Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Working with People and Communities Policy

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Document Control	
Document Owner:	Chief of System Assurance and Corporate Services
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Version Control			
Version	**Date**	**Reviewer(s)**	**Revision Description**
v1.0	01-07-2022		The Board of the Integrated Care Board adopted the policy as approved.

Implementation Plan

Development and Consultation:	This policy has been derived from the Working with People and Communities strategy, which was co-designed with partners and members of the public. Contributors to the strategy include: ▪ Directors from the VCSE in Bedfordshire and Milton Keynes ▪ Chief Executive Healthwatch Milton Keynes ▪ Chief Executive Healthwatch Central Bedfordshire ▪ Chief Executive Healthwatch Bedford Borough ▪ Chief Executive Healthwatch Luton ▪ Chief Executive Bedford Borough Council ▪ Leader of Luton Council ▪ Overview and Scrutiny Chair, Bedford Borough ▪ Directors of Adult Social Services, Bedford Borough Council and Central Bedfordshire Council ▪ Director of Transformation, Luton Council ▪ Chair of the Joint Committee Integrated Care Partnership ▪ Primary Care Network Clinical Directors ▪ Governors NHS Foundation Trusts ▪ Director of the Milton Keynes Provider Alliance ▪ Director of the Bedfordshire Care Alliance ▪ Members of the public ▪ NHS England (NHSE) participation and involvement teams
Dissemination:	Staff can access this document via the website and will be notified of new / revised versions via the staff briefing. This document will be included in the organisation's Publication Scheme in compliance with the Freedom of Information Act 2000.
Training:	The following training will be provided to make sure compliance with this document is understood: ▪ Community of practice events ▪ Co-production training
Monitoring:	Monitoring of and compliance with this document will be carried out via: ▪ The Working with People and Communities Committee ▪ Health and Wellbeing Boards ▪ Overview and Scrutiny Committees
Review:	The Working with People and Communities Committee of the Integrated Care Board will review this policy after three months to ensure that it remains relevant as the Integrated Care Board (ICB) establishes. It will then be reviewed annually. As this is an essential policy as defined in the ICB Constitution, any amendments to the Policy require approval of the Board of the ICB.
Equality, Diversity and Privacy:	Appendix 1 - Equality Impact Assessment Appendix 2 - Data Protection Impact Assessment Appendix 3 - Process for statutory consultation

Associated Documents:	The following documents must be read in conjunction with this document: ▪ The draft Working with people and communities strategy
References:	This policy has been drafted with reference to the following documents: ▪ Section 14Z44 of the Health and Care Act, 2022 ▪ The working with people and communities guidance, NHSE – May 2022

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1.0 Introduction

1.1 NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) aims to ensure robust governance through its formal written procedural documents, such as this document, which communicate standard organisational ways of working. These documents help clarify operational requirements and consistency within day-to-day practice. They can improve the quality of work, increase the successful achievement of objectives and support patient safety, quality and experience. The ICB aims to ensure its procedural documents are user friendly, up-to-date and easily accessible.

1.2 The ICB must design and implement procedural documents that meet the diverse needs of our service and workforce, ensuring that none is placed at a disadvantage over others, in accordance with the Equality Act 2010. The Equality Impact Assessment initial screening, which was used to determine the potential impact this policy might have with respect to the individual protected characteristics is incorporated at Appendix 1.

1.3 A Data Protection Impact Assessment is a process which helps assess privacy risks to individuals in the collection, use and disclosure of personal information. The Data Protection Impact Assessment initial screening, which was used to determine the potential impact this policy might have with respect to an individual's privacy is incorporated at Appendix 2.

1.4 The purpose of this policy is to set out how the Integrated Care Board will seek to work with people and communities to involve them in shaping health and care, as set out in Section 14Z44 of the Health and Care Act, 2022.

1.5 It is designed to help the system reduce health inequalities, make better decisions about service changes and how much money is spent. It will improve population health outcomes, as well as reducing the risks of legal challenges associated with non-compliance of the ICB's statutory duty to involve.

1.6 In line with subsidiarity principles, the ICB will ensure that decisions are taken at place, as close to residents as possible, and that the central function will perform only the tasks that cannot be undertaken at a local level. In discharging this duty, the ICB will seek to work with partners to ensure residents are involved at every level of decision making.

2.0 Scope

2.1 This policy **applies** to all staff members of the Integrated Care Board, including Members of the Board of the ICB, involved in policy-making processes, whether permanent, temporary or contracted-in under a contract for service (either as an individual or through a third-party supplier).

2.2 The policy is for working with people and communities and does not include the policy for co-production, which will be developed as a stand alone policy in due course.

3.0 Definitions

3.1 This section provides an explanation of terms used within this policy.

Term	Meaning
Integrate	A principle of the programme, which refers to creating more co-ordinated care for the patient, making sure all parts of the NHS and social services work more closely and effectively together.
Neighbourhoods	Local areas where between 30-50,000 people live. They are usually served by a group of GPs and primary care networks (PCNs).
Places	A local authority area i.e., Bedford Borough, Central Bedfordshire, Luton, and Milton Keynes.
Health and Care Act, 2022	The new legislation that has been passed by parliament and given Royal Assent in April 2022. Section 14Z44 of the Act is the section of law that relates to involving residents in shaping health and care. This is a legal duty that the Integrated Care Board is responsible for delivering.
People and residents	Everyone of all ages, their representatives, relatives, and unpaid carers.
Communities	Groups of people that are interconnected by where they live, how they identify or share interests.
VCSE	Organisations working within the voluntary, community and social enterprise sector.
Decisions	A conclusion reached after careful consideration.

Engagement	Seeking local views, listening, and feeding back what has been heard and how this is shaping health and care.
Involvement	An action to become involved with something – shaping health services or speaking to local people.
Consultation	Usually, a formal 12-week process to listen to local people and ask their views on options for changing services. All formal consultations will need to be presented to the statutory Health Overview and Scrutiny Committee. The findings from the consultations and any decisions made by Boards on the way forward will also need to be scrutinised.
Co-production	Co-production is the practice in the delivery of public service where residents are involved in the creation of public policies and services.
Co-design	An act of creating with stakeholders, residents, partners to ensure the results meet their needs and are usable.
Communications	Sharing information, which has been informed by the engagement work, with local people to support understanding and demonstrate how we are working in the interests of taxpayers. In this document, we have taken communications to mean two-way communications, which goes from the centre out to residents and uses communications to engage with local people.
Statutory duties	The legal requirements that are set out in the Health and Care Act to make sure that all Integrated Care Partnerships involve local people in shaping health and care locally.
Participation	In the context of our strategy this is finding out about and getting involved in activities which help to shape the local health and care services.
Subsidiarity	Decisions made at the most local level, as close as possible to the communities they effect

4.0 Policy Statement

4.1 The ICB's ambition is to help people who live in Bedfordshire, Luton and Milton Keynes to live longer lives in good health and to reduce health inequality by ensuring seldom heard voices and lived experiences are part of the decision-making process to improve health outcomes in our area.

4.2 This will be achieved by working with trusted people and community leaders in neighbourhoods and places. Continuous involvement of local people in shaping health and care services will reduce the risk of legal challenges associated with non-compliance of the Act.

4.3 In keeping with principles of subsidiarity, statutory consultation and engagement will be undertaken by the ICB, or by its partners on behalf of the ICB with co-production, co-design and engagement focused at a place level, closer to communities and local decisions. The ICB may decide to delegate responsibility for the undertaking the consultation process to an external body such as an NHS Trust or local authority, but it cannot delegate its accountability for this statutory duty.

4.4 The ICB's approach to working with people and communities will evolve based on learning from best practice and local experience, but is based on the following principles, which have been developed through a process of co-design with partners, stakeholders, and members of the public, and by building on examples of best practice developed through the pandemic.

1. Reach out to people rather than expecting them to come to you and ask them how they want to be involved, avoiding assumptions.
2. Listen more and broadcast less, so that we understand what really matters to people.
3. Residents should be involved in shared decision making from a formative stage to ensure they are involved in how health and care services are run.
4. Support training for leaders to help them work collaboratively with communities in in partnership with residents, community leaders and officers, so that residents are involved from the start.
5. Work with local communities to identify new ways to empower local people so they can take an active lead in engaging with their communities i.e., through co-production.
6. Form partnerships built on mutual trust across the system to help make better decisions that deliver the changes people want.
7. Provide a feedback loop so that participants can see how their views have shaped health and care.
8. Engage in continuous conversations will help to build trust and deepen understanding between health and care partners and local people

4.4 The following framework will support all ICB staff in applying the policy.

1. **Act on insights** – insights and intelligence heard from facilitated engagement, patient experience and discussions with communities should be reviewed, analysed, shared, and included in all activity across the system	2. **Think neighbourhood** – all participation should be meaningful, authentic, and culturally appropriate to the communities we are engaging. Keeping discussions local and relevant is the best place to start.
3. **Work with trusted people –** there are trusted people in the system who can open doors to communities and meaningful conversations. These could be faith leaders, the VCSE, GPs or people who work in the council in an advocacy role – for example the Gypsy, Roma, Traveller community.	4. **Go to where people are** – we know that people who experience health inequality don't engage with existing structures. To break down barriers, we must go to where people are, and consider intersectionality – for instance Muslim women can be engaged at the Mosque, but we can also hear their views via schools and workplaces.
5. **Do it together** – listening to local people, sharing information, and working together will help us to create a deeper understanding of the communities we serve and help to break down barriers, build on best practice and establish trust.	6. **Delivering the spectrum of involvement –** being consistent in our approach and engaging in several different ways will increase openness, transparency, communication, and discussion – and will help us to build strong relationships with local people.
7. **Continuous conversations** - and feeding back to people regularly to show how their views have made a difference will build trust with communities and increase participation.	8. **Co-produce where appropriate** - co-production is an important function when working with people and communities and can empower communities shape services for themselves.

5.0 Roles and Responsibilities

5.1 All staff of the Integrated Care Board have a role to play in strengthening involvement from local people and communities in our work. All staff are responsible for considering the need for including lived experiences in their work and undertaking this as appropriate. The following have specific responsibilities in relation to this policy.

5.2 **The Board –** The Board of the Integrated Care Board is responsible for performance in relation to all legal duties including the duty to involve people and communities in its work (Section 14Z44). The Board have a responsibility to ensure that lived experiences and people from seldom heard communities are appropriately considered by the Board in all decision making.

5.3 **The Working with People and Communities Committee -** is responsible for ensuring that all legal duties including the duty to involve has been met and that local views and lived experiences have shaped decisions. The committee should also work with partners to assure the Board that these duties have been discharged at place, as well as at scale. The Terms of Reference for this committee are provided in the Governance Handbook [DN: link to be inserted].

5.4 **Chief Executive** – is accountable to the Board and holds the responsibility to embed a culture of involving people and communities, ensuring that all directors adhere to the policy and rolling the approach across directorates.

5.5 **Chief of System Assurance and Corporate Services –** has responsibility for sponsoring the ongoing development and implementation of this policy.

5.6 **Director of Communications and Engagement** - oversees the team that supports and advises the organisation in its statutory duties and ambition to strengthen the involvement of local people and will agree with partners how these activities will be delivered at system, place and neighbourhood levels based on the principle of subsidiarity. To co-ordinate the ICB's work with Overview and Scrutiny Committees in relation to the duty to involve.

5.7 **Chief Transformation Officer –** has the responsibility to ensure that all service transformations undertaken involve local people and communities and that seldom heard voices are considered. This involves attending and working with overview and scrutiny committees, as outlined in Appendix 3.

5.8 **Chief Primary Care Officer** – as above.

5.9 **Line Managers** – all managers have the following responsibilities:

1. Ensuring that the need for local participation and involvement is considered and appropriate action is taken for the work they are accountable for.

2. Contributing to the implementation of this policy and promoting an organisational culture in which involving local people and communities is 'everyone's business'.
3. Ensuring that those responsible for commissioning are aware of our duty to involve local people and communities in decision making.
4. Sharing best practice, monitoring, evaluating, and reporting the implementation of this policy to strengthen local involvement.
5. Ensuring that any external bodies engaged to undertake work for the ICB are aware of their responsibilities in relation to this policy.

5.10 **All Staff** – have the responsibility to follow this policy and ensure they deliver on their statutory duty to involve people and communities in decision making. A guide for staff has been included in Appendix 3 to support staff in understanding when a change requires consultation or engagement.

5.11 **External bodies** – any external bodies undertaking work on behalf of the ICB will be responsible for ensuring that their work is in line with this policy and this should be stated in any contracts or agreements for such work. Such bodies may include local authorities, NHS Trusts, Healthwatch and VCSE organisations who are engaged by the ICB to undertake work on its behalf. The Board of the ICB remains accountable for discharging the statutory duty.

5.12 Healthwatch – As a participant member of the Board of the ICB and as a member of the Working with People and Communities Committee, Healthwatch will also have an important role in providing independent assurance to the ICB that it is discharging its statutory duty to involve.

5.12 **Voluntary, Community and Social Enterprise** (**VCSE) Alliance -** As a core member of the Working with People and Communities Committee, the VCSE also has a role in providing independent assurance to the Board that all the duty to involve has been discharged.

6.0 Processes and Procedures

6.1 Overview and Scrutiny process

The Overview and Scrutiny Committees remain the main vehicle for public scrutiny and have the powers to provide a legal challenge to the ICB if it is believed that statutory duties have not been met. The process for understanding what needs to be presented at Overview and Scrutiny Committee has been provided in Appendix 3.

6.2 The Director of Communications and Engagement

The Director of Communications and Engagement will work with directors and line managers to support the process, but overall responsibility for attendance at Overview and Scrutiny meetings lies with the responsible executive directors leading on the transformation. They will be required to provide papers for meetings (in line with local authority guidelines) and attend meetings to present to elected members.

6.3 The Working with People and Communities Committee

Managers that are leading service changes or introducing new services will be required to attend the committee to outline how they have involved local people and communities in their work. Members of the committee will make recommendations and provide assurance to the ICB that work meets statutory duties. The committee will meet at least quarterly and a work programme will be developed. A process for presenting at the committee is in development.

Appendix 1 - Equality Impact Assessment Initial Screening

Please answer the questions against each of the protected characteristic and inclusion health groups. If there are significant impacts and issues identified a full Equality / Quality Impact Assessment (EQIA) must be undertaken. It is against the law to discriminate against someone because of these protected characteristics. For support and advice on undertaking EQIAs please contact: agcsu.equalities@nhs.net

Name of Policy:	Working with People and Communities Policy
Date of assessment:	8 June 2022
Screening undertaken by:	Associate Director Communications and Engagement

Protected characteristic and inclusion health groups. Find out more about the Equality Act 2010, which provides the legal framework to tackle disadvantage and discrimination: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics	This policy aims to remove health inequalities and increase access for people with protected characteristics. Our aim to is to work with trusted people and community leaders to engage with to ensure lived experiences are heard as part of the decision-making process.	When engaging with people with protected characteristics, we will use accessible tools including easy read to support engagement. In addition, all service changes will require a full EQIA for presentation at Overview and Scrutiny meetings and the working with people and communities committee, which will ensure that people with protected characteristics have been considered as part of this process and seldom heard views involved in shaping decisions.
Age A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).	As above	As above
Disability A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	As above	As above
Gender reassignment The process of transitioning from one gender to another.	As above	As above
Marriage and civil partnership Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.	As above	As above
Pregnancy and maternity	A co-production group has been established for maternity services	As above

Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.	and pregnancy, which is working to ensure that seldom heard voices and the voice of the family is involved in decision making. This is being rolled out as part of the Local Maternity and Neonatal Services work.	
Race Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.	This policy aims to remove health inequalities and increase access for people with protected characteristics. Our aim to is to work with trusted people and community leaders to engage with to ensure lived experiences are heard as part of the decision-making process.	When engaging with people with protected characteristics, we will use accessible tools including easy read to support engagement. In addition, all service changes will require a full EQIA for presentation at Overview and Scrutiny meetings and the working with people and communities committee, which will ensure that people with protected characteristics have been considered as part of this process and seldom heard views involved in shaping decisions.
Religion or belief Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	As above	As above
Sex A man or a woman.	As above	As above
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none.	As above	As above
Carers Individuals within the ICB which may have carer responsibilities.	As above	As above

Please summarise the improvements which this policy offers compared to the previous version or position.
The working with people and communities policy puts involvement with communities at the centre of the ICB and has developed mechanisms to assure the board that legal duties have been discharged. Whilst there was a committee for public involvement in the CCG previously, the duty for the ICB is enhanced and this essential policy is provides clarity to executive directors, board members and all staff of the role they have in discharging this important duty.
Has potential disadvantage for some groups been identified which require mitigation?
Yes / **No**

Appendix 2 - Data Protection Impact Assessment Initial Screening

Data protection is the fair and proper use of information about people. Before completing this form, please refer to the Data Protection Impact Assessment (DPIA) Guidance in the Information Governance (IG) section on the staff Intranet or contact the Data Protection Officer for support via blmkicb.ig@nhs.net

A DPIA is a process to help you identify and minimise the data protection risks. You must do a DPIA for processing that is likely to result in a high risk to individuals. You can use our screening checklist below to help you decide when to do one. If you have answered 'Yes' to any of the 10 screening questions, you must then carry out a full DPIA using the Stage 2 form, which is also available on the Intranet in the IG section.

Name of Policy:	Working with People and Communities Policy
Date of assessment:	08 June 2022
Screening undertaken by:	Associate Director Communications and Engagement

Stage 1 – DPIA form **please answer 'Yes' or 'No'**

1.	**Will the policy result in the processing of personal identifiable information / data?** This includes information about living or deceased individuals, including their name, address postcode, email address, telephone number, payroll number etc.	**Yes** / ~~No~~
2.	**Will the policy result in the processing of sensitive information / data?** This includes for living or deceased individuals, including their physical health, mental health, sexuality, sexual orientation, religious belief, National Insurance No., political interest etc.	**Yes** / ~~No~~
3.	**Will the policy involve the sharing of identifiers which are unique to an individual or household?** e.g., Hospital Number, NHS Number, National Insurance Number, Payroll Number etc.	**Yes** / ~~No~~
4.	**Will the policy result in the processing of pseudonymised information by organisations who have the key / ability to reidentify the information?** **Pseudonymised data -** where all identifiers have been removed and replaced with alternative identifiers that do not identify any individual. Re-identification can only be achieved with knowledge of the re-identification key. **Anonymised data -** data where all identifiers have been removed and data left does not identify any patients. Re-identification is remotely possible, but very unlikely.	**Yes** / ~~No~~
5.	**Will the policy result in organisations or people having access to information they do not currently have access to?**	**Yes** / ~~No~~
6.	**Will the policy result in an organisation using information it already holds or has access to, but for a different purpose?**	~~Yes /~~ **No**
7.	**Does the policy result in the use of technology which might be perceived as being privacy intruding?** e.g., biometrics, facial recognition, CCTV, audio recording etc.	~~Yes /~~ **No**
8.	**Will the policy result in decisions being made or action being taken against individuals in ways which could have a significant impact on them?** Including profiling and automated decision making. (This is automated processing of personal data to evaluate certain things about an individual i.e., diagnosis and then making a decision solely by automated means - without any human involvement)	~~Yes /~~ **No**
9.	**Will the policy result in the collection of additional information about individuals in addition to what is already collected / held?**	**Yes** / ~~No~~
10.	**Will the policy require individuals to be contacted in ways which they may not be aware of and may find intrusive?** e.g., personal email, text message etc.	~~Yes /~~ **No**

Appendix 3 - Overview and Scrutiny process – A guide for ICB staff

When services change – no matter how small a change is, the ICB has a legal duty to involve local people in that change. That doesn't necessarily mean we have to undertake full consultation, but we need to demonstrate that we're involving residents and we need to go to the Overview and Scrutiny Committee to discuss the change with them. If we don't, we could end up in Judicial Review. **If you're planning a service change, ask yourself:**

1. What is the **nature of the proposed change** or development of services? (e.g., new service model / change of location) - what is the current model?
2. What are the **reasons** for this proposed change?
3. **How many patients** will be affected, and what is the composition of this group? Does this affect a particular group of patients? (e.g., older people, children, other vulnerable groups)
4. Where do the patients live? Have other health scrutiny committees been contacted if patients come from other council areas?
5. Will this affect the **location** of the service and/or its accessibility?
6. Is this an **enhancement** of services? (note: a service enhancement may be no less a substantial variation than a service reduction)
7. What **engagement** has there been? - What preliminary work, in planning or development, has already taken place under the duty to involve? Have any changes to the proposals been made as a result? What are the views of those who have taken part?
8. What **clinical engagement** has there been and what were the outcomes?
9. Is this high profile, or likely to be controversial?
10. Is the cumulative effect of small changes substantial?
11. What is the financial impact the health services?
12. What is the impact on other health services? Are there any interdependencies?
13. Will there be a wider impact on the community, such as economic impact, regeneration, or transport?
14. Has an equality impact assessment been undertaken? If so, any specific issues? If not, when will this be done?

For help and advice, or for more information about our legal duties and what this means for your project, please contact the Communications and Engagement Team.