Health Inequalities and Engagement in Morecambe Bay

Exploring PCN-led approaches to embed workable, replicable and sustainable processes for engaging with the population

Evaluation Report
April 2021

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Introduction

Introduction

About the project

Between September 2020 and March 2021, Co-create has been working with Morecambe Bay Clinical Commissioning Group (MBCCG), Primary Care Networks (PCNs), Integrated Care Communities (ICCs) and other local partners in Morecambe Bay. During this time, approaches to engaging with groups in the local population that experience health inequalities have been tested. These tests have been undertaken with a view to embedding successful approaches as a new 'business as usual'.

The purpose of evaluating the project is to understand the best ways to do this and to facilitate learning to support other areas to address health inequalities through better engagement with communities. The evaluation also aims to understand how this work can be sustained in the longer term, both in Morecambe Bay and for adoption in other areas of England. The project has been funded by NHS England and NHS Improvement and MBCCG. The work has been overseen and delivered locally through MBCCG with a large amount of in-kind support from stakeholders including Midlands and Lancashire Commissioning Support Unit (MLCSU), ICCs, and many Voluntary, Community and Faith Sector partners.

As part of a broader approach to population health and reducing health inequalities in the Morecambe Bay area, this project was devised to contribute to the following objectives:

- **To reduce local health inequalities with a focus on the most vulnerable communities;**
- **To support PCNs to develop skills to utilise population health management and engagement approaches;**
- **To identify and engage with local communities to understand the issues important to them and co-produce solutions;**
- **To develop and deliver learning that can be replicated in other areas in the Lancashire and South Cumbria ICS and across England;**
- **To encourage PCNs and ICCs to work more closely together for the benefit of their populations;**
- **To develop engagement with local authority and Voluntary Charity and Faith Sector (VCFS) partners.**

About Morecambe Bay

Morecambe Bay covers a large and dispersed geographical area including urban, rural and coastal communities with a total population of around 370,000 people. The area straddles the boundaries of Lancashire County Council, Cumbria County Council and a small portion of North Yorkshire County Council. It includes areas of the Lake District and Yorkshire Dales National Parks, the Arnside and Silverdale Area of Outstanding Natural Beauty (AONB) and part of the Forest of Bowland AONB.

The majority of residents live in the districts of Lancaster, South Lakeland and Barrow-in-Furness. The area is served by 35 GP practices, three hospitals (in Barrow-in-Furness, Kendal and Lancaster), eight Primary Care Networks (PCNs) and eight Integrated Care Communities (ICCs).

ICCs were first set up in Morecambe Bay in 2014 as part of the new care models work undertaken across England, and are specific to Morecambe Bay. They are integrated teams of health and care workers, voluntary organisations and wider community assets who address health and wellbeing in a holistic sense, and work together to support citizens to take a greater role in managing their own health and wellbeing.

The population of Morecambe Bay is considerably less ethnically diverse than the population of England. Black and minority ethnic groups account for only 5% of the resident population (including white non-British). Just over a fifth (22%) of the population is aged 65 or over and 28% are aged 0-24, reflecting the large student population in Lancaster.

Deprivation measures show that whilst Barrow-in-Furness and Lancaster are two of the more deprived districts in England, South Lakeland is amongst the least deprived districts in the country (bearing in mind of course that pockets of deprivation and affluence exist within these larger areas).

About the process we went through

Eight PCN areas were involved with this project. They are listed below and you can click on the links to see some of the specific outputs from those areas:

- **Bay;**
- **Barrow & Millom;**
- **Carnforth and Milnthorpe;**
- **Grange & Lakes;**
- **Kendal;**
- **Lancaster;**
- **Mid Furness;**
- **Western Dales.**

It should be noted that Mid Furness have worked with MBCCG using Co-create's methods, but without Co-create's direct involvement. Co-create do not have observations or feedback relating to Mid Furness, and therefore the learning in this report does not include Mid Furness except where specifically mentioned.

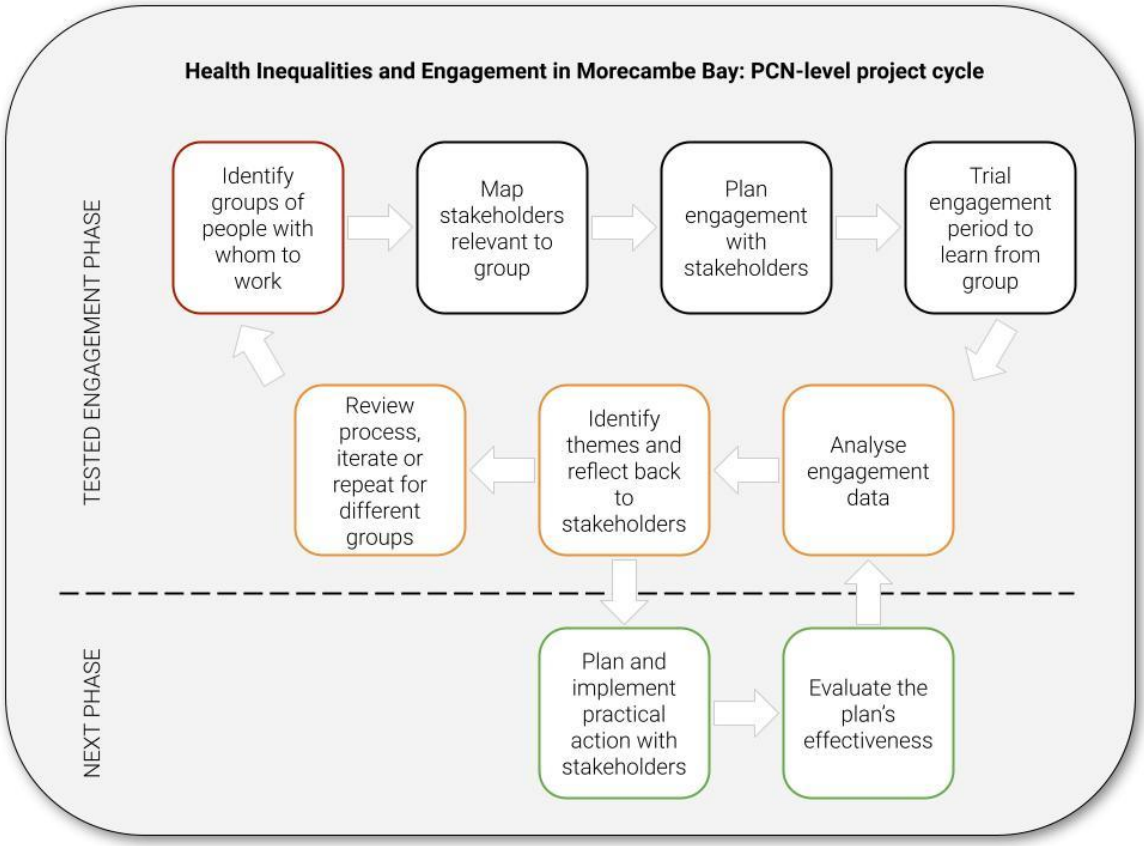
Excluding Mid Furness, each area followed the same set of stages as part of the overall project approach. The steps taken in each area were:

- **Co-create led a (virtual) welcome meeting September 2020 for the CCG and PCNs/ICCs that set out the project milestones and outlined what would be needed at each stage;**
- **PCN/ICC groups used a population health management approach to identify groups of patients that may experience health inequalities, with support from the CCG and Midlands and Lancashire Commissioning Support Unit;**
- **Co-create facilitated a remote workshop with each PCN to work through Co-create's asset mapping process and create a map of all the local people and organisations that could potentially support with this work;**
- **Each PCN/ICC group participated in a second remote workshop with Co-create to decide how they would engage with the group of people they selected, and create an action plan with roles and a timeline (with additional support on this provided by the CCG and Co-create);**
- **Co-create hosted an evaluation workshop, with follow-up support from Co-create and the CCG, to co-produce engagement outcomes to measure the impact and success of the project;**
- **Co-create provided live (recorded) training sessions on running online workshops, creating inclusive surveys, and carrying out phone interviews. They also provided written training sessions on question design and**

thematic analysis;

- **PCN and ICC groups (including local authority and VCSE partners) carried out their chosen method of engagement (in most cases virtual);**
- **For PCNs and the CCG, this phase of the project concluded with a Co-create-facilitated session to co-produce methods for "closing the loop" and thinking about taking action on what they had heard from their chosen groups;**
- **Co-create produced this report to evaluate the process and develop learning to share nationally.**

This diagram shows the cycle that was tested during this project and how it relates to what's next:



"We now plan to carry out this process every 1-2 years to get feedback from different groups in our community as well. We have learnt some valuable skills and processes to do this."

Reflection from Kendal

About the evaluation and this report

This report sets out the key findings and recommendations that have emerged through evaluating this overarching process across the seven areas. Its intention is to focus on the common things that have either worked well or could benefit from revision if approaches were to be adopted elsewhere. In essence, we have been trying to answer the following question:

> ***Building on Co-create's previous work with PCNs, what are the most effective ways to support all people within Morecambe Bay's Primary Care Networks and broader health ecosystem to embed a workable, replicable and sustainable process for engaging with the population as part of ongoing, existing efforts to reduce health inequalities?***

As a consequence of doing this work, there are a number of core outcomes for people that we have been particularly interested in learning about through this evaluation.

Outcomes for PCN staff:

- **People understand why co-production and public engagement will support their work;**
- **People are more confident with co-production and public engagement;**
- **People have some tools and resources to support them with public engagement for different groups of people;**
- **People are aware of how to repeat and refine the process beyond the life of this project.**

Outcomes for partners and local people:

- **People feel that they are being listened to;**
- **People feel that they are part of a conversation about their own health;**
- **People feel more positive about their relationship with health professionals and the health and social care sector.**

The general findings in this report should also be considered alongside the specific practical outputs from each PCN, such as stakeholder maps, engagement plans and associated data collection, as well as the PCN-level evaluation plans. This report includes four individual PCN case studies to reflect the experiences of those involved.

It's important to note that at the individual PCN level, separate and specific evaluation activities have also been planned as part of the project cycle, which are not part of this evaluation report. As a consequence of this, there will be a variety of things that will need measuring beyond the scope of this initial evaluation period. For these things, the role of Co-create has been to support people to build an approach towards this. These things include:

- The measurement of - or reporting on - any changes to health outcomes for the population as a consequence of this work;
- The measurement of - or reporting on - any changes to health inequalities for the population;
- The effectiveness of any approaches tried in this initial period in achieving specific health outcomes;
- The measurement or reporting of accessibility to healthcare, which sits upstream from health outcomes;
- Analysis of any data collected through individual PCN's evaluation approaches beyond March 2021.

A note on COVID-19

At the time of writing, the COVID-19 pandemic is at the forefront of everyone's minds and daily lives. This is clearly the priority for the NHS, which has impacted the amount of time and energy people have been able to commit to this project. We acknowledge the impact that the pandemic has had on our collective ability to carry out the intended work in all project areas, as well as to collect all of the evaluation data. This is worth noting as a backdrop to this report and evaluation activities.

Nevertheless, it should be noted that despite these constraints there was a good level of enthusiasm and engagement by PCN/ICC staff, VCFS partners and members of the local community or target group throughout this pilot project. This demonstrates the local commitment to the work.

"It was lovely hearing the enthusiasm in some of the areas. It would be great if we could tap into or create that in other parts too… I also enjoyed the process of making sense of the responses and the meaning they have on how we proceed next."

Reflection from Grange and Lakes

Section 2
Recommendations

Recommendations

About the recommendations

The following recommendations stem from the findings of this evaluation, which are detailed later in the report. The recommendations are intended as practical changes to the approach and support channels we have tested in Morecambe Bay so that similar approaches could be adopted and iterated in other parts of the country.

The recommendations have been split into three sections:

1) **Refining and adapting the process at the PCN level;**
2) **Supporting PCNs to adopt and embed approaches;**
3) **Data, measurement and finding a focus.**

In addition, we have 'tagged' each recommendation with the level at which it should be put into action; PCN, CCG and/or NHS England and NHS Improvement (NHSE/I).

Please note:

- References to PCNs assume that they would also be applicable to ICCs or equivalent elsewhere;
- References to CCGs also apply to their equivalent in the future.

Refining and adapting the process at the PCN level

Carry on engaging in Morecambe Bay by repeating the cycle with the same or different groups

PCNs | CCGs

The purpose of this project was to test out a cycle of activities and approaches that could be used again in the same or other areas, to engage with identified groups. This work should continue and evolve beyond the life of this funded project and, over time, focus on different cohorts.

The PCNs involved in this project now have the understanding of the process, what works and what doesn't to begin supporting other PCNs to begin this journey, with direct help from the CCG whose capacity can be built to do this (see findings section).

Ensure there's a shared understanding of 'population health management'

PCNs | CCGs | NHSE/I

The context for this project has been a 'population health management approach'. It has been clear, however, that there are two different conceptions of this: the quantitative, data-driven description of what's going on for people in the first instance (i.e. the present); and one that is centred on building relationships between services and the population over the longer term to achieve better health outcomes.

They are not necessarily at odds with each other, but clarity of which version is being spoken about at any one time would be beneficial for the purposes of embedding co-production as business as usual. As such, existing definitions of 'population health management' should be shared widely and efforts should be made to confirm they are understood by everyone in the same way at a local and national level.

Understand needs and wants for meaningful methods for PCNs and CCGs to share their experiences and approaches with each other

PCNs | CCGs | NHSE/I

It was clear from this project that people were learning from one another across PCNs, particularly through scheduled events. It was harder, however, to facilitate this learning informally in between the structured points of the tested approach. It is therefore recommended that further work be undertaken in Morecambe Bay and beyond to understand if PCNs want to talk to each other about their ongoing experiences on this journey and find appropriate ways to do this. This is particularly pertinent for when the funded support from Co;Create comes to an end.

Replicate the process elsewhere but move away from a temporary 'projects approach'

NHSE/I

There is enough to suggest that the test process is refined (but flexible) enough to try

in other places too, with revisions made as recommended in this evaluation. To encourage uptake, however, the framing of the approach and the series of activities it entails needs to shift.

This reframing needs to focus on supporting these activities as 'business as usual' rather than treating this kind of engagement as a 'project'. The project approach can mean that people de-prioritise the work and are more likely to see it as an additional burden, rather than complementary and beneficial to their existing work.

Allow the order of the activities delivered as part of this approach to adapt to different PCNs' needs

PCNs | CCGs

The process did not always make sense to everyone in the order in which people went through it. In addition, some PCNs feel like they have done some of the steps previously. As such, the order of activities should not be prescriptive and they should be allowed to flex.

Extend the process to ensure that people are supported to close the loop and bolster activities that firm up these plans

PCNs | CCGs | NHSE/I

Acting on the insight gained through engagement is a critical part of building relationships through co-production. Therefore, it is recommended to ensure that equal time is spent on making actionable plans for how to follow up on engagement - 'closing the loop'. The approach as tested to date in Morecambe Bay did include this at the end, but with less resource than planning the engagement and without support available for PCNs beyond initial thinking about what's next.

Develop communications that help understanding in the broader PCN population

PCNs

During this project, some PCNs experienced feedback suggesting that by focusing on one group of people with which to engage they were excluding others. Although this approach does encourage the identification of a group, it is with a wider aim of repeating the process for multiple groups over time. This needs communicating to the

broader population, some of whom may feel ignored or excluded. To facilitate this, PCNs should have a plan in place for this and ensure that all relevant staff (and partners) adhere to that.

Develop the process to ensure it builds on existing local engagement projects

PCNs | CCGs | NHSE/I

Don't assume that relevant stakeholder mapping or equivalent exercises aren't happening elsewhere too, perhaps within health services or through VCFS partners. In Morecambe Bay during this project, organisations in some areas were duplicating efforts in this regard and it was felt that combining efforts would have been more productive. Spend time before stakeholder mapping (or during it) to identify existing engagement projects and tap into those.

Supporting the PCNs to adopt and embed approaches

Facilitate PCNs to take ownership of the process in their area

CCGs | NHSE/I

PCNs need to feel like they own these activities. When the approach is perceived as coming from the outside (and not being treated as 'business as usual'), there can be local resistance, which means that the activities are unlikely to be sustainable. Don't look over people's shoulders too much; rather provide a flexible support framework within which PCNs can adapt.

Provide resources to enable adoption and time to embed, along with clear guidance and simple processes for how to access the resources

CCGs | NHSE/I

The promise and ultimate provision of resources - time, agency and money to backfill - have been essential during this project to get people on board, but not all of the PCNs have accessed what was on offer.

Support PCNs to access the resources available to them, particularly backfill, and make processes easier to do this. Without a clear plan and mechanisms for the roles or time to which it relates, it isn't utilised. Ultimately, if PCNs are going to do this regularly and well, they need the resources (or reduced duties in other areas) to cover the adoption of this approach, particularly in the early stages while it is being embedded.

Promote the approach, not finding the 'perfect cohort'

PCNs | CCGs | NHSE/I

Assuming the approach will be sustainable, PCNs will have the opportunity to engage with, learn from and build lasting relationships with a whole host of groups, including those experiencing the highest levels of health inequality.
As such, the key tools and general mindset of the approach are the important things on which to focus while introducing this for the first time. Needless to say, the identification of groups is important too but it can distract from, stall and override the broader culture of engagement if there's indecision or a sense that there may always be another group on which the focus should lie instead.

Data, measurement and finding a focus

Incorporate engagement and qualitative themes into broader inequalities data for identifying groups with which to engage

PCNs | CCGs | NHSE/I

The engagement data analysed in Morecambe Bay gives an insight into how some people may feel excluded from health services or experience health inequalities.

This provides a different lens through which to identify people at risk from health inequalities to the initial data sets used, which tend to focus on either NHS-driven health outcomes, service uptake or broader deprivation statistics.

In the longer term, as areas begin to collect and analyse such data through their

engagement activities, it is recommended that this new information be incorporated into the data-driven approaches for identifying people who are experiencing health inequalities. This isn't to replace the existing approach, it is a mechanism by which the approach can be enhanced and redefine health inequalities in multiple ways.

Align PCN and ICC boundaries and map these against useful data sets so that it's easier to understand where relevant inequalities are most prevalent

CCGs | NHSE/I

Through this project, it was recognised that the usual geospatial data used to identify needs - more specifically, the geographic boundaries to which the data relate - don't neatly align with the places covered by individual PCNs or ICCs. As such, it can be difficult to find comparable and PCN-specific data to highlight those experiencing health inequalities. It is, therefore, recommended that some work be done to support this, or at least define a methodology for how PCNs can approximate need in their areas based on existing (if incompatible) data sets.

Connect measures of success to prevention and engagement, not just symptomatic health outcomes or service uptake

PCNs | CCGs | NHSE/I

As with all interventions, measurable change takes time, particularly when it comes to health outcomes. In the interim, necessary changes will happen as stepping stones but represent harder-to-measure, non-clinical outcomes, some of which will be explicitly raised by those responding to engagement activities. This might include things like personal confidence, or knowing where to go for support if it was needed and feeling comfortable to do this. It is also important to recognise the ripple effect of engagement work that may be outside the direct field of vision for PCNs.

It is important for these outcomes to be measured by PCNs and their partners, where possible, and for those to contribute to what good looks like for engagement activities. This will help to create the case for continued support for this approach in a way that will realise the longer term health outcomes and reduction in inequalities.

Section 3
Headline Findings

Headline findings

There has been a positive shift despite difficult circumstances

As a broad observation, positivity and receptiveness to the process, activities and approach across the PCNs increased as the project progressed. COVID-19 has been challenging and has led to a sense that this kind of work is a 'nice to have' rather than an integral part. Despite that, however, good things happened, and the challenging environment may mean that these can be replicated appropriately. The case studies show specific examples of this (see later in the report).

The participants from PCNs particularly valued working with colleagues, new partners and creating opportunity for people to come together. In addition, people expressed how they enjoyed thinking about, working with and reaching out to the community.

Some reflections on the project from those involved included:

> "I enjoyed meeting the young people and their leaders. I learnt that young people are more resilient and mature than I thought they would be (maybe based on my experience as a teenager) and that they are keen to engage with this project."

> "We learnt that some of the challenges facing our cohort were things we could do something about which is reassuring!"

The elements of the approach are sufficient to equip people for adopting this in the longer term

Despite some uncertainty early on in the process, the series of activities and related support that was available to PCNs through this approach has meant that those involved now feel better equipped to continue this work. This relates to both how they have been able to plan what to do next with the information gathered through the test engagement periods, and also how they might replicate the process independently (or with reduced support) for a different cohort in the future. That said, and as detailed in the recommendations, some flex in the process will be required for some PCNs to make it more applicable to their needs.

The process has highlighted different and effective ways for PCNs to work, particularly virtual ones, and people recognise that the approach should be part of day-to-day roles

On reflection of the approach taken, PCNs have noted that, alongside the engagement methods adopted, they have been able to try out 'innovative' remote working techniques.It has surprised some as to how much can still be achieved in this way using digital means of working, such as virtual flipcharts, for example. During the 'What Next?' workshop towards the end of the project, PCN representatives recognised that people had different levels of involvement locally, but agreed the processes they have tried out should be used in their day-to-day jobs, not just one project.

The approach has challenged some assumptions about where inequality lies

Whilst the engagement resulted in the confirmation of some expected challenges which can be addressed, there were reports from the PCNs involved that it also challenged some assumptions. In particular, the process of cohort identification highlighted that inequality wasn't always where people traditionally looked in their areas. This represents an important outcome for this project and demonstrates the value of the approach taken in creating the conditions for change..

Taking practical action after the engagement is a key element yet to be realised, but the approach tested has resulted in people knowing what to do next

The process as tested through this project was only part of the picture. It was recognised and acknowledged that engagement, while helpful in developing relationships, is not an end unto itself. The thing you do afterwards with the information that engagement unearths is what makes it work in the long-run. Listening on its own can sometimes feel like tokenistic research unless it leads to visible attempts to change things as well. Those attempts, however, are shaped and informed by the listening. Although the post-engagement steps have yet to come to fruition for the PCNs taking part in this project, it is clear that the processes followed mean that most areas were clear what they were going to do next.

Multiple layers of resourcing are required to introduce these approaches but one size doesn't fit all

Resourcing, back-filling and mutual peer support between PCNs and all partners are

essential to put in place. PCNs welcomed these options and in many cases it was what made it possible for areas to be involved in this project. As the project progressed, it became clear that these resources are not necessarily used. In part, this was due to the processes through which the support was accessed. At the PCN level too, there were challenges to accessing the resources on offer. Some don't have a setup where they can simply take someone extra on for a few hours to complete a task. Some people also expressed some feeling that this is part of their job already.

Attempts to support ongoing conversation between PCNs didn't work as well as expected

As the project was being set up, the PCN representatives were asked about the method through which they would like to communicate throughout the process in between the scheduled activities. On the back of this a WhatsApp group was set up based on the preferences expressed. There was very little proactive participation in this channel aside from the occasional reminder form Co-create staff. This may have been due to time pressures, but it should also be recognised that what wasn't asked was "do you want to communicate with each other?". This should be explored further in future iterations of the approach.

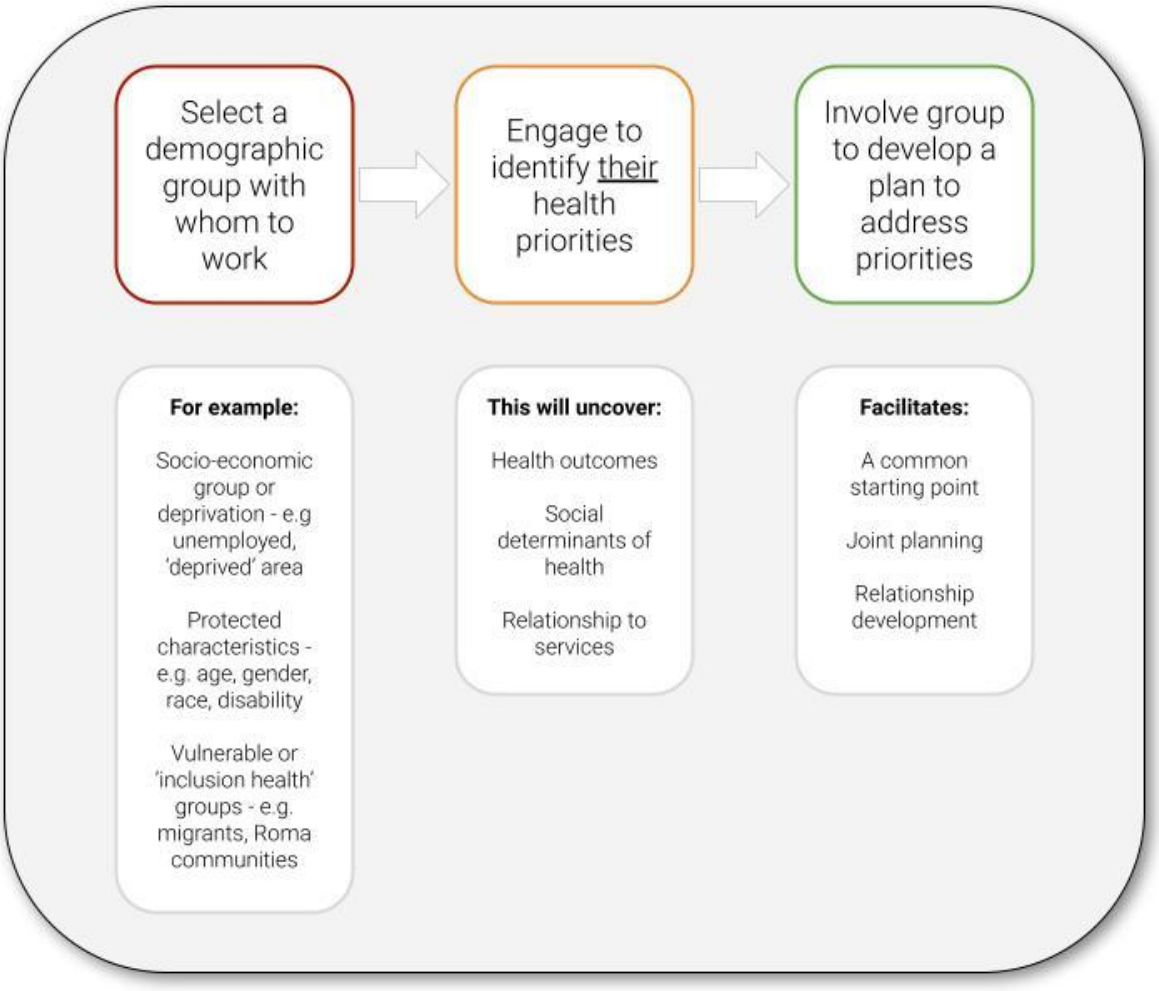
Some people already know the group with which they want to engage

Early on, some PCNs had a very clear sense of who they wanted to focus on before there was any support with selecting a cohort. An example of this is Kendal choosing young people. This should be encouraged if it prevents too much time being taken up by the selection process, especially where based on "soft intelligence" such as experience from clinical practice However, it should be stressed that the attachment of assumed challenges or interests to that group before the engagement should be avoided.

Thinking about engaging with groups of people independently from health-related problems is hard

Through this project, there have been a number of times where the intuitive cohort selection has been based upon or framed in terms of a health outcome (e.g. people with diabetes) or, for example, low uptake of a particular service. As part of co-production's focus is to listen to the concerns of people first before assuming what the thing to address is, it was necessary for Co-create to try and move people away from this impulse towards thinking about groups of people in the first instance. This

often took more effort than was anticipated. To assist with this, the Co-create team found that the following aid was useful in communicating how to approach cohort selection at a high level:



Data is useful but it shouldn't hold things up

Relying on a data-driven approach is useful, but it can hold things up if limited data are available for a cohort. It can also add a stage that isn't always necessary, particularly when we already know that a group experiences worse health outcomes in our area or nationally. This shouldn't hold up the intuitive focus and certainly shouldn't exclude people either. In the end, it's about developing a process for any given group.

In relation to the previous findings, data helped move PCNs from health outcomes to population groups. It also helps to challenge assumptions, such as showing inequality where people didn't know it existed. It is worth noting too that some PCNs discovered a lack of available data of a particular kind, either about the demographics in an area or how they experience health inequalities. This in itself represents an inequality.

Fostering trust in the process - in and across PCNs - are crucial to the approach but this is hard

Generating trust in the process is hard, particularly when it is being introduced by 'outsiders' (e.g. Co-create in this project) and the approach presented is the same across multiple PCNs with potentially different needs. Not everyone is at the same stage too and some may feel intimidated by or ahead of others. The one size fits all approach was certainly an issue in some places - e.g. Kendal and Barrow felt they were already ahead of what we were asking them to do. At the end of the project, some PCNs reflected that they felt they could have been supported more. As such, a more bespoke approach to providing tailored support across multiple, varied PCNs in an area may be more appropriate in future.

Have dedicated and clear leadership roles for the approach in each PCN area are beneficial

Leadership was really important - project teams with clear leads who are willing and able to take on this role have generally been more successful. Having these leaders present at the scheduled activities also helped to link the activities back to health services when new people and partners were engaged.

It takes time to see changes and realise positive outcomes, and this time needs to be protected and resourced if people are to adopt the approach in the longer term

It takes time for change to be realised - it's important to fund and resource this time. People may not be so engaged with the next phase if there's an expectation of 'outcomes' by the end of a short project period, further reason for adopting approaches as 'business as usual'. In the main, we observed that people don't like being pushed to do things on someone else's timescale - such as the CCG's, NHSE/I's or Co-create's - particularly when priorities may be elsewhere as has been the case with COVID-19.

Further support may be required to recognise value in the responses gathered through engagement activities

After the engagement period and upon analysing what some people have said, some PCNs expressed that they were underwhelmed with how insightful it had been. On further inspection of the same responses by the Co-create team, however, this

unearthed a tendency to the health-focused bounds of PCN's expectations in a similar way to that described at the cohort selection stage. This meant that they struggled to see the value in what was said if it wasn't directly applicable to their preconceptions of what's valuable. An example of this included people's views on whether waiting rooms were spaces in which people wanted to be in which, in reality, was having an impact on whether people with learning disabilities were likely to attend their appointments. As a consequence of this, some PCNs may need extra support with spotting the value when it's outside of the usual clinical boundaries.

New ways of working can provide a challenge, and this should be addressed early in the process

Alongside the need to foster a culture of trust in the process, it was observed that the flexible ways of working required in taking an open approach to working with partners and communities at both CCG and PCN level could be challenging for these organisations. This was predominantly noticed in two ways:

- The CCG would have felt more comfortable starting with a more traditional, precise long-term project plan detailing tasks, events and other activities for the entirety of the project;
- PCNs would have liked to know the exact time commitments and resources required at the beginning of the process, and did not easily take up the invitation to plan their own engagement project based on the resources available to them.

Flexibility is key to an approach that aims to accommodate PCNs and partners with widely varying starting points, and needs that are often not clear at the beginning of the project. Thought should therefore be given to supporting CCGs and PCNs to find comfort in new ways of work earlier on, should the approach be adopted elsewhere.

The CCG's capacity to support new PCNs with the same approach was catalysed

Although it wasn't the primary objective of this approach in Morecambe Bay, the CCG's capacity to support PCNs with embedding co-production and engagement methods appeared to increase. This meant that they were able to bring other PCNs - most notably, Mid Furness - up to speed with the approach mid-way through the project without Co-create's involvement and with a view to sustaining activities beyond the initial funded period. This is an area to explore further in future: how CCGs (or equivalent) can be the focus for introducing the approach so that it can be disseminated across a locality or region.

Maintaining momentum is crucial and scheduling activities enables this

It was observed that maintaining a sense of activity was crucial in keeping PCNs engaged and feeling part of something. It also prevents people from people feeling like they're not sure what to do. This has been observed in previous Co-create projects elsewhere. Scheduled and blocked-out time in diaries to do specific things - stakeholder mapping, planning engagement, thinking about evaluation, planning next steps etc. - seems key in keeping momentum and ensuring things happen. During this project those times were the same for all of the PCNs involved. A model that is more sensitive to PCNs individual timescales and less off the peg, however, would be more expensive but probably maintain momentum better.

COVID-19 has meant that the relationship building element of the project may not have been as pronounced as the data gathering

The vast majority of the PCN time during this project has been focused on gathering insight from identified groups of people. In an ideal world, an equal amount of time would have been given to creating spaces for local relationships to develop further between cohorts, services and partners independently from data gathering exercises alone. We have heard how COVID-19 has impacted this greatly. It has also meant that Clinical Directors from PCNs have not always had opportunities to get involved first hand.

Despite the positives relating to the adoption of online working practices, it was clear during the engagement planning stage of this project that PCNs had a preference for face-face engagement and felt that that would be easier. This also affected whether people were looking forward to engagement activities, with PCN representatives reporting that they are more confident about the next steps than they are looking forward to them.

Section 4

Case studies

Case study 1: Bay

About the PCN and its area

- **One practice in the PCN**
- **Practice area covers some of the most deprived areas in the country**
- **Seaside town with lots of nursing homes**
- **Proactive local CVS with strong links with the Integrated Care Community**

Engagement focus for this project

- **Adults with learning disabilities living in the community (i.e not residential or nursing care) and their carers**

Engagement methods

- **Survey to collect views**
- **Promotion of survey through social media**
- **Face to face survey completion where possible through community teams**
- **Survey completion promoted at annual reviews**

"This [is] an opportunity to reassess...our annual learning disability health checks...providing care...that makes our patients feel comfortable, cared for and listened to"

Joanne Price, GP, Bay PCN

Reflections from the PCN

“At the start of the project when ideas were developing, I felt that the project sounded very interesting and likely to yield some useful information as to how we can best support our community. The project was, however, done at a really inappropriate time. We had some concerns about this project in terms of the manpower we are able to offer at present due to workload pressures.

We recognise that both historically and recently we have struggled to ensure all our patients with learning disabilities are able to have an annual health check, for a variety of reasons. We felt that the project would unearth some of those reasons and allow us to collaborate with our patients in finding solutions to this challenge.

Throughout the project, I particularly enjoyed getting to know the community teams and finding out more about the work they do. I also enjoyed working with the project team from Co-create and the CCG - Danny, Vicky and Mark. They were very supportive with the process and engaging.

Having been through the engagement period, I now really hope that this project will allow us an opportunity to reassess how we organise and structure our annual learning disability health checks, improving uptake and providing care in a way that makes our patients feel comfortable, cared for and listened to.

Some themes that have emerged include: making sure doctors have enough time during appointments; seeing the same doctor each time; having happier things on the waiting room walls; and minimising waiting (room) time.”

Case study 2: Grange and Lakes

About the PCN and its area

- **A large area**
- **A mix of large, remote rural areas with three other areas who are all very different**
- **Many smaller communities who identify themselves individually**

Engagement focus for this project

- **Hospitality workers from migrant communities**

Engagement methods

- **Online survey to collect views**
- **Survey link disseminated through community links with known support groups locally**

"This project means to me that the health care system has shown its willingness to actively listen and act on what it has learned. I hope that this taster can encourage us to go further."

Erika Ghinelli, Community Development Worker

Reflections from the PCN

“I felt that the issue of health inequalities is huge and multi-faceted. I was worried that the scope of the project would not cover enough ground to tackle the problem. It also felt like another request on stretched time. But during the developing process I realised that what can be done with a pilot project is to uncover a clear and authentic snapshot of the topic we want to work on and call attention to the subject to be the spark for more research and action.

Sometimes for our area, the standard stuff didn't fit. It was great that the Co-create stakeholder mapping showed we were different. It was nice to do something for our hidden population who I think feel a bit victimised and unsure about things with Brexit, let alone Covid.

It was lovely hearing the enthusiasm in some of the areas. It would be great if we could tap into or create that in other parts too, which were less engaged. I enjoyed reading people's answers and discovering what is important to other fellow human beings in terms of health, which is an incredibly fundamental and globally shared subject for all humans. I also enjoyed the process of making sense of the responses and the meaning they have on how we proceed next.

This project means to me that the health care system has shown its willingness to actively listen and act on what it has learned. I hope that this taster can encourage us to go further in terms of wider reach and deeper understanding. I would love to work with the PCNs in the future to tackle barriers and inequality in the communities where we live.”

Case study 3: Kendal

About the PCN and its area

- **3 GP practices**
- **PCN formed in 2020, following on from the Kendal United partnership**
- **Integrated Care Community was established in 2016 and covers these GP practices with links to third sector organisations, councils, community groups, charities and support groups.**

Engagement focus for this project

- **16-21 year olds in the area**

Engagement methods

- **Co-produced survey to collect views**
- **Partnerships with local schools, the college, Health and Wellbeing Coaches, and youth workers to disseminate and collect survey responses**

"I have certainly learned about...not presuming how a target group will want to be approached. We involved a group of young people on setting the questions and deciding the format of the process which was invaluable."

Cara Stride, Development Lead, Kendal ICC

Reflections from the ICC

“I was really interested in learning more about engagement processes and more of the strategy behind engaging with members of the public. Wasn't really sure of the commitment required at the start but we picked a group we had wanted to reach out to since we were established. We also picked an area of focus which is central to our aims.

Young people's mental health was identified at an engagement event at the beginning of the ICC formation. This has been an area of focus throughout our work. There have been a number of high profile suicides in the town, notably those of young people. Waiting list for mental health services are long and we have recently had reductions in third sector support for mental health too. We chose not to focus on this in our questions, but mental health was still a strong theme.

All of the tools, methodology and on hand expert advice and support during this project were really useful. The structured approach with clear deadlines was helpful in planning work and thinking ahead. We were a bit unclear of the process at the beginning but we asked lots of questions and got there in the end. We were surprised with the response we got, considering the lockdown.

I have certainly learned about taking a step back and not presuming how a target group will want to be approached. We involved a group of young people on setting the questions and deciding the format of the process, which was invaluable. It’s better to get a few in depth answers rather than asking lots of people for tick box responses. If your suspicions are correct you will get those responses and even more. We feel like we have the tools to engage with another group of people in the future. We have also developed good working relationships to maintain.”

Reflections from a GP

“Initially I was excited because it linked up and enabled aspirations that we already had. It also gave opportunity to strengthen existing partnerships. It was refreshing too as it was not directly Covid-related, so a good contrast to other work.

I felt a bit frustrated about how long the set up seemed to take and it was difficult to maintain engagement with partner organisations. Although it was explained to us, the timescale, time commitment and process didn't seem clear at the start until after the third meeting.

We hadn't had the opportunity to listen to the voices of 16-21 year olds before. We already had informal feedback from young people and parents about unmet needs and had experienced these for ourselves in our daily work.

Introducing the project face to face with 6th form students was particularly enjoyable. From this, one student asked for work experience and ended up worked with my team on the vaccine project. They have agreed to be our ICC youth rep. It felt really good to get the feedback from others too.

We will now use the feedback from the young people to shape some services in Kendal that are currently being developed for them. We will also build on relationships developed in the secondary schools. We are hoping to engage other teenagers with work experience and have the youth rep on the ICC as an ongoing position/opportunity changing annually.

We now plan to carry out this process every 1-2 years to get feedback from different groups in our community as well. We have learnt some valuable skills and processes to do this.”

Case study 4: Lancaster

About the PCN and its area

- **A large PCN covering 85,000 people**
- **A diverse population which includes city centre, rural/farming, students and pockets of high deprivation**
- **Two practices within the PCN working closely together with each other and the community through their Integrated Care Community**

Engagement focus for this project

- **Women in Skerton (an area of Lancaster) eligible for a smear test**

Engagement methods

- **Survey to collect views**
- **Using videos on social media to promote survey completion**
- **Partnerships with local schools and food clubs**
- **Strengthening relationships with stakeholders through workshops**

"Talking to Julie from the food club about her experiences of working within the Skerton community, it was incredibly insightful and useful"

Kirsty Hagan, GP, Lancaster PCN

Reflections from the PCN

"We were incredibly busy (and still are) with the covid pandemic at the time this project was proposed. It was overwhelming to try and make time and space to dedicate to this with other issues competing for our time, but we felt it was important.

We were aware from national data that cancer referral rates and detection alongside screening uptake had significantly reduced due to the covid pandemic. We were also aware from our own data that our personal smear rates were lower than the Morecambe Bay average. It was highlighted that screening rates were lower in deprived wards in Lancaster. Cancer care were beginning a project looking at improving cancer screening rates in Gypsy Roma traveller communities. Skerton was one of the areas flagged up as low smear rates and deprived, so we focused here.

Through the process of engagement the big thing which came out (and which we expected) was difficulty in getting an appointment and their availability. Embarrassment and having previous bad experiences were cited in a lot of cases too.

There is a lot for us to unpick and lots of ways we can take this forward. We hope that we can take the learning from our questionnaires and improve our service regarding smears – we hope to improve access to booking, improve information and provide a short explanatory video for patients to view on our website. We hope that this encourages ladies to book in for their smear and feel less worried about coming.

We would like to then re-evaluate what we have done later in the year and see if there is any general learning that we can take into other areas too."

Section 5

Evaluation methodology

Evaluation methodology

About the evaluation methodology

To focus everyone's efforts on the core process of this project we have centred our evaluation data collection on observations and ongoing feedback to minimise the extra effort required by those involved, particularly given the backdrop of COVID-19. We have adopted a mix of methods to gather the evidence used in arriving at the recommendations and findings in this report. This section gives an overview of each of those methods.

Just to reiterate, all evidence collected was analysed for themes relating to the overarching evaluation question:

> ***Building on Co-create's previous work with PCNs, what are the most effective ways to support all people within Morecambe Bay's Primary Care Networks and broader health ecosystem to embed a workable, replicable and sustainable process for engaging with the population as part of ongoing, existing efforts to reduce health inequalities?***

The methods

Ongoing observations

We have collected ongoing observations, thoughts and ideas from Co-create Associates involved with the project from the start.

Ongoing, anonymised feedback

Where appropriate we have collated (and anonymised) written notes or thoughts conversations with people in the Morecambe Bay area - staff, the public and partners - via email, telephone or video call.

WhatsApp group

Following a discussion at the project kick off event, a WhatsApp group was set up for

sharing across PCNs that are involved with the project. Its intention was to highlight potential support needs, share best practice and highlight other evaluative evidence throughout the life of the project. The group was not not used widely and did not provide any meaningful insight for this evaluation.

Formative survey

A short electronic survey (using Google Forms) was set up to gather formative, ongoing views on what was going well and what could be improved as the project progressed. It was set up to be completed each and every time someone takes part in an event or receives support as part of this project, including after:

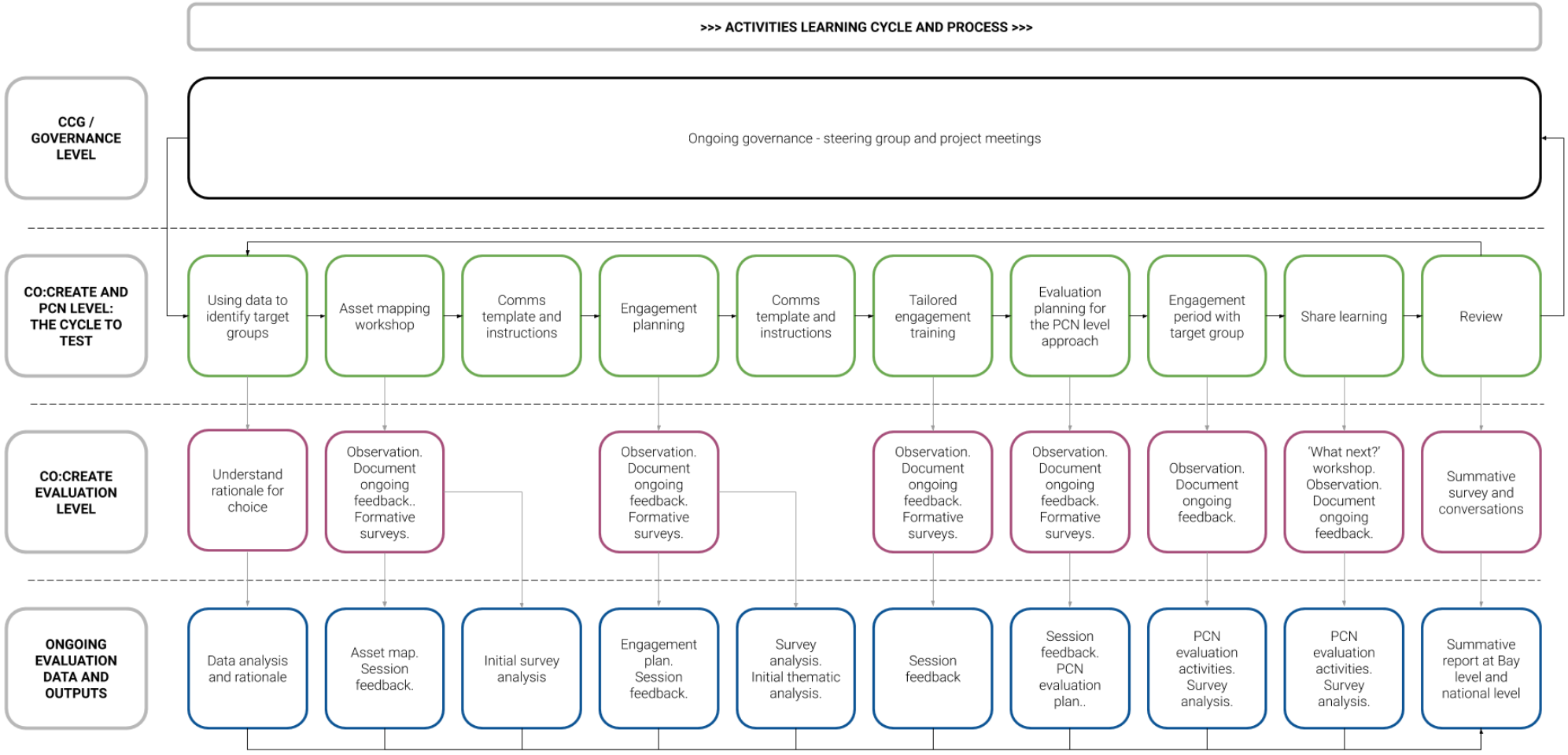
- Project meetings;
- Steering group meetings;
- Stakeholder mapping workshops;
- Engagement planning;
- Receiving any communications templates and/or instructions;
- Any further training;
- Evaluation planning workshops;
- The 'What Next?' workshop.

Uptake of this was relatively low. 14 responses were collected across all activities and all PCNs.

Retrospective case study survey

At the end of the project, we sent out a retrospective survey with open questions to PCN staff and partners to understand outcomes and mechanisms. We also mirrored (but reworded) this survey for people who took part in the engagement activities to understand things from their perspective too. These survey responses formed the basis of this report's case studies.

The diagram on the next page details how these methods work in relation to each other over time.


>>> ACTIVITIES LEARNING CYCLE AND PROCESS >>>
CCG / GOVERNANCE LEVEL
Ongoing governance - steering group and project meetings
CO:CREATE AND PCN LEVEL: THE CYCLE TO TEST
Using data to identify target groups
Asset mapping workshop
Comms template and instructions
Engagement planning
Comms template and instructions
Tailored engagement training
Evaluation planning for the PCN level approach
Engagement period with target group
Share learning
Review
CO:CREATE EVALUATION LEVEL
Understand rationale for choice
Observation. Document ongoing feedback.. Formative surveys.
Observation. Document ongoing feedback. Formative surveys.
Observation. Document ongoing feedback. Formative surveys.
Observation. Document ongoing feedback. Formative surveys.
Observation. Document ongoing feedback.
'What next?' workshop. Observation. Document ongoing feedback.
Summative survey and conversations
ONGOING EVALUATION DATA AND OUTPUTS
Data analysis and rationale
Asset map. Session feedback.
Initial survey analysis
Engagement plan. Session feedback.
Survey analysis. Initial thematic analysis.
Session feedback
Session feedback. PCN evaluation plan..
PCN evaluation activities. Survey analysis.
PCN evaluation activities. Survey analysis.
Summative report at Bay level and national level

Section 6

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