

Involvement Plan Template

V4.2 2021 02

This document provides guidance to Clinical Commissioning Group (CCG) staff, GP practices and patient groups (The Patient Assurance Group at the CCG or Patient Participation Groups at GP practices) about how to involve members of the public, patients and wider stakeholders when making service changes. These changes might include;

- Starting a new service
- Closing a service
- Changing the way a service is provided
- Changing opening hours at a GP practice
- Merging with another practice

Overarching principles

When involving patients or the public you should consider the following principles:

<p>Involve your Involvement team and/or PPG (Patient Participation Group)</p>	<ul style="list-style-type: none"> • If you are a commissioner or practice manager, speak to the involvement team at the earliest opportunity so that you can assess the scale and impact of the change. • For changes at a GP practice, the PPG should be involved at the earliest stage and before the proposal is shared with the CCG. The PPG should be kept informed and involved throughout the process.
<p>Leave enough time</p>	<p>The length of time you need to plan, deliver and report on your involvement will depend on;</p> <ul style="list-style-type: none"> • the scale of the change • the impact on members of the public/patients (especially those from 'seldom heard' groups) • other factors such as political interest.
<p>Consider levels of influence</p>	<p>Be clear about what is changing and what people can actually influence.</p>
<p>Make the involvement accessible</p>	<ul style="list-style-type: none"> • You will need to demonstrate that you have made your involvement accessible to people from different communities. • Provide information in alternative formats when requested such as easyread. • Use different methods to involve such as drop-ins, paper surveys, online surveys.
<p>Feedback 'you said, we did'</p>	<p>Feeding back the findings of the involvement and demonstrating what difference people's feedback has made is an essential part of the involvement process. You should write a brief report and outline '<i>you said, we did</i>'.</p>

You should also consider the **gunning principles** when planning your involvement:

<http://www.nhsinvolvement.co.uk/connect-and-create/consultations/the-gunning-principles>

Guidance for commissioners and practice managers – **Appendix A**

Guidance for patient groups providing assurance – **Appendix B**

Involvement Plan

Outline your plans for involving patients, the public and wider stakeholders about your service change.

Project Title: The name of your project. Make this really clear and concise.	Community Mental Health Transformation
Date: The date you will share this with the PAG or PPG.	13 October 2021
Project lead: Name and contact details of person leading the project (commissioner or practice manager).	Programme Manager: Liz Hindmarsh liz.hindmarsh@nhs.net Senior Responsible Officer: Eddie Devine (Pathway Lead for Head of Pathway Integration- Mental Health, Learning Disability and Neurodiversity NHS Leeds CCG) eddie.devine@nhs.net
Involvement Lead: Name and contact details of person from the CCG involvement team overseeing the involvement (if applicable).	Adam Stewart adam.stewart1@nhs.net We have recruited a dedicated Involvement Lead. The post-holder will start mid October 2021 and be employed by Leeds Involving People. They will lead on involvement and engagement in the programme, with accountability to the Community Mental Health Transformation Programme Board.
Communications Lead: Name and contact details of person from the CCG communications team overseeing the involvement (if applicable).	Penny Allison – Leeds CCG penny.allison@nhs.net Oliver Tipper – Leeds and York Partnership NHS Foundation Trust oliver.tipper@nhs.net
1. Background <i>Provide a background to your project. Keep this brief and to the point. Consider including:</i> <ul style="list-style-type: none">• An outline of the service (who is it for, what does it provide?)• How does this change meet the requirements of local/national strategy (The NHS Long Term Plan or Leeds Health and Wellbeing Strategy etc)• An outline of what is changing (what will be different after the change?)• Why are you making the change? (What impact will it have on patient safety, patient experience or clinical effectiveness?)• What is the involvement aiming to do?• What do we already know? Including contacting patient experience (they need 2 weeks to prepare a report on the topic)	
Background The Community Mental Health Transformation Programme is a national requirement, which was	

mandated in the NHS Long Term Plan (NHS England, 2018). It set out a plan for significant investment into community and primary mental health services with the need for local health and care systems to radically transform existing services. The Community Mental Health Framework for Adults and Older Adults (NHS England, 2019) then set out more detail on what transformed community mental health services should look like.

In Leeds, we are working with all partners across the city, including service users, carers and people with lived experience, to implement this vision through our Community Mental Health Transformation Programme. We want to transform how primary, and community mental health services are currently organised and delivered for adults and older adults with serious mental illness and complex needs.

Our aim is to ensure that people can access the right care and support at their earliest point of need, with wide ranging support closer to home so that people can live as healthy and fulfilling lives as possible in their community.

We will be working in three pilot Local Care Partnership areas in 2021/22: HATCH (Chapelton and Burmantofts, Richmond Hill and Harehills); Leeds Student Medical Practice and the Light and West Leeds, where we will develop and test new ways of working. We will then expand to cover half of Leeds' Local Care Partnerships in 2022/23 and then full roll out across all remaining Local Care Partnerships in 2023/24. The programme will end in April 2024. The pilot sites have a diverse population between them in order for us to work with a wide range of different groups and communities.

Objectives of engagement:

This is an ambitious and complex transformation programme. We need to radically rethink how services are currently organised and delivered. To do that, we have to ensure that the diverse voices of service users/patients, people with lived experience and carers are at the heart of this transformation and are integral and embedded in how we design, deliver and evaluate these new models of community mental health care in Leeds

We also need to go further and faster in our efforts to reduce the health inequalities we know exist for people using community mental health services – in their access and experience of those services and also their outcomes. We need to work as equal partners with diverse individuals and communities so we can work better to understand the structural and systemic barriers and address them so we make real and lasting difference.

Involvement and co-production needs to be significant and part of the assurance of this programme includes specific assessment of how we have involved people with lived experience and carers in the design and delivery of transformed models of care.

Outcomes of engagement:

- We will explore 'what we already know' by reviewing existing feedback and insight on mental health services collected across Leeds to help shape our plans and approach to involvement.
- We will produce reports from engagement work with clear messages and recommendations
- We will develop a 'you said' 'we are doing' and 'what next?' feedback mechanism to highlight any impact and outcomes from the engagement work
- We will have an understanding of peoples experiences and know where the gaps are
- We will be able to demonstrate that the model has been co-produced and the voice of service users, carers and people with lived experience has been central to this.
- There will be greater involvement from diverse groups and individuals and there will be less gaps in involvement.
- We will have a diverse group of people with experience of mental health services (including service users, carers and people from the LCP areas we are working in), who are well supported and feel they are equal participants in the process.
- We will have created a wide range of involvement and engagement pathways to allow people from seldom heard groups to have their voice heard.
- Involvement and co-production will be embedded in and across all parts of this transformation

work – from how the programme is governed, to how new services are designed to actively working with diverse communities across our Local Care Partnerships to ensure that we have all the right people involved, as equal partners.

We will use an insight and engagement log to capture all insights and feedback. This will be reviewed as part of the ongoing model design and development work and we will capture, within that log, how feedback has informed decision making.

Patient assurance (to be filled out by the patient group)

Does the plan clearly outline the background and reasons for the change?

Yes (fully assured)

2. Level of change and potential influence

Outline the level of change (see appendix C). Explain why you have chosen this level, for example;

- *What can people actually influence?*
- *How many people will it affect?*
- *Is it potentially controversial? (political, public)*

Category 3
Consider completing
QEIA

The Community Mental Health Transformation programme will require category 3 engagement for the following reasons:

Who will be affected?

- It will affect a significant number of people. The NHS England guidance defines the population in scope for the transformation as adults and older adults with ‘severe mental illness’. For the purposes of this report, the term ‘severe mental illness’* covers a range of needs and diagnoses including but not limited to psychosis, bipolar disorder, ‘personality disorder’ diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may coexist with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use.
- In Leeds, there are nearly 8,000 people recorded with serious mental illness (SMI). These are only the people known to services where this is recorded and so, in reality the number is likely to be far greater. We know there are people whose needs aren’t met by current service provision. We also know that Leeds has a higher rate than the national average of people experiencing first episode psychosis.
- There will also be a significant number carers affected who provide support and care to those with ongoing complex mental health needs.

What can be influenced

- The design, development, implementation, and review of the model can be influenced, as long as it meets the principles for transformed community mental health as set out in the NHS long term plan and community mental health framework (<https://bit.ly/2X6ON7V>)

Effect on existing services

- We will be developing and testing integrated community mental health hubs which will bring together into a single team existing services that provide care and support across the NHS, local authority and third sector. This isn’t just about structural change though; the transformation and integration will require significant culture change, new ways of working. <https://www.youtube.com/watch?v=8x-WxYcSBo8>
- There are no plans to close or decommission any existing services. This is about expansion and integration.
- In re-designing services people may receive an offer different to the one that they may have had in the past. We recognise that this may have a destabilising effect on people with moderate to severe mental illness, as dealing with any change could be potentially harmful or distressing for people., even if the impact is positive. We will ensure that conversations of this

nature are had on a personalised basis, through health and care staff with who individuals have contact.

- There is a significant funding increase over the next three years to expand and test new forms of care and support for people in the community. This will include new roles (clinical and non-clinical) and there is expected to be significant expansion of roles and support in the third sector (e.g. peer support, community connectors, experts by experience).

*We have heard feedback that this language is not always sensitive or indeed helpful as it focuses on diagnosis, not need. We are adopting the description of 'ongoing and complex mental health needs' but recognise this can be challenging as the policy guidance and indeed our own primary care Quality Outcomes Framework (QOF) registers use the term 'SMI'. It is an important language sensitivity point that needs to be considered.

Patient assurance (to be filled out by the patient group)

Does the involvement reflect the size and topic of the change?

Yes (fully assured)

The PAG would like to see a simplified version of the community mental health framework used as a point of reference to help people who are getting involved understand the principles and aims that they are working to, to help clarify their role.

3. Timescales

Outline the timescales for your project. Ensure these are realistic.

This is a three-year transformation programme. Engagement and involvement are an integral part of overall programme design and delivery. We will do an initial focused piece of engagement work Oct-Dec 2021 in our year one pilot sites, and this insight will be used to inform model design and development.

We will review learning towards the end of Q4 2021/22 so we can reflect on learning in terms of methods of engagement and involvement, experiences of those involved and the impact that it has had. This will then help inform the involvement and engagement plan for years 2 and 3 as more LCPs come on board.

The nature of the work is that engagement and involvement work and methods will evolve, as the learning and model development progresses. This will be overseen by the Engagement and Involvement working group (which will be led by the Involvement Lead who starts in post October 2021). We will also ensure that the Programme Board regularly reviews how insight and engagement has been acted on, as part of ongoing assurance.

Recruit CCG volunteer/s	May 2021 CCG volunteer and LYPFT volunteers. We need to build and expand a network of 'experts by experience' to co-design the new models of care, and also be embedded in the governance, design, delivery and evaluation of this programme.
Build and expand network of experts by experience, with a particular focus on pilot sites and people in scope in yr. 1	August 2021 Plans to build this network will commence from August onwards and it will be an ongoing, iterative process. There will need to be a flexible approach to involvement and involvement at all levels. We have drafted role descriptions, based on good practice, specifying activities and reimbursement.
Initial draft of involvement plan	September 2021
Develop Quality and Equality Impact Assessment	September 2021
Set up steering group to plan the activities	October 2021
Build presence on Mindwell website	September 2021
Year 1 LCP pilot sites focused involvement activities	October-December 2021

Review of year 1 learning and planning for year 2	March 2022
Review of year 2 learning and planning for year 3	March 2023
End of programme and final learning/evaluation	March 2024
Patient assurance (to be filled out by the patient group)	
Does the plan clearly outline the timescales for the involvement and they are realistic?	
Yes (fully assured)	
Having a good review of existing insight will help with timescales as it will help us focus on gaps and avoid potential duplication.	

4. Who is affected by the change?

Clearly outline who is affected by the change and how it will affect them.

- *What do you already know about peoples' access, experience, health inequalities and health outcomes when they use this service? (where has this information come from? – local/national involvements, best practice, patient experience reports etc)*
- *How well do people from protected groups (Appendix D) fare in relation to the general population? (what groups do you not have information about?)*
- *Consider positive or negative impact on:*
 - **Patient reported experience** (National surveys, complaint themes and trends, Patient Advice and Liaison Service (PALs) data, Friends and Family data, incident themes and trends)
 - **Patient Choice** (Informed choice, choice of provider, choice of location)
 - **Patient Access** (Physical access, systems or communication, travel and accessibility, threshold criteria, hours of service including out of hours)
 - **Compassionate and personalised care** (Patient dignity and respect, empathy, control of care, patient/carer involvement, care that is tailored to the patient's needs and preferences)
 - **Responsiveness** (Communication, waiting times, support to patients)
 - **Promotion of self-care and support for people to stay well** (People with long term conditions, social prescribing initiatives, social isolation, help and advice elements)

The Equality Act 2010 requires the CCG to have due regard to a number of equality considerations when making changes to services. As part of this process we are expected to carry out an assessment to understand the impact of the change on different communities in Leeds. This is called an Combined Impact Assessment.

The assessment has not identified any groups who may experience negative impacts, or be disproportionately affected as a result of this work. The expected changes and developments all seek to improve services, and service users should expect to see more integrated services, working collaboratively together with clearer, more accessible information and guidance.

We do recognise, though, that in re-designing services people may receive an offer different to the one that they may have had in the past. We recognise that this may have a destabilising effect on people with moderate to severe mental illness, as dealing with any change could be potentially harmful or distressing for people, even if the improvements are positive in nature. We will ensure that conversations of this nature are had on a personalised basis, through health and care staff with who individuals have contact.

The Combined Impact Assessment and what we already know, has helped us identify groups that are often more affected by mental health problems. We know that some groups with protected characteristics generally fair worse than the wider population in regards to their mental health. These are:

- Younger adults
- Older adults
- Women – more likely to experience common mental health disorders
- Men – more likely to die by suicide
- Disability
- Gender reassignment

- Marriage/civil partnership
- Pregnancy/maternity
- Race
- Religion/belief
- Sexual orientation
- Socio-economic deprivation

(See Appendix E for further information on the above categories considered). The full Combined Impact Assessment has been viewed by the chair of the Patient Assurance Group and will be regularly reviewed by the Programme Board for this work.

Additional considerations we will bear in mind include:

- **Populations of each Local Care Partnership (LCP)** - We will be working in three pilot Local Care Partnership areas in 2021/22:
 - HATCH (Chapelton and Burmantofts, Richmond Hill and Harehills) – has higher deprivation, larger diverse ethnic communities and higher rates of mental health.
 - Leeds Student Medical Practice and The Light – larger population of students, younger people and females as well as a higher diverse ethnic community population.
 - West Leeds – has a higher prevalence of mental health difficulties in the older adults population.
 - We will develop and test new ways of working considering the needs and specific demographics of each location to ensure we hear from the right communities and that they have the opportunity to be involved.
- **‘Offline stakeholders’** – These are people who struggle to get online with access, technology or internet issues. Barriers (Healthwatch Digital Inclusion report, 2020, <https://healthwatchleeds.co.uk/wp-content/uploads/2020/07/Digitising-Leeds-Risks-and-Opportunities-For-Reducing-Health-Inequalities-in-Leeds.pdf>) may include:
 - access - not everyone has the ability to connect to the internet
 - skills - not everyone has the ability to use the internet and online services
 - confidence - some people fear online crime, lack trust or don't know where to start online
 - motivation - not everyone sees why using the internet could be relevant and helpful
 - Digital exclusion can be hyper-localised (e.g., some streets may have poor internet access due to access points for the internet) making it varied across the city.

They may be excluded from being involved as they may not be able to contribute or find out about opportunities to have their say. COVID-19 regulations about social distancing have also severely restricted 'in-person' meetings. These groups of people, in addition, may often be socially isolated and in need of extra support. We will ensure that there are a variety of methods for people to get involved to ensure people are not digitally excluded.

- **Working age adults** – experience from previous engagement work has identified working age people as one of the more difficult groups to involve due to being at work when engagement activities are often held, during the day on weekdays.
- **Carers** – experience from previous engagements has identified that carers can find it difficult to be actively engaged or spend time taking part in involvement activities due to their caring responsibilities.
- **Younger people in children's mental health services** – although this programme is for adult mental health services, there are young people who are currently in children's services who will be accessing adult mental health services during the rollout of this programme.

COVID-19

The impact of the COVID-19 outbreak and local and national lockdown restrictions and guidance have had far-reaching impacts on people's lives, especially on their mental wellbeing. More than two-thirds of adults in the UK (69%) report feeling somewhat or very worried about the effect COVID-19 is having on their life (<https://www.health.org.uk/news-and-comment/blogs/emerging-evidence-on-covid-19s-impact-on-mental-health-and-health>).

There is evidence that people are experiencing both an increased awareness of their mental wellbeing as well as experience of negative impacts brought on by the current situation.

Patient assurance (to be filled out by the patient group)

Does the plan clearly outline the groups affected by the proposal, especially the impact on people with protected characteristics?

Yes (fully assured)

PAG would encourage working with digital inclusion mapping organisations to collaborate on the development of digitally inclusive services.

5. Methodology and mechanisms

Outline what methods you will use to involve people. Consider:

- *Using methods appropriate to your audience: surveys, interviews, social media, focus groups etc*
- *Explain why you have used these methods*
- *How many people do you intend to involve with and why?*
- *How will you target groups identified as specifically affected by the change?*

This is a three-year transformation programme and involvement will be an integral component of the programme throughout. We aspire to ensure that everyone who is affected by the changes within this transformation programme is given the opportunity to be engaged with and be involved in the work, should they wish to be.

We aren't going to attach a numerical target. We can baseline involvement in year 1 and measure how that grows, but we value the qualitative measurement of impact from involvement and engagement more.

We will always use a mixed method approach to involvement, recognising this is not a one size fits all approach. The types of involvement activities will be determined over the course of the three years based on iterative learning as we go; identified gaps and need in certain populations, and emerging evidence.

People involved in a number of different workstreams will be entitled to remuneration for their involvement. This can include being paid at the national living wage rate and covering of expenses (depending on involvement and project work). This will adopt the LYPFT expenses policy.

Focused involvement work - Year 1

There is some specific targeted involvement activity planned in our year 1 pilot LCPs from October-December 2021 which will be led by Healthwatch Leeds. This will include face-to-face* and online work, through:

- Big Leeds Chat events booked during October in pilot site areas
- University events for Leeds Student Medical Practice (LSMP) and The Light (LSMP covers a student population)
- Running focus groups in community locations – we are working with the pilot LCPs to set these up
- Accessing networks in the localities, with a focus on those communities that we do not usually hear from
- Surveys online and sending out through GPs and relevant stakeholder networks

How will we use the work?

- The report from work will feed into the model development for the pilot LCPs.
- The engagement work will make recommendations on future engagement for the citywide roll out.
- The work will support recruitment of experts by experience in the local areas
- The feedback from the involvement activities will be recorded in the feedback and outcomes log. This will be widely shared to demonstrate the impact of the feedback on development of the new service.

*Any face-to-face work will be reviewed should there be a change in guidance/restrictions relating to COVID-19. When conducting any public facing work, we will ensure that, as needed, staff and supporting volunteers will be supplied with appropriate PPE (such as face masks, hand sanitisers etc.) and that they follow social distancing guidelines to ensure that people feel safe to be involved.

Co-production

Co-production is an integral tread of this transformation programme design and delivery. It's vital that we involve people with lived experience (including carers) in the design and delivery of this programme, so that we design the right forms of care and support to meet people's differing needs.

This is particularly true for those groups of people who we know experience poorer access to, experience of, and outcomes from current provision. We also need to provide evidence to NHS England, as part of our ongoing assurance to them, that we have involved people with lived experience in our programme governance throughout this work.

We will do this by:

- Formally recruiting people with experience of mental health services with a clear role description and remuneration
- Ensuring we have people with experience of mental health services represented throughout our programme governance, including recruiting someone with lived experience to become an independent Chair of the Programme Board.
- People with experience of mental health services will be supported to take a step back from their personal experiences and represent the wider mental health community when involved in project groups and programme boards.

The CCG volunteer involved in this work will provide ongoing assurance for new methods and approaches as they develop.

Patient assurance (to be filled out by the patient group)

Does the plan clearly outline the methods that will be used to involve people, especially seldom heard groups?

Yes (fully assured)

The PAG have suggested that a regular and dynamic 'You said, we are doing, what next' updates are monitored and provided to demonstrate the difference that people's involvement is having.

The PAG are also keen that any remuneration for people being involved can be claimed in a fair and easy way.

6. Partnership working

Outline which partners you need to involve in your involvement project and why. Consider:

- Staff
- Provider partners
- Voluntary sector
- Local counsellors.
- *How will they be involved? (attending events, promoting the activities, informing etc)*
- Governance of the programme is multi agency and we have representation from all partners across the health and care system. These include:
 - NHS organisations in Leeds, including commissioners and providers (Primary Care services, LTHT, Leeds Community Healthcare and LYPFT)
 - Leeds City Council
 - Voluntary, Community and Social Enterprise (third sector) including Healthwatch Leeds, Forum Central, Voluntary Action Leeds and social prescribing services.
- We will be including people with lived experience and carers in our governance structures
- We will be working with and through local care partnerships which bring together a number of

local partners and elected members – partners from across those categories identified above).

- The involvement lead will have direct connection with the People's Voices Group (PVG) and the mental health sub-group that is part of the PVG.

Patient assurance (to be filled out by the patient group)

Does the plan clearly outline which partners and community, voluntary and faith sector organisations we need to work with and how we will do this?

Yes (fully assured)

7. Involvement Questions

Outline what questions you will ask people in the involvement. Consider:

- *What questions you will ask in the survey and other methods you are using (focus groups etc)*
- *Providing the patient group with a worked up draft of the survey – including an introduction and equality monitoring questions.*
- *Demonstrating how you have tested these questions to make sure they are easy to understand.*

As per section 5, there will be some targeted local engagement during October-December 2021 in the year 1 LCP pilot sites.

Some example questions asked will include:

1. We want to work closely with people with lived experience and carers to develop and deliver the new service. What (if anything) would encourage you to help us design this new approach to mental health support?
2. Please tell us up to 3 things that you think are important to consider when we develop and deliver the new service so that people have the best possible experience.
3. Is there anything else you would like to say about this planned new approach to mental health support?

As noted earlier, the ongoing approach to engagement and involvement will evolve, in response to learning as we go. The CCG volunteer involved with the project will provide ongoing assurance to ensure the questions and methods used are robust and appropriate.

Patient assurance (to be filled out by the patient group)

Does the plan clearly outline what questions people will be asked?

Are the questions and introduction clear and easy to understand and have they been tested with groups that represent patients?

Partially (reasonably assured)

Partial assurance given due to not being able to sign off on questions and information being used to inform people. Assured by the ongoing involvement of the CCG volunteer in the programme.

8. Ongoing patient assurance

Outline how you will involve people throughout the project. Consider:

- *How have people been involved so far?*
 - *involving patient representatives (PPG members or CCG volunteers) in aspects of the involvement (such as filling in the survey with patients, analysing data etc)*
 - *adding the involvement report to your website*
 - *outlining how you have responded to people's feedback (you said, we did)*
- CCG and LYPFT volunteers have been involved in supporting model development and the involvement activities.
 - The Involvement and Engagement working group will have responsibility and oversight for delivery of the programme's involvement and engagement plan. The Involvement Lead, once in post, will have accountability to the Programme Board for delivery of that plan. This will ensure we have good assurance processes in place.
 - Two online events have been held involving people from a range of organisations, sectors and

people with lived experience and carers to introduce this work and help start conversations about the development of this programme.

- Further locality-based focus groups will be held.
- People with experience of mental health and volunteers have been involved in the recruitment of the Involvement Lead role and will be involved in similar future recruitment opportunities.
- 'You said, we are doing, and what next' report will be produced based on the feedback from the involvement events, focus groups and other involvement work carried out.
- The plan is to develop a range of different roles for experts by experience and recruit to these roles.
- We will develop different levels of involvement for service users and carers to allow for greater involvement from more diverse groups.
- We will build in involvement and co-production as an integral part of the service
- We will use an insight and engagement log to capture what we have heard and how it has fed into decision making.

Patient assurance (to be filled out by the patient group)

Does the plan clearly outline how patient representatives will be involved throughout the project?

Yes (fully assured)

Other things to consider

You might like to consider the following:

- *do you need additional staffing to carry out the involvement? (carrying out the survey, inputting data onto a computer, analysing the data, writing a report)*
- *Do you need a budget for the involvement (to pay for things like survey design, printing, easyread etc)*

Involvement Lead – interim support from Healthwatch. Likely that there will be further recruitment and capacity building to increase involvement and engagement – this could be recruitment of specific roles to sit under the Involvement Lead or commissioning work/capacity building in existing forums and networks for involvement across Leeds.

We have funding available (via transformation funds) to cover engagement and involvement costs - direct costs to individuals as well as costs for venue hire, catering etc. We will need an agreed policy on how we do this.

Covid-19 – impacts on how engagement work is carried out

Cultural sensitivity and appropriateness and language.

Considering inclusion and access requirements in all the work we do – e.g. VSL language interpreters.

Budget for the above plus any literature and materials we need to produce and thinking about things like easy read, different languages etc.

Budget for some simple public information about the transformation programme – marketing and information campaign

Appendix A – Q&A for commissioners and practice managers

Why do we need to write an Involvement Plan?

Engaging with patients and the public is a **statutory duty** (<https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf>). To help us get it right first time we have developed this planning template.

Do I need to complete a separate Quality, Equality Impact Assessment (QEIA)?

Evidencing that we have considered the impact our activities will/may have on patients and the public; and identifying changes we can make to reduce/remove any negative impacts is a **statutory duty**. Filling in a QEIA is good practice and should be done for Level 3 involvements and level 4 consultations.

Who should fill in this plan?

This plan should be written by the person leading the change (commissioner/practice manager). You can get support from the CCG involvement, equality and communications leads. It is a joint plan for the project. Because the plan will be reviewed by patients it is really important that it is concise and that you use plain English, avoid jargon and explain any terms or acronyms that you use.

Where does the plan go?

This plan will be used to get patient assurance for involvement activity. Patient assurance is a process whereby members of the public review your involvement plan to make sure it is meaningful and involves the right people in the right ways. Patient assurance will usually come from the CCG Patient Assurance Group (PAG) or the GP practice Patient Participation Group (PPG). Their role is to help you to develop a robust plan and they should be seen as a 'critical friend'.

When does the plan need to be finished?

The plan should be shared with patients at the earliest opportunity. You will need a completed plan **two weeks before you attend a group for patient assurance** so that members can read through. This will help them understand your plan and save you time when you present it. If you are developing a survey you should present this with your plan.

What will we be asked when we present our plan to a patient group?

When you present your plan to patients you will have a few minutes to outline your proposal. If you have been working with a patient on the project you might like to invite them to the group to support your presentation. You should be prepared to talk about:

1. **Background** – briefly give a background to the service change
2. **The level of change** – does the involvement reflect the size and scale of the change?
3. **Timescales** – what are key dates for your involvement?
4. **Who is affected by the change** – who will the change will impact on? (especially groups with protected characteristics)
5. **Methodology and mechanisms** – how will you involve people?
6. **Partnership working** – who do you need to work with on the involvement?
7. **Survey questions** – what questions have you asked and why have you asked them?
8. **Ongoing patient assurance** – how will you involve people throughout the project?

Having the answers to all these questions when you seek patient assurance will help you manage the meeting.

If you have any questions please speak to the involvement team.

Appendix B – Guidance for patient groups providing assurance

Engaging with patients and the public when we change services is a **statutory duty**. We also know that we commission safer and more efficient services when we involve patients in the design.

The role of patient groups like the PAG and PPG is to make sure that **when we change services we are engaging patients, carers, the public and wider stakeholders in a meaningful way**. When we make a change to a service or develop a new service we have to write an involvement plan to outline how we will involve local people. We ask our patient groups to review this plan and work with us to ensure that our involvement gives all communities and stakeholders an opportunity to share their needs and preferences.

What can you expect from us?

- You will be given a draft involvement plan **two weeks** before any meeting to discuss the plan.
- The project will be at an early stage and there will be an opportunity for you to **influence the plan**.
- At the meeting the project lead will give you a **short presentation** about the project and outline their plans for involvement.
- You will be given some time to **ask questions** about the project.
- Time will be limited for questions but you will be able to **contact the project lead** outside of the meeting to ask further assurance questions.
- We will keep you updated on the project and demonstrate **how people's feedback has been used** to shape the work.

What do we expect from you?

- Your role as a patient representative is to champion the needs and preferences of the **wider public**.
- We ask you to take a **step back from your personal views** about the project and consider the needs and preferences of all the different people that live in Leeds.
- We ask you to act as a **critical friend** to our commissioners and practice managers and support them to develop a strong and meaningful involvement.
- We will ask you to limit your questions and keep questions **focussed on the involvement**.
- Based on the information provided you will be asked if you are:
 - **Fully assured** – you are very confident that the involvement plan will involve the right people in the right ways
 - **Reasonably assured** – you may ask for some changes to the plan but with those changes you are fully assured that the involvement plan will involve the right people in the right ways
 - **Not assured** – you have serious concerns that the involvement plan is not robust or meaningful

Appendix C – Levels of change

This is a **guide** and decisions about the level of change should be done with the support of the CCG involvement and equality teams.

Level 1 – Ongoing development

- A small scale change or a new service
- Affecting small numbers and/or having low impact
- There is good evidence that the change will improve or enhance service provision
- Often requires an information-giving exercise (2-4 weeks)
- May require some low level involvement

Example (please note these examples would be assessed individually and be subject to local circumstances)

- The merger of GP practices where there is either an improvement or no change to the services being offered to patients
- Extending the hours of a service

Level 2 – Minor Change

- A small/medium scale change or a new service
- Affecting low numbers of people
- Often requires a small involvement (4-6 weeks)

Example (please note these examples would be assessed individually and be subject to local circumstances)

- The closure of a branch practice at a GP surgery
- Changing or reducing the hours of a service

Level 3 – Significant change

- A significant service change
- Affecting large numbers of people and/or having a significant impact on patient experience
- A significant change from the way services are currently provided
- Potentially controversial with local people or key stakeholders
- A service closure
- Limited information about the impact of the change
- Requires a significant involvement (3 months)

Example (please note these examples would be assessed individually and be subject to local circumstances)

- A significant change to the way a service operates (such as a referral criteria or location)

Level 4 – Major change

- A major change that requires formal consultation and follows NHS England guidance
- Affects majority of the local population and/or having a significant impact on patient experience
- A substantial change from the way services are currently provided
- High risk of controversy with local people or key stakeholders
- A service closure
- Limited information about the impact of the change
- Requires a significant involvement (3 months+)

Example (please note these examples would be assessed individually and be subject to local circumstances)

- A major transformation of a large service
- The proposed closure of a large service following a national directive

Appendix D – Protected characteristics (*Equality and Human Rights Commission 2016*)

1. Age

Where this is referred to, it refers to a person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).

2. 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.

3. Gender (Sex)

A man or a woman.

4. Gender reassignment

The process of transitioning from one gender to another.

5. Marriage and civil partnership

Marriage is no longer restricted to a union between a man and a woman but now includes a marriage between a same-sex couple. [1]

Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples (except where permitted by the Equality Act).

[1] Section 1, Marriage (Same Sex Couples) Act 2013, Marriage and Civil Partnership (Scotland) Act 2014.

6. Pregnancy and maternity

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.

7. 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.

8. Religion or belief

Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

9. Sexual orientation

Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

Appendix E – Protected characteristics and mental health

The table below outlines the evidence considered in our equality impact assessment to highlight people who may need to be targeted as part of this ongoing involvement work.

Group	Source	Comments
Age (under 25/ over 65)	Leeds MHNA 2017 and Adult Psychiatric Morbidity Survey 2014	National population prevalence modelling indicates that rates of Common Mental Health Disorders (CMHD) are higher in young people and in older people than working age groups. The services under review are all for people over the age of 18.
Gender (male/female/intersex/ other)	Leeds MHNA 2017 and Adult Psychiatric Morbidity Survey 2014 Samaritans, 2018 The CALMzone, 2019	Women have x 2 higher estimated rates of CMHD than men. In Leeds, 19% of women have a recorded CMHD in Primary Care, compared to 11% of men. Suicide is the biggest killer of men and women under the age of 45. Men are three times more likely to die by suicide than women, with men aged 45-49 having the highest suicide rate.
Disability (sensory/ mental health/ long term illness/ addiction)	Leeds MHNA 2017 and Adult Psychiatric Morbidity Survey 2014 Mind, 2015 Urgent Treatment Centre (UTC) engagement, NHS Leeds CCG, 2019	<p>Sensory impairments</p> <p>People with sensory impairments (for example, visual/hearing impairments) are at increased risk of CMHD and experience barriers in accessing mental health support.</p> <p>Long-Term Conditions (LTCs)</p> <p>Nationally, 30% of people with a Long-Term Condition are estimated as having a CMHD. However, in Leeds 37% of people with a LTC have a diagnosed CMHD that is recorded in Primary Care.</p> <p>Learning Disability</p> <p>People with a learning disability have markedly worse health than the general population as a whole and are therefore more likely to use health services (Equality and Human Rights Commission, 2013)</p> <p>In Leeds there are estimated to be around 12,900 adults with a learning disability (Joint Strategic Needs Assessment) and there are around 3,090 people recorded by Leeds GPs having a learning disability (Leeds, the compassionate city: tackling inequalities, 2017).</p> <p>Autism</p> <p>People with autism are particularly vulnerable to developing mental health problems. Mind (2015) found that existing services tend to treat people either for their autism or for their mental health problems, while failing to recognise the complex dynamic between the two.</p> <p>People with autism have told us that accessing services can be difficult as it can be overwhelming to attend due to noises, not knowing what to expect or is going to happen and experiencing poor attitudes and a lack of understanding about their needs.</p>

<p>Gender Reassignment</p>	<p>Leeds MHNA 2017 and LGBT Leeds mapping project</p>	<p>The transgender population is at increased risk of experiencing poor mental health.</p> <p>Feedback during the Primary Care mental health engagement work highlighted that health services can feel unwelcoming to members of the LGBTQ+ community.</p>
<p>Marriage/ civil partnership</p>	<p>SCIE, 2020</p>	<p>There has been no identified impact on marriage/civil partnerships, however any noted themes or trends that are identified over the course of the engagement will be reported on and taken into consideration as part of the final recommendations.</p> <p>However, due to the COVID-19 pandemic, domestic abuse organisations have observed increased household tension and domestic violence due to forced co-existence, economic stress, and fears about the virus. Increased isolation could create an escalation in abuse, where those who are living with an abusive partner or family member, may be less likely to ask for help. Fewer visitors to the household mean that evidence of physical abuse could go unnoticed.</p>
<p>Pregnancy/ maternity (breastfeeding/ adoption/ single or teenage parents)</p>	<p>Leeds PNMH needs assessment 2018</p>	<p>Women in the perinatal period experience similar risk (20%) of CMHD as women in general - however, they may experience barriers to accessing mental health support associated with having young children and self-stigma.</p> <p>Young Parents in particular are more than twice as likely to experience mental health problems in the perinatal period as the population of childbearing women overall.</p>
<p>Race (including non-English speakers/ refugees/ asylum seekers/ travellers)</p>	<p>Leeds MHNA 2017 and Adult Psychiatric Morbidity Survey 2014</p> <p>Equality impact assessment to support the walk-in centre review/ engagement (2017)</p> <p>Mental Health Foundation, 2019</p> <p>LankellyChase & Mind, 2014</p>	<p>There is significant evidence that some people from some Black, Asian and Minority Ethnic (BAME) groups experience both poorer mental health and increased barriers to accessing care including:</p> <ul style="list-style-type: none"> • Black Caribbean men • Black African men • White/Black Caribbean mixed people • White/Black African mixed people • Asylum seekers • Refugees • Gypsy and Traveller groups • Asian women • Black women <p>The number of Leeds residents that were born outside of the UK almost doubled - from 47,636 (6.7% of the population) in 2001 to 86,144 (11.5%) in 2011. Of these, 27,221 people were born in Europe, including 12,026 from EU accession countries (mainly Poland) and 58,923 were born elsewhere in the world.</p> <p>Different communities understand and talk about mental health in different ways. In some communities, mental health problems are rarely spoken about and can be seen in a negative light and/or stigmatised. This can discourage people within the community from talking about their mental health and may be a barrier to engagement with health services.</p>

<p>Religion/ Belief (or non)</p>	<p>Academic Research</p>	<p>There is evidence that some people within Muslim communities experience higher levels of depression which are more chronic in nature than in the general population (Spronston and Nazroo 2002).</p> <p>Muslim clients are also more likely to use religious coping techniques than individuals from most other religious groups in the UK (Loewenthal, Cinnirella et al. 2001)</p>
<p>Sexual orientation (lesbian, gay/ bisexual)</p> <p>LGBT+ is the often referred to acronym for people represented in the Lesbian, Gay, Bisexual, Transgender and others community. It represents more than just sexual identity.</p>	<p>Leeds MHNA 2017 and LGBT Leeds mapping project</p>	<p>National work highlights that LGB groups are at increased risk of experiencing CMHD. This has been found to be the case in Leeds through the local LGBT mapping project.</p> <p>Feedback during the Primary Care mental health engagement work highlighted that health services can feel unwelcoming to members of the LGBTQIA+ community (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual as well as others not identified in the acronym).</p> <p>LGBT hate crime has risen 147% since June 2016. LGB people are twice as likely as heterosexual people to have suicidal thoughts or to make suicide attempts (LGBT Foundation), and are two to three times more likely to suffer from depression.</p>

<p>Socio-economic deprivation</p>	<p>Socio-economic data is based on postcode data which shows presentation levels are higher from some of the most deprived wards.</p> <p>Mind, 2020: https://bit.ly/33JuA8F</p> <p>Mental Health Taskforce, 2016</p>	<p>In Leeds, nearly 200,000 people live in the most deprived 10% of neighbourhoods (when ranked nationally). These people have 2-3 times the risk of a CMHD compared to the general population. Specific associations/causes include – poor housing/homelessness/debts/unemployment.</p> <p>Homeless people and/or those with chaotic lives (such as people with a dependency on drugs/alcohol) need to be engaged to find out how they access services currently and whether mental health services provided would help them.</p> <p>A survey of over 14,000 adults by the mental health charity Mind has revealed that existing inequalities in housing, employment, finances and other issues have had a greater impact on the mental health of people from different Black, Asian and Ethnic Minority (BAME) groups than white people during the coronavirus pandemic. The online survey of over 25s in England and Wales (Existing Inequalities Survey, 2020) found:</p> <ul style="list-style-type: none"> • Almost one in three (30 per cent) people from BAME communities said problems with housing made their mental health worse during the pandemic, compared to almost one in four (23 per cent) white people. • Employment worries have negatively affected the mental health of 61 per cent of people from BAME communities, compared to 51 per cent of white people • Concerns about finances worsened the mental health of 52 per cent of people who identified as from a BAME community, compared to 45 per cent of those who identified as white. • Other issues saw a similar pattern, including getting support for a physical health problem (39 per cent vs 29 per cent) and being a carer (30 per cent vs 23 per cent). <p>People from BAME communities are more likely to live in poorer and/or over-crowded conditions, increasing the risk of developing mental ill-health.</p>
--	--	--