MIAA

2022/23 ICB Checklist Series

Integrated Care Boards – Patient and Public Engagement

March 2023

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The Health and Care Act 2022 mobilises partners within Integrated Care Systems (ICSs) to work together to improve physical and mental health outcomes. These new partnerships between the NHS, local authorities, social care 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 communities they serve.

The legal duties on public involvement require organisations to secure arrangements to ensure that people are appropriately 'involved' in planning, proposals and decisions regarding NHS services.

Key requirements of ICBs, trusts and NHS England include that they:

- assess the need for public involvement and plan and carry out involvement activity;
- clearly document at all stages how involvement activity has informed decision-making and the rationale for decision; and
- have systems to assure themselves that they are meeting their legal duty to involve and report on how they meet it in their annual reports

The *Working in Partnership with People and Communities Statutory Guidance document; issued 4th July 2022* supports Integrated Care Boards (ICBs), NHS trusts and foundation trusts in meeting their public involvement legal duties and the new 'triple aim' of better health and wellbeing, improved quality of services and the sustainable use of resources. Involvement can be in a variety of ways and neither the legal duties nor the statutory guidance, seek to prescribe exactly how to involve people in any given case. ICBs need to be able to demonstrate that they assess whether the duties apply to decisions about services and, where they do, that they are properly followed.

There are also policy requirements for ICBs, Integrated Care Partnerships (ICPs), place-based partnerships and provider collaboratives to involve people, including in their membership and when developing plans and strategies. Involvement is a contractual responsibility for Provider organisations, including General Practice, as set out in the NHS Standard Contract.

The guidance is structured around 10 key principles, developed from good practice already taking place to help organisations achieve the benefits of effective working with people and communities. They are intended to be a golden thread running through systems, whether activity takes place within neighbourhoods, in places, across system geographies or nationally.

10 principles for working with people and communities

01 Centre decision-making and governance around the voices of people and communities.

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

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

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

05 Work with Healthwatch and the voluntary, community and social enterprise sector.

06 Provide clear and accessible public information.

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

08 Have a range of ways for people and communities to take part in health and care services

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

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

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 will be included in the new System Oversight Framework and the process will include providing evidence of the how the ICB meets the 10 principles and the difference that working with people and communities has made (*currently under development*). It will look for evidence of meaningful involvement taking place consistently across the ICB's places and neighbourhoods.

MIAA has developed the checklist below to support ICBs in reviewing their patient and public engagement arrangements. The checklist is structured in line with the 10 principles for working with people and communities.

Diagram Source: Working in Partnership with People and Communities Statutory Guidance July 2022

Patient and Public Engagement Checklist

Areas for ICBs to consider		ICB's Response
Decision Making and Governance	**1. Ensure people and communities have an active role in decision-making and governance**	

	• Does the ICB Patient and Public Engagement Strategy clearly describe the:
	
	   o principles and approaches to working with people, communities and partners in priority setting and decision-making forums across the ICS?
	   o 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?
	
	• Have the Public and Patient Engagement Strategy monitoring and review arrangements been defined including how these will be evidenced?
	• Is the Patient and Public Engagement Strategy fully aligned to the ICB Constitutional requirements?
	• Does the ICB Board and sub-committee terms of reference set out the responsibilities in relation to public and patient engagement dependent on the remit of the committee and are reporting lines clear?
	• If there is a dedicated public and patient engagement committee/group, how is the effectiveness of this group in decision making be measured/assurances provided? Are the roles, responsibilities and reporting arrangements defined?	

Areas for ICBs to consider	ICB's Response
• Is there a central oversight point to assess the engagement at system, place and neighbourhood for consistency of approach and to avoid duplication? • Is there adequate representation of Healthwatch and voluntary, community and social enterprise (VCSE) groups at relevant ICB groups/committees? • How are assurances provided that the ICB identifies and engages its population, including those who are seldom heard and/or experience the worst health outcomes, to ensure their voices are heard? • Are public parts of ICB meetings and relevant papers, including those relating to the ICB public and patient engagement groups easily accessible to the public?	

Areas for ICBs to consider		ICB's Response
Involvement and Feedback	**2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions**	
	• Is a formal decision-making tool in place to review the requirement to involve public/patients and the circumstances in which this would apply (service redesign, commissioning new services etc)? Have the approval processes been defined and can this be evidenced if requested? • Are controls in place to ensure public and patient engagement/consultation is undertaken as early as	

Areas for ICBs to consider	ICB's Response

possible (e.g. built into business case development process)?
 	
• Are the approaches/methods to involve patients and public captured including hard to reach and minority groups? How is it ensured that approaches are fair, proportionate and have regard to equality?
 	
• Are equality impact assessments undertaken prior to starting any engagement activities including reference to protected characteristics? Can the assessment review process be evidenced?
 	
• Has the ICB published at least the following information on its website:
 	
   1. Involvement opportunities, including formal roles, consultation and public meetings
   2. Details of how to make complaints and comments
   3. A summary of key needs in the ICB area and how these are being addressed
   4. Links to local Healthwatch
   5. Links to other relevant local organisations including voluntary, community and social enterprise groups/organisations?
 	
• Are patient and public activities designed to take place at times and in ways that encourage participation? Is the ongoing dialogue with public and patient groups encouraged to identify what works best?
 	
• Are feedback processes in place to communicate engagement impact? How will the ICB demonstrate this on an ongoing basis (in addition to the annual report to	

Areas for ICBs to consider	ICB's Response
demonstrate how the Public Involvement Duty has been discharged)? • Has information about how the ICB supports members of the public who are involved in decision making and governance been published, for example through a training/reimbursement policy?	

	Areas for ICBs to consider	ICB's Response
Engagement Impact	**3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working**	
	• How is data about the experiences and aspirations of people who use (and do not use) health and care services, care and support collated and stored? • Are the trends and themes identified shared with communities as appropriate to seek their insight/ solutions to the problems the data identifies? • Can the approaches to sharing and using this information/insight to inform decision making and quality governance be demonstrated? • Are mechanisms in place to stay informed with work undertaken locally which may have an impact on ICB business/plans i.e. involvement in partner organisation patient/public activities to help avoid consultation fatigue? How is this intelligence shared to inform decision making? • Does the evaluation framework development process include involvement from the patients/carers/public that will	

Areas for ICBs to consider	ICB's Response
be affected by the decisions made to decide what 'good' looks like? • Is the impact of the data collated and engagement activities reported through the ICB governance structure?	

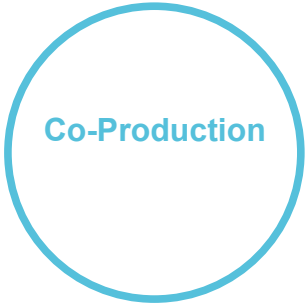|	Areas for ICBs to consider	ICB's Response
Building Relationships	**4. Build relationships based on trust, especially with marginalised groups and those affected by health inequalities** • Are the approaches and methods of engagement used to meet the needs of the ICB area (including those protected by a characteristic under the Equalities Act 2010 and those affected by health and social inequalities) promoted through diverse community channels? • Can demographic monitoring for public involvement be demonstrated and how this is used to inform improvement/decision making? • Is the input from marginalised groups and those affected by inequalities including those already identified in ICB priorities/plans sought proactively and can this be demonstrated? Are there prompts in key documentation to help ensure this occurs? • Do staff have the correct skills to engage with patients/ public encouraging patient/public led discussions as opposed to directed discussion? • Are engagement and feedback processes tailored to include people in accessible and inclusive ways?	

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Areas for ICBs to consider	ICB's Response
• Does the ICB Equality, Diversity and Inclusion Strategy include reference to public and patient engagement/links to the public and patient engagement strategy and has this been published on the ICB website? • Is the link between the ICBs approach/strategy for patient/public involvement and Equality Delivery System (EDS2) made clear? • Are reporting and feedback on engagement activity arrangements consistent and timely?	

Areas for ICBs to consider		ICB's Response
	5. Work with Healthwatch and the voluntary, community and social enterprise sector as key partners	
Partnership Working	• Has clear direction been provided in relation to the involvement of Healthwatch and VCSE as key partners in ICB activities around patient/public engagement? • Is there adequate partner representation in the ICB public and patient engagement forums/committees? • Local authorities, social care providers and the VCSE sector may already have well-established mechanisms in place for including people in decision-making, are partners consulted with prior to and during engagement activities to share intelligence? Are existing forums utilised? • Are relationships with partners developed to promote the sharing of lessons learned?	

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	Areas for ICBs to consider	ICB's Response
Clear and Accessible Information	**6. Provide clear and accessible public information** • Has the ICB published details about providing information in accessible formats and assistance available to those who require other support to enable them to engage? • Are public facing communications accessible to local communities, for example in accessible formats and using a range of methods? • Are processes in place to assess if the Accessible Information Standards are met and where is this reported? • Is the ability to influence decisions clearly communicated providing examples of impact?	

	Areas for ICBs to consider	ICB's Response
Community Centred Approaches	**7. Use Community centred approaches that empower people and communities, making connections to what works already** • Is the use of community centred approaches clearly communicated in ICB patient/public engagement publications? • Do staff have the required skills and experience to engage using different approaches and utilise existing community assets, activities, venues etc to full effect?	

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	Areas for ICBs to consider	ICB's Response
Co-Production	**8. Have a range of ways for people and communities to take part in health and care services**	
	• Are co-production approaches with people, health and care professionals (those with learnt experience) encouraged and is there are a wider range of approaches beyond those who already contribute to provide a more representative view of the whole population? • How does the ICB assess that decisions are genuinely co-produced and issues and solutions are jointly agreed?	

	Areas for ICBs to consider	ICB's Response
Partnership with People and Communities	**9. Tackle System Priorities and Service Reconfiguration in Partnership with People and Communities**	
	Covered within principles 2,3 and 4 above.	

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