Paper 3 (submitted by HWR and HW Leicester/Leicestershire to Head of Engagement & Insight for CCGs 28/01/22)

Joint Healthwatch review of the draft ICS Public Involvement and Engagement Strategy 2022-24 v1.5

Healthwatch Rutland and Healthwatch Leicester and Leicestershire thank the CCG Engagement and Insights team for the opportunity to comment on the developing Strategy.

We find version 1.5 much more comprehensive and readable than the earlier version shared at the end of last year, and, further to that, have several observations.

1. Partnership working

At present, the document reads very much as a 'CCG' document and applicable only to health services with other partners positioned as 'Other'. For this to be understood as a System Strategy we suggest:

- Healthwatch is listed as a 'system partner' on page 4, a 'wider system partner' on page 25 and omitted from the list of organisations to receive feedback on page 25. We would prefer to see a consistent approach to the statutory role and position of Healthwatch. We suggest a paragraph explaining the role of Healthwatch might add clarity and we would be happy to help formulate this.
- The role of Local Authorities within the system and their provision of social care needs to be further clarified in the document. Their involvement in the wider determinants of health such as housing, education, transport, environment and employment should also be acknowledged.
- There needs to be a clear definition of what is understood by each of '*voluntary and community sector, social enterprises and individual communities'* on page 7 in preparation for Action 5 on page 16 proposing to 'scope out' these organisations.
- Further clarification is needed about the proposed 'customer relationship management system' (p16 action 4), and how this would enable a shared communications structure to encourage full partnership-involvement for sharing co-ordinated and consistent messages to the LLR population. This clarification could also include more detail of how the developing ICS Strategy aligns with partners' and stakeholders' existing strategies. As an example of how value would be added through these measures, we have noted avoidable local confusion caused by inconsistencies in public information from multiple stakeholders about the availability and services of COVID-19 vaccination clinics.

2. Financial considerations

- In relation to the voluntary and community sector, social enterprises and individual communities, page 7, bullet point 11 states: 'We have started discussions with the sector and communities about establishing a new way of working, moving 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.' This leads to the

question of how these groups, often with limited resources, will have their costs reimbursed or be rewarded for their ongoing participation if not awarded contracts?
- The Budget and Skills section, action 5, allows for 'developing strong and mutually beneficial relationships with the voluntary sector, community groups and social enterprise'. However there seems to be no budget allowed for training, developing or mentoring people in the community, especially those with lived experiences of the health and care systems, in order for them to fully participate?

3. Data management

- We are uncertain about the reference on page 27 to the 'Quality, Safety and Performance Committee'. Is this referring to the Quality Performance and Improvement Assurance Committee which, currently, has no provision for reviewing and evaluating experiential insight.
- We welcome the development of the Marketing and Insights Hub but suggest that reference is made to the need to respect public and patient confidentiality and anonymity.

4. Governance roles, responsibilities, and resources

- Whilst we understand that the design groups (p22) mirror the Core20Plus scheme and are still being developed, it is not clear where urgent and emergency care and the management of long-term conditions, such as respiratory, cardiac, renal and biliary, are reflected in the ICB's governance of delivery.

5. Engagement activities

- Although co-production is fully defined and is included as a priority action we would like to see this theme further developed and emphasized throughout the document.
- Likewise, we feel that 'lived experience' and its value in providing insight needs greater prominence.

6. Structure of the document

We are aware that this document is still in draft form, however we thought it useful to pull out areas of language/grammar that would benefit from clarification or amending;

- Business intelligence is a term used throughout the document. For those unfamiliar with the terminology, this may have connotations of involving private business in NHS matters and wonder whether another term would be more appropriate eg 'information *(or data)* gathered'?
- Likewise, 'Our expertise in working with local people and communities' (p6) implies a power imbalance with 'local people and communities' being implied as non-expert and somewhat objectified. The grammar and language in this section would benefit from review.

- The first extra principle on p12 ‘Build on the engagement….’ ‘*[T]o make connections to social change*’ is ambiguous and needs clarification.
- Both bullet points at the bottom of page 13 seem to make the same point.
- P23 – the term ‘social seeding’ is not defined.
- We welcome the acknowledgement that giving feedback is important but suggest that there should be a commitment to going further with ‘*timely*’ feedback.
  Some areas would benefit from referencing to external publications for example (give a few figures or page numbers where refs are missing)

7. Future considerations

- We suggest that, as the ICS develops, this strategy should be regularly reviewed and the inclusion of a review date would ensure this happens.

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