# Community participation and co-production resource invitation to tender – frequently asked questions

## Applying as a lead organisation

**Q:** I represent a national charity where we work with a network of small grassroots organisations led by and embedded in the minoritised ethnic communities they serve. We act a lead accountable body (LAB), directing contracts and funding, providing infrastructure support etc., as many of the organisations are very small/volunteer led. We have looked at this proposal together and the current suggestion is that we take the role of lead organisation. Is it a problem that my organisation is a national charity and not a communityled organisation? Could you please advise whether we could apply as LAB or whether one of the organisations would be better to apply?

**A:** We would encourage you to submit a bid with a named co-lead from the network of community-led organisations, emphasising your role as LAB, i.e., providing supportive infrastructure, building capacity, not determining the network's activity, and how you would support the network to co-ordinate their experience of delivering similar work locally at a national level to deliver this project.

Referencing section 6.3. of the ITT:

*Non-community-led applicants or co-applicants will be expected to demonstrate their experience of working in ethnical partnership with, building capacity in, and ceding power to, community-led organisations/initiatives and racially minoritised communities.*

## Submission format

**Q:** Submission format: How would you prefer our submission to be formatted (e.g. Word document or PowerPoint deck) and do you have a rough idea of length?

**A:** We have no preference and encourage bidding teams to use whichever format best conveys the details their proposal, ensuring that the information corresponds to the headings outlined in section 7 of the ITT. This could include, for example, a Word document, a PowerPoint slide deck, other formats, or a combination.

## Geographic focus

**Q:** We would like to ensure representation of the regions that will ultimately be asked to use the resource, please could you clarify the geographical focus of this project?

**A:** Our geographic scope is England. Our aim for the resource is to be able to enable co-production with racially minoritised communities across England's regions, accounting for the determining impact of living in, for example, deprived, urban, rural regions.

## Intended users of the resource

**Q:** The list of target users include national, regional, and local bodies within the health system; many of these organisations and institutions have their own patient and public involvement (PPI) teams, are these the groups that would be tasked with ultimately using the resource?

**A:** Yes, they would be among those we aim to use the resource. We also know, from the Government's 10 Year Health Plan and the English Devolution and Community Empowerment Bill, that the future of PPI teams and responsibilities for co-production and community participation will be

changing. Our aim for the resource is to account for these shifting responsibilities and prioritisation, resulting from, for example:

- Decisions to abolish Integrated Care Partnerships, Healthwatch and its local organisations, and the consolidation of their duties into other bodies.
- Proposals to make Integrated Care Boards coterminous with strategic authorities, to closer align the work of local government and the health system.

**Q:** Why doesn't this project target the research sector, given that a lack of ethnically diverse inclusion in research plays a determining role in inequitable care design and delivery, leading to ethnic health inequalities?

**A:** We absolutely agree that embedding community participation and co-production in research is critical to tackling ethnic health inequity. As part of our ongoing work, the RHO is partnering closely with the NIHR and the wider research funding community to address these challenges. Our current work programme focuses on improving diverse ethnic inclusion in research through the development of sector-wide standards and expectations, including for accounting for ethnicity in research design, delivery, and funding criteria. This includes looking at mechanisms for accountability and incentives for meaningful inclusion. Further to this, we are also working with the health system to improve the collection and use of ethnicity data.

While this specific project focuses on embedding co-production and community participation across care provision, it will intentionally complement and align with, rather than duplicate, our existing work with the research sector.

## Accountability for implementation

**Q:** Phase 3 of the project scope states that the resource must enable target users and partners to identify accountability pathways to ensure community participation and co-production activity is incentivised and enforced. Are you able to share more information on where the power sits currently, or how you anticipate it being operationalised in the future? We're keen to ensure that we are transparent and realistic with what accountability may look like to those identifying new pathways.

**A:** As above, these pathways are shifting, for example the 10 Year Health Plan outlines how the Government will be testing how they can use patient feedback to directly determine financial flows and regulatory action in the NHS. Local government bodies are facing new legal responsibilities to tackle health inequalities. Integrated Care Boards have been granted further responsibility for co-production, and Board members will be professionally regulated in the coming years, so we anticipate a range of new accountability pathways.

To reiterate, we do not expect bidding teams to know the full detail of this, especially in the face of all this system change. We are looking for bidding teams to demonstrate an understanding of how they might use a topline understanding, to work with RHO to engage with these bodies and identify real-world examples of pathways to accountability over the course of the project.

## Design and format of the resource

**Q:** Format of the resource: We're conscious of making decisions about the format of the resource before Phases 1-3 of the project, but wondered if you have specific types of content in mind based on previous projects? E.g. videos, visual graphics, printable downloads from a website.

**A:** Similarly, we do not want to predetermine this. The main formatting requirement is that the final resource must be digitally enabled, updateable, and not static. For example, it could host printable downloads, but we are keen for the overarching resource to be future-proof. We are looking for bidding teams to demonstrate capability in creating such tools, this could take the form of websites, videos, etc., rather than a finalised outline of what you will create.

## Engagement of service users

**Q:** Do you have a target or expectation for the number of service users you would like to engage in the focus groups? Can you advise how many Integrated Care Boards, local government bodies, and healthcare providers you anticipate being involved in or consulted during the project?

**A:** For engagement with patients, communities, and staff, we do not have a target number. Rather, we want to see bidding teams outline their capability of ensuring participation from people across minoritised ethnic groups and across England's regions. There are multiple ways this could be done, e.g. across Integrated Care Board footprints, or the seven regions of the NHS in England.

For engagement with bodies and organisations across the health system and local government, ensuring a meaningful spread across those functions and across England will be key. The RHO will support the awarded team with our access to existing networks of leads within Integrated Care Boards, local government bodies, and providers. We encourage bidding teams to outline their experience of working with such partners.

## Testing of the resource

**Q:** Testing the resource: In Phase 4, the resource will be tested, refined, and validated. Do you have a proposed project or partner in mind for this testing process, or would we lead on this?

**A:** We would want the bidding team to lead on this in partnership with us (specifically RHO's Implementation Team), and we are looking for bidding teams to demonstrate their experience of such processes.

## Project timelines

**Q:** Is this a 12-month project, as an 18-month timeline had been previously alluded to? This will restrict the technical complexity of the materials that can be produced. Would you be open to a proposal that proposed a base set of content in the first 12 months, and a wider range of more technologically innovative materials in a follow up six-month period?

**A:** Yes, the project is for 12 months. The 18 months previously mentioned was to reflect our plan to independently evaluate the resulting resource. As the resource is designed to be iterated and improved, we would certainly welcome receiving proposals of more technologically innovative materials in the following 6-month period, but encourage bidding teams to prioritise outlining what they can deliver in 12 months at this stage.

**Q:** We anticipate needing to adjust the timeline to include more time on co-production of the content with the RHO and stakeholders (Phase 3). We want to confirm that you're open to proposals that propose a slightly different approach, based on experience, to the one in the tender?

**A:** Absolutely, we encourage bidding teams to outline different approaches if their rationale is meaningfully informed by their previous experience. The timescales of project phases and the funding allocation we have outlined are indicative. We have tried to be as explicit as possible in our Invitation to Tender document that bidding teams will not be placed at a disadvantage if they propose different approaches.

## Past projects

**Q:** Has the RHO previously commissioned the creation of resources to enable community participation and co-production?

**A:** The RHO has internal community participation and co-production ways of working through our advisory groups and networks, which informs all our work. Externally, our Seven Anti-Racism Principles form the foundation of our activity to improve community participation and co-production practice across the health system.

More specifically, we have previously commissioned a report and resource toolkit to address healthcare communications within Jewish communities across England. Poor community participation and co-production practice is a common finding in our research outputs, and this is outlined in our recommendations from the research we have commissioned.