Leicester, Leicestershire, and Rutland Integrated Care Board

People and Communities Strategy 2022-24

A Strategy for the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board for working with people and communities

Contents

Introduction

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area. They exist to achieve four aims:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

National ICS implementation guidance on working with people and communities sets out the following key points:

- A strong and effective ICS will have a deep understanding of all the people and communities it serves
- The insights and diverse thinking of people and communities are essential to enabling ICSs to tackle health inequalities and the other challenges faced by health and care systems
- The creation of statutory ICS arrangements brings fresh opportunities to strengthen work with people and communities, building on existing relationships, networks and activities.

Integrated Care Boards (ICBs) are NHS bodies. Local authorities are included as members of its Board to strengthen collaborative working. The ICB will take on the NHS commissioning functions of CCGs, as well as some of NHS England's commissioning functions. It is also accountable for NHS spend and performance within the system.

Key actions for ICBs:

- ICBs are expected to develop a system-wide strategy for engaging with people and communities by late Spring 2022, using the 10 principles in the guidance as a starting point (see page 16)
- ICB constitutions are expected to include principles and arrangements for how the ICB will work with people and communities
- ICBs should work with partners across the ICS to develop arrangements for ensuring that Integrated Care Partnerships (ICPs) and place-based partnerships have representation from local people and communities in priority-setting and decision-making forums
- ICBs are expected to gather intelligence about the experience and aspirations of people who use care and support and have clear approaches to using these insights to inform decision-making and quality governance

The guidance sets out that ICBs should set out principles for how they will engage with people and communities and how they will develop arrangements for engagement across 'place' based areas, ensure appropriate representation, and how they will gather and use information to inform decision-making and quality governance.

The ICS design framework sets the expectation that partners in an ICS should agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

Each area will also have an Integrated Care Partnership or ICP, a joint committee which brings together the ICB and their partner local authorities, and other locally determined representatives (for example from health, social care, public health; and potentially others, such as social care or housing providers).

The ICP will be tasked with developing a strategy to address the health, social care and public health needs of their system, and being a forum to support partnership working. The ICB and local authorities will have to have regard to ICP strategies when making decisions.

The ICB and ICP will also have to work closely with local Health and Wellbeing Boards (HWBs) as they have the experience as 'place-based' planners, and the ICB will be required to have regard to the Joint Strategic Needs Assessments (JSNAs) and Joint Local Health and Wellbeing Strategies (JHWSs) produced by HWBs.

The LLR ICB and ICP will have Provider collaboratives. They are partnership arrangements involving at least two trusts. working at scale across multiple places, with a shared purpose and effective. decision-making arrangements. The collaboratives work will focus on reducing unwarranted variation and inequality in health outcomes and improving access to services and patient experience.

Purpose of this Strategy

The LLR (LLR) ICB is committed to inclusive involvement of our local population. The purpose of this strategy is to outline our ICB strategic approach to engagement including the principles that will underpin all our work.

This collaborative strategy sets out how the ICB will work with people and communities. It has been developed by partners in the health system and after discussion with stakeholders. It recognises that we are committed to discussions with key partners including upper tier local authorities (Leicester City Council, Leicestershire County Council and Rutland County and District Councils) during 2022 and early 2023, which will result in a clear definition of how organisations will work together, which currently is at a formative stage.

This Strategy responds to the views and experiences from the local population and stakeholders collected over the last 2 years and engaged on in April 2022. It brings together strategies for collaborative working across ICB partners and with communities.

ICS overview

The local NHS and councils have come together to create the LLR ICS with the purpose of helping our local population to have healthy, fulfilling lives.

Our job is to coordinate all of the resources available (including people, money, buildings, talent, volunteering, local knowledge and innovation) to better join up GP practices, community services and hospitals; physical and mental healthcare; social care and other NHS services; to give the people of LLR more seamless care.

We were formally designated as an ICS on 1 April 2021. The ICS is due to take on a statutory role from 1 July 2022.

Figure 1: LLR ICS partner organisations

More than 1.1 million people live in LLR, with an NHS workforce of 21,000 and a social care workforce of 32,000.

The people of LLR represent one of the most diverse populations in the country in terms of age, education, ethnicity, wealth, health and health needs. The proudly diverse city of Leicester has about half of its population identifying as from an ethnic minority. Leicester has the highest proportion of British Indians in the UK (28% of its population). Leicestershire is predominantly rural, but each of the seven local authorities district that it comprises of have their own distinctive characters. 70% of the population of Leicestershire live in areas classed as Urban City and Town. Even though Leicestershire is relatively affluent there are pockets of deprivation in some

neighbourhoods in Loughborough and Coalville. Rutland is also a very rural county with a population set to grow by 5% to 42,277 by 2025 (increase of 1,890 residents). Although largely affluent there are some communities known to have poorer health outcomes including the Armed Forces, the prison population, carers, people living with learning disabilities, some farming communities and children with special educational needs.

Our ICS is marked by stark health inequalities, both within LLR and when compared to the rest of England. A boy born today in the most deprived area of LLR could be expected to die up to 8.7 years earlier than a boy born in the least deprived area.

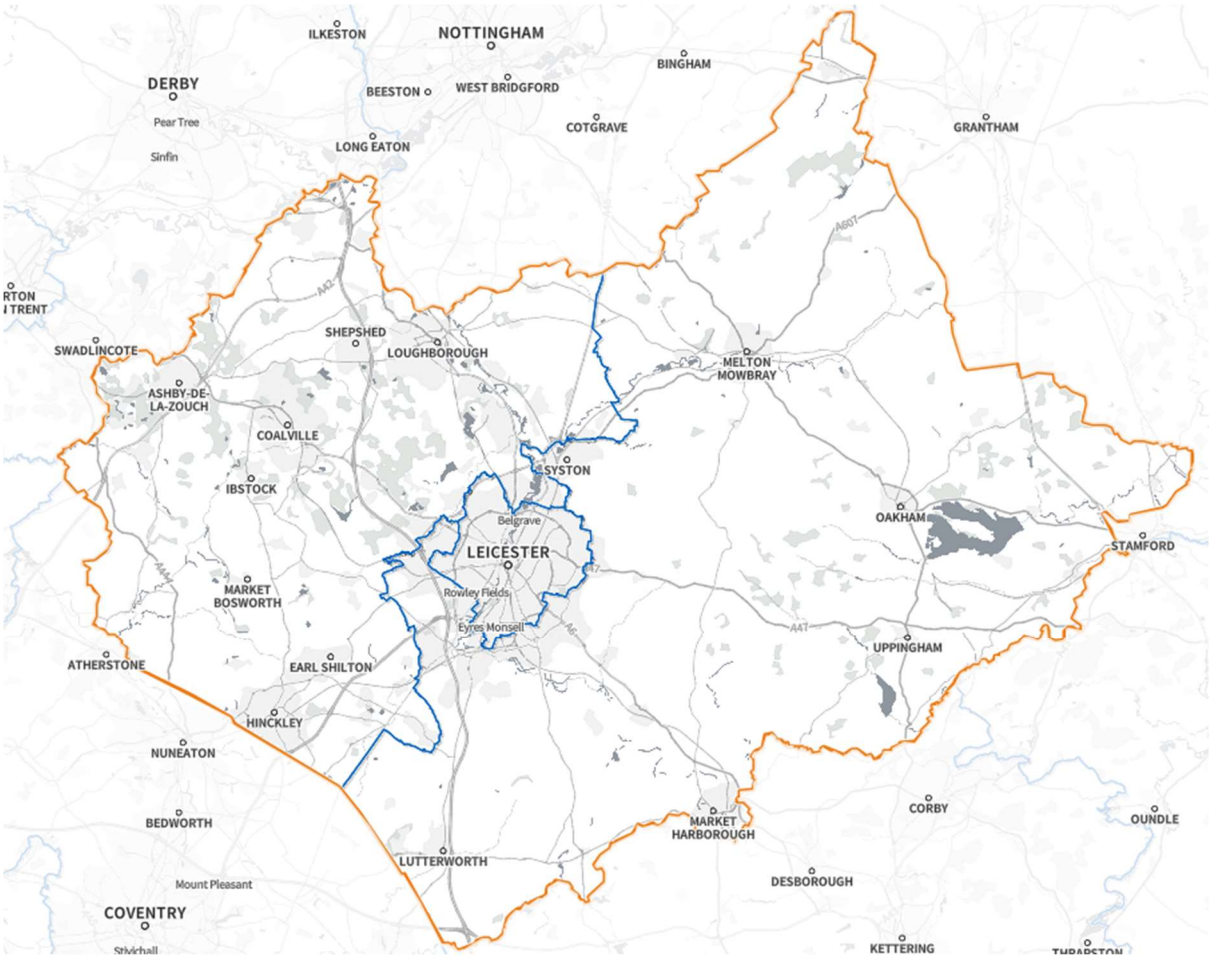


Figure 2: Area covered

Over the last two years we have maximised our care to patient, carers, service users and staff during the pandemic by working with local authorities at the city, county, district and parish authority level, driving out organisational boundaries. This has been particularly successful in tackling the inequalities agenda, where joint working has considered the wider determinants of health such as housing, education, transport, employment and environment. It has given us foundations on which to build, and the partnership approach represents the best way forward joining forces with colleagues in local authorities and collaborating even more closely. However, this strategy outlines that we are at the early stages of a shared enterprise in terms

of engagement with people and communities. We still work in two different worlds with distinct cultures and sometimes in the ‘tone of voice’ we use.

Through this strategy we will work to bring our worlds together and develop joint partnerships that result in more co-design and the improved health and wellbeing of our local communities

Working with local people and communities

This People and Communities Strategy builds on firm foundations of participation, involvement and engagement with people and communities over many years in LLR organisations – commissioners, providers and partners.

The Strategy has also been built on an inclusive learning culture. We have recognised what has worked well and what can be done better - reflected on it and implemented improvements.

We combine this strong track record with modern and effective systems of engagement that link into ICS and ICB governance systems and processes. In LLR we benefit from:

1. **A communications and engagement cell** (meets weekly) and comprises of communications and engagement professionals from health organisations. This group shares knowledge and information, and where cross-cutting solutions are needed, develops plans to reach out to communities, for example, as seen in the Covid-19 vaccination programme which targeted specific community groups.

2. **System engagement partners** (meet bi-weekly), comprising of communications and engagement professionals from health organisation meet **with Healthwatch Leicester and Leicestershire and Healthwatch Rutland** – to discuss strategy and operational issues. In addition, both Healthwatch organisations meet the LLR ICS chief executive every six weeks and sit on ICS Board.

3. We have two Healthwatch organisations across our health system – Healthwatch Leicester and Leicestershire and Healthwatch Rutland. Established following the Health and Social Care Act 2012, local Healthwatch are statutory organisations and **the local consumer champion for patients, service users and the public**, covering both health and social care.

With its network of local organisations, Healthwatch listens to what people like about services and what could be improved, and shares this insight with commissioners, providers and regulators. Healthwatch has a broad remit, covering health and social care for both children and adults. It serves the whole community, not specific groups, and provides an independent source of insight gathered outside service delivery.

It is expected that legislation will change the existing statutory duties of local Healthwatch to advise and inform CCGs so that they apply to ICSs.

In LLR we already have system-level arrangements in place with Healthwatch organisations that link them to the CCGs (to become ICB) and the ICP. We also have a history of joint working on programmes of work This includes an ICS team approach to improving mental health services which is a partnership of commissioners, Leicester Partnership NHS Trust, all local authorities and primary care. This Strategy will see those joint working arrangement continue and be enhanced particularly through initiatives like the Insights, Behaviour and Research Hub.

4. Across our key health partners we have a **dedicated engagement and patient experience workforce**. At the time of writing this strategy, we have recruited to our first joint engagement post for the ICS, where the role holder will focus their attention on engagement with children, young people and families.

5. The foundations in place for **an Insights, Behaviour and Research Hub**. The hub will be a valuable tool for enhancing services and improving the health and wellbeing of people locally. The hub will be a central point for research and inequality data. Data and insights from patients, carers and staff which helps us to understand needs will support us to develop our services to fit these needs.

The Hub will contain all public and patient involvement and experience data, insights and business intelligence from NHS and other sources. For a long time, we have collected a reach seam of insights from people, essential to design and deliver high quality services, but it has not always been used effectively in the design of services. The data will now be brought together in one place and promoted across the ICB and ICS. Staff who are designing and delivering services will be supported to both understand the insights and use them appropriately to plan health and care services in a way that truly means that people are at the heart of care. We will also work with staff to ensure that they can articulate clearly to people how their insights have shaped services.

Figure 12 shows how the hub will function. It outlines an engagement architecture for hearing from patients, public, staff and carers, as well as key organisations and groups, who provide valuable information about experiences of health and care. It also outlines the Hub partners, data retrieval system and management system, publication schemes, both with partners and the public and the feedback mechanisms.

6. Engagement being embedded into **place and neighbourhood-led plan groups and design cells**, supporting business intelligence and informing plans and decision-making.

7. A **Citizens' Panel** in place, made up of more than 1,100 people. This panel largely works online, providing a systematic approach to gathering insight and feedback on a range of health and care issues from a representative sample of our 1.1 million population. It assists in gathering the views of citizens that demographically and attitudinally are representative of the citizens of LLR.

8. A **Public and Patient Involvement Assurance Group** (PPIAG) that brings creative, fresh, objective and independent perspectives on our decision-making and is a critical friend of the NHS in relation to engagement and involvement. The group exists to gain assurance that (a) all proposals to change and improve healthcare services are developed with appropriate and sufficient public and patient involvement, and (b) that insights and business intelligence from patients, staff, carers and public that tell us what matters to them are regarded and have influenced the decision that are made.

9. **A network of Patient Participation Groups** (PPGs) In LLR (Meeting monthly - virtually) to provide key information and engage with their communities. This

network has traditionally had the ability to network on behalf of the NHS, amplifying messages to their local communities and provided insights. During the pandemic many PPGs have been less active, and work that was commencing with Primary Care Networks (PCNs) has not gathered the desired pace.

10. Leicester's Hospitals regularly **communicate via email with more than 5,500 of their public members**. Members are located across LLR and receive regular invitations to participate in events, focus groups and research as well as reviewing news from across the local NHS. Leicester's Hospitals also support two long-standing patient and community reference groups. The Trust's **Patient Partners** are members of the public with experience of hospital services. The group meets every six weeks and acts as a consultation group for staff. Patient Partners sit on a number of keyboards and committees to provide a patient perspective. Patient Partners participate in service development projects, review patient literature and also provide a patient perspective on serious incident review meetings. The Trust also has an **Equality Advisory Group**. The group meets quarterly and is comprised of representatives from across the protected characteristics identified in equalities legislation. Some services at UHL also support their own patient reference groups. Recent examples include the renal services patient group and a newly formed youth forum which has been established by the children's hospital. The various cancer services also support a number of patient groups.

The Patient Experience Team at UHL oversees the Friends and Family Test (FFT) collection process within UHL, ensuring all inpatient areas, the Emergency Department, Maternity Services and Outpatient Departments collect feedback from patients and families in line with national guidance. During 2021-22 approximately 206,000 responses were received. Methods of collection include paper forms, touch screen devices, QR codes, Web Surveys and SMS Text mobile phone feedback.

In addition to the FFT, feedback is sought and shared through patient stories, and "Message to Matron" cards. Patient Feedback Driving Excellence' is another key work stream involving support to all areas to access and interpret their Patient Experience results, and a number of reward schemes such as the Star Award for Wards and departments that most improve their positive scores and the Patient Recognition Award for staff following individual positive feedback from patients.

The Trust also has a free online programme of health talks to support people, Trust colleagues and members called Leicester's Marvellous Medicine. Hosted by a different leading medical expert each month, the programme offers an insight into medical specialties at Leicester's Hospitals and an opportunity to experience what is at the forefront of medicine in Leicester, Leicestershire and Rutland.

11. Leicestershire Partnership NHS Trust has a **People's Council**, an advisory body for the trust board, made up of individuals with a lived experience of receiving healthcare from the trust, patient and carer leaders, and representatives from the voluntary and community sector. The Trust also has an involvement **network of 140 patients and carers** who are working with the Trust in the design and delivery of its services. Work is underway to develop a Lived Experience Framework which will establish a lived experience workforce with capability in improvement methodology. This alongside trust-wide systems and processes will allow for the creation of paid

opportunities for those with lived experience whilst developing skills and experience, which may in turn support them to return to full time paid employment. LPT also has a **membership database of our 2,500 public members** from across LLR who have signed up to receive regular information, news and involvement opportunities within the Trust. These are managed through a specific paid database and receive regular news and invitations to LPT events including the annual general meeting. In addition, LPT has a **Youth Advisory Board,** which is jointly managed by the city council, with the aim of involving young people in service improvements, testing out ideas and codesigning solutions specifically targeted at young people. There are also around **500 volunteers** at LPT who offer insight and a patient voice. An enhanced volunteer voice initiative is also being developed. In addition, LPT has a network of community groups and corporate partners who with the LPT **charity – 'Raising Health'** have influence into the local population. Ten voluntary sector agencies have received specific funding to support community health and wellbeing through outreach initiatives from National Charities Together – managed jointly by UHL, LPT and EMAS.

12. A genuine **partnership arrangement with the voluntary and community sector, social enterprises and individual communities, initially with NHS and overtime across all partners**. We have started discussions with the sector and communities about establishing a new way of working of involving people in decision about designing and providing services. We want to move beyond a system of merely contracting in support as and when needed to a basis where we attempt to find solutions to issues on an ongoing mutual basis that is commissioned and financial recompensed with consideration of sustainability. This will build on the relationships and alliances that we have already established through recent public consultations.

We recognise that concurrent to these conversations, additional financial resources have come into our health system during late 2021 and early 2022 to support the voluntary, community and social enterprise sector, particularly supporting mental health care including the Getting Help in Neighbourhoods initiative which aims to and tackle health inequalities. We need to be mindful of the impact this may have to ensure that it doesn't put due strain on the sector, cause confusion or create duplication.

13. Having undertaken **significant work over the last 18 months** to engage with our population. Key projects have seen qualitative information gained from nearly 22,000 people including patients, service users, staff and carers, including work with communities including those with protected characteristics. Engagement has included Building Better Hospitals for the Future (5,675 people), Step Up to Great Mental Health (6,650 people), Covid 19-hesitancy engagement (4,094 people) and primary care survey (5,483 people).

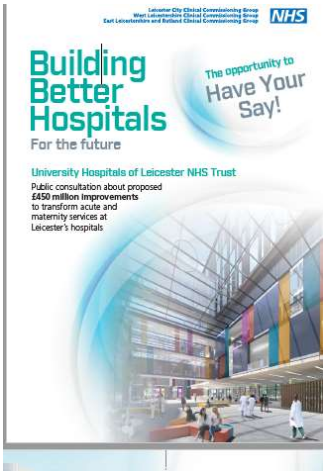
14. **Digital methods of engagement in the NHS have increased significantly** during the pandemic. Investment in digital involvement across all NHS partners has been created to mirror new ways of living and working. Whilst some audiences are not digitally enabled, the vast majority have moved to a digital world. How long this behaviour will continue is unclear, but we do know there will be no return to the old ways of engaging and at the very least face-to-face engagement will need to sit

alongside digital but digital interaction surpassed it. Peoples' expectations for what constitutes "basic" digital capabilities have shifted permanently, and the ICS will be expected to support digital enablement. Convenience and ease will become key drivers, likely leaving face-to-face activities for specific and niche programmes of work.

15. There are examples of joint working between the NHS and upper tier local authorities, districts and parish councils. The response to the pandemic and particularly tackling health equalities brought partners together to work jointly. The LLR Local Resilience Forum, bringing wider organisations together is another instance of organisations working in partnership.

Engagement case study one

The Building Better Hospitals public consultation, which ran from September to December 2020, was hugely successful in attracting more than 5,000 responses and becoming shortlisted for a HSJ Award in the 'communications initiative of the year' category.



The consultation on £450 million proposals to transform local hospitals in LLR reached a staggering 1.8 million people. It was held during the Covid-19 pandemic which led to many traditional forms of face-to-face engagement being replaced by cutting edge, multi-channel, real time online techniques. The consultation findings are critical in shaping the future of acute and maternity services in LLR.

With innovation central to our approach and an energised and committed team in place (with clinical and non-clinical members of staff), our engagement figures were staggering – 971,657 digital media engagements, 853,048 print and broadcast media reach, 4,960 through online event promotion, 1,049 stakeholders (including MPs, councillors, voluntary sector organisations) and 25,000 staff engaged with.

Where face-to-face engagement was legally possible this was utilised, but we knew we had to rely more on utilising the latest in online techniques – paid, earned, owned and shared digital and social media, using channels such as Microsoft Teams, Facebook Live and smart TV advertising.

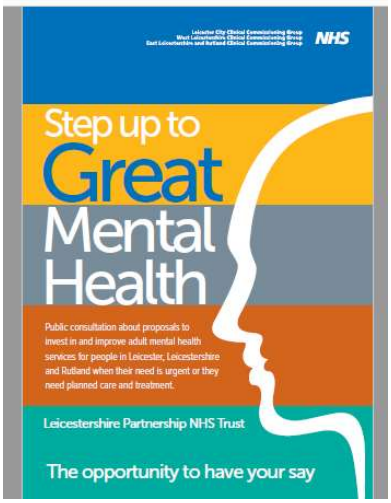
We set up an adaptive strategy, with demographic response analysis happening on a real time basis, so we could continually reach out to communities that were at that time seen as being under-represented. We recognise that not all communities are digitally-enabled, so we partnered up with local voluntary and community sector organisations to use their networks to get messages out and increase response rates. And yet, despite all this progress in new approaches and techniques, there was still a place for publicity postcards in community village shop windows.

Our ambition was that we wanted to give every adult in LLR every conceivable opportunity to take part and have their say, getting to the heart of all our local

communities. Everything we heard fed directly into the Report of Findings and the Decision-Making Business Case. We also used the insights to develop a set of principles which we would adhere in the implementation of the plans.

Engagement case study two

Our Step up to Great Mental Health public consultation, which closed in August 2021, covered a range of services largely provided by Leicestershire Partnership Trust. The consultation received 6,650 responses from across the community – with a final report expected to be received by November 2021.



We asked people about proposals to invest in and improve adult mental health services for people in LLR when their need is urgent, or they need planned care and treatment. This included proposals for building self-help guidance and support, introducing a central access point, expanding and strengthening the role of crisis cafes, improving and expanding the crisis service, and expanding the hours and the use of the triage car.

We used a multi-channel approach, both online and offline tools and techniques. Among the many different activities carried out, we built on our previous work and commissioned 40 voluntary and community organisations to reach out to seldom heard and often overlooked communities, gained extensive media coverage, placed newspaper, TV and radio adverts, used social media to reach more than two million people, held 70 online events and had 74 events hosted by voluntary and community groups. In other areas, we carried out email marketing to schools, engaged local business HR professionals, engaged with sports clubs, hairdressers and beauty clinics.

The insights from this engagement were captured in the consultation's Decision-Making Business Case and its Equality Impact Assessment. Both reports noted the huge success of the stakeholder engagement and the need for this to continue so that we 'co-design' the improvements that are planned under the transformation of mental health services. This will result in the voluntary and community sector partners being brought into the new governance arrangements for 'Better Mental Health for All', the new name for the transformation of mental health services across LLR.

Legislation and guidance

The ICS Design Framework (2021) sets the expectation that ICS partners should agree how they listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

The ICS implementation guidance on working with people and communities (2021) sets out how ICSs should have a deep understanding of their communities, using these to tackle health inequalities, and taking the opportunity to strengthen existing work and build stronger relationships. The guidance also outlines that **ICBs are expected to develop a system-wide strategy** for engaging with people and communities by July 2022, using the 10 principles in this document as a starting point.

Gathering insights from our diverse population about their experiences of care and understanding what matters most to them is a key component of an effective and high performing ICS to ensure equality of access. There is a clear expectation in the guidance that this will be implemented in a range of ways, including embedding co-productive purposes.

"*The parties in an ICS, including those of the NHS Partnership, the NHS ICS Body and place-based partnerships, will be expected to agree how to listen consistent, to, and collectively act on, the experience and aspirations of people and communities*".

The creation of statutory ICS arrangements will bring new opportunities in how we work with people and communities, that build on existing work, networks and relationships.

This strategy has considered the guidance. It also takes account of the range of legislation that relates to involvement and decision making including:

1. Section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012 (current guidance)
2. Brown and Gunning Principles
3. Human Rights Act 1998
4. NHS Act 2006
5. NHS Constitution
6. Communities Board Principles for Consultation

The LLR ICB, once formed, is subject to legal duties to give due regard or regard to addressing health inequalities and advancing equality of opportunity. These separate duties are the Public Sector Equality Duty (PSED), section 149 (1) of the Equality Act 2010 and the health inequalities duties set out as section 13G of the National Health Service Act 2006 as amended.

An Equality and Health Inequalities Impact Assessment (EHIA) has been produced and explains how the LLR ICB has considered and addressed these 'equality duties'

in developing this People and Communities Strategy. The EHIA has assisted partners to make informed decisions about the Strategy and these legal obligations.

In developing this strategy, we have also followed guidance produced by NHS England and NHS Improvement – *Strategic content guide for Integrated Care Boards – working with people and communities (November 2021 draft).* We have also paid due regard and consciously considered the equality duty: eliminate discrimination, advance equality of opportunity and foster good relations.

Our engagement vision

The purpose of this strategy is to outline the LLR ICB strategic approach to involving people and communities in setting the priorities for the local health system and ensuring the voice of the local population influences all decision-making.

The strategy will act as a blueprint for collaborative working with ICS partners. We understand the values, aims and objectives of each partner, and recognise our commonality. But, while recognising that working together, we prove stronger and more effective, we have also appreciated that individual organisations have key requirements placed on them that they have a duty to deliver. It is worth noting here that this is the involvement and engagement strategy of the ICB and that individual organisations such as Leicestershire Partnership NHS Trust and University Hospitals of Leicester NHS Trust will also have their own complementary organisational strategies.

Principles of engagement

The principles that underpin this strategy and our subsequent action plan include the ten national principles for how ICSs should work with people and communities, as shown below:

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

Figure 3: Ten national ICS principles for engagement

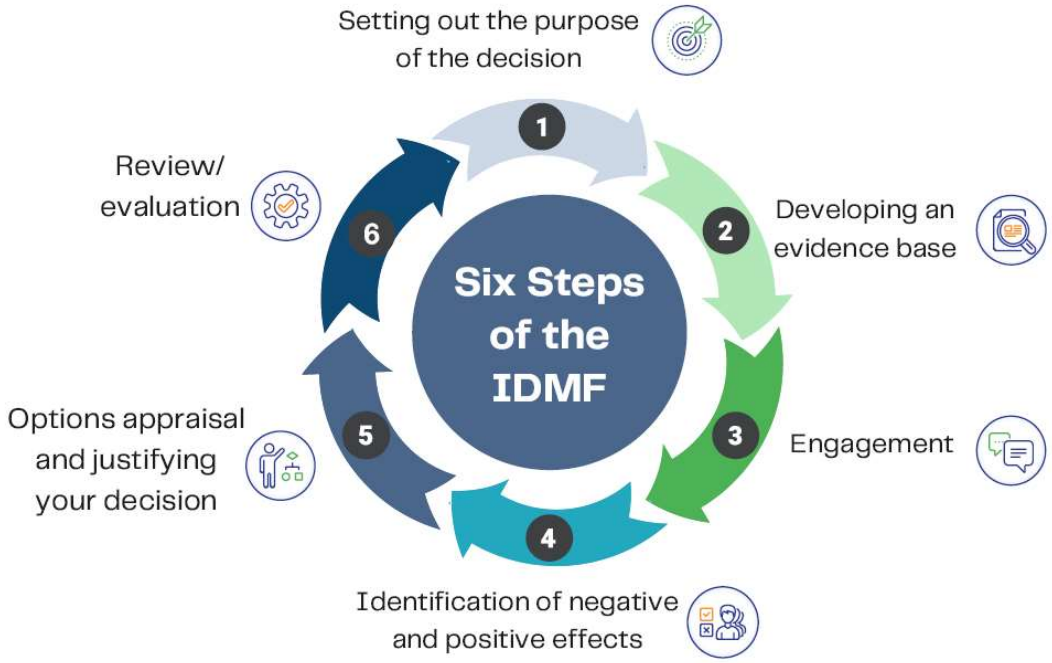
In addition to the ten national principles, we are adding the following additional principles at a local level:

The 5 local principles

Five local principles for how ICS work with people and communities

- Build on the engagement capability and capacity in our workforce and empower our 21,000 members of staff – as the NHS or social care family, service users/patients, community members and carers, to make connections to social change
- Embed business intelligence and insights from people and communities into the heart of the ICS, ensuring that at all levels of decision making and implementation they are a valued asset, used to improve experiences and enhance the health and wellbeing of our population
- Harness the power of Equality Impact Assessments to support the eradication of health inequalities. To help embed equality considerations (including health inequalities) within decision-making, we will use the six steps approach of the LLR Inclusive Decision -Making Framework.
- Build relationships with children, young people, families and groups that represent them ensuring that they have a voice in decision making across health and care.
- Build stronger relationships with family carers and groups that represent them ensuring that they can share their experiences of care and drive improvements across health and care.

Inclusive Decision-Making Framework



Our engagement approaches

Public involvement is not about a single methodology - it is a continuum of different methods and approaches – as show in the 'ladder of engagement and participation' illustration below.

Figure 4: The ladder of engagement and participation

The LLR ICB wants to build on all our engagement work, particularly activities developed over the past 18 months, and aspires to develop deeper and stronger relationships using more of the activity at the top of the ladder. It is important to note that when the ladder is applied to different programmes of work, that the level of interest and power of individuals and communities involved will mean that they will move to different points on the ladder

We recognise that when we use the word 'community', this conjures up different meanings for people. Our work will take appreciation of this and recognises that a community could be a social group whose members have something in common e.g. geographic location, work, culture, sense of identity or heritage. We also now that community could be where people live which could be a town, city village or other geography boundaries. It could be that a group shares some trait, common interest or quality that separate them from the wider population.

These communities are often already strong and resilient networks. It is our desire to work with these communities, rather than impose on them. We recognise that this could be directly or through leaders of these established communities or through local authorities or voluntary, community and social enterprises.

In developing system-wide research and insight projects, partners have committed to base their approach to public, community or patient involvement and patient

experience predicated on the e-cycle, shown below, which allows for involvement at every stage of the commissioning and planning cycle.

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Figure 5: The e-cycle of engagement

Moving from theory (the 'ladder') to practice, LLR ICB benefits from an established system architecture for engagement, as shown in Figure 6. This sets out the forums and processes for an engagement loop within the system.

All insights gathered from people through a range of mechanisms shown in the e-cycle would be consolidated into an Insights, Behaviour and Research Hub (explained later in this document). Work undertaken and the insights gathers would be assured by the Public and Patient Involvement Assurance Group (a group of patients/public). The insights would then be shared across all decision making, collaboratives and deliver groups to inform plans and services. Decision making would then feedback to the public on how their insights had influences the healthcare services – 'you said, we did'.

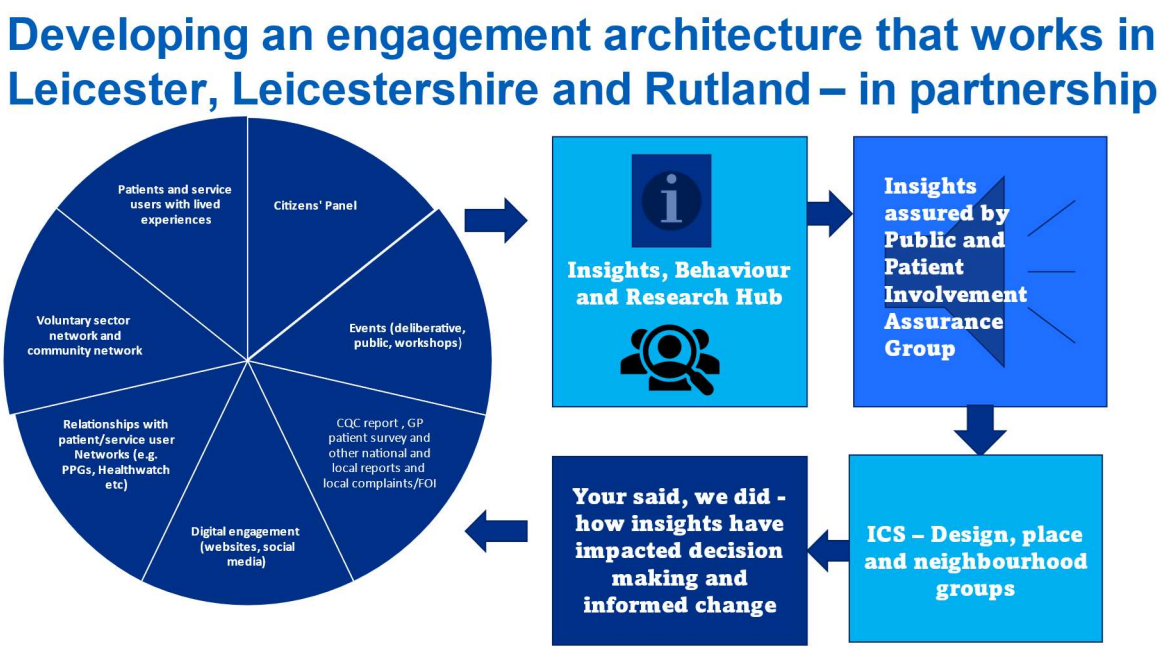


Figure 6: Engagement system architecture in LLR

We are committed to investing sufficient time and attention to all forms of engagement. We know that since the pandemic that digital engagement has increased considerably. But we also know that while for some it may be a preferred method of interaction, particularly young people, many other people want to be assured that more traditional engagement channels will continue to be used. In addition, some people may want the interaction to be with someone they trust and recognise as 'like them' a member of their community. Therefore, our engagement architecture responds to this by offering multiple ways of engaging both directly and indirectly.

Priorities and action planning (2022-24)

This strategy sets the direction for engagement within the LLR ICB. Detailed action plans will be drawn up to sit alongside this strategy, guiding implementation. At this stage, we are setting out our priorities that the system will be taking forward. Some initiatives are already in place, some will need to be launched in support of the strategy.

Priorities in detail

The table below elaborates on the priority actions. Each priority will have strategic leadership, but the operational ownership will reside with all partners who have the collective responsibility to deliver. A delivery plan will be developed jointly by partners for each priority action.

Priority action	Strategic Lead organisation / individual	From/to dates
1. Build on the engagement capability and capacity in our workforce and **empower our 21,000 members of staff**. They are part of the NHS family, they are service users, friends, neighbours and part of communities and possibly carers and as such have considerable insights. We will develop plans to train staff to share insights, which will integrate into the Insights, Behaviour and	Joint leadership across ICB, UHL and LPT	July 2022 – July 2023

Research Hub to inform decisions and also embed work into existing quality improvements frameworks		
2. **Develop further the Insights, Behaviour and Research Hub (see Figure 11)** and our capacity and capability to interrogate high quality data to provide robust business intelligence that allows excellence in decision-making across the ICS. Maintain a high standard of data that is trusted and not devalued by poor research models. Promote the data and business intelligence across all ICS partners and ensure that it impacts on all decision making. Overtime explore with Healthwatch, local authorities and public health their role in further development of the Hub.	ICB	December 2021 – December 2022
3. Review governance architecture for engagement, mapping key stakeholder groups, in light of new system structure and degree of commonality on priorities to ensure it is fit for purpose.	ICB (formerly CCGs)	July – August 2022
4. **Promote more widely the existence of business intelligence** and stimulate its use by educating teams on how to use it to improve the health and wellbeing of our population.	Joint leadership across ICB, UHL and LPT	July – December 2022
5. **Create a customer relationship management system** that brings our stakeholder data together to provide better knowledge of stakeholders and partners. But particularly to improve communications across key health partners to ensure that messages are not duplicated or inconsistent and there are no gaps. This piece of work *does not* include our various patient memberships and panels as each partner will still have the requirement to maintain their own engagement specific to their organisation.	LPT	Project start in June - September 2022
6. Develop strong and **mutually beneficial relationships with the [1]voluntary and community sector, social enterprises, individual communities and the volunteering infrastructure (see figure 10)** to tackle health	ICB (formerly CCGs) and LPT	December 2021 – September 2022

[1] Voluntary and community sector, social enterprises and communities includes a very diverse range of organisations including some or all of the following components: voluntary organisations, community groups, tenants and residents groups, faith groups, housing associations, most co-operatives and social enterprises (provided profits are retained for the benefit of the members or community served), most sports organisations.

inequalities and empower communities. Firstly, we need to scope out and understand the breadth of organisations working as formal voluntary and community sector organisations or social enterprises, as well as informal community group across LLR, from the largest to the smallest bodies. Secondly, we want to develop a cascade alliance model - the ICB will develop alliances with voluntary sector organisations, social enterprises and communities which then, in turn, will form their own alliances to widen ICB reach and reach into the ICS.		
7. Leverage lived experiences and business intelligence through potentially developing a number of paid employment roles. These roles would act as **ambassadors for embedding business intelligence** to ensure it influences all decision-making. This will be a blueprint for the system to consider. Alongside this, reignite expert patient panels to support self-care and prevention.	LPT	October 2021 – July 2022
8. Ensure all projects are informed by the production of an **Equality Impact Assessments** [2]and they harness the power of the assessment to drive out inequalities, including any engagement or consultation plans. This to be combined with rigorous use of the LLR Inclusive Decision-Making Framework.	Joint leadership across ICB, UHL and LPT	From July 2022 and ongoing
9. **Share knowledge and learning across engagement teams** within the ICB to ensure continued innovation and design a development programme for 'leaders' and staff highlighting the importance of involvement and business intelligence.	Joint leadership across ICB, UHL and LPT	From July 2022 and ongoing
10. Understand the current membership of the Citizens' Panel and **Grow the Citizens' Panel**, increasing membership to ensure that it is statistically representative of the LLR population, in particular, of young people (18 to 24-year-olds) and family carers. Develop a benefits package to health and wellbeing to support the retention of members	ICB (formerly CCGs)	March 2022 - ongoing

[2] An equality impact assessment (EIA) is an evidence-based approach designed to help organisations ensure that their policies, practices, events and decision-making processes are fair and do not present barriers to participation or disadvantage any protected groups from participation. In programme design where engagement and or/consultation is undertaken it is useful to do an EIA before and after involving the public to demonstrate how insights have impacted on decisions.

and develop a self-care asset. Explore and enhance access options to the Citizens' Panel through different devises. Liaise with our various engagement groups including voluntary groups and the PPGs across LLR to understand how we best develop the Citizens' Panel.		
11. Work with the ICB to enable partners to move away from compartmentalised engagement and involvement to **system co-design**, outlining a systematic process to ensure that it is embedded into our ways of working across the ICS and that the process of involving people starts at a formative stage on all programmes of work. (This does not remove the need for engagement at the level of a single organisation where a topic is specific to that organisation). We have established clear definitions for co-design and co-production as part of this process, so everyone has the same understanding. The following section sets out our definitions for these key terms.		Development starts January 2023 to March 2023
12. **Create a primary care engagement framework** (see figure 12) which outlines how, at ICB, primary care networks and GP practice levels, will work with and involve people and communities to co-deliver the best possible health and wellbeing outcomes.	ICB (formerly CCGs)	March - December 2022
13. Develop plans for the **systematic and effective delivery of engagement activities and public consultation**, ensuring that legal requirements are adhered to and the views of our communities, including those with protected characteristics, the vulnerable, those living in areas of deprivation and those living across our borders, but dependent on services, are sought using multiple engagement techniques and methods and that their views influence decision making.	Lead dependent on project	Timeline appropriate to project
14. **Support the development of place and neighbourhood-based plans** by working in partnership with local authorities at a county, city, district, town and parish level to reach communities to ensure that we hear from and involve people in developing solutions to issues and break down barriers.	ICB (formerly CCGs)	Timeline appropriate to project

15. Support the development of a **framework for engaging with families, carers and children, young people and families,** ensuring that they have a voice and their views influence decision making across health and care.	ICB (formerly CCGs)	May – December 2022
16. Continue to digitally (engagement) innovate enhancing our capabilities to engage and develop relationships with people and groups by improving and **making the digital experience with the NHS more human and interactive.**		From May 2022
17. Work with decision makers and programme leads to ensure that post-decision making that the impact that **insights and business intelligence have made on programmes are clearly fed back to the public without exception** – to ensure a 'you said, we did' culture across the ICB.	ICB (formerly CCGs)	From May 2022

Key definitions

Considerable work has been undertaken nationally to develop definitions for both co-design, co-production and co-delivery. The terms of often confused and used interchangeably along with involvement, engagement and consultation. We define them here to distinguish them.

In the next two years this Strategy commits us to move to **creating a culture of co-designing, adopting and embedding this approach in all that we do**. We recognise that this is ambitious. It is only once this initial step is taken that we can move to co-production and then co-delivery. We see this as a longer-term strategy.

Co-design

We can define co-design as the:

"Effective engagement of people and communities to help get services right for them. This goes beyond basic stakeholder consultation to encourage joint working, aiming to create solutions. It is the engagement of people in decisions about the buying, planning, design and reconfiguration of health services, proactively as design partners."

Co-production

NHS England, NHS Improvement and the Coalition for Personalised Care define 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 acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.

"Co-production is part of a range of approaches that includes citizen involvement, participation, engagement and consultation. It is a cornerstone of self-care, of person-centred care and of health-coaching approaches."

The co-production model outlines five values and seven steps to making co-production happen (set out below).

For co-production to become part of the way we work, an organisation has to create a culture where the following values and behaviours are the norm:

Figure 7: Values required to achieve co-production

Figure 8: Seven steps required to achieve co-production

Co-delivery

We can define co-delivery as the:

"Development and recruitment of individuals with lived experience to work in a range of paid/volunteer roles within services and the system to support patients and carers, leadership and delivery of services."

Public involvement roadmap

Our roadmap for aims and activities in 2022-23 and 2023-24.

Governance roles, responsibilities, and resources

Often patient and public engagement or service user experience can feel like a last-minute thought or an add-on rather than being at the heart of health and care organisations. We will place the voice and experience of people and communities in LLR at the heart of the work of the ICB and ICS and as a golden thread through the governance structure. This will help the system and all partners to understand what people need, what is working, what can be improved and how they can work together to deliver what matters to the people they serve.

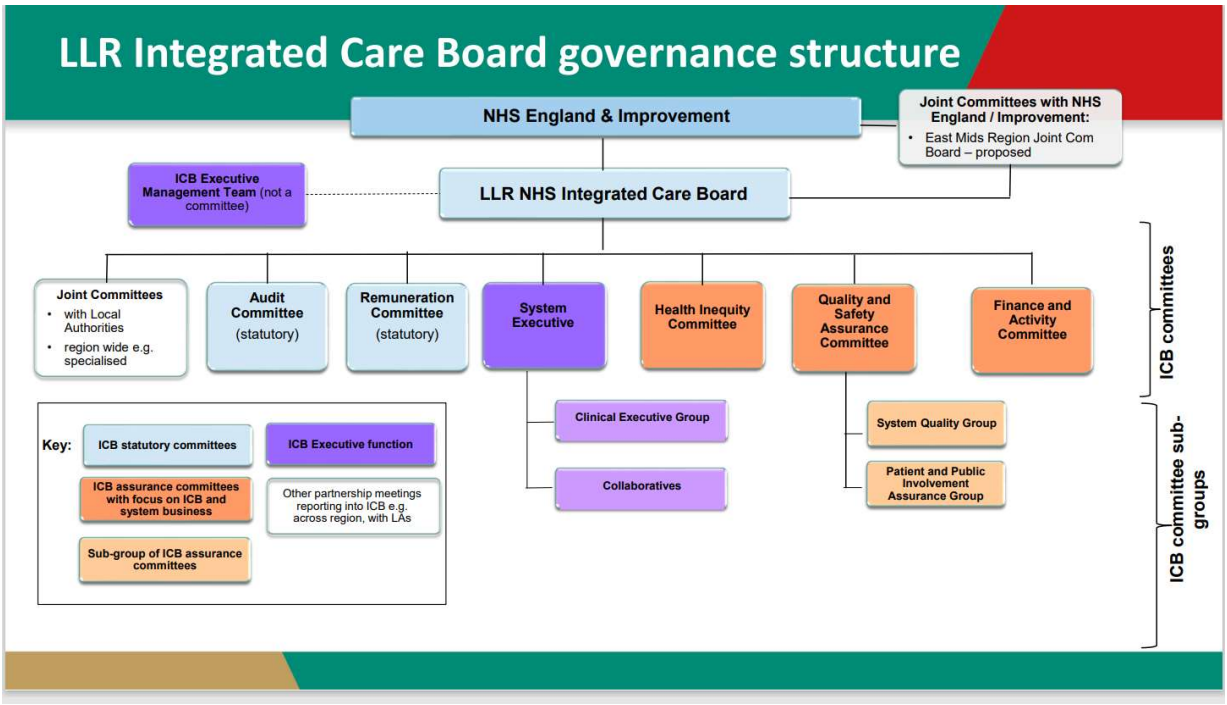
Figure 9 below, shows the key governance points for the public voice to integrate into the ICS. It is important that at all stages we can demonstrate clearly that we have created a culture in which listening to people and communities is valued and influences decision.

At the Strategy and Assurance level, the Quality, Safety and Performance Committee can be advised of and act on evidenced based insights and business intelligence, of the experiences of people into the delivery of safe, high quality and compassionate care by local health and care providers. It is this committee that then provides assurance to the LLR ICB Board.

In addition, it will be the role of the Public and Patient Involvement Assurance Group (PPIAG) to assure the system that appropriate engagement and involvement has been undertaken across all communities yielding high quality insights, which are impacting on decision making.

At Executive Level the Communications and Engagement Cell will drive insights and business intelligence through the Delivery Groups, strategy and assurance and executive functions. Business intelligence will be managed through the Insights, Behaviour and Research Hub and Voluntary and Community Sector Alliance, both of which are explained later in this section.

Figure 9



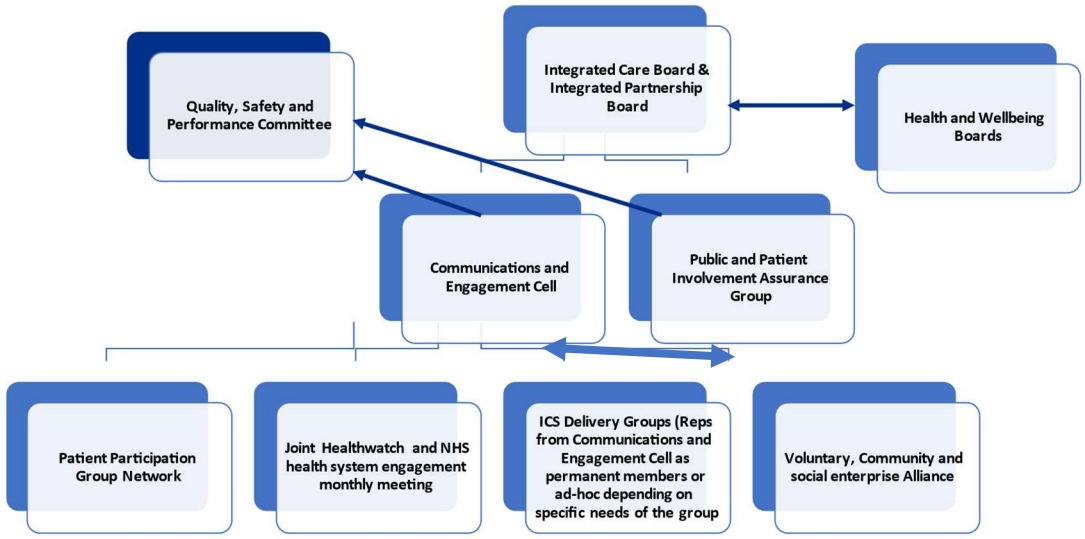
NB – the final governance chart currently being finalised

Each partner organisation will also use their own current governance and assurance structures to feed in the work of the wider ICS alongside their organisational activities at the different levels. This will ensure multiple points of entry. However, to ensure clarity and consistency and to avoid duplication the Communications and Engagement Cell and Insights, Behaviour and Research Hub will be the central points for all ICB activities to be logged and discussed. Overtime and with further discussion with ICS partners this central point may expand or have defined links to system partner insights.

Figure 10 below shows the second-tier governance for engagement and involvement, as it looks currently. It shows new groups being introduced to implement some our priorities that are more advanced in their development. Going forward, as we implement our priority to review our architecture, the structure below is likely to change.

Figure 10

Second tier governance for engagement and involvement



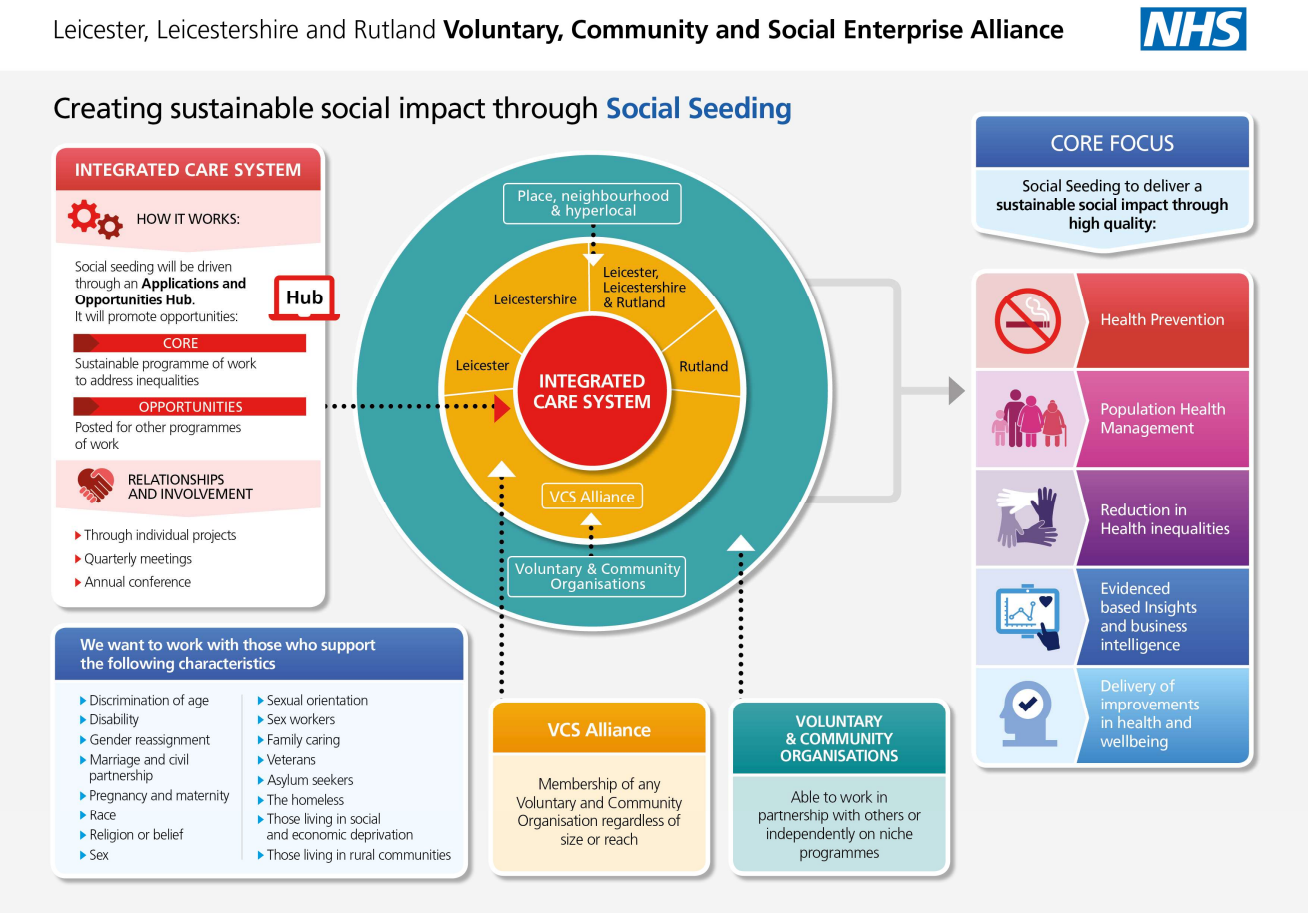
Creating sustainable social impact through Social Seeding

Voluntary, Community and Social Enterprise (VCSE) contribute to shaping, improving and delivering healthcare services. They also support the development and implementation of plans that tackle the wider determinants of health.

Figure 11 shows a model of how we will effectively include this diverse and creative sector in the emerging ICS in LLR, through an Alliance created supported by Social Seeding resources. This will ensure it influences decision making, whilst remaining resilient and an effective part of the wider system.

Social Seeding has a number of definitions across a range of sectors. In this instance, Social Seeding is the process of bringing together a carefully selected group who it is felt will maximise the effectiveness of a programme or programmes of work to improve the health and wellbeing of people in LLR. This work would be financially recompensed recognising that the sector needs to maintain financial resilience through longer term income sources.

Figure 11


Leicester, Leicestershire and Rutland **Voluntary, Community and Social Enterprise Alliance**
NHS
Creating sustainable social impact through Social Seeding
INTEGRATED CARE SYSTEM
HOW IT WORKS:
Social seeding will be driven through an **Applications and Opportunities Hub**. It will promote opportunities:
Hub
CORE
Sustainable programme of work to address inequalities
OPPORTUNITIES
Posted for other programmes of work
RELATIONSHIPS AND INVOLVEMENT
Through individual projects
Quarterly meetings
Annual conference
Place, neighbourhood & hyperlocal
Leicestershire
Leicester, Leicestershire & Rutland
Leicester
INTEGRATED CARE SYSTEM
Rutland
VCS Alliance
Voluntary & Community Organisations
CORE FOCUS
Social Seeding to deliver a **sustainable social impact through high quality:**
Health Prevention
Population Health Management
Reduction in Health inequalities
Evidenced based Insights and business intelligence
Delivery of improvements in health and wellbeing
We want to work with those who support the following characteristics
Discrimination of age
Disability
Gender reassignment
Marriage and civil partnership
Pregnancy and maternity
Race
Religion or belief
Sex
Sexual orientation
Sex workers
Family caring
Veterans
Asylum seekers
The homeless
Those living in social and economic deprivation
Those living in rural communities
VCS Alliance
Membership of any Voluntary and Community Organisation regardless of size or reach
VOLUNTARY & COMMUNITY ORGANISATIONS
Able to work in partnership with others or independently on niche programmes

Approach to reviewing engagement activity and impact, for continuous improvement

Too often data drawn from patient, carer and service user experience is not given as much importance as other operational data such as admissions to A&E or waiting times. Placing people's voices on an equal footing with other key operational data, creating population health management business intelligence, demonstrates both its importance and how it can add understanding and meaning to other data and information collected rather than being treated separately.

In addition, when designing, commissioning and implementing services it is important that the approach used is built around the idea that if we listen to and deeply understand people's experiences, we will design and implement better, more person-centred services that delivery better care for people in LLR.

Over the last 5 years there has been a history of engagement and involvement with a range of stakeholders. Public and patient participation has been refined over time with the NHS and local authorities doing more work to understand the needs of the local population in partnership and sharing the insights, learning and business intelligence to inform design and delivery of care.

We are moving to the term of 'business intelligence' [3]to describe insights about healthcare to enhance the standing it has against all other data and make decisions truly patient-centred. We are bringing all this business intelligence together into an Insights, Behaviour and Research Hub. The hub would contain raw data and Reports of the Findings produced by NHS bodies and other local organisations including Healthwatch Leicester and Leicestershire and Healthwatch Rutland. The Reports of Findings from just the last eighteen months alone total insights from 22,000 people, including staff, patients, carers and public. Combined with data pre-Covid-19, the Hub will provide a rich understanding of what people want from local NHS services now and in the future including our most vulnerable groups. The Insights, Behaviour and Research Hub will fully with General Data Protection Regulations (GDPR) in recognition that we are the guardians of health and care data and have a duty to ensure that data is handled securely and in line with the regulations.

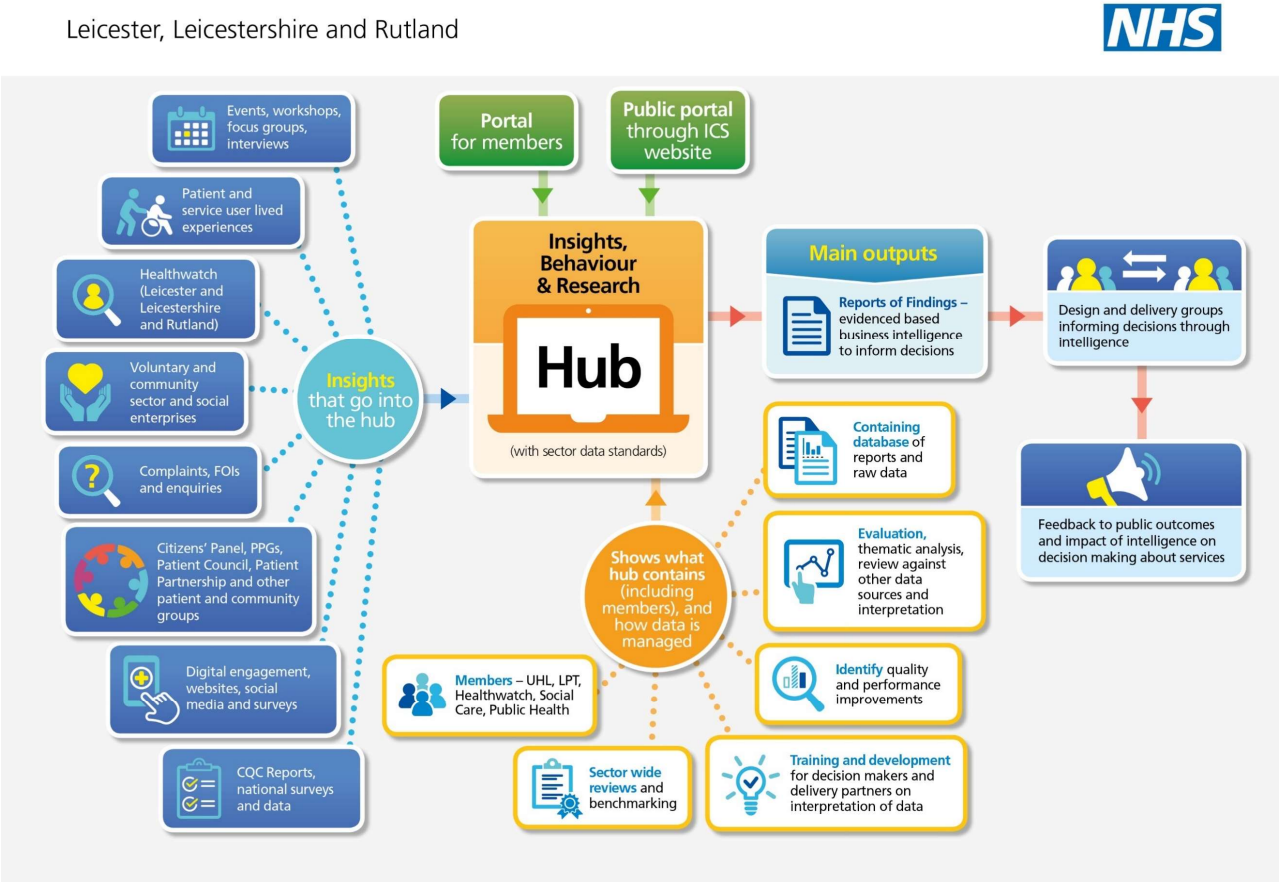
Figure 12 shows how the hub will function. It outlines an engagement architecture for hearing from patients, public, staff and carers, as well as key organisations and groups, who provide valuable information about experiences of health and care. It also outlines the Hub partners, data retrieval system and management system, publication schemes, both with partners and the public and the feedback mechanisms.

A key factor of the Hub will be staffing. A professional market research resource was brought into the LLR CCGs early in 2021 on a temporary basis. This experienced member of staff has proved invaluable in supporting the evaluation of

[3] Business intelligence (BI) combines business analytics, data mining, data visualisation, data tools and infrastructure, and best practices to help organisations to make more data-driven decisions for us these means patient-centred decisions.

insights and undertaking thematic analysis and reviewing different data sources. The business intelligence and health management data produced has impacted on many programmes of work including Covid-19 and Mental health and has influenced service changes and system transformation programmes.

Figure 12



Having good analysis is just one key area that we wish to develop further. However, the ability to interpret business intelligence and to use the information effectively is an essential element in any learning health care system. Analysis can help shape care for individual patients as well as informing decisions for services or across organisations and health systems. We will support ICB and ICS teams and delivery groups to interpret and utilise the data in planning and decision-making processes.

We will also improve the system for feeding back to people and communities, so that they can see how their voice has impacted on services. This is a key element to complete the 360-degree e-cycle of engagement and needs to be consistent across the ICB and ICS and the individual groups that form the governance. We will work with delivery groups to identify the impact of intelligence and articulate clearly, the difference it has made. This information will be added to the public facing section of the Insights, Behaviour and Research Hub on the ICB website and ICS website and people will be informed through mechanisms including the Citizens' Panel, the Voluntary and Community Sector Alliance, People's Council, Youth Advisory Board, Patient Partners and PPGs and LPT and UHL members.

Joint working

This strategy shows joint working across UHL, LPT and the ICB (currently the LLR CCGs) on programmes of work where there is a common interest and added value for organisations and patients. The Alliance with the voluntary sector, communities and social enterprise would also bring clarity and consistency of approach to this important sector. There are also financial savings by developing joint systems and processes that reduce duplication including the Hub and the Customer Relationship Management System.

The strategy also shows opportunities for partnerships, where appropriate. This is particularly apparent through the Insights, Behaviour and Research Hub which would have the potential for bringing together insights and data from local authorities and Healthwatch organisations, ensuring this is firmly embedded.

Joint work with patients, carers, practices and Primary Care Networks is vital to develop the primary care engagement framework. The framework would ensure that PPGs are revitalised and linked into their GP practice, their Primary Care Network and the ICB. Figure 12 shows a framework for working with and involving people and communities at all three levels to ensure the best possible health and wellbeing outcomes through primary care.

Figure 13

Monitoring and evaluation

The monitoring and performance of this strategy will be undertaken through the following groups:

1. The Communications and Engagement Cell who will be responsible for producing and delivering the individual plans for each of the 16 priority actions identified in this strategy.
2. The Quality and Performance Improvement Assurance Committee through Quarterly Reports who in turn provides assurance to the LLR ICB Board.
3. The Public and Patient Involvement Assurance Group, meeting monthly, reporting to the LLR ICB Board through the Chair.

The following evidence of delivery will be provided:

1. Patient, carer and public engagement activities and outputs report into the progress on delivery of the 16 priority actions and the plans produced to achieve the overall objectives.
2. Report of Findings from all market research showing public experiences and views
3. Shared learning from both positive and negative patient experiences and high impact actions needed to improve services
4. Demonstration of how patient experience and staff satisfaction correlates.
5. Compliance with equality duties, through Equality Impact Assessments.
6. Compliance with statutory and legal duties through Report of Findings.
7. Quarterly review of qualitative and quantitative feedback about patient experience and engagement across the ICB and ICS with a summary of what is going well, and lessons learned.
8. Priority plans to demonstrate how insights have impacted change – ‘you said, we did’.
9. Annual review of this Strategy by a range of stakeholders on learning what we are doing well, what we could do better, what is having the best outcomes.

Budget and skills development

The NHS is committed to investing in the delivery of the priorities identified in this Strategy. Funding for the next two years will come from a range of budgets currently being discussed. A budget will be agreed as we progress into the ICB from 1 July 2022 and allocated to the priority actions shown below.

Project investment

Priority action
1. Empower our 21,000 members of staff.
2. Develop further the Insights, Behaviour and Research Hub
3. Promote more widely the existence of business intelligence
4. Create a customer relationship management system
5. Develop strong and mutually beneficial relationships with the voluntary sector, community groups and social enterprise
6. Create ambassadors for embedding business intelligence
7. Ensure the production of Equality Impact Assessments for all projects and the utilization of the findings impact on engagement/consultation.
8. Share knowledge and learning across engagement teams
9. Develop all aspects of Citizens' Panel – growth in membership, retention, benefits scheme and access
10. Work with ICS to move from compartmentalised engagement and involvement to full system co-production
11. Create a primary care engagement framework
12. Develop plans for the systematic and effective delivery of engagement activities and public consultation
13. Support the development of place and neighbourhood-based plans
14. Support the development of a framework for engaging with family carers and children, young people and families
15.Continue to digitally innovate making the digital experience with the NHS more human and interactive
16. Work with decision makers and programme leads to ensure that post-decision making the impact is clearly fed back to the public without exception – to ensure a 'you said, we did' culture across the ICB.

Skills development

In 2022, we will see the first joint post for the ICS recruited to. This post will enhance the engagement of our children, young people and families.

We have also invested on a temporary basis in the role of Market Research and Insights Officer to ensure that we produce high quality business intelligence and population health management data. We would like to permanently invest in this post to enhance the skills of the team and develop the Insights, Behaviour and Research Hub.

We are also committed to enhancing the current skills within ICB teams to refresh their knowledge of our statutory duties to ensure that insights from people are used to shape all decisions about services. We will particularly upskill staff to ensure we adhere to existing and any new requirements of an ICB and an ICS.

We will upskill our staff giving them opportunities to gain the knowledge, tools and ability they need to use advanced and ever-changing technologies that will support us to engage with people and communities.

Future needs

Community and voluntary sector development – building capacity and capability and developing new and emerging groups to become system partners

Quality Improvement expertise – using insight for improvement and working in collaboration with patients, carers and service users in QI

Training design and delivery – building capacity and capability of our workforce, do we want to consider developing our own local offer and then deliver through a train the trainer approach

Skills and capability development for lived experience/patient partners – programme to develop skills and competencies for those who are working in such roles

Volunteers – do we need to consider what role volunteers could play in our approach, if so what support/coordination would be required

Appendix

1. How the strategy was developed with people and communities

This Strategy have evolved over time. It has been developed taking the learning and feedback from over 2 years of conversations taking the learning from engagement and consultation activities that have undertaken.

Since creating the first draft version, we have continued to talk to people and have made changes based on those conversations. The engagement activity has included:

- Discussions with voluntary, community and social enterprise sector (VCSE) at an event in December 2021, one-to-one interviews with representatives VCSE sector in February and a second event in April 2022
- Healthcare colleagues – Primary Care Cell, GP practice manager forums, CCGs webinar
- UHL Patient Partners
- LPT People's Council
- Healthwatch Leicester and Leicestershire
- Healthwatch Rutland
- Citizens' Panel
- Public and Patient Involvement Assurance Group
- LPT Youth Advisory Board
- LPT Senior Leaders Forum
- East Midlands Patient Public Involvement Senate
- Voluntary Action Leicester
- VAL Health Event (61 VCSE organisations)
- Survey in April 2022 – 208 people responded, 2 email received and 2 reports

2. Links to other strategies (e.g., communications, carers, health inequalities)

This strategy links to a number of local Strategies and Plans including:

- Leicester City Council's Health, Care and Wellbeing Delivery Plan 2022-2027
- Leicestershire County Council's Strategic Plan 2022-2026
- Rutland Health and Wellbeing Strategy 2022-2025
- LLR Carer's Strategy (in development)
- NHS Long Term Plan
- Reconfiguration Communications and Engagement Strategy
- 'Step up to Great' Mental Health Communications and Engagement Strategy