create connections to communities and with local democratic representatives. This should sit alongside other pathways to reach local communities
- give place-based partnerships and PCNs the resources and support to deliver on working with people and communities
- work with people and communities in the discharge of their statutory duties in relation to innovation and research (sections 14Z39 and 14Z40 respectively of the Health and Care Act 2022). These cover how ICBs must:
 - ‘facilitate or otherwise promote research’
 - ‘promote innovation in the provision of health services (including innovation in the arrangements made for their provision)’
 - explain in Forward Plans how ICBs propose to discharge their innovation and research duties; and
 - Include in annual reports an assessment of how the ICB has discharged its research and innovation duties.

Where a process to involve people has already started by one of its legacy CCGs, ICBs will need to be assured that this meets the legal duty for which they are now responsible. Where good arrangements are already in place, ICBs should continue and build on the work already underway.

Under section 14Z59 of the National Health Service Act 2006, NHS England has a duty to assess the performance of ICBs on various duties, including those under section 14Z45 for public involvement. This builds on the assessment that took place for CCGs where a specific indicator was included in the oversight framework. The process will include providing evidence of the how the ICB meets the 10 principles in this guidance and the difference that working with people and communities has made.

NHS England will issue specific guidance for ICBs on the indicator as part of the overall system oversight framework in 2022/23.

Integrated Care Partnerships

ICPs should:

- be open and transparent, agreeing arrangements for accountability, including meeting in public and accessible information about their plans and strategies
- build on the expertise, governance arrangements and engagement forums that already exist, such as Health and Wellbeing Boards, and so avoid duplication and ensure joined-up decision-making
- develop a structured and meaningful approach to how they work with people which bring accountability. This could include engagement on its strategy, co-producing sections with people with relevant lived experience, and collecting quantitative and qualitative evidence
- membership from the VCSE sector, Healthwatch and people with lived experience can bring expertise on how the ICP can engage its population and provide scrutiny that it takes place effectively.

Working with people and communities at place level

It is at the level of place that many engagement activities will happen. It contains the health and care services at town or district level, including those provided by councils and the VCSE sector, and so is a level that people can often recognise more easily than a system. It is also to place level that some commissioning will be delegated by ICBs and NHS England.

Place-based partnerships

Place-based partnerships should:

- have clear and transparent mechanisms for ensuring strategies and changes are developed with people with lived experience of health and care services and wider communities
- build on existing approaches to engaging and co-producing with people and communities, including those run by providers and the former CCGs
- support PCNs and neighbourhood teams to work with people and communities using community-centred approaches to strengthen health promotion and treatment. This might mean working with existing neighbourhood provision such as from the local authority or housing associations. Resourcing this work at neighbourhood level can support place and system level engagement.

Provider collaboratives

Provider collaboratives should:

- share and build on the good practice that exists in their member organisations, such as co-production approaches and partnerships with experts by experience
- draw on the community connections of foundation trust governors, and use insight and feedback from patient surveys, complaints data and partners like Healthwatch
- each provider organisation within the collaborative will need to meet its own legal duties on public involvement where programmes result in changes that impact how patients receive services
- explore community-centred approaches to enable both better decision-making and new approaches to outreach for communities of both geography and experience (for instance, people with the same condition).

Quality groups

ICSs have responsibilities for quality to ensure services are consistently safe, effective and provides a personalised experience. Working with people and communities forms part of how systems can achieve these aims.

System Quality Groups

All ICSs must have a System Quality Group (SQG) to engage and share intelligence and improvement for quality. These groups provide an important strategic forum within ICSs at which partners can share and triangulate intelligence, insight and learning on quality matters across the ICS and identify actions for improvement.

Guidance on SQGs is available [here](#). Part of their scope is to improve the safety of NHS care and people's experience of care through co-design and co-production. This includes involving people with relevant lived experience as equal partners in the full range of SQG activities, including co-designing improvements. Membership must include at least two patient safety partners (see below) and two members with lived experience or from local Healthwatch. It is possible that the patient safety partners may also have lived experience and work for Healthwatch. The groups are therefore an important source of insight into what matters to patients and a forum which works with people to make quality improvements.

The guidance also covers place-based quality groups which are expected to include two lay people with lived experience. It is also expected that people with lived experience are on any task and finish groups reporting to SQGs. Examples established to date include maternity, children and young people, and safeguarding.

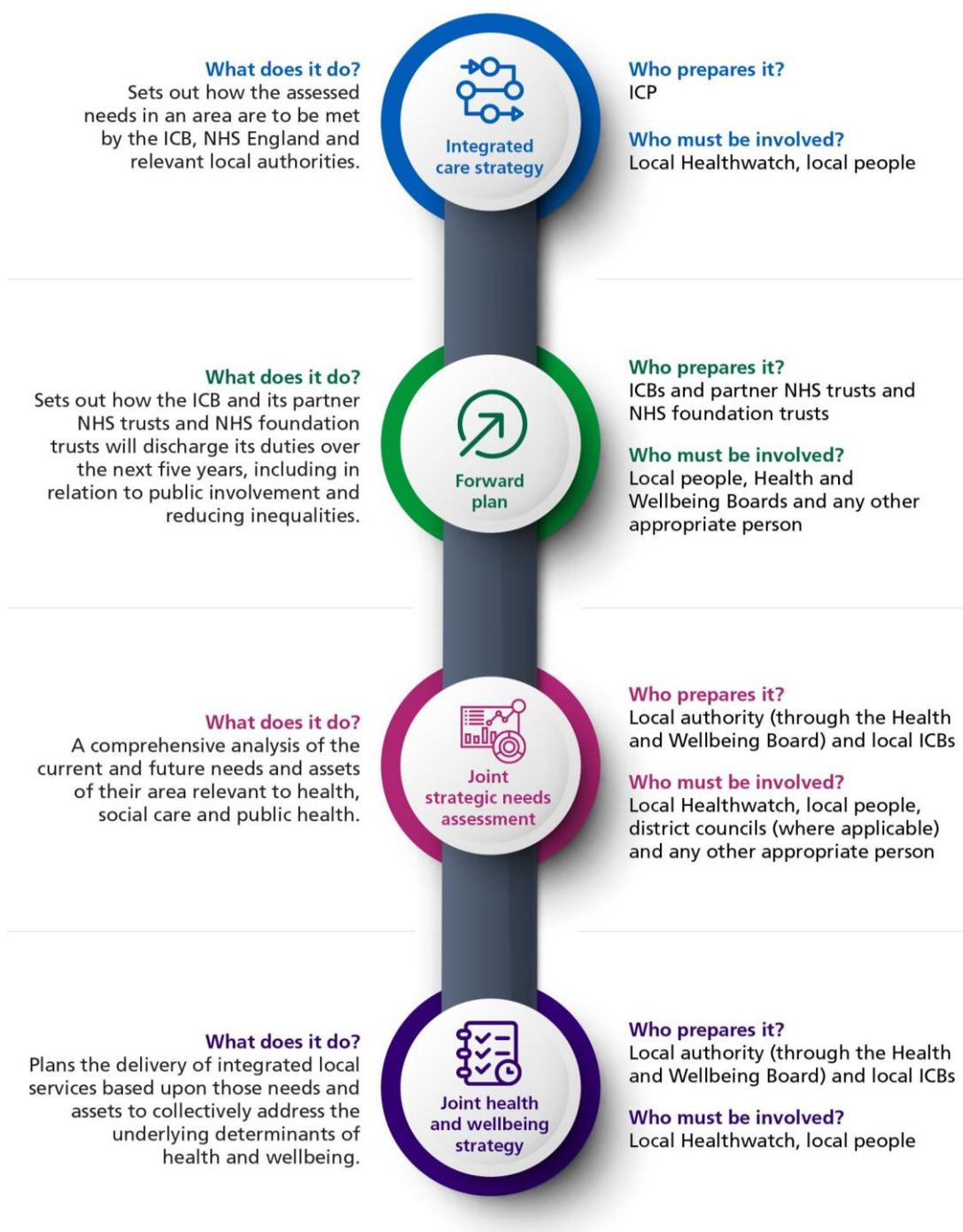
Patient Safety Partners

The [NHS Patient Safety Strategy](#) recognises the importance of involving patients, their families and carers and the public in improving the safety of NHS care. One way this is

achieved is through the new role of Patient Safety Partners (PSPs) which is required in all NHS organisations. PSPs are patients, carers, family members or other lay people who work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation. Their roles include involvement in patient safety improvement projects, membership of safety and quality committees and participation in investigation oversight groups. They therefore offer unique insight into safety from a patient perspective and as potential partners in quality improvement projects. Further guidance is available [here](#).

12. Strategies, plans and reports

There are statutory requirements for organisations in ICSs to produce strategies and plans for health and care. These are the minimum requirements for who must be involved:



Annual reports

In their annual reports, ICBs and NHS England must explain how they discharged a variety of their duties, including their duties in relation to improvement in quality of services, research, reducing inequalities, the triple aim and public involvement.

While organisations can take different approaches to how they do this and can incorporate it in their main annual report or produce a separate one dedicated to public involvement – the following should typically be included:

- governance and assurance information: an overview of the structures and processes that support working with people and communities, and how these work at different levels of the organisations, including place partnerships and primary care networks.
- how the ICB strategy on working with people and communities has been put into practice: how the role of the public in governance structures have been achieved, how it has worked with people in priority setting and decision-making, examples of methods used to work with people and communities.
- the key involvement activities that have taken place: what the changes have been for service delivery and health outcomes, how activities were designed to reach specific groups and the voices of those affected by health inequalities were heard.
- patient insight and data: how intelligence about people's needs and experiences was gathered and how this informed decision-making and quality governance.
- information presented in an accessible and appealing way for a public audience. This applies to the main annual report and to any separate one covering engagement.
- the evidence that equality and inclusion principles were considered when with working with diverse communities.

NHS England is producing new guidance in 2022 which explains these requirements in detail, and updates [Annual reporting on the legal duty to involve patients and the public](#) from 2016.

ICB strategies on working with people and communities

NHS England has asked ICBs to prepare a strategy for engaging people and communities, using the 10 principles as a starting point.

The strategy should describe:

- the ICB's principles and methods for working with people and communities.
- the ICB's approach to working with partners so people and communities are involved in priority-setting and decision-making forums across the ICS.

- the ICB's arrangements for gathering intelligence about the experience and aspirations of people who use care and support and its approach to using these insights to inform decision-making and quality governance.

The strategy will help promote consistency of approaches across systems. They may decide to have one strategy that is also adopted by the ICP.

It is an important element in how ICBs demonstrate to people they intend to work with them, and one which will develop over time. NHS England's assurance of ICBs' engagement approach will include how the strategy is monitored and reviewed, and how further iterations are developed with people and communities.

Provider Quality Accounts

A Quality Account is a report published annually about the quality of services offered by an NHS healthcare provider, including trusts. It reports on patient safety, the effectiveness of treatment and patient feedback, so is an important way to demonstrate how providers are acting on insight to improve continuously its services

Drafts must be shared with NHS England and relevant ICBs, local Healthwatch and HOSCs, with any comments included in the final version. Healthwatch and HOSCs are best placed to provide meaningful comment when there has been continuous engagement with them by the provider on their priorities.

Producing a Quality Account should not be a one-off exercise, but rather a year-round process of engagement with the public, including with foundation trust governors and members, local Healthwatch and patient groups. Providers may organise specific engagement on their Quality Accounts to agree with people the actions that it will take improve the services it delivers.

Quality Accounts must be published by the trust. The language and layout should be accessible and appealing to the public to improve accountability and meet trusts' responsibilities under the Accessible Information Standard.

Case study: Co-producing a Patient and Public Involvement Strategy

East of England Ambulance Service NHS Trust (EEAST) needed to develop a Patient and Public Involvement Strategy to provide clear direction to how it works with its communities. It was decided that the strategy should be approached as a co-production project and to effectively start from a blank page.

The Trust understood the importance of co-production to produce the strategy but had not previously had much experience working in this way, especially for such a large project. Co-production was a move away from the traditional consultation process, and collectively led by the people who would be affected by the strategy. The Trust reached out to Healthwatch Suffolk, who then delivered comprehensive co-production training, with these sessions explaining the culture of co-production, the underpinning principles, and the benefits of using co-production for such a project.

With support from their Healthwatch partners, the strategy was developed through a series of 16 co-production workshops, with 70 attendances by patients, community representatives, volunteers, and specialist groups. Each session took an open approach but included key questions which were used to build foundations for the strategy. Co-production sessions were as inclusive as possible and were offered at a variety of times to suit the needs of individuals and community groups.

All the feedback received was collated and a thematic review was then undertaken, which identified five key themes (Ethos, involvement and engagement, accessibility, networking and communication). In true co-production style, further sessions were organised to feedback and sense check in relation to the themes identified, concluding with strategy writing workshops with the patients and the public, to decide on the language used within strategy.

The strategy is currently into the process of being officially launched, although both the [strategy on a page](#) and [easy read version](#) are available on the Trust's public website.

Appendices

Resources and learning

In the final version this section will include links to resources, training and other relevant guidance on working effectively with people and communities, including the approaches described in this draft. It will include links to the training offered by NHS England for staff and the public.

Glossary

The final version will include definitions of the main terms used in this draft.