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Brent

NHS

Brent Clinical Commissioning Group

Health and Wellbeing Board

Thursday 22 January 2015 at 7.00 pm

The Village School, Grove Park, Kingsbury, London NW9 0JY

Membership:

Members		Substitute Members
Councillor Pavey (Chair)	Brent Council	Councillors:
Councillor Crane	Brent Council	Butt, Denselow, Mashari and McLennan
Councillor Hirani	Brent Council	
Councillor Moher	Brent Council	
Councillor Warren	Brent Council	
Christine Gilbert	Brent Council	
Sue Harper	Brent Council	
Phil Porter	Brent Council	
Dr Melanie Smith	Brent Council	
Gail Tolley	Brent Council	
Dr Sarah Basham	Brent CCG	
Rob Larkman	Brent CCG	
Dr Ethie Kong	Brent CCG	
Sarah Mansuralli	Brent CCG	
Ann O'Neill	Brent Health Watch	

For further information contact: Toby Howes, Senior Democratic Services Officer 0208 937 1307, toby.howes@brent.gov.uk

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democracy.brent.gov.uk

The press and public are welcome to attend this meeting

recycle for Brent

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item		Page
	PART A	
1	**Health and wellbeing for under 5s** Facilitated workshop.	
	PART B	
2	**Declarations of interests** Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.	
3	**Minutes of the previous meeting held on 18 November 2014** The minutes are attached.	1 - 6
4	**Matters arising**	
5	**NHS Brent Clinical Commissioning Group independent review of patient engagement and equality** In August 2014, CCG Governing Body commissioned an independent review of patient engagement and equality. On 26 November 2014, NHS Brent CCG Governing Body accepted in full the recommendations of the independent review. The report from the independent review made twelve recommendations. Of particular note to the Health and Wellbeing Board is recommendation 2. This calls for "closer collaboration with Brent Council, in particular the Health and Wellbeing Board, and other local agencies, to strengthen the momentum towards more integrated services and greater emphasis on prevention”.	7 - 84

6	**Brent Clinical Commissioning Group commissioning intentions 2015/16**	85 - 136

The commissioning intentions attached set out the framework within which Brent Clinical Commissioning Group (CCG) operates. The clinical commissioning principles are clearly defined and the intentions reflect the national, North West London wide and local context that the CCG operates within. The intentions further incorporate what our patients have told us during the consultation period.

7	**Annual Report from Brent Safeguarding Adults Board 2013-14**	137 - 156

The Director Adult Social Care and Independent Chair of the Adults Safeguarding Board will present the Board's Annual Report for 2013-14. This report reviews the work carried out by the partnership in 2013-14, provides analysis of the safeguarding statistics collected for that period and outlines priorities for the Board in 2014-15.

8 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Democratic Services Manager or his representative before the meeting in accordance with Standing Order 64.

Date of the next meeting: Thursday 19 March 2015

Please remember to switch your mobile phone to silent during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

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MINUTES OF THE HEALTH AND WELLBEING BOARD
Tuesday 18 November 2014 at 1.45 pm

PRESENT: Councillor Pavey (Chair and Deputy Leader, Brent Council), and Councillor Hirani (Lead Member, Adults, Health and Wellbeing, Brent Council), Dr Madhukar Patel (GP, Brent CCG), Sarah Mansuralli (Chief Operating Officer, Brent CCG), Councillor Moher (Lead Member, Children and Young People, Brent Council), Ann O'Neill (Brent Healthwatch), Phil Porter (Strategic Director, Adult Social Services, Brent Council), Dr Melanie Smith (Director of Public Health, Brent Council), Gail Tolley (Strategic Director, Children and Young People, Brent Council) and Councillor Warren (Brent Council)

Also Present: Dr David Finch (NHS England) and Miranda Wixon (Brent Healthwatch)

Apologies were received from: Councillor Crane (Lead Member, Environment, Brent Council), Christine Gilbert (Chief Executive, Brent Council), Sue Harper (Strategic Director, Environment and Neighbourhoods, Brent Council), Dr Ethie Kong, (Chair, Brent Healthwatch) and Rob Larkman (Chief Officer, Brent CCG)

1. **Community Action on Dementia**

For the first part of the meeting, members of the board took part in a facilitated workshop on dementia.

The board adjourned for 15 minutes and reconvened at 4:00pm to consider the remaining business on the agenda.

2. **Membership**

RESOLVED:

that the appointments of Councillor Crane, in place of Councillor Perrin and Sarah Mansuralli, in place of Jo Ohlson be noted.

3. **Declarations of interests**

None declared.

4. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 24 July 2014 be approved as an accurate record of the meeting.

5. **Matters arising**

Whole systems integrated care

Phil Porter referred to resolution (i) and reported that the deadline date of 31 October for submission of the Implementation plan had been extended.

6. **Better Care Fund**

Phil Porter (Strategic Director, Adult Social Services) introduced the report which updated the board on the progress made in respect of the health and social care integration in Brent and specifically the 'Better Care Fund' (BCF) programme.

He emphasised that the focus of the Brent BCF plan was largely unchanged from the previous presentation to the board but with more detail on what was in the schemes making up the plan. The schemes remained:

- Scheme 1 – keeping the most vulnerable well in the community,
- Scheme 2 – avoiding unnecessary hospital admissions,
- Scheme 3 – efficient multi-agency hospital discharge,
- Scheme 4 – improving urgent mental health care.

There had been a fifth scheme in the original submission. This was focused on the key changes to systems, process and culture which would underpin delivery of the other four schemes. These included co-production with service users and carers, required changes in IT, workforce, and learning and development. Due to the changes in the national criteria and reporting these no longer made up a scheme in themselves, instead they had been integrated into the other four schemes

Work now needed to take place over the next 5/6 months to engage with the community, including with Healthwatch, towards implementation.

In response to a question on what was meant by community engagement, Sarah Mansuralli explained that this would concentrate on the user under each of the scheme headings and key was to work to deliver an improved patient experience.

In addressing the issue of receiving an assurance rating of Approval with Conditions the Board recognised that this was partly as a result of a technical error in one of the financial templates which would be straightforward to correct. Sarah Mansuralli explained that work would now be undertaken to strengthen and refine the BCF plan template in order to move towards a fully approved status.

Councillor Hirani added that the submission process had been frustrating with a series of changes having to be accommodated but he was confident now that it was moving forward in the right direction.

RESOLVED:

(i) that the Better Care Fund submission be noted, including:

- the additional detail in the plans for further developing the schemes and delivery,
- the revised mental health scheme included in the plan,
- the approach to implementation and in particular, the planned programme management office involvement, the importance of service user and carer co-production and ongoing governance and oversight;

(ii) that the assurance letter from NHS England, attached to the report submitted, be noted.

7. **Annual report of the Director of Public Health for Brent 2014**

Dr Melanie Smith (Director of Public Health) introduced the report by saying that it had been kept deliberately brief in order that people could retain the main areas it covered which needed leadership and where measurable outcomes could be achieved.

In answer to questions asked, Melanie Smith explained that child obesity rates rose between reception year and year 6 as children continued to eat too much and not get enough exercise; a situation not confined to Brent. Whilst pleased to report that 38 schools had signed up to the Brent Healthy Schools programme, she hoped more schools would do so. Gail Tolley (Strategic Director, Children and Young People) stated that this was an issue that had already been identified for discussion with schools and she felt many schools were doing good work in this area but had not necessarily signed up to the programme.

Dr Madhukar Patel welcomed the report as a useful working document for GPs and for outlining how joint working at different levels could tackle the issues identified.

RESOLVED:

that the Annual Report of the Director of Public Health be noted in advance of its publication.

8. **Joint Strategic Needs Assessment highlight report 2014**

Dr Melanie Smith (Director of Public Health) introduced the report which attached the Brent Joint Strategic Needs Assessment (JSNA) 2014 highlight summary report.

Sarah Mansuralli pointed out that the CCG was using the JSNA throughout the development of its commissioning role. Melanie Smith undertook to get back to Councillor Warren who drew attention to the estimate of 37% of the Brent population who were achieving the target of eating 5 portions of fruit and vegetables a day and asked what the national average was.

Anne O'Neill expressed concern over the absence of reference to people with disabilities and also mental health concerns in the list of information sheets. Melanie Smith responded that she hoped to see a strengthened focus on these two areas following ongoing work.

RESOLVED:

that the Joint Strategic Needs Assessment be approved prior to publication and dissemination.

9. **Tackling Violence against Women and Girls in Brent Action Plan**

Melanie Smith (Director of Public Health) introduced the report on behalf of Ben Spinks, Assistant Chief Executive who had led the development of the action plan. Between March 2013 and March 2014, a scrutiny task group was convened to examine the issues of violence against women and girls in Brent, focusing on the issues of Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriages (FM). The report identified a recommendation of the task group which was partly the responsibility of the Health and Wellbeing Board. Consequently an action plan had been drafted by a wide range of partners which was now before the board for approval.

The Chair stated that members of the Council had received a full briefing on the work of the scrutiny task group and suggested that the board be updated on progress in 6 months time. It was agreed that the report back should be co-ordinated with a report back from the Children Safeguarding Board.

RESOLVED:

(i) that the Tackling Violence against Women and Girls in Brent action plan attached to the report submitted be agreed for implementation;

(ii) that a joint report be submitted to the Children Safeguarding Board and the Health and Wellbeing Board in 6 months time detailing progress on implementing the action plan.

10. Pharmaceutical Needs Assessment Consultation

The report submitted proposed an amendment to the Pharmaceutical Needs Assessment (PNA) steering group terms of reference.

RESOLVED:

that the PNA steering group be delegated the task of reviewing PNAs from neighbouring boroughs on behalf of the Health and Wellbeing Board and responding to consultation as required, as detailed in the revisions to the terms of reference for the PNA steering group attached as appendix 1 to the report submitted.

11. Forward Plan

A draft forward plan for topics to form the basis of workshops at future meetings of the Health and Wellbeing Board was tabled at the meeting.

It was agreed that the topic on children centres/early years should be revised to be called ‘healthy under fives’. Dr Melanie Smith (Director of Public Health) emphasised the importance of childhood immunisation to the health and wellbeing of 0 -5 year olds and expressed the hope that those in NHSE responsible for commissioning these services would be able to participate in the event to be planned. Gail Tolley (Strategic Director, Children and Young People) suggested that the currently dormant Children’s Trust be revised and tasked to deal with the issues affecting the health of children on behalf of the board.

Councillor Warren requested that the topic of obesity be timetabled in the plan.

It was acknowledged that the board's forward plan would need to take into account the themes running under the Health Partners Forum.

Given the number of issues facing the board it was felt that it would need to meet more than the currently programmed four times a year.

RESOLVED:

(i) that the meeting of the Health and Wellbeing Board scheduled for 23 April be moved to a date in March 2015 and that the first meeting of the board in the new municipal year 2015/16 be held in late May;

(ii) that six meetings of the board be programmed for 2015/16;

(iii) that subject to the comments made above at the meeting, the board's forward plan be agreed.

12. **Other business**

It was reported to the Board that Sarah Mansuralli wished to inform the Board that the independent review of Brent CCG's arrangements for meeting its statutory duties on equality, diversity and engagement would be made public on 19 November 2014.

The meeting closed at 4.45 pm

M PAVEY
Chair

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Brent Clinical Commissioning Group

Health and Wellbeing Board

22 January 2015

Report from NHS Brent CCG

For approval

NHS Brent CCG independent review of patient engagement and equality

1.0 Summary

1.1 In August 2014, CCG Governing Body commissioned an independent review of patient engagement and equality.

1.2 On 26 November 2014, NHS Brent CCG Governing Body accepted in full the recommendations of the independent review. The report from the independent review made 12 recommendations.

1.3 Of particular note to the Health and Wellbeing Board is recommendation 2. This calls for *"closer collaboration with Brent Council, in particular the Health and Wellbeing Board, and other local agencies, to strengthen the momentum towards more integrated services and greater emphasis on prevention".*

2.0 Recommendations

2.1 The Health and Wellbeing Board is asked to:

2.1.1 Note the CCG independent review of patient engagement and equality, and decision by the CCG Governing Body.

2.1.2 Support the development of joint public and patient engagement structures between NHS Brent CCG, Brent Council and Brent HealthWatch.

3.0 Detail

3.1 In April 2014, NHS Brent Clinical Commissioning Group (CCG) identified concerns about the current arrangements for meeting its statutory duties of pubic and patient engagement and equality.

3.2 In August 2014, CCG Governing Body commissioned an independent review of patient engagement and equality.

3.2.1 The review was led by Dr Angela Coulter, a recognised international expert in patient engagement and equality. The support for the review was provided by outside the CCG to allow the review to operate independently.

3.2.2 The review began 01 September 2014, and ended on 12 November 2014.

3.2.3 The review consulted a diverse range of stakeholders, including a number who did not support the review.

3.2.4 The review reached an independent view, taking into account the full range of views, and made 12 recommendations.

3.3 On 26 November 2014, NHS Brent CCG Governing Body accepted in full the recommendations of the independent review.

3.3.1 By accepting the recommendations in full, CCG Governing Body sought to keep a coherent package of patient engagement improvements that delivered the greatest benefit and minimised disadvantage to people with protected characteristics.

3.3.2 The CCG Governing Body recognised the urgency of implementing the recommendations. The report provided clear evidence that substantiated the concerns that lead the Governing Body to commission the review in the first place. It also provided evidence that Brent CGG was in real danger of failing not only in its statutory duties but more importantly in its personally declared aspiration to engage and empower patients, carers and the public in conversations about their health and the services that support them.

3.4 The report made 12 recommendations. Of particular note to the Health and Wellbeing Board are:

3.4.1 Recommendation 2 - This calls for *"closer collaboration with Brent Council, in particular the Health and Wellbeing Board, and other local agencies, to strengthen the momentum towards more integrated services and greater emphasis on prevention".*

3.4.2 Recommendations 1,7 and 8 – These require changes to the CCG constitution. A consultation begin 02 Jan 2015 regarding the impact of the proposed constitution changes. The Governing Body decision to submit the application to NHS England will be on Wednesday 28 January 2015. Applications to amend the CCG constitution must be submitted to NHS England by Friday 30 January 2015.

3.5 The CCG analysed the independent review recommendations.

3.5.1 To implement recommendation 2, the CCG suggested that work begin by mapping the strategic opportunities with Brent Council

and the Health and Wellbeing Board as part of the current development of the 2015-19 Brent Borough Plan.

3.5.2 It was suggested that relevant public events, such as the Brent Connects Forums, include standing items on health.

3.5.3 There may also be further opportunities to collaborate on population data analysis as part of a new 'insight' function.

4.0 Financial Implications

4.1 There may be economies of scale in public and patient insight, communication and outreach.

5.0 Legal Implications

5.1 To implement recommendations 1, 7 and 8, NHS Brent CCG must amend the CCG constitution.

6.0 Diversity Implications

6.1 The recommendations from the independent review provide a coherent package of patient engagement improvements that deliver the greatest benefit and minimise disadvantage to people with protected characteristics

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 The independent report recommendations 3, 4 and 5 suggest further investment and recruitment by NHS Brent CCG in the functions of insight, communication and outreach.

7.2 Collaboration between NHS Brent CCG, Brent Council and Brent HealthWatch in these areas may require consideration of staffing resources.

8.0 Background papers

Appendix 1 – The independent review report "*Independent review of Brent Clinical Commissioning Group's arrangements for Meeting its statutory duties on equality, diversity and engagement*"

NHS Brent CCG Governing Body papers from 26 November 2014 are available on the CCG website (link below). The independent review report and implications were item 12.
http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/344-26-november-2014

Contact
Duncan Ambrose, Assistant Director, NHS Brent CCG

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INDEPENDENT REVIEW OF BRENT CLINICAL COMMISSIONING GROUP'S ARRANGEMENTS FOR MEETING ITS STATUTORY DUTIES ON EQUALITY, DIVERSITY AND ENGAGEMENT

ACKNOWLEDGEMENT

The members of the Independent Review Team wish to thank all stakeholders who have contributed to this report. We hope and trust that it will assist Brent CCG to succeed in its laudable ambition of achieving meaningful engagement with patients, carers and their communities.

Angela Coulter

Frank Donlon

David Grant

November 2014

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G. Engagement strategies in selected CCGs
H. Template for planning and assuring engagement activities

EXECUTIVE SUMMARY

In response to concerns about current arrangements for meeting its statutory duties on equality, diversity and engagement (EDEN), Brent CCG commissioned an independent review to look at these and develop a set of options for consideration by the Governing Body.

The review team makes the following recommendations:

- The EDEN strategy is out-of-date and insufficiently detailed. It is not appropriate to include the engagement strategy in the CCG's constitution. It should be removed and replaced (but not in the constitution) with a more dynamic document, for annual review and updating, providing details on how the CCG's aims will be achieved.
- The EDEN strategy should promote opportunities for closer collaboration with Brent Council, in particular the Health and Wellbeing Board, and other local agencies, to strengthen the momentum towards more integrated services and greater emphasis on prevention.
- Brent CCG should employ or contract with an insight manager (data analyst) who knows how to obtain and analyse data on patients' experience and outcomes. This person could also be responsible for advising commissioners on the design and implementation of special studies, where necessary.
- The CCG should employ or contract with a communications specialist with expertise in designing public information and consultations to take a lead in redesigning all communications media and outputs, and to work alongside commissioning leads to facilitate an improved dialogue with local people.
- Brent CCG currently employs an Equality and Engagement Manager. This important role should be supported with sufficient resources to extend and increase the various outreach activities, ensuring that they link directly to commissioning priorities and are planned systematically and proactively.
- The CCG should adopt an engagement template for use by commissioners throughout the development and production of a commissioning plan and provide training in how to use it. The same template could be used by the group responsible for providing assurance to the Governing Body, alongside the NHS Equalities Delivery System template. A suggested draft is attached at Appendix H.
- The Governing Body should review and reorganise its committee structure to include patient representation more effectively in all relevant committees and sub-committees. The aim should be to embed engagement throughout the organisation and beyond, instead of confining it to a single committee. Strategy implementation and oversight should be separated from the provision of assurance by delegating these responsibilities to different committees, both with significant lay membership.
- The Locality Patient Participation Groups are a relatively inefficient means of gathering intelligence on the health and social care experiences of Brent residents. This can be better achieved by developing an insight function and by strengthening outreach initiatives.
- Community engagement in specific commissioning initiatives should begin at an early stage in the commissioning cycle and continue throughout the process. Working groups established for specific tasks should be well resourced and well supported. Training should be provided for community group members and for commissioning leads. Priorities should be determined with reference to the Joint Strategic Needs Assessment and the Health and

Wellbeing strategy. Grants should be made available to community groups to facilitate and strengthen their involvement to inform commissioning.

- The Health Partners Forums should be retained and strengthened, ensuring that they facilitate genuine community participation and debate. The CCG should measure the impact of its engagement activities and feed the results back via the Health Partners Forum.
- The CCG should allocate a defined budget to support its engagement activities, including insight, communications, outreach and governance arrangements. It should make substantive staff appointments to lead these activities.
- Brent CCG's Governing Body should give serious consideration to implementing the recommendations we have set out as Option C in their entirety. This would involve significant changes to the CCG's culture and mode of working, but we believe these are necessary to ensure that the CCG achieves its goal of securing a more person-centred health and care system for the people of Brent.

1. Background to the review

Brent Clinical Commissioning Group (CCG) has set itself ambitious goals in respect of equality, diversity and engagement. Its aims include the following:

- to achieve meaningful engagement with patients, carers and their communities
- to ensure that patients and the public are involved and engaged throughout the commissioning cycle and that patient experience and feedback is listened to and acted upon
- to monitor and reduce health inequalities.

In April 2014, Brent CCG undertook an annual governance review across all its committees and sub-committees to check arrangements for providing assurance on its statutory duties and to ensure these were up-to-date and working well. They concluded that the governance arrangements for Equality, Diversity and Engagement (EDEN) were no longer fit for purpose and required amendment. Particular concerns were as follows:

- the EDEN strategy, which had been developed prior to the issuance of guidance by NHS England, was out-of-date
- the governance arrangements did not take account of the statutory duty to promote health and social care integration by working closely with the Local Authority
- the Eden Committee was no longer providing adequate assurance to the Governing Body.

The CCG therefore decided to commission an independent review to identify options for change (see Appendix A). The review team, which began work on 1st September, 2014, was led by Dr Angela Coulter, assisted by Frank Donlon and David Grant. The aim of the review was to identify options for ensuring that Brent CCG:

- meets its statutory duties for equality, diversity and engagement[1]
- meets its statutory duties for working in partnership with Brent Council
- meets its statutory duties for working with the oversight of Brent Health and Wellbeing Board
- removes unnecessary duplication of effort in equality, diversity and engagement between the CCG and the Council
- builds on existing precedents and models established with Brent Council for integrated equality, diversity and engagement assurance.

The review team had two months to look at the EDEN strategy, structures and governance arrangements and to develop a set of options and recommendations for consideration by the Governing Body.

The context of the review was challenging for all concerned. Relations between the CCG and some lay members of its governance structures, in particular the elected chairs of the Locality Patient Participation Groups (LPPGs) who sit on the EDEN Committee, had been strained for some time. The

[1] Various terms are used to describe this topic, including involvement, participation, consultation and engagement. This report uses 'engagement' as a general term referring to any or all of these activities.

review commenced at a time when relations were particularly fraught. The July meeting was adjourned following a dispute about the agenda, leading to a vote of no confidence in the chair. Minutes of the previous three meetings had not been approved. The CCG Chair and senior executives had received numerous emails from the LPPG chairs and others objecting to the way business was being conducted by the CCG.

In the light of this the CCG Executive had taken the decision to suspend normal EDEN business pending the outcome of this review. Instead they initiated a workshop-style meeting, with a specific focus on engagement processes related to commissioning priorities, in the hope that this would mitigate the committee's tendency to get bogged down in procedural issues. Patient representatives on the EDEN Committee, who were unhappy about this, saw no need for a review and objected to its terms of reference, although they eventually agreed to cooperate. Mediation and conflict resolution had been tried previously, but had failed and the review team was not asked to repeat the process. Instead our task was to identify options for the future, including noting any constitutional implications if the Governing Body decided to amend the governance structures. We were asked to ensure that any recommendations were both proportionate and affordable.

REVIEW METHODS

The review focused on four main questions:

- What is Brent CCG doing now and how well is it working?
- How could it strengthen its engagement strategy?
- What level of resource is required to achieve this effectively and efficiently?
- What are the implications for the CCG's governance arrangements?

Information and advice was sought from as many people and sources as possible, given the time constraints. Methods included:

- seeking the views of a wide range of stakeholders, including patient and service user representatives, committee members, other lay members, CCG staff, voluntary sector organisations, partner organisations such as Brent Healthwatch, Brent Health and Wellbeing Board, London Borough of Brent officers and councillors, and others (Appendix B)
- attending relevant meetings (Appendix C)
- thematic analysis of interviews and face-to-face meetings focused on adequacy of current arrangements and any changes required (Appendix D)
- reviewing a range of documents relating to current and past activities, relevant correspondence, emails and committee minutes, including local developments in integrated and personal care (Appendix E)
- reviewing constitutional and governance arrangements in Brent and 13 other CCGs (Appendix F)
- reviewing relevant guidance from NHS England
- obtaining information from other CCGs to identify examples of best practice (Appendix G)
- drafting a template for use in planning and assurance of engagement activities (Appendix H).

In summary, the review team carried out interviews, on the phone and in person, attended various meetings, including some that were specially arranged, and read a large number of documents and emails, including those sent by various members of the EDEN Committee. We asked people to tell us what was working well in respect of Brent CCG's equality, diversity and engagement activities and

structures, what was working less well, and what needed to change. Not surprisingly, this revealed a wide variety of views on the relative effectiveness, or otherwise, of the current arrangements.

The main issues we discussed with stakeholders, and their responses, are outlined in the sections below. First we describe CCGs' legal responsibilities in respect of patient and public engagement and NHS England's expectations and guidance.

2. CCGs' STATUTORY DUTIES

In recent years, successive governments have introduced measures to strengthen patient and public involvement in healthcare. By emphasising commissioners' responsibilities to engage with local people, they hope to:

- improve the quality of health and care services, ensuring that any improvement plans develop from an understanding of patients' experience and preferences
- build trust among local people to facilitate service change and modernisation
- strengthen accountability for local decision-making, ensuring that plans and decisions are transparent and the basis for these is understood
- ensure compliance with relevant legislation.

CCGs' statutory responsibilities cover both individual and collective engagement. They must ensure that individual patients and, where appropriate, their families and carers, are involved in decisions about their treatment and care (individual engagement), and that local people are involved in commissioning processes and decisions (collective engagement).

LEGAL REQUIREMENTS

The law[2] requires CCGs to:

- set out in their commissioning plans how they intend to involve patients and the public in their commissioning decisions
- involve the public in the planning and development of services and in decisions about any changes that would have an impact on service delivery or the range of services available
- consult on their annual commissioning plans to ensure proper opportunities for public input
- secure continuous improvements in the quality and outcomes of services, in particular clinical effectiveness, safety and patient experience
- promote the involvement of individual patients in decisions about their prevention, diagnosis, treatment and care
- ensure that health services are provided in an integrated way and promote integration of health and social care
- advance equality of opportunity for those with protected characteristics and those without and foster good relations between those with protected characteristics and others

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[2] NHS England: The Functions of Clinical Commissioning Groups, 2012; Transforming Participation in Health and Care, 2013; A refreshed Equality Delivery System for the NHS (EDS2), 2013; Planning and Delivering Service Changes for Patients, 2013

- reduce inequalities between patients in access to health services and outcomes
- eliminate discrimination, harassment and victimization
- cooperate with relevant local authorities and participate in their Health and Wellbeing Boards, contributing to and taking account of the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS)
- have at least two lay members on their governing body
- have regard to the NHS Constitution in carrying out their functions
- have due regard to the findings from local Healthwatch
- report on involvement in their annual report.

Guidance from NHS England

Guidance from NHS England[3] echoes and expands on the legal requirements, stating that CCGs should:

- make arrangements for, and promote, individual participation in care and treatment through commissioning activity
- listen to, and act upon, patient and carer feedback at all stages of the commissioning cycle – from needs assessment to contract management
- consult with patients, carers and the public when redesigning or reconfiguring healthcare services
- provide information to show how public involvement and consultations have informed their commissioning decisions
- make arrangements for the public to be engaged in governance arrangements by ensuring that the CCG governing body includes at least two lay people
- publish evidence on what 'patient and public voice' activity has been conducted, its impact and the difference it has made
- publish feedback received from local Healthwatch about health and care services in their locality.

3. Equalities, Diversity and Engagement strategy

The current strategy

The EDEN strategy is currently enshrined in an appendix to Brent CCG's constitution (Constitution Appendix P). This describes the mechanisms by which the CCG intends to achieve its aim of "meaningful engagement with patients, carers and their communities". The stated goals are as follows:

- to support the delivery of the mission, values and aims of the CCG
- to establish a mechanism to provide regular assurance, advice and guidance to the CCG Governing Body in respect of its relevant statutory duties

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[3] NHS England: Transforming Participation in Health and Care, 2013

- to ensure that patients and the public are involved and engaged throughout the commissioning cycle and that patient experience and feedback is listened to and acted upon
- to support the CCG in monitoring and reducing health inequalities across Brent by means of the NHS Equality Delivery System (EDS).

The strategy describes four main mechanisms or structures by which this is to be achieved:

- the *EDEN Committee*, to provide the Governing Body with advice, guidance and assurance
- the five *Locality-based Patient Participation Groups (LPPGs)*, the CCG's "primary" source of patient experience, feedback and complaints
- the *Commissioning Specific Initiatives*, by which commissioning leads are responsible for ensuring that engagement is embedded throughout the commissioning cycle
- the *Health Partners Forum,* to share information and listen to the concerns of the public.

Each of these is described in more detail in section 4 below.

The document setting out the EDEN strategy lists four elements of effective patient and public engagement:

1) involvement of individual patients in decisions about their care;

2) collective involvement in shaping services;

3) patient feedback on their experience of using services; and

4) lay involvement in governance.

It goes on to outline the governance structures, but provides very little detail on how the aims will be achieved. Co-design of services is mentioned briefly, but it says nothing at all about how individual involvement will be encouraged and facilitated, nor about how feedback on patients' experiences will be obtained and acted upon.

The EDEN strategy document includes several appendices: an outline communications plan; a stakeholder engagement report; a list of seven priority groups; a person specification for community group representatives; some case studies on stakeholder engagement; and a draft Equality Delivery System action plan for 2012-13. The strategy has not been updated since 2012. The documents were clearly produced to meet the requirements of the CCG authorisation process, rather than as working documents setting out ongoing actions and measures of performance.

A much more dynamic document is required, setting out who will do what, coupled with detailed action plans and performance indicators. This should be regularly reviewed and refreshed, probably on an annual basis. We suggest looking at how some other CCGs have tackled this task. Haringey CCG's engagement strategy for 2014-15 and Leicester City CCG's equality and diversity strategy are good examples.

Several members of the EDEN committee told us that they felt it was important to retain Appendix P in the CCG's constitution, but we disagree. It is not customary to include strategies within a constitution document, as these are normally seen as working documents, regularly revised and refreshed. Inclusion in the constitution makes revision particularly difficult as it means that any amendments must go through NHS England's bi-annual process for variations to constitutions. In recognition of this the CCG made a previous attempt to remove the EDEN strategy from the

constitution, but this failed due to a procedural irregularity. We recommend that Appendix P should now be removed from the CCG's constitution.

> ***Review team recommendation:*** **The EDEN strategy is out-of-date and insufficiently detailed. It is not appropriate to include the engagement strategy in the CCG's Constitution. It should be removed and replaced (but not in the constitution) with a more dynamic document, for annual review and updating, providing details on how the CCG's aims will be achieved.**

INTEGRATED CARE

The EDEN strategy, as set out in the CCG's constitution, is out-of-date in another respect. It indicates a desire to work in partnership with Brent Council, but it has little to say about how integrated care will be achieved or how the public will be engaged in initiatives to improve the health of the population.

The Health and Social Care Act, 2012 s195 and the Care Act 2014 provide the principal legislation on the planned move towards greater integration of health and social care. The 2012 Act refers to Health and Wellbeing Boards, which are vested with a duty to encourage integrated working. Additionally, s75 of the NHS Act 2006 refers to mechanisms underpinning integrated working, including joint commissioning and pooled budgets for specific services.

The current documentation of the EDEN strategy includes nothing about how the CCG will collaborate with Brent Health and Wellbeing Board, with local authority social services, or with the other CCGs in North West London in implementing its public engagement plans. Notwithstanding this lacuna in the strategy document, Brent CCG is a key contributor to the Brent Health and Wellbeing Board. It is also involved in a range of relevant integrated care initiatives, including the Better Care Fund and North West London Whole Systems Integrated Care initiative (WSIC). The CCG is working with Brent Healthwatch and Brent Council for Voluntary Service to plan and implement these initiatives, with some involvement from members of the EDEN Committee.

The local authority, Brent Council, has a parallel set of engagement activities, including five locality groups - the Brent Connects Forums, a Brent-wide Citizens Panel, and several user consultative forums. It makes sense for the CCG and the Council to work together on their engagement strategies, exploring further opportunities for collaboration and hopefully avoiding 'consultation fatigue'. Indeed, we were told that such discussions are already in train, with several joint initiatives planned. In the light of this, the CCG should review its governance arrangements to ensure that its public engagement strategy takes account of, and supports, this type of joint working. Wherever possible the CCG's plans and activities should align with the priorities of Brent Health and Wellbeing Board and with other local services to promote public health.

Many other CCGs are in the process of reviewing and revising their governance structures and procedures to facilitate more joint working with local authority Health and Wellbeing Boards. In our comparative analysis (Appendix F) we found a wide spectrum of integrated working reflected in committee structures. Whilst public health representatives were often included, few other local authority staff were members of either the patient and public engagement (PPE) committees or on governing body assurance committees. In our sample of 14 CCGs:

- four had local authority representation (other than public health) on their PPE committees, and eight did not;
- three had local authority representation (other than public health) on their governing body assurance committee, and ten did not;
- and there was a lack of information and clarity on the others.

However, some CCGs are further ahead: Newham's Partnership Commissioning Committee is a particularly strong example of close working, as is Tower Hamlets Engagement and Communications Sub-Group (of the Health and Wellbeing Board). The recently launched Hull 2020 initiative is another good example. In these cases, the Health and Wellbeing Boards have expanded their focus to encompass a wider range of local agencies, seeing the development of a comprehensive strategy as the most effective way to improve the health of local people. The situation can be expected to evolve as CCGs and local authorities begin to work more closely together on recent initiatives, such as the Better Care Fund, and to embed integrated working within their governance arrangements.

***Review team recommendation*: The EDEN strategy should promote opportunities for closer collaboration with Brent Council, in particular the Health and Wellbeing Board and other local agencies, to strengthen the momentum towards more integrated services and greater emphasis on prevention.**

REFRESHING THE ENGAGEMENT STRATEGY

Brent CCG's engagement strategy aspires to engage local people in all aspects of the commissioning cycle, but does not say how this will be achieved. Effective engagement requires careful analysis of evidence on the needs and experiences of local people (the *insight* function), clear communication plans and effective feedback loops (the *communications* function), and an in-depth understanding of the priorities and concerns of local groups, especially those in the nine 'protected' categories (the *outreach* function). There are three main stages to the commissioning cycle: *analyse and plan*; *design and improve*; *procure monitor and learn*. We can put the three stages and the three functions together to make a nine box model (see below and Appendix G).

Commissioning Engagement Strategy

Analyse and plan	Design and improve	Procure, monitor and learn
Insight		
Communications		
Outreach		

We suggest this could be a useful template around which to structure a revised engagement strategy. Our observations lead us to believe that the CCG's insight and communications functions are currently weak in respect of patient and public engagement, and while a number of community outreach initiatives have been successfully carried out, a more systematic and better resourced approach is required. Below we suggest a number of ways in which the strategy could be strengthened.

INSIGHT

Currently the CCG's main source of evidence on the experience of patients and other service users comes via formal committees, public forums and occasional ad hoc surveys. We saw no evidence of effective use by the CCG of routinely collected data on patients' experience to monitor quality, or to support the case for changes in commissioned services.

Detailed data on patients' experience and outcomes is available for each local provider from the following sources: CQC patient experience surveys, adult social care surveys, Friends and Family Test results, GP patient surveys, and Patient Reported Outcome Measures (PROMs), in addition to comments, complaints and compliments via NHS Choices, Patient Opinion, IWantGreatCare and MyHealthLondon. These sources could provide a much fuller picture of patients' experience than is achieved by relying on feedback from LPPGs and public forums. Each of the provider organisations that Brent CCG commissions should be able to supply the commissioners with summaries of the feedback that they collect on a routine basis. Most of it is also available on public websites, accessible to anyone who knows where to look.

Patient experience surveys can be used as a source of Key Performance Indicators (KPIs) to monitor and compare the quality of local services. These are also a useful source of data on individual engagement, since they include questions about information provision, involvement in treatment decisions, provision of care plans, coordination of services, etc. In addition to providing an important source of evidence on the quality of care to inform commissioning plans, the requirement to gather and make effective use of patient experience data can be incorporated into service contracts to further improve intelligence on how the system is performing. Various examples of how other CCGs are developing the insight function are shown in Appendix G.

Analysing routinely collected data on patient experience and patient-reported outcomes, and summarising it in a form usable by commissioners, requires the skills of an experienced data analyst.

Some CCGs have access to these skills via their Commissioning Support Units (CSU), but this does not appear to be the case in Brent. Since other CCGs commission healthcare from the same NHS trusts (all of which collect feedback from their patients), it would make sense to contract for this service in concert with other local CCGs. If, as we suspect, NW London CSU does not currently employ anyone with relevant expertise, this service could be commissioned from another CSU (e.g. NE London), from an external research organisation, or from elsewhere. Special studies should be commissioned to fill any known gaps in local intelligence, but no decisions about commissioning new research should be taken until existing freely available data sources have been fully exploited.

Review team recommendation: **Brent CCG should employ or contract with an insight manager (data analyst) who knows how to obtain and analyse data on patients' experience and outcomes. This person could also be responsible for advising commissioners on the design and implementation of special studies, where necessary.**

COMMUNICATIONS

External communications appears to be a particular weakness in Brent CCG at present. Until recently the CCG employed a communications officer on an interim basis whose role was confined to internal communications between CCG staff and member practices. We understand this person has now left the organisation. The CSU employs a communications officer who provides some services to Brent CCG, but this organisation was not given a specific brief to work on patient and public engagement. We understand that implementation of external communications plans were put on hold until after the CSU 'in-house' transition had been effected. This opens up an opportunity to start afresh with the development of an effective communications strategy. We believe this would work best if it spanned both internal and external communications, with a particular focus on supporting the CCG's public engagement efforts.

At the very least the communications strategy should include production of clear, well designed, prompt and timely summaries of commissioning initiatives for public consumption (see, for example, Tower Hamlets CCGs website), simple web surveys with incentives to provide feedback (see Islington CCG's website), use of Twitter, Facebook and other social media, (e.g. Instagram, Pinterest, Whatsapp), development of audio-visual materials to stimulate discussion (see Newham CCG's Young People Speak Out), and information about the impact of engagement on commissioning plans and outcomes (see Haringey CCG's 'You said, we did' report). More examples of what other CCGs are doing can be found via the links in Appendix G.

Many stakeholders we talked to acknowledged the aspirations and genuine desire of the CCG to undertake patient and public engagement effectively and to incorporate it into their commissioning work. There was also much support for specific individuals who were perceived to be doing some excellent work, albeit in isolated silos. But stakeholders raised a range of issues about the way in which the CCG has failed to achieve its aspirations in respect of public engagement. Many of these can be attributed to a failure of communications. Aside from the self-evident breakdown of relationships on the EDEN Committee, the CCG's relations with its lay committee members and the

public presents a somewhat chaotic picture. Papers for meetings often arrive late and sometimes contain inaccurate information. Presentations are not always well adapted to the needs of the target audience. Documents published on the website tend to be lengthy and full of NHS jargon. Communications sometimes appear muddled and inconsistent. Some suggested this was due to the (over)use of interim staff, leading to inefficiencies and loss of continuity and organisational memory. The CCG is clearly working within tight financial constraints, but economising on communications seems to us short-sighted to say the least, and likely to lead to even greater problems in the longer term.

In the absence of timely, clear information, people tend to assume the worst. Several people told us that CCG staff were "secretive" or "defensive" and unwilling to share information about their commissioning plans until they are a *fait accompli.* Interviewees suggested that the CCG needs to do more to embed awareness of patient and public engagement into its DNA, investing in staff training and development to improve their understanding of equality, diversity and engagement issues. The CCG should try to ensure that excellent communications and transparency are a normal feature of all commissioning activities.

Review team recommendation: **Brent CCG should employ or contract with a communications specialist with expertise in designing public information and consultations to take a lead in redesigning all communications media and outputs, and to work alongside commissioning leads to facilitate an improved dialogue with local people.**

Outreach

Brent CCG's current EDEN strategy places too much emphasis on formal committees and public meetings and too little on establishing direct links with community groups and outreach visits. It is usually much more effective to talk to local people in places where they normally gather, rather than expecting them to attend formal meetings in unfamiliar surroundings, especially those from 'seldom heard' groups, or categories with 'protected' status under the equality legislation. Also, people tend to respond willingly and more constructively when they are asked for their views on a service they are familiar with, rather than being expected to comment on an entire commissioning plan. This argues for a carefully targeted approach, ensuring that the most relevant groups are involved and consulted directly wherever possible.

The CCG has made use of this type of direct approach in its consultations on the Wave 2 changes to musculoskeletal and gynaecology services, in co-production workshops involving people with type 2 diabetes, in reviewing service provision for mental health and learning difficulties, and in the development of self-care support. We believe this type of outreach exercise can be more productive than any other, so it should be properly prioritised, systematically planned, and effectively resourced and facilitated. Brent CCG currently employs an interim equality and engagement manager and we heard many positive reports of her work. This activity is fundamental to good patient and public engagement, so we recommend that this post should be properly supported on a permanent basis, with a clearly-defined and increased budget to enable effective outreach across the patch.

Relations between the CCG and Brent Healthwatch and Brent Council for Voluntary Service are good, but the CCG could do more to support local community groups as this is only happening to a limited extent at present. Some other CCGs have provided funds to enable community groups to participate in commissioning and health promotion activities. For example, in Hull the CCG offered small grants of up to £5,000 per group to fund Healthier Hull projects, with direct involvement from local people. The selection process involved around 250 members of the public in live voting, and 500 accessing an online voting facility for the citywide projects. Approximately £360,000 in funding was awarded to 79 projects across the city by this means. Furthermore, Hull CCG has also recruited 25 engagement ambassadors, local people who have volunteered to help the CCG with its engagement and public involvement work, and they are actively recruiting for more. Brent CCG should explore these and other means of strengthening its outreach and engagement with local community groups.

Review team recommendation: **Brent CCG already employs an Equality and Engagement manager. This important role should be supported with sufficient resources to extend and increase the various outreach activities, ensuring that they link directly to commissioning priorities and are planned systematically and proactively.**

Planning and Assuring Engagement Activities

A plan for engaging with local people likely to be affected by a specific service change should be developed at an early stage in every major commissioning initiative. This should include explaining and consulting on outline plans, learning more about local people's requirements and experiences, listening to their concerns, informing them about commissioning decisions, and giving feedback on what was done with their comments and suggestions. We recommend the adoption of a standard approach to this, based on clear criteria and evidence.

We have drafted the attached Engagement Template (Appendix H) as a suggested guide, recognising that its implementation will need to be adapted to the specific circumstances of each initiative. It may not be necessary to respond to each question in the template on every occasion, nor should it be followed slavishly in a 'tick box' fashion, but it may help to ensure that the CCG covers all relevant bases and keeps a record of what was done to counter any subsequent challenge. The same template could be used for providing assurance to the Governing Body that it has complied with its statutory responsibilities.

The engagement template should be used alongside the standard NHS Equality Delivery System (EDS) template. We understand EDS is used by Brent CCG, but we were told that it has proved difficult to persuade various parties to engage with it in the manner intended.

We believe CCG staff, board and committee members could benefit from training in how to engage with local people and how to promote the equalities agenda. There are various training programmes available, some of which are provided by NHS England. The CCG should encourage its members to enrol in these programmes.

***Review team recommendation*:** **Brent CCG should adopt an engagement template for use by commissioners throughout the development and production of a commissioning plan and provide training in how to use it. The same template could be used by the group responsible for providing assurance to the Governing Body, alongside the NHS Equalities Delivery System template. A suggested draft is attached at Appendix H.**

4. ENGAGEMENT STRUCTURES

GOVERNANCE AND REPORTING ARRANGEMENTS

Every CCG is required to develop a plan for patient and public engagement, together with an assurance process to check on the delivery, implementation and impact of the plan. In Brent both of these functions have been delegated to the EDEN committee. We do not believe that these dual responsibilities can be carried out effectively by the same body: as one interviewee said to us, "it's like marking your own homework". These functions should be separated, and we suggest below a way in which this separation could be achieved in Brent.

Brent CCG is by no means unusual in attempting to combine strategy and assurance, but few CCGs have delegated both of these functions to a single committee with a lay majority, with CCG executives confined to a support role only. In our view the strategic and action-oriented function is best placed within the CCG's executive structure, whereas assurance should be the responsibility of a more independent group. Both groups require lay involvement. Ideally an independent lay-led group such as Healthwatch should carry out the assurance function, but Brent Healthwatch may need more time to develop into this role. In the meantime, we suggest separating the functions by establishing a Patient and Public Engagement Committee with both lay and executive involvement that would report to the CCG's Executive Committee, while handing responsibility for assurance to the CCG's Quality, Safety, Clinical Risk and Research Committee which reports directly to the Governing Body. This issue, which has significant implications for the EDEN committee, is discussed further below and in Section 6.

When benchmarked against 13 other CCGs, Brent CCG governance structures and reporting arrangements are relatively unusual, and similar only to City & Hackney CCG in the sample group. There are two significant differentiators in our comparison (Appendix F):

- Whether the committee/sub-committee/group charged with leading PPE activity is also the committee providing assurance to the Governing Body (Category 1 – with 8 out of 14 CCGs) or not (Category 2 – with 6 out of 14 CCGs)

- Whether patient representatives are in a majority on the PPE committee and/or the governing body assurance committee (2 in Category 1 and 0 in Category 2).

Our analysis shows that there is no 'one size fits all' model structure, and that CCGs have adopted a wide variety of arrangements, which are likely to continue to evolve. Many CCGs have carried out

governance reviews in 2013/14 and it is to be expected that some will apply to NHS England for new arrangements to be approved as part of variations to CCG constitutions.

For a direct comparison, based on our limited research, the minutes of City & Hackney's Patient and Public Involvement Sub-Committee (which meets monthly) and of their Governing Body seem to indicate that their arrangements are effective. Like Brent's EDEN Committee, this is a large group with a majority of patient members, although it does not encompass a similar locality structure. However, this type of arrangement has not worked well in Brent.

Below we consider each of the distinct engagement structures or activities - EDEN committee, LPPGs, Specific Commissioning Initiatives, and Health Partners Forum. We have included a set of three options for consideration by the Governing Body: Option A is the status quo; Option B suggests various enhancements to current mechanisms; and Option C outlines a more radical shift to an integrated model. The ultimate aim is to work towards a state in which patient involvement is embedded in all relevant CCG committees and commissioning activities, and opportunities for effective collaboration between the CCG and Brent Council are fully exploited. We believe that Option C provides the best chance of achieving this.

EDEN Committee

The EDEN Committee meets up to six times a year, chaired by a lay member of the Governing Body. The CCG's constitution gives it delegated responsibility for providing assurance that the CCG is fulfilling its statutory Equality Duty and "has effective systems and processes in place to effectively engage with patients, partners and the public as part of commissioning decisions". It is directly accountable to the Governing Body. It has defined membership and a built-in patient/lay majority, with a lay chair from the governing body, five elected members (LPPG chairs), eight lay appointees (community group representatives), four CCG officers, the chair of Healthwatch, and two reps from Brent Council (including the public health lead). The lay members have voting rights, while the CCG officers and representatives from Healthwatch and Brent Council do not.

Views on the effectiveness of the EDEN Committee were highly polarised (Appendix D). The extent, variation and intensity of this difference of opinion was expressed by many of our interviewees and goes clearly to the heart of the review. Generally speaking, those patient representatives who continue to attend EDEN Committee meetings are supportive of the current arrangements, whilst acknowledging that its effectiveness could be enhanced – but only if the CCG would address its own inadequacies. In contrast, members of the CCG Executive and other local stakeholders do not rate the performance of the committee highly, and wish to see fundamental changes. They are especially frustrated and exhausted by the time spent on process and procedure at, they believe, the cost of a focus on issues of real concern to Brent residents and patients.

EDEN Committee members include committed and highly capable patient representatives who have contributed a great deal of time and effort, but relations between these people, in particular the LPPG chairs and their deputies, and the CCG representatives are characterised by a lack of trust and respect on both sides. The five chairs of the LPPGs and their deputies form an inner group, communicating between meetings and preparing motions for tabling. They are keen to proclaim and protect their elected status, in a manner which suggests that they believe it gives them greater legitimacy and associated freedom of comment over other appointed or employed patient representatives. This, coupled with their undoubted expertise in matters of procedure, makes for a somewhat unbalanced committee. We were told that that this can be confusing for some of the community group

representatives, and upsetting for CCG executives. Some of the community appointees appear to have voted with their feet and no longer participate in the meetings.

The CCG has not always managed the committee well. Agendas and other relevant papers are often circulated late or not at all, and patient representatives complain that they receive little or no feedback on the outcome of their efforts. There is some confusion about the exact composition of the committee, but several community group members, including Healthwatch, appear to have withdrawn.

We heard about some successes, notably the development of a new complaints procedure (with important input from some EDEN committee members) and useful advice on several commissioning initiatives, but no one we spoke to described the EDEN Committee as a constructive partnership. Lay committee members claimed the CCG was unclear about what it wanted from them, commissioning projects were not clearly defined, and they did not follow logical consultation and involvement procedures. CCG representatives told us that patient members were reluctant to get to grips with the substantive issues, with the LPPG chairs and their deputies preferring to focus on procedures and declining to provide assurance to the Governing Body.

There is also confusion about the committee's role. Is it primarily a conduit to convey the views of local residents to the CCG? Is it an expert group to provide advice on the 'how' of engagement? Or is its main purpose to provide assurance to the Governing Body on their statutory responsibilities? The CCG's Constitution and the EDEN Committee's terms of reference suggest that the primary function is, or should be, assurance, but the strategy document outlines a broader role for the committee. Patient representatives on the committee tend to stress the conduit or 'critical friend' function. In the view of the CCG's Governing Body, the EDEN Committee is "not fit for purpose".

The one thing on which everybody agrees is that relationships on the EDEN Committee have broken down, probably irrevocably, and there is a mutual lack of respect and trust between groups and individuals. This was vividly illustrated in the minutes of meetings and in many e-mail exchanges between the various parties.

A fundamental change in the understanding and practice of patient and public engagement in Brent is required. This can probably be achieved by reorganising the structures, by improving the planning, management and resourcing of the equality, diversity and engagement strategy, by offering training to all stakeholders, and by an infusion of new blood into the committees and outreach efforts. Our suggestions for structural change are illustrated in section 6 below.

Greater clarity on committee roles and ground rules, timely circulation of papers and minutes, plus effective chairing would go a long way to make the processes work better. For the reasons described above, we would also urge the CCG to clarify roles and separate the strategic and assurance functions, as outlined in Option C.

Future options for the EDEN Committee:

- **A.** Clarify and retain the current arrangements.

- **B.** The EDEN Committee would keep responsibility for acting as a conduit of information on patients' experience and for providing advice on the engagement strategy, but its assurance function would transfer to the Quality, Safety, Clinical Risk and Research Committee (which could be renamed Integrated Governance Committee to reflect this additional role). EDEN

Committee membership and voting rights would remain unchanged, and it would continue to report directly to the Governing Body.

C. The EDEN Committee would cease to exist, to be replaced by a Patient and Public Engagement Sub-Committee (PPE) reporting to the CCG's Executive Committee (in common with the CCG's other 'action-oriented' sub-committees). This would include both lay and executive members, all of whom would be appointed, not elected, and all members (lay and executive) would have equal voting rights. This committee would focus on strategy development and implementation, advice to commissioning leads, and support for local community groups. Responsibility for providing assurance on the statutory duties would transfer to the Quality, Safety, Clinical Risk and Research (or Integrated Governance) Committee, which reports directly to the Governing Body (in common with the other assurance committees). This committee would include a minimum of three lay members to reflect its increased responsibility for assurance.

Review team recommendation: **The Governing Body should review and reorganise its committee structure to include patient representation more effectively in all relevant committees and sub-committees. The aim should be to embed engagement throughout the organisation and beyond, instead of confining it to a single committee. Strategy implementation and oversight should be separated from the provision of assurance by delegating these responsibilities to different committees, both with significant lay membership.**

Locality Patient Participation Groups (LPPGs)

The five LPPGs were originally intended to be part of the formal governance structure, but following representations from patients they were eventually established as independent entities with their own terms of reference, controlling their own agendas, and electing their chairs, supported by the CCG. The EDEN strategy describes these groups as "Brent CCG's primary source of patient experience, feedback and complaints". We understand that they do not have any formal connection with the Locality Sub-Committees, which are made up of GP practices in each locality.

The LPPGs meet at varying frequencies but generally every two months, attended by an average of three CCG representatives per meeting. The CCG's Locality Commissioning Support Managers provide administrative support and minute-taking. LPPG members are drawn from Patient Participation Groups attached to (some of) the local general practices. Meeting attendance is often low, ranging from about four to twenty four local people. This has led the CCG's Governing Body to conclude that they are "disproportionately resource intensive" and "deliver poor patient engagement (in terms of frequency, attendance and scope)".

The relatively poor attendance at some LPPG meetings is acknowledged by the LPPG chairs, but they blame the CCG for doing little to promote membership and attendance. Another disputed area is whether or not the CCG should be responsible for providing training to LPPG members, given their independent status. Some interviewees mentioned that, on occasion, locality events were arranged

without consulting or involving the relevant LPPG. This would suggest that the CCG does not have confidence in the LPPGs to engage in such events, a point disputed by the LPPG chairs.

The locality-based structure in itself is an unusual arrangement, in that most other CCGs we looked at have a single CCG-wide PPE committee, sometimes involving representation from practice PPGs. The strategy outline in Appendix P of the CCG's constitution clearly limits the LPPGs' focus to "patient experience, feedback and complaints", indicating that other engagement activities are not intended to be exclusively geographically-focused. We concur with the CCG's view that this is a relatively ineffective and unnecessarily resource-intensive means of gathering information on patients' experience. In general, committee meetings are the least effective means of gaining intelligence on the breadth and diversity of patients' experience. As we have noted above, extensive data on patients' experience is available from the various provider-based surveys, drawing on much larger, and more representative samples, and from other more qualitative feedback initiatives, including complaints. As mentioned above, the CCG could make much better use of these alternative sources of intelligence on patients' experience, obviating the need to resource the locality groups. Any resources released could be better spent on extending and strengthening outreach efforts. The LPPGs' stated function also overlaps with the role of Healthwatch, which has statutory responsibility to act as the local consumer champion.

There is no doubt that the LPPG chairs and their deputies have devoted considerable energies to their roles and their knowledge and experience could be of great value to the CCG as it develops its engagement strategy. Other ways should be found to involve them if the Governing Body decides to reduce support for the LPPGs. We have recommended an extension of lay involvement in all relevant committees and sub-committees, so there would be increased opportunities to continue their input.

Following the government's recent announcement that all general practices will be required to set up a PPG, there may be a need to provide locality support for the development of these, where they have not already been established by individual general practices. This is an important initiative that the LPPGs might be willing and able to support, especially if the CCG was to continue covering some of their expenses, such as costs of venue hire.

Future options for locality groups

A. Clarify and retain the current arrangements.

B. LPPGs would remain in place, but they would relinquish their independent status in return for CCG support and training. They would be required to work to agendas planned in collaboration with CCG staff to ensure a focus on the CCG's main commissioning priorities. They could usefully take on a new role of supporting practice PPGs, including helping to establish new ones in practices where these do not currently exist.

C. Most CCG support for LPPGs would cease, although as independent entities they could, of course, continue to meet as before if they so wished. The CCG might continue to cover some expenses, such as venue costs, in return for their help in establishing and strengthening practice PPGs. Any resources released by this means would be used to strengthen the CCG's outreach activities. At the same time, the Governing Body should review and extend lay membership on all relevant committees and sub-committees, including the locality sub-committees. Where a specifically geographical focus on commissioning is needed, consultations and other engagement activities could be planned in collaboration with the

locality sub-committees and with Brent Council through their locality-based Brent Connects forums.

***Review team recommendation*: The Locality Patient Participation Groups are a relatively ineffective and inefficient means of gathering intelligence on the health and social care experiences of Brent residents. This can be better achieved by developing an insight function, by strengthening outreach initiatives and by increasing lay participation in all relevant CCG committees and sub-committees. The aim should be to embed patient engagement throughout the organisation and beyond.**

Specific Commissioning Initiatives

The CCG's recent report to NHSE London on their participation duties details a number of initiatives carried out during the past year, including various stakeholder engagement groups, a formal public consultation carried out by an external organisation (Mott MacDonald), a series of clinical service design groups comprising external experts, commissioners and service users, focus groups, attendance at faith and community events, and information provision via leaflets and the website. Highlights included a dedicated group for people with learning disabilities, and user involvement in redesigning services for musculoskeletal problems, gynaecology, and adult mental health care. Local people were also involved in thinking through integrated care initiatives, including NW London's Whole Systems Integrated Care programme. In addition, the CCG was represented on various local groups, including the Learning Disability Partnership Board, BHeard learning disability and mental health service user forum, Brent Sickle Cell Society, DraB learning and physical disabilities group, Help Somalia Foundation, Multi Faith Forum, Carers Forum, Mencap and a variety of mental health and older people's forums across the borough. Training should be offered to community group members to strengthen their ability to co-design services and feed into commissioning plans.

It is clear that there is a fair amount of engagement activity going on in Brent CCG, but this was not always obvious to those we spoke to, including members of the EDEN Committee. They complained of poor communications about plans and activities, and a lack of feedback on outcomes – what impact have the various engagement exercises made to the CCG's commissioning plans? During the course of our review an attempt was made to address this criticism with the production of a short report detailing the commissioning intentions engagement plan and actions to be taken. This was a commendable response that may help to allay suspicion that the CCGs approach to engagement is merely concerned with ticking boxes.

The fact that engagement initiatives are led by commissioning leads was appreciated by most interviewees, but questions were raised about whether they had sufficient knowledge and experience to do an effective job. We were told by some that the CCG's approach was reactive rather than proactive, and scatter gun rather than strategic. Some interviewees felt there had been insufficient investment in engagement activities, and ineffective use of connections with voluntary and community groups. Others argued that it would be better to focus on specific topics at any one time,

rather than consulting about the entire commissioning strategy at once. The picture painted by our interviewees was of patches of good practice interspersed with poor understanding and lack of focus on the issues and needs of specific stakeholder groups. We recommend that all commissioning leads should receive training in patient and public engagement, and they should adopt a more systematic approach, guided by the Engagement Template (Appendix H).

Future options for Specific Commissioning Initiatives

A. Clarify and retain the current arrangements.

B. Specific Commissioning Initiatives would be initiated at an early stage in the commissioning cycle. They would be proactive and outgoing, linking with relevant community groups and working mainly through face-to-face outreach and electronic media (interactive web tools, videos, social media) to co-design services. Working groups established for specific tasks should be well resourced and led jointly by commissioning leads and engagement specialists, working to an agreed set of priorities. Input from relevant local groups and individuals would be sought at all stages of the commissioning cycle (see Appendix G for examples of how other CCGs' are tackling this). Training and support would be provided for community group members and for commissioning leads.

C. The Commissioning Initiatives would proceed as outlined under Option B, but priorities would be explicitly determined with reference to the Joint Strategic Needs Assessment (JSNA) and the joint Health and Wellbeing strategy. The engagement programme would be planned in association with Brent Healthwatch, Brent Council for Voluntary Service and Brent Council. Grants would be available to community groups to facilitate and strengthen their involvement to inform commissioning.

Review team recommendation: **Community engagement in specific commissioning initiatives should begin at an early stage in the commissioning cycle and continue throughout the process. Working groups established for specific tasks should be well resourced and well supported. Training should be provided for community group members and for commissioning leads. Priorities should be determined with reference to the Joint Strategic Needs Assessment and the Health and Wellbeing strategy. Grants should be made available to community groups to facilitate and strengthen their involvement to inform commissioning.**

Health Partners Forum

Meetings of the Health Partners Forum, which take place roughly every three to four months, attract a good number of attendees and feedback is generally positive. After initial teething problems when meetings were disrupted by a small group of lobbyists, the format was changed and external facilitators were appointed, helping to make the meetings more focused. We heard a few criticisms –

a sense of frustration that the same people turn up saying the same things, yet nothing changes, and a feeling that issues are not dealt with in any depth. Some interviewees told us that the events were too stage-managed, with few opportunities for genuine debate.

All the CCGs we looked at have some kind of public forum to inform local people about their commissioning plans and gain feedback on these. Brent CCG's Health Partners Forum works in similar ways to these and is a useful component of the engagement strategy. There may be scope for improving the format, with fewer formal presentations and more opportunities for small group discussions on specific topics. The CCG should measure the impact of their engagement activities and provide feedback via the Health Partners Forum.

Future options for public forums

A. Clarify and retain the current arrangements.

B. The Health Partners Forums would continue as before, but with briefer presentations and longer discussion time, including small group discussions using independent facilitators (i.e. not CCG staff).

C. The Health Partners Forums would continue, but taking place more frequently and focusing on only one or two pre-specified and well-advertised topics each time. They would be organised in collaboration with Brent Council, making full use of their Citizen's Panel and database, adopting a joint approach to area-based user forums and public meetings for specific population groups (including those with 'protected characteristics'). These could be supported by a network of trained community champions, user surveys, public consultations and other outreach initiatives. The impact of engagement activities should be measured and critically reviewed, with the results fed back at Health Partners Forum events.

Review team recommendation: **The Health Partners Forums should be retained and strengthened, ensuring that they facilitate genuine community participation and debate. The CCG should measure the impact of its engagement activities and feed the results back via the Health Partners Forum.**

5. Resources for Patient and Public Engagement

It has proved difficult to gather reliable information about the type, level and cost of CCG resources dedicated to patient and public engagement. All CCGs are required to have a Governing Body lay member for patient and public engagement, but their time commitment varies according to individuals' circumstances, interests and level of activity. This is usually the only directly attributable resource and cost. Most CCGs can also identify the direct cost of staff who work on communications, equality and stakeholder engagement, but the exact proportion of their time devoted to engagement activities can be hard to unpick. Non-pay budgets used to support any these activities are often shared between external engagement with the public and internal communications with GP

members. There are also less obvious resource costs, such as line management and administrative support, which may be very difficult to isolate.

As a very rough rule of thumb, the following examples give an idea of the types of resources and costs involved in two other London CCGs.

Resources for Patient and Public Engagement		
	Staffing	**Non-payroll**
CCG A	1 x Governing Body lay member for PPE 1 x WTE head of communications (8a) 1 x WTE communications assistant (4) Estimated cost c. £100,000	All communications and engagement expenses Support and facilitation Design and printing Venues and catering Translation services Estimated cost c. £50,000
CCG B	1 x Governing Body lay member for PPE 1 x clinical lead for PPE 1 x programme board director 1 x PPE project officer Estimated cost not stated	Non-pay budget of £50,000 + £30,000 contracted out for communications support
Brent CCG	1 x Governing Body lay member for PPE 1 x clinical lead for PPE 1 x engagement lead Estimated cost: £110,000	External communications contracted out Estimated cost: minimal – no specific brief for engagement

Our rough estimate, based on the above examples, suggests that CCGs A and B spend somewhere in the region of £150,000 to £250,000 on patient and public engagement, while Brent CCG's costs appear to be at the lower end of the spectrum. The estimated figure of £110,000 is almost certainly too small a budget for effective delivery of such an important statutory function.

We were also dismayed to find that the CCG has relied so heavily on interim appointments to support its engagement responsibilities. By all accounts the CCG's finances are relatively healthy, so it could almost certainly afford to spend more. We would urge the Governing Body to increase spending on its statutory responsibilities for equality, diversity and engagement, to allocate a defined budget to this

important area, and to make substantive appointments to lead this work along the lines we have suggested.

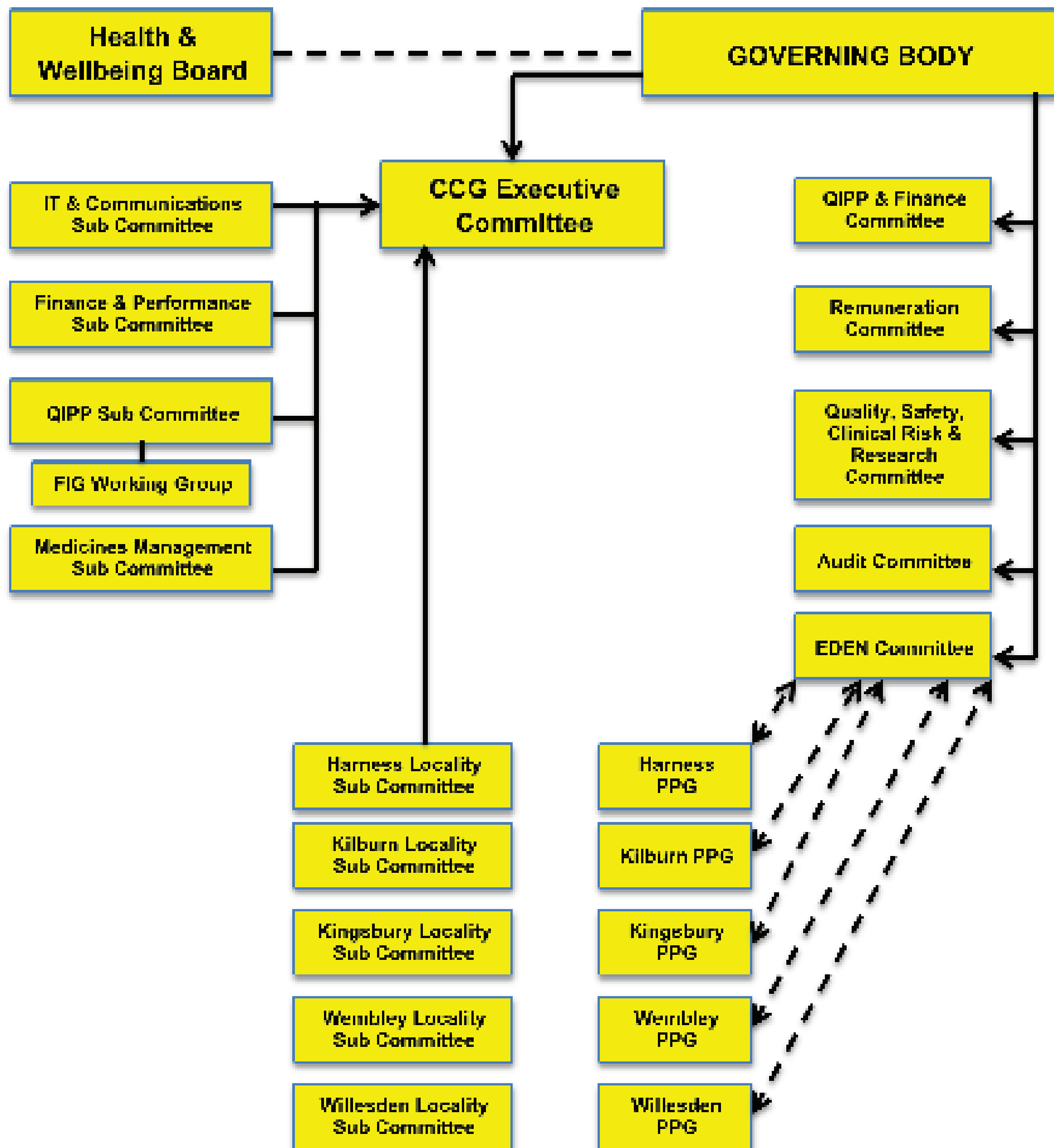
Review team recommendation: **The CCG should allocate a defined budget to support its engagement activities, including insight, communications, outreach and governance arrangements. It should make substantive staff appointments to lead these activities.**

6. Governance structure and constitution

Organisational changes

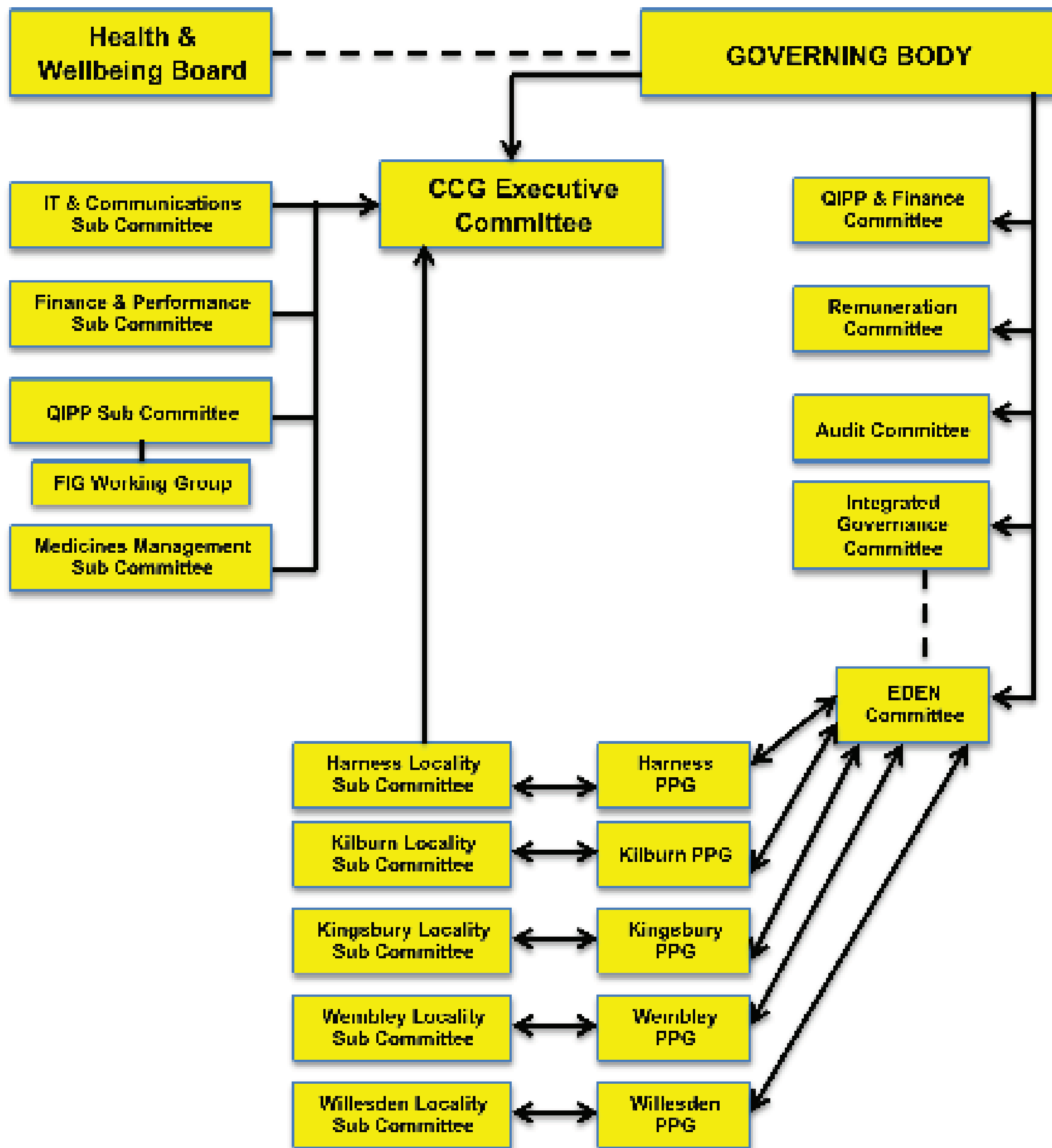
All of the above, when added to the Governing Body's concerns described earlier about the EDEN Committee's lack of effectiveness in giving assurance, creates a compelling case for, at least some change, and probably for radical change in Brent CCG's patient and public engagement structures and governance arrangements. On the next pages we chart the implications of Options A, B and C for the CCG's governance structures.

BCCG GB Committee Structure – A – Existing reality



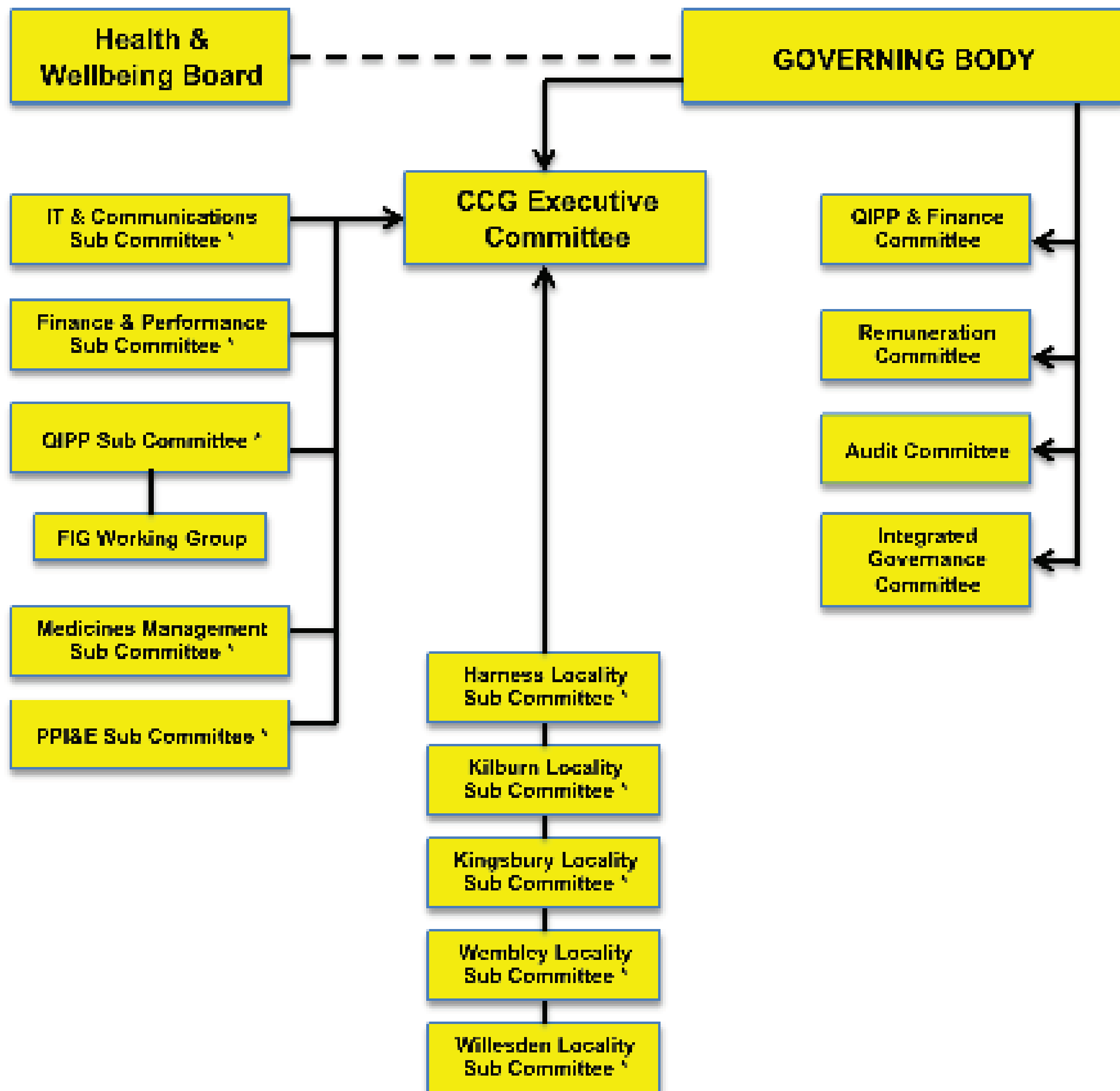
The chart above describes our understanding of the current position. It differs from the organisational chart in the CCG's current Constitution because we were told that the original plans had evolved somewhat since that was published. For example, the original version showed dotted lines between the LPPGs and the Locality Sub-Committees, but in practice these groups appear to have no direct connections.

BCCG GB Committee Structure – Option B



Option B, as outlined above, removes the LPPGs' independent status and brings them back into the formal governance structure, including direct links with the Locality Sub-Committees. The EDEN Committee continues, but its responsibility for assurance transfers to the Quality, Safety, Clinical Risk and Research Committee, which we suggest should be renamed Integrated Governance Committee.

BCCG GB Committee Structure – Option C



* The default assumption should be that there will be patient representatives on all CCG Executive Sub Committees, and where appropriate, on the Assurance Committees, in addition to the Lay Members.

In Option C, the EDEN Committee and the LPPGs are replaced by a newly established Patient and Public Engagement Committee (with substantial patient membership) reporting to the CCG Executive Committee. Assurance for equality, diversity and engagement would be carried out by the Integrated Governance Committee. There would also be increased patient membership on all relevant committees and sub-committees.

Constitutional changes

These changes would clearly involve amendments to the CCG's Constitution. Any such changes require a formal application to NHS England. This should include the following steps:

1. The application should have already been discussed and agreed with CCG member practices and other stakeholders should have been consulted.
2. The CCG should have considered whether it needs to take legal advice.
3. The likely impact on the resident population should have been considered.
4. The CCG should clarify the extent to which it has sought the views of the local authority and any other person or body who may be affected.
5. The CCG should state how it has sought the views of patients and public, what those views are, and how they have been taken into account.

We believe our investigations and this report may be considered sufficient justification for any proposed changes to Brent CCG's constitution.

We have set out options for consideration by the Governing Body, as requested. The Governing Body might decide to opt for a combination of Options A, B and C, or modifications of these. We believe the suggestions set out in Option B would mark a step forward, but we hope they will give serious consideration to Option C, which would help to ensure that the CCG is at the forefront of efforts to produce a more patient-centred health and care system.

Review team recommendations: **The Governing Body should give serious consideration to implementation of Option C in its entirety. This would involve significant changes to the CCG's culture and mode of working, but we believe these are necessary to ensure that the CCG achieves its goal of securing a more person-centred health and care system for the people of Brent.**

7. Conclusions

It is our view that the current governance arrangements for equality, diversity and engagement are not working well and require change if Brent CCG is to succeed in its laudable ambition of achieving meaningful engagement with patients, carers and their communities. At the very least, the CCG should revise and update its engagement strategy, ensuring that its commissioning plans are evidence-based, clearly communicated, and built on effective partnerships with local people.

Whatever decision is taken in respect of our recommendations will require careful attention to transitional arrangements and an effective communications plan. Even if the Governing Body decides to retain the current arrangements, as outlined in Option A, there remains a need to rewrite the strategy and clarify these arrangements, which are not understood by everyone involved at present. If, as we hope, the Governing Body decides more fundamental change is required, this must involve careful planning and clear communications to all local stakeholders. Such changes will inevitably stir up opposition and resentment in certain quarters, so the transition must be managed sensitively.

Ultimately, successful commissioning and service change rest on effective engagement with local people. The best way to secure their trust and support is to listen to their concerns and try to reflect their priorities. We believe Brent CCG is strongly committed to this goal, which is eminently achievable and affordable.

The challenges of implementing Option C in its entirety will require structural, cultural and behavioural changes. We hope that the Governing Body will provide the essential leadership to the CCG executives and all patient representatives to work together constructively to achieve this common goal.

APPENDICES

A. Terms of reference for the review
B. Who we spoke to
C. Meetings attended by the review team
D. Analysis of key themes and issues raised during the interviews
E. Documents reviewed
F. Governance arrangements in selected CCGs
G. Engagement strategies in selected CCGs
H. Template for planning and assuring engagement activities

APPENDIX A

Proposed terms of reference

Review of how Brent CCG will meet its statutory duties on equality, diversity and engagement

1. Purpose

1.1. This report sets out the background of the proposed review, offers a proposed Review Terms of Reference (TOR), and proposed interim arrangements to allow the CCG to meet its statutory duties. The review will develop an approach to equality, diversity and engagement that is fit for purpose.

1.2. The review will identify options for ensuring Brent CCG:

- meets its statutory duties for equality, diversity and engagement
- meets its statutory duties for working in partnership with Brent Council
- meets its statutory duties for working with the oversight of Brent Health and Wellbeing Board
- removes unnecessary duplication of effort in equality, diversity and engagement between the CCG and Council
- builds on existing precedents and models established with Brent Council for integrated equality, diversity and engagement assurance.

1.3. The options will be presented to Brent CCG Governing Body in September 2014 for decision.

1.4. The agreed option is likely to require a change to the CCG Constitution (submitted to NHS England by 01 November 2014).

2. Background

2.1. *Policy direction for greater integration between health and social care planning*

2.1.1. In 2013/14, clarification was issued on the way CCGs and partner agencies should discharge their existing statutory duties:

- *Integrated Care and Support: Our Shared Commitment* (May 2013) clarified that CCGs and Health and Wellbeing Boards had "*statutory duties, respectively, to promote and encourage the delivery and advancement of integration within their local areas at scale and pace*"
- *Health and Wellbeing System Improvement Programme Development Tool* (September 2013) clarified the need for engagement structures across partner agencies (including CCGs) to be aligned "*to key priorities so that there is a coordinated approach to involving and engaging communities and citizens*"
- NHS England's planning guidance to CCGs, *Everyone counts: planning for patients 2013/14* required integration, including the pooling of budgets to reflect local need, to be given "*explicit consideration*" in local area planning.

2.2. *Outcome of the annual CCG governance review*

2.2.1. In April 2014, as part of good governance processes and in accordance with NHS England guidance, Brent CCG undertook an annual review of governance across all its committee's and sub committees. The purpose of this annual review was to determine whether, for the forthcoming year:

- The CCG had adequate arrangements for providing assurance that statutory duties its were being met
- And whether these arrangements adequately reflected the organisational priorities and plans.

2.2.2. As part of the annual CCG governance review, the CCG Governing Body reviewed the membership, performance and Terms of Reference for its committees.

2.2.3. The outcome of the annual review will inform the CCG's Annual Governance Report, identify changes needed to committee arrangements, and will help identify any constitutional amendments required.

2.2.4. The annual CCG governance review identified a number of governance arrangements that required amendment. These included:

- The need for the governance structures to reflect local integration arrangements; delivery of the Better Care Fund and Whole Systems Integrated Care
- The need for committee membership to reflect new lay member, chair arrangements and council representation
- The need to update the CCG's governance arrangements regarding Locality PPGs, which had adopted their own constitutions since November 2013.
- The urgent need review CCG's governance arrangements for equality, diversity and engagement, which were no longer fit for purpose.

2.3. SUMMARY

- **The annual CCG governance review identified an urgent need review CCG's governance arrangements for equality, diversity and engagement, which were no longer fit for purpose.**

3. Rational for the comprehensive review

3.1. *Existing assurance arrangements no longer fit for purpose*

3.1.1. Through the annual CCG governance review, Brent CCG Governing Body identified that its existing assurance arrangements for equality, diversity and engagement were no longer fit for purpose. This was because:

- Strategic direction regarding the way CCGs and partner agencies discharge their statutory duties had changed significantly since the EDEn Strategy was developed
- The governance arrangements and EDEn Strategy engagement structures needed to take greater account of the statutory duties to promote and encourage the delivery and advancement of health and social care integration
- The existing EDEn Committee was no longer providing adequate assurance to the Governing Body

3.1.2. Brent CCG Governing Body identified an urgent need to review how Brent CCG will meet its statutory duties on equality, diversity and engagement. The EDEn Committee was informed of the intention to undertake this review, and that it would be led the incoming Lay Chair of the EDEn Committee.

3.1.3. There is a difference of opinion between the CCG Governing Body and the EDEn Committee members who may be affected by the review.

- The EDEn Committee was informed of the intention to undertake this review, and did not fully share the opinion of the Governing Body:
    - Committee members did recognise the need for the existing EDEn Strategy to be revised to reflect the policy direction for greater integration between health and social care
    - The committee recommended that any review of the EDEn Strategy exclude consideration of changes to the EDEn Strategy engagement structures, particularly any changes to the EDEn Committee itself or to Locality PPGs (see appendix 1).
    - The committee did not agree that it was no longer providing adequate assurance to the Governing Body.

3.2. *Scoping the review*

3.2.1. In April and early May, scoping of the review identified that:

- A comprehensive review over a longer time period would be required to adequately explore the significant new strategic opportunities for Brent CCG and Brent Council, with the oversight of Brent Health and Wellbeing Board, to work jointly on meeting their statutory duties around integration
- Interim working arrangements for the EDEn Committee would be required if it was to provide adequate assurance to the Governing Body during the period of a comprehensive review

3.3. *Comprehensive review*

3.3.1. Brent CCG has a significant integration agenda driving delivery of its five-year plan objectives. Key elements of this agenda include work under the Better Care Fund and our involvement with the North West London Whole Systems Integrated Care Pioneer programme. Brent CCG has an established intention to work closely with Brent Council and other partners for Brent.

3.3.2. To support our integration agenda, a comprehensive review would need to conclude by October 2014.

3.4. *Interim working arrangements for the EDEn Committee*

3.4.1. Brent CCG Governing Body had identified that the current working arrangements for the EDEn Committee were not fit for purpose. The existing working arrangements would need to be revised if the EDEn Committee were provide the Governing Body with assurance during time taken for the review to be completed.

3.4.2. This paper includes principle components for interim working arrangements that the Governing Body could choose to introduce to the EDEn Committee.

3.5. SUMMARY

- **A comprehensive review is required to adequately explore the significant new strategic opportunities for Brent CCG and Brent Council, with the oversight of Brent Health and Wellbeing Board, to work jointly on meeting their statutory duties around integration.**

- **Interim working arrangements for the EDEn Committee could improve the level of assurance it provides to the Governing Body during the period of a comprehensive review.**

4. Equality, Diversity and Engagement (EDEn) Strategy no longer fit for purpose

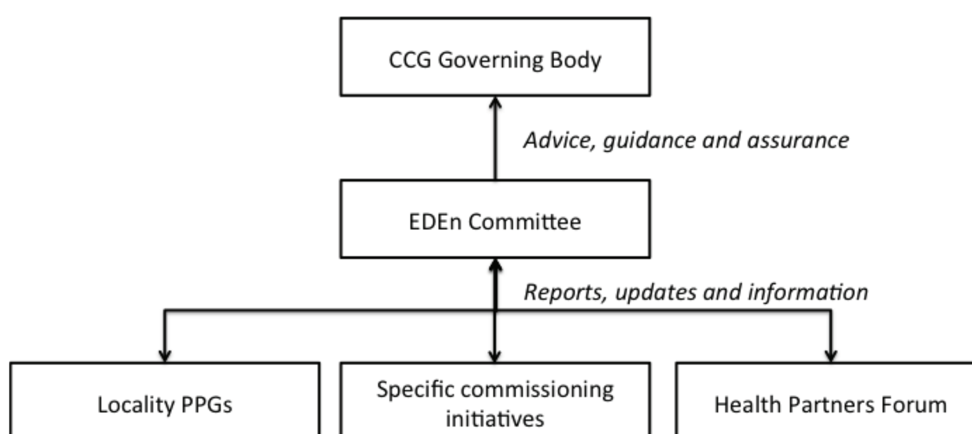


Figure 1: Public and patient engagement structures within the EDEn Strategy

4.1. Currently, Brent CCG seeks to fulfil its statutory duties through implementation of the EDEn Strategy. The EDEn Strategy does not reflect changes during 2013/14 in strategic direction regarding the way CCGs and partner agencies discharge their statutory duties, placing far greater importance on health and social care integration, with oversight from Health and Wellbeing Boards.

4.2. *EDEn Committee*

4.2.1. The EDEn Committee is an engagement structure within the EDEn Strategy that has delegated responsibility from Brent CCG Governing Body for assurance that the CCG is discharging its statutory duties in regard to equality, diversity and engagement. This delegation is set out in the Brent CCG Constitution (December 2013).

4.2.2. It was noted, despite the often challenging nature of the relationship between the EDEn Committee and the wider CCG, committee members had supported the CCG to deliver a number of engagement activities.

- Brent MIND supported consultation on mental health services

- Locality PPG Chairs worked with Mott MacDonald to plan the public consultation of Wave 2 re-commissioning, and improved the public consultation and information regarding gynaecology and musculoskeletal services

- Locality PPG Chairs contributed to reviews of services at Central Middlesex Hospital and GP Hubs.

4.2.3. The annual CCG governance review concluded that an engagement structure of the EDEn Strategy, and in its current form, the EDEn Committee:

- No longer provided adequate assurance to the Governing Body, in the context of a drive towards greater integration;
- Had not engaged sufficiently with the Brent CCG's equalities and diversity objectives;
- Did not conduct committee business in accordance with the terms of reference or accepted behaviours of other Brent CCG committees.

4.3. *Locality Patient Participation Groups (PPGs)*

4.3.1. Locality PPGs were intended as an engagement structure to gather and reflect the expectations of Brent residents in each of the five localities: Harness, Kilburn, Kingsbury, Wembley, and Willesden. To be effective, Locality PPGs need to be sufficiently frequent, have sufficient attendance and cover a sufficiently wide range of services.

4.3.2. As each Locality PPG established its own constitution in 2013/14 outside that of the CCG, there is uncertainty about the degree to which the CCG should support PPG Chairs around their training needs analysis and performance management.

4.3.3. In 2013/14, Locality PPGs were:

- Variable in frequency and attendance (Kingsbury PPG was exceptional in holding meetings that regularly attracted 15 or more service users, see appendix 2a)
- Variable as conduits for disseminating and gathering information from Brent residents about their experience of services (Wembley PPG was exceptional in covering more than five service areas on their agendas in the year, see appendix 2b).
- Disproportionately resource intensive for the CCG (on average three CCG staff attended each meeting)

4.4. *Specific commissioning initiatives*

4.4.1. Within the EDEn Strategy, the CCG was expected to have six core areas for commissioning, with bespoke engagement exercises linked to different stages of the commissioning cycle.

- The strategic priorities for the CCG have changed, with greater emphasis on integrated care, self-management, community capital and co-production.

4.5. *Health Partners Forum*

4.5.1. The Health Partners Forum was intended as an engagement structure for two-way communication with patients and the public. Attendance at the meetings has been consistently good, and the format is well suited to large group discussion.

- The strategic direction of integrated care has created additional opportunities to collaborate with Brent Council on engagement, and reduce any unnecessary

duplication of effort. The CCG is actively exploring these opportunities with Brent Council.

- A greater range of engagement approaches are needed to reflect the diverse demography and age-profile of Brent. Other specialist forums, such as the Learning Disability Partnership Board, have been used to engage service users on interdependent health and social care issues.
- The format is well suited to large-group discussion, but less suited to working in small focus groups.

4.6. SUMMARY

- **The current EDEn Strategy is not fit for purpose**
- **The EDEn Committee, as an engagement structure of the EDEn Strategy, is no longer providing adequate assurance to the Governing Body**
- **Locality PPGs are often resource intensive and deliver poor patient engagement (in terms of frequency, attendance and scope). There is a need to clarify the appropriate level of support to offer to PPG Chairs.**
- **The strategic direction for specific commissioning initiatives has changed, with greater emphasis on integrated care, co-production and self-management**
- **Health Partners Forum is effective at engaging with part of the population of Brent. Opportunities exist for greater collaboration with Brent Council, and to reach a greater number and diversity of Brent residents**

5. Future strategic direction for integrated care

5.1. *Legal advice commissioned by Brent CCG*

5.1.1. In November 2013, in the context of changing strategic priorities and the EDEn Strategy becoming unfit for purpose, Brent CCG commissioned legal advice on its statutory duties. Brent CCG was advised that it has a statutory duty to:

- Engage with current and potential patients when changing commissioned services
- Use engagement approaches that are proportionate in size and nature to the size and importance of the potential impact on patients

5.2. *Five-year plan*

5.2.1. The North West London five-year strategic plan sets out the strategic priorities of the eight CCGs of NWL, working in partnership with NHS England.

5.2.2. A core principle is that, in all settings, healthcare (both physical and mental) and social care services should be integrated to deliver a seamless person centred experience.

5.2.3. The five-year plan builds on the co-design approach developed through the Whole Systems Integrated Care (WSIC) programme.

5.2.4. Sustainability of services is dependent on integration and co-production, taking into account wider social determinants of health and wellbeing as well as personal circumstances and capacity for self-care.

5.2.5. Significant opportunities exist for collaborative equalities, diversity and engagement work with Brent Council, and with other North West London CCGs on shared priorities.

5.3. *Health and Wellbeing Board (HWB)*

5.3.1. Brent HWB is a statutory body bringing together the key health and social care commissioners with Local Healthwatch. Brent CCG has a statutory duty to work in partnership with the local authority.

5.3.2. HWBs are intended to build strong and effective partnerships, which improve the commissioning and delivery of services across NHS and local government

- Brent HWB coordinates the development of the Joint Strategic Needs Assessment which articulates the health and wellbeing needs of the residents of Brent,
- Brent HWB produces a Health and Wellbeing Strategy to align Brent CCG commissioning plans and Brent's Social Care Commissioning Plans
    - Brent HWB promotes joint commissioning and integrated provision between the NHS, public health and social care
    - Brent HWB brings together senior representatives from Brent Council, Brent CCG and Brent Healthwatch to work in partnership to improve the health outcomes of the population of Brent

- The *Health and Wellbeing System Improvement Programme Development Tool* (September 2013) clarified the need for engagement structures across partner agencies (including CCGs) to be aligned "*to key priorities so that there is a coordinated approach to involving and engaging communities and citizens*"

5.3.3. Opportunities exist for the HWB to support collaborative work between Brent CCG and Brent Council to reduce duplication of effort embedding equality considerations into planning and delivering integrated care. There may be a need to expand Brent HWB membership to health provider organisations.

5.4. *NHS Mandate April 2013 to March 2015*

5.4.1. In 2013/14, clarification was issued on the way CCGs and partner agencies should discharge their existing statutory duties, placing far greater importance on health and social care integration.

5.4.2. The NHS Mandate stated that '*local commissioners have the vital role of stimulating the development of innovative integrated provision*' of care for long-term conditions.

- This requires the CCG to identify and challenge the '*practical barriers that stop services working together effectively*'.

- Health and Wellbeing Boards are identified as key partnerships for CCGs and Local Authorities to increase local empowerment in delivering the Mandate's objectives.

5.4.3. The NHS Mandate objectives were reinforced in *Integrated Care and Support: Our Shared Commitment (May 2013)*. This stated:

- CCGs and Health and Wellbeing Boards have '*statutory duties, respectively, to promote and encourage the delivery and advancement of integration within their local areas at scale and pace*'.
- CCGs must give '*explicit consideration*' to integration in local area planning.

5.5. *Integration pioneer status*

5.5.1. North West London is one of 14 integration pioneers identified by NHS England.

- The NW London Whole Systems Integrated Care (WSIC) programme is at the core of our five-year plan to deliver financial sustainability and improve health and social care outcomes
- The Integrated Care and Support Exchange was established as a national resource. It showcases the North West London Value Case as an approach to challenging siloed approaches to delivering complex services

5.6. *Increasing involvement of Lay Partners*

5.6.1. Following the success in WSIC, Lay Partners will play in increasingly important role in helping Brent CCG to achieve co-production in future major service redesign and commissioning, including the Prime Minister's Challenge Fund.

5.6.2. A possible development may be a Brent wide Lay Partners Advisory Forum that will supplement formal arrangements that the CCG has in place to meet statutory duties on patient engagement.

5.7. *Brent CCG and Brent Council development of a Joint Engagement Strategy*

5.7.1. The CCG and Council are developing a joint engagement strategy that recognises the strategic change, potential benefits and cultural shift associated with integrated services and co-production.

5.7.2. The CCG and Council recognise the value of mapping the community groups that take part in consultations, and reflecting on which engagement approaches (such as outreach, standing groups, events) are effective in different situations.

- *Health and Wellbeing System Improvement Programme Development Tool* (September 2013) recognised mapping as characteristic of a 'young' HWB, and clarified the need for an 'established' HWB to have engagement structures across partner agencies (including CCGs) aligned "*to key priorities so that there is a coordinated approach to involving and engaging communities and citizens*"

5.7.3. The CCG and Council are keen to improve efficiency and increase pace by reducing unnecessary overlaps and duplication of effort in their engagement structures.

5.8. SUMMARY

- **New strategic priorities and statutory duties to promote integrated care create the need for equalities, diversity and engagement work regarding both health and social care outcomes**

- **Future CCG commissioning plans rely on the development of integrates care, self-management and community capital to deliver health outcomes and financial objectives.**

- **Equality, diversity and engagement work applies across all commissioning work streams, and is a logical area to for Brent CCG and Brent Council to develop a joint strategy, supported by Brent HWB**

6. Review TOR

6.1. As part of the annual review of its governance and accountability arrangements, Brent CCG Governing Body has decided to conduct a comprehensive review of its equality, diversity and engagement strategy.

6.2. *Refinement of Review TOR through stakeholder engagement and co-design*

6.2.1. This document serves as the basis for Review TOR; it describes why, what, how, who and when. The initial stages of the review will include stakeholder engagement to refine and co-design the scope. The suggested stakeholders should include, but would not be limited to:

- CCG Officers, GP members and Lay Members and Lay Partners (Brent and other NW London CCGs)
- EDEn Committee Members
- Expert Reference Group Chairs associated with North West London CCGs Transformation Programmes
- Healthwatch
- Health and Wellbeing Board Chair
- Local Authority Officers
- Service providers
- Service user representatives

6.2.2. Final detailed Review TOR should be produced no later than the end of June 2014, and should take account of:

- Work done in late 2013 by the EDEn Committee and Brent CCG to revise the current engagement strategy, and develop alternative options
- The readiness of partner agencies, particularly Brent Council, to implement options for collaborative equality, diversity and engagement assurance
- Up to date legal advice, where necessary, on CCG statutory duties

6.2.3. The Review TOR should have explicit arrangements for:

- Securing CCG resources (including admin support, venue hire and travel reimbursement)
- Oversight by CCG Lay Member Chair of the EDEn Committee, and the CCG Assistant Director with responsibility for equality, diversity and engagement

6.3. *Developing options for delivery to the September CCG Governing Body meeting*

6.3.1. The review should include stakeholder meetings with partner agencies, particularly Brent Council, in July 2014. These would explore the range and extent of opportunities and existing models for collaborative equalities, diversity and engagement work regarding:

- Self-management/ wellbeing of the general population
- Current health service providers, their service users and under-represented groups
- Service users impacted by proposed changes to services

6.3.2. By the end of August 2014, the review should produce a number of detailed options for the CCG to meet its statutory duties on equality, diversity and engagement. These options must be 'fit for purpose' to 'promote and encourage the delivery and advancement of integration at scale and pace'. These options should be developed taking into account the following key questions:

- What would be key indicators that Brent CCG has equality, diversity and engagement assurance processes in place that would be fit for purpose next year? In two years? In five years? How would value for money be evaluated?
- Are there any existing opportunities for improving equality, diversity and engagement assurance processes by integration with the Brent Council? Brent Health and Wellbeing Board? Other North West London CCGs?
- Are there any existing opportunities for improving equality, diversity and engagement assurance processes by co-production with service users, service providers and partner agencies (particularly Brent Council)?
- Are there any best practices for addressing issues of equality, diversity and engagement around protected characteristics (age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation)? How can meaningful engagement with representative groups be sustained?
- Can the pace of integration and co-production for equality, diversity and engagement assurance process vary across different service areas? Which service areas can progress quickly, and which need more time to develop?
- Are there criteria to help the CCG judge a proportionate level of engagement for a given service development? Do they take into consideration the urgency of change and the size of impact on service users? Are there any existing precedents and models that would be helpful?

6.3.3. The options should detail the proposed governance arrangements, particularly for collaborative meetings with partner agencies, so that there would be clear systems for:

- Making decisions
- Reporting trends to the CCG Governing Body
- Monitoring the group/committee performance
- Escalating concerns
- Ensuring meetings are conducted in line with other CCG Governing Body committees

6.4. *Independent reviewer skills and competencies*

6.4.1. Support and facilitation could be obtained from an organisation or individual with recognised expertise in health and social care policy. Impartiality would be important to mitigate any criticism that the scale of the review is disproportionate to the scale of policy change, and any criticism that the review might introduce a less effective assurance process.

6.4.2. The reviewer(s) needs to be:

- Experienced in working in a senior role in health
- Independent from Brent CCG, Brent Council and the existing EDEn Strategy
- Familiar with current NHS policy
- Familiar with CCG constitutional issues
- Familiar with NHS equality, diversity and engagement assurance processes
- Familiar with the requirements for integration
- Familiar with co-production
- Able to analyse complex information
- Able to communicate complex concepts simply
- Able to foster creativity when generating ideas and options
- Able to deliver work to deadlines

6.4.3. The total maximum duration of involvement would be five days per week for four to six months.

6.5. *Timeline and milestones*

6.5.1. See appendix 3

6.6. *Communication plan*

6.6.1. The review should produce and follow a communication plan to pro-actively explain the potential benefits of integration, collaboration and co-production as a way for Brent CCG to meet its statutory duties on equality, diversity and engagement.

6.6.2. The communication plan should promote awareness of the strategic direction and statutory duties around integrated care, and be receptive to questions and the diversity of opinions on future arrangements.

6.6.3. The plan should anticipate that changing the status quo arrangements for CCG equality, diversity and engagements may be challenged.

- Challenges about the process of the review are partially mitigated, as the Review TOR has built in flexibility to be shaped through co-production.
- Challenges about the idea of a review should be mitigated by conveying clear messages from the CCG Governing Body that:
  - The old ways of working are unsustainable
  - The new ways of working (integration and co-production)

- are essential to delivering our five-year objectives
- will require a culture shift for the CCG
- and will need to be implemented incrementally, year on year

6.7. SUMMARY

The Review TOR sets out:

- **Why – To develop options on how the CCG can meet its statutory duties on equality, diversity and engagement through integration, co-production and collaboration with partner agencies, particularly Brent Council.**
- **What – Options will be developed for the CCG Governing Body to consider in September; the agreed option will support the NHS England submission for changes to the CCG constitution in November.**
- **Who – The views of a range of key stakeholders, including EDEn Committee members, will be used to refine the Review TOR; A wide range of service users and other stakeholders will be invited to help co-design options; Essential characteristics of an independent reviewer have been identified.**
- **How – The final Review TOR will be shaped with key stakeholder input; Stakeholder meetings will use principles of co-design to develop options; A communication plan will be used to support consistent messages about the Review, and be receptive to feedback.**
- **When – Final Review TOR June; Stakeholder meetings July; Options developed August; CCG Governing Body decision September; submission to NHS England on constitutional changes October/November.**

7. Principles for interim working arrangements for EDEn Committee: July and September 2104

7.1. *Current arrangements no longer provide adequate assurance*

7.1.1. Current arrangements are no longer providing adequate assurance to the CCG Governing Body about equality, diversity and engagement. Interim working arrangements for the EDEn Committee are proposed as a way of providing the Governing Body with some assurance during the period of the review. This is proposed as an alternative to having no assurance arrangements in place during the period of the review.

7.1.2. Interim working arrangements would be a pragmatic option because:

- The CCG cannot stop service developments during the six-months of the review. Engagement activities will continue, and the CCG Governing Body would want to have assurance that these are compliant with our statutory duties on equality, diversity and engagement.
- The existing arrangements for assuring compliance with our statutory duties on equality, diversity and engagement are not fit for purpose.
- Brent CCG has a statutory duty to:
  - Engage with current and potential patients when changing commissioned services

- Use engagement approaches that are proportionate in size and nature to the size and importance of the potential impact on patients

7.1.3. Interim working arrangements could be introduced by the CCG Governing Body to ensure the EDEn Committee Meetings in July and September were streamlined and delivery focused. They would follow many of the principles in the original EDEn Committee TOR.

7.2. *Principles for interim working arrangements*

7.2.1. The principles for interim working arrangements would include:

- Ensuring that the Committee's conduct and decision-making is in line with other Governing Body Committees
- Ensuring EDEn Committee membership avoids multiple roles for members
- Providing a CCG-led work plan for specific commissioning initiatives to be brought to the committee for advice on assurance
- Using an agenda structured into three parts:
    - An opportunity for the CCG to give information about the CCG's plans and priorities for Committee Members to take back and share with their respective user groups
    - An opportunity for the CCG to receive information from the CCG's communities about healthcare and services
    - Request views from the Committee on specific commissioning initiatives about whether CCG engagement plans are proportionate to the level of service change/development that is taking place

7.3. *Communication plan during the period of the review*

7.3.1. The urgency of the review is a reflection of the current arrangements not being fit for purpose. The interim working arrangements during the period of the review would allow the Governing Body to receive greater assurance than is currently the case.

7.3.2. Any option taken by the Governing Body during the period of the review in regard to its interim arrangements for seeking assurance on equality, diversity and engagement will require clear, consistent and robust messages.

7.4. SUMMARY

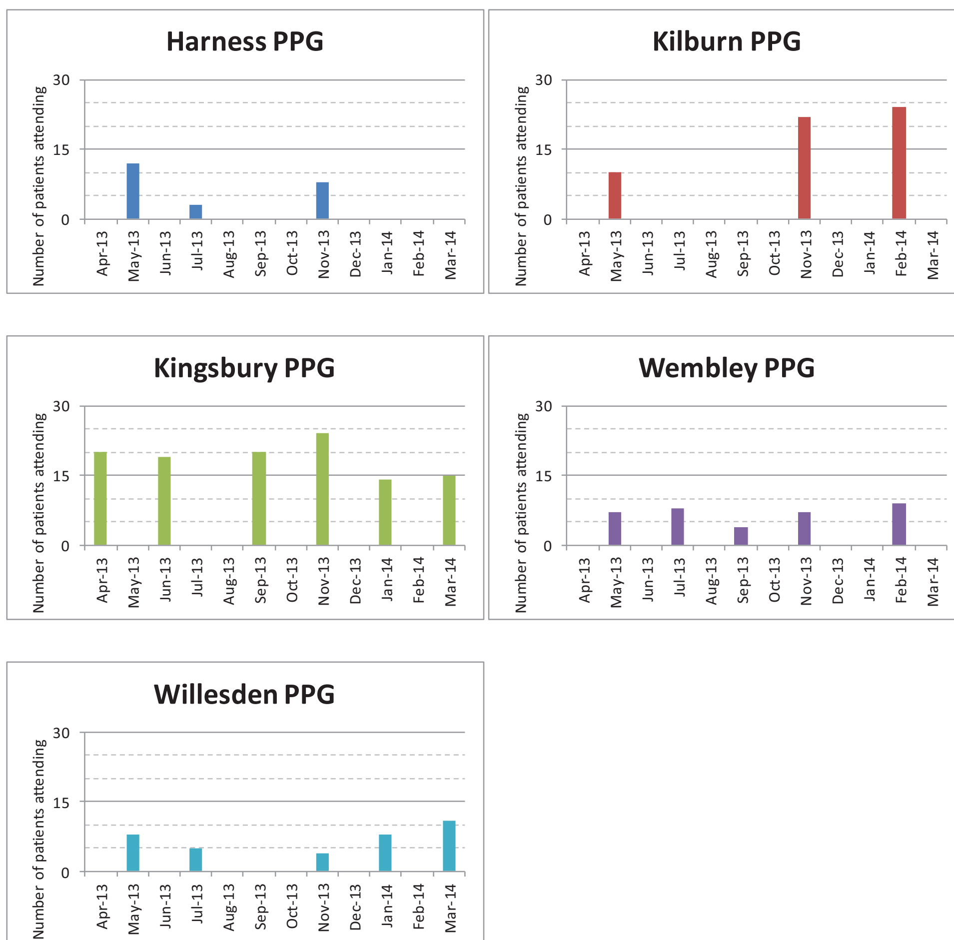
- **The Governing Body are asked to retain the current EDEn Committee until completion of the review, and new management arrangements are put in place subject to the principles for interim monitoring arrangements being put in place and adhered to.**

Appendix 1: Motion proposed and agreed by the EDEn Committee members in response to the draft paper for the Review TOR, 21 May 2014

In the light of the factors set out in the supporting paper the EDEN Committee concludes that the CCG has not made out a persuasive case for a radical and complicated review of the way in which it carries out its duties in relation to equality, diversity and engagement. EDEN recommends that such a review be not proceeded with but instead that the EDEN Strategy as set out in Appendix P to the Constitution be revised and updated to embrace recent NHS strategic directions such as Better Care and the Integration Pioneer initiative. An initial paper could be presented to the July EDEN meeting.

Appendix 2: Locality PPG frequency, attendance levels and range of services discussed

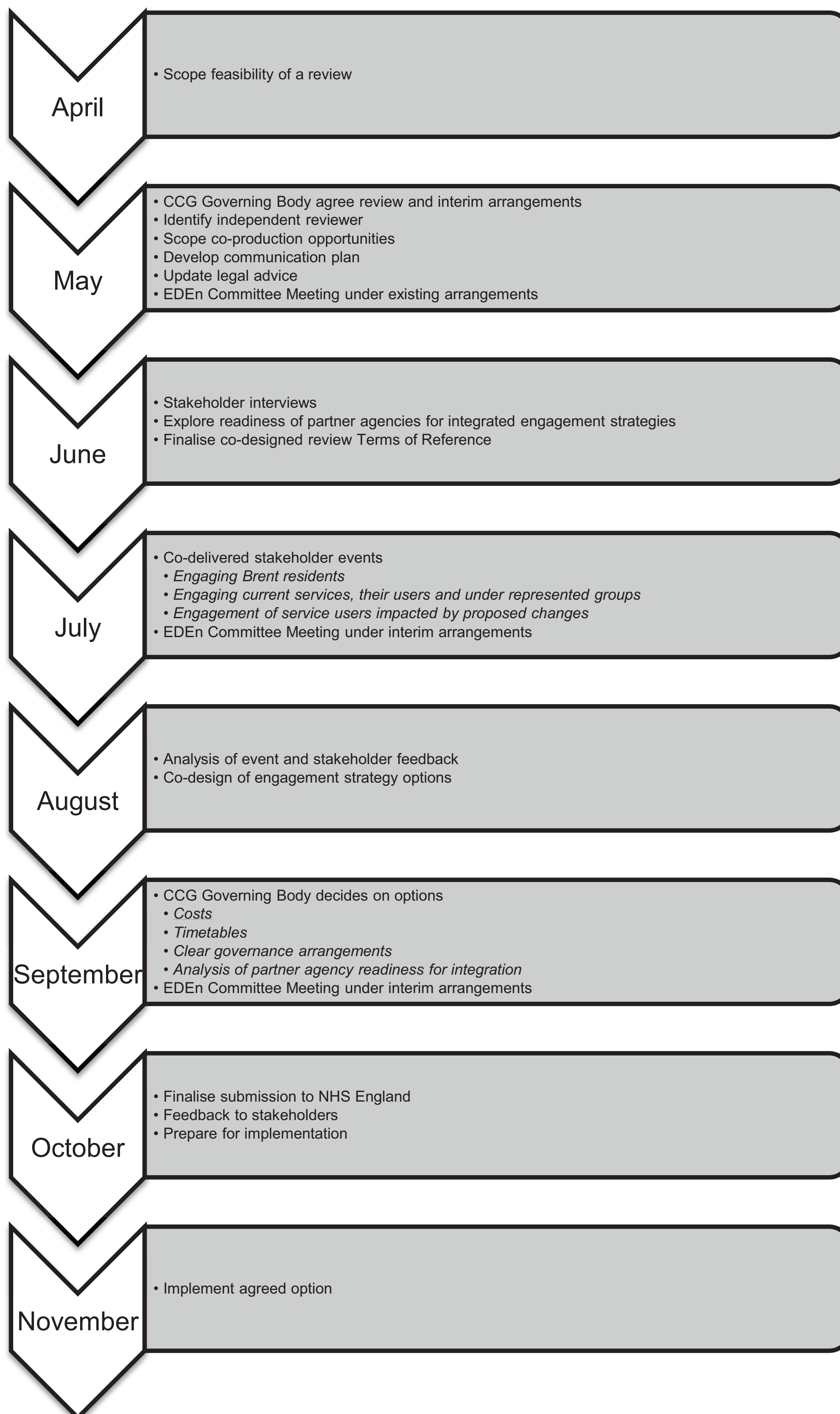
a) Locality PPG frequency and attendance levels 2013/14



b) Locality PPG service discussions 2013/14

Services on agenda for discussion 2013/14	Locality PPG Service discussion on agenda 2013/14 HARNESS	KILBURN	KINGSBURY	WILLESDEN	WEMBLEY	Total of all PPGs
Total	3	5	2	3	7	
Description						
Wave 1 Out-patient Procurement	No	Yes	Yes	Yes	Yes	4
Wave 2 Cardiology & Ophthalmology	No	Yes	No	Yes	Yes	3
111 Service	Yes	Yes	No	No	Yes	3
Bowel Screening	No	No	Yes	No	Yes	2
Primary Care Extended Access (including pilots)	Yes	Yes	No	No	No	2
Referral Facilitation Service	Yes	No	No	No	Yes	2
Dementia	No	Yes	No	No	No	1
FCP Endoscopy	No	No	No	No	Yes	1
GP Initiative for >75	No	No	No	No	Yes	1
Proposal for Central Middlesex Hospital	No	No	No	Yes	No	1

Appendix 3: Timeline for review of equality, diversity and engagement assurance processes



APPENDIX B

BRENT CCG ENGAGEMENT REVIEW

WHO WE SPOKE TO

Name	Role/Organisation
Sola Afuape	Lay Member, Whole Systems Integrated Care, Brent
Duncan Ambrose	Assistant Director, Brent CCG
Tessa Awe	CEO, Brent CVS
Jacqueline Carr	Director, Brent Citizens Advice Bureau; Director, Healthwatch Brent
Carl Cheevers	Head of Partnerships & Engagement, LB Brent
Patricia Dale	Lay rep, Wave 2 Planned Care
Keith Dickinson	Head of Governance, BHH Federation
Varsha Dodhia	Lay Member, Whole Systems Integrated Care Harrow
Claudia Feldner	Community rep (physical & learning disabilities), EDEN Committee
Harbi Farah	Director, Somalia Foundation
Kathleen Fraser-Jackson	Community rep (carers), EDEN Committee
Ursula Gallagher	Director of Quality & Safety, Brent CCG/BHH Federation
Maurice Hoffman	Deputy Chair, Harness PPG
Rosalind John	Kilburn Locality engagement lead
Julia Kirk	Lay rep, Wave 2 Planned Care
Ethie Kong	Chair, Brent CCG
Gaynor Lloyd	Wembley Locality rep, EDEN Committee
Paula Lloyd-Knight	Head of Public, Patient Voice, NHS England (London)
Sarah Mansuralli	Chief Operating Officer, Brent CCG
Richard McSorley	Whole Systems Integrated Care Project Manager
Keritha Olivierre	Equality & Engagement Manager, Brent CCG
Lis Paice	Chair, NW London Integrated Care Programme; Chair, Embedding Partnerships Workstream, NW London WSIC
Keith Perrin	PPG Chair (Wembley), Community rep (Long Term Conditions), EDEN Committee
Phil Porter	Director of Adult Services, LB Brent
Robin Sharp	PPG Chair (Kilburn), Community rep (older people), EDEN Committee
Melanie Smith	Director of Public Health, LB Brent
Ben Spinks	Asst Chief Executive, LB Brent
Duncan Stroud	Head of Comms, NW London Commissioning Support Unit
Nan Tewari	PPG Chair (Harness Locality), EDEN Committee
Sarah Thompson	Senior Responsible Officer, Planned Care Waves 1&2

Irwin van Colle	PPG Chair (Kingsbury Locality), EDEN Committee
Miranda Wixon	Chair, Healthwatch Brent
Iram Yaqub	Community rep (children & young people), EDEN Committee
Nick Young	Lay member, Brent CCG Governing Body; Chair of EDEN Committee

Other colleagues contacted but who have not yet responded:

Krupesh Hirani	Lead Member, Adults Health and Wellbeing, LB Brent
Judith Lockhart	Independent Engagement Practitioner
Michael Pavey	Chair, Brent Health and Wellbeing Board

Other meetings with representative groups were held as follows:

22 September 2014: Community/Patient Representatives of the EDEn Committee
22 October 2014: Members of the CCG Governing Body (seminar)
12 November 2014: Community/patient representatives with whom the review team interviewed and/or met

APPENDIX C

BRENT CCG: ENGAGEMENT REVIEW

SUMMARY OF MEETINGS ATTENDED BY THE REVIEW TEAM

Date (2014)	Meeting	Review Team members
2 September	CCG Chair; EDEN Committee Chair	AC
3 September	Health Partners Forum (observers)	FD
8 September	EDEN Committee Planning Meeting (observers)	DG
17 September	EDEN Committee (observers)	AC/DG
22 September	EDEN Committee community reps meeting	AC/FD/DG
30 September	GP Forum meeting	AC/FD
30 September	Best Practice meeting	AC/FD/DG
16 October	Best Practice meeting	AC/FD/DG
22 October	Brent CCG Governing Body seminar	AC/FD/DG
12 November	Community/patient reps meeting	FD/DG
26 November	Brent CCG Governing Body Meeting	FD/DG

AC: Angela Coulter
FD: Frank Donlon
DG: David Grant

APPENDIX D

ANALYSIS OF KEY THEMES AND ISSUES RAISED DURING INTERVIEWS AND MEETINGS

This is a comparative analysis of interviews with 32 people from Brent CCG, lay representatives and other organisations, together with issues raised at several meetings. This is not intended as a statistically representative sample.

EDEN Committee		
What works well	**What works less well**	**What needs to change**
• Effectiveness of the committee • Good strategy • Strong links with Locality PPGs through the chairs • Commitment and effort by patient representatives	• Lack of effectiveness of the committee • Out-of-date strategy • Role played by PPG Chairs • CCG behaviour towards EDEN • Lack of training/induction for committee members • CCG's lack of preparation and planning for EDEN meetings • Confusion about purpose and functions • Individual bad behaviour • Too many procedural challenges • Service user representation - rationale • Withdrawal of Healthwatch • Formality of meetings	• EDEn strategy • Membership • Terms of reference • Balance of effort – engagement and equalities policies and assurance vs procedural issues • Role clarification for EDEN – back to basics
Review Team comments		
Opinions were sharply divided, with no consensus on what works well and what doesn't, nor on the best way forward. There was a general sense that a re-balancing of effort is required, including greater emphasis on direct engagement activities and ensuring that the CCG complies with its statutory duties, including the Equality Duty.		

Locality PPGs		
What works well	**What works less well**	**What needs to change**
• CCG support to LPPGs – induction, training, information sharing • LPPGs as legitimate representatives of patients • Role and influence of LPPGs • Role/influence of LPPG Chairs	• CCG support to LPPGs – induction, training, information sharing • LPPGs as legitimate representatives of patients • Role and influence of LPPGs • Role/influence of LPPG Chairs • Advertising of, and attendance at, meetings • Links to (a number of) Practice PPGs • Links to volorgs in respective localities • PPGs working in relative isolation	• Process and procedure vs patient outcome focus • Use LPPG Chairs' skills elsewhere (e.g. other governance/quality cttes/readers' group) • Strengthen links with Practice PPGs, esp in light of DoH announcement viz all Practices now required to have them
Review Team comments		
Again there was a lack of consensus on the value or otherwise of the focus on geographical localities, as opposed to specific patient or population groups. CCG staff felt the Locality PPGs took up considerable staff time for a relatively poor return. Some suggested they could have a role in supporting the development of practice PPGs.		

Commissioning Specific Initiatives		
What works well	**What works less well**	**What needs to change**
• Establishment/use of stakeholder groups • Joint working between the CCG and the Local Authority • Co-production/co-design initiatives • Targeted work with community groups around the WSIC project • Outreach to minority groups • Appropriate physical environment for engagement and/or	• Establishment/use of stakeholder groups • Joint working between the CCG and the Local Authority • Co-production/co-design initiatives • Lack of feedback on consultation results • Lack of CCG investment (£ and personnel) in engagement • Amount of time given to	• Information must be accessible and timely. • Volume and timeliness of paperwork • Early and continuing engagement • Define groups and target messages to them • Consult on fewer things at a time – single issues and not broad concepts • CCG communication skill sets

<table>
<tr><td>consultation events</td><td>engagement and consultation
Use of sample surveys, analysis and evidence
Focus on patients/public as customers
Use of soft intelligence - anecdotes, stories
Internal and external communications
Managing expectations
Outreach to specific groups
Understanding of engagement issues/principles
Maximizing capacity of lay people in community (e.g. establish pool)
Use of voluntary organisations (Healthwatch, CVS etc) as change agents/delivering engagement
Advocacy and capacity building for community reps
Early and continuing engagement
Timing (day/evening) of meetings
Links to voluntary organisations
Better Care Fund
Health and Wellbeing Board</td><td>Use of technology in communications (eg social media)
Work more closely with voluntary organisations (Healthwatch, CVS etc)
Advocacy and capacity building for community representatives
Bespoke communications with different community / ethnic groups</td></tr>
<tr><th colspan="3">Review Team comments</th></tr>
<tr><td colspan="3">As above, views were widely dispersed, with the same issues cited as both strengths and weaknesses. Many suggestions were made for improving contact and communication with local groups, including the need for a proactive, targeted approach, working more closely with agencies such as Brent Healthwatch and Brent Council for Voluntary Service.</td></tr>
</table>

<table>
<tr><th colspan="3">Health Partners Forum</th></tr>
<tr><th>What works well</th><th>What works less well</th><th>What needs to change</th></tr>
<tr><td>Attendance, feedback all very positive
Food</td><td>Same faces / same issues/ always the same / nothing changes
Too stage managed</td><td>Less formal presentations, more focused topic-specific work</td></tr>
<tr><th colspan="3">Review Team comments</th></tr>
<tr><td colspan="3">There were relatively few comments under this theme. Many stakeholders said that, in principle, it was a good thing to do, but that in practice, it feels stage-managed. There may be scope for improving the format.</td></tr>
</table>

<table>
<tr><th colspan="3">CCG culture and behaviour</th></tr>
<tr><th>What works well</th><th>What works less well</th><th>What needs to change</th></tr>
<tr><td>CCG individuals' commitment
CCG open style</td><td>Activity not progress
Individuals working in silos, not teams
Secretive
Defensive
Excessive (non-clinical) risk management
Fulfilling accountability as a public body
CCG leadership
CCG day-to-day work pressures, time, staff resources, interims, turnover
Building/embedding trust
Reactive, not proactive
CCG organisational memory
GP network provider/locality commissioning relationships
Management of conflicts of interest (esp. GPs)
GP Forum</td><td>Improve/increase joint working
Increase patient engagement awareness across all CCG staff – embed into DNA. Needs a change in mind set
Undertake surveys; develop dashboards which are easy to read and understand
Embed EDE issues into CCG annual cycle more clearly</td></tr>
<tr><th colspan="3">Review Team comments</th></tr>
<tr><td colspan="3">Interviewees told us that there was a lot of activity under this heading, but it was not planned and communicated in a systematic manner. People were critical of the CCG's public face, especially its lack of effective communications.</td></tr>
</table>

APPENDIX E

BRENT CCG ENGAGEMENT REVIEW

DOCUMENTS REVIEWED

1 Brent CCG Constitution and other corporate documents

- 1.1 Brent CCG Constitution Aug 2012 (reviewed Dec 2012)
- 1.2 Brent CCG constitution amendments proposed (for Governing Body July 2013)
- 1.3 Brent CCG Governing Body minutes July 2013
- 1.4 Brent CCG Constitution Dec 2013 appendices
- 1.5 Brent CCG Constitution Dec 2013
- 1.6 Brent CCG Communications Plan draft v4 13 May 2014

2 EDEn Committee

- 2.1 EDEn duties - comments
- 2.2 20 March 2013 – EDEn Committee meeting
- 2.3 24 July 2013 – EDEn Committee meeting
- 2.4 25 September 2013 – EDEN Committee meeting
- 2.5 29 January 2014 – EDEn Committee meeting
- 2.6 22 May 2013 – EDEn Committee meeting
- 2.7 27 November 2013 – EDEn Committee meeting
- 2.8 26 March 2014 – EDEn Committee meeting
- 2.9 8 April 2014 – exceptional facilitated meeting
- 2.10 21 May 2014 – EDEn Committee meeting
- 2.11 16 July 2014 – EDEn Committee meeting
- 2.12 17 Sep 2014 – briefing note prepared for EDEn Committee meeting by Duncan Ambrose regarding commissioning intentions

3 Health Partners Forum

- 3.1 12 February 2014 Forum meeting
- 3.2 11 June 2014 Forum meeting

4 Specific Commissioning Intentions

- 4.1 Wave 2 Planned Care Programme Board Terms of Reference
- 4.2 Wave 2 Gynae Re-design Group Terms of Reference
- 4.3 Wave 2 MSK Re-design Group Terms of Reference
- 4.4 Wave 2 Gynae Engagement Group Terms of Reference 260614
- 4.5 Wave 2 MSK Engagement Group Terms of Reference 210714
- 4.6 Wave 2 Planned Care Programme Board Terms of Reference
- 4.7 NHS Brent CCG Wave 2 Planned Care Programme Consultation Report

5 Whole Systems Integrated Care (WSIC)

- 5.1 WSIC Model of Care Engagement Letter
- 5.2 PPE Co-production
- 5.3 WSIC Engagement Plan
- 5.4 WSIC Co-production Strategy
- 5.5 WSIC Co-production touchstone
- 5.6 WSIC Early Adopter Outline Plan

6 Better Care Fund

- 6.1 Brent Better Care Fund Plan
- 6.2 Brent Better Care Fund – planning template
- 6.3 Better Care Fund – national allocations for 2015-16

7 Health and Wellbeing Board

- 7.1 Brent Health and Wellbeing Strategy 2014-17

8 Brent CCG Governing Body Meetings - papers

- 8.1 6 November 2013
- 8.2 26 March 2014
- 8.3 4 June 2014
- 8.4 27 August 2014

9 Key Stakeholders

- 9.1 Key stakeholder list

10 Review – Outline Terms of Reference

- 10.1 Item 6 EDEn review of Meeting Statutory Duties draft paper 21 May 2014
- 10.2 Review Outline Terms of Reference agreed by Governing Body 4 June 2014 (corrected data)

11 Legal Advice Obtained by Brent CCG

- 11.1 Discharging PPI and equalities duties pending review of current arrangements
- 11.2 DAC Beachcroft letter 6 Aug 2014
- 11.3 Capsticks – advice re PPE arrangements 3 May 2014

12 Sample of e-mails/letters from Locality PPG Chairs

- 12.1 PPG Chairs response to letter of 9 Aug 2014
- 12.2 Letter to PPG Chairs 9 Aug 2014
- 12.3 Peter Latham 12 Aug 2014 EDEn review – response to Duncan Ambrose
- 12.4 Peter Latham 12 Aug 2014 EDEn review - letter
- 12.5 Peter Latham re Wave 2 Stakeholders Engagement Group 17 Mar 2014
- 12.6 Nan Tewari re CCG Commissioning Intentions 1 Dec 2013
- 12.7 Peter Latham re 8 April 2014 facilitated discussion meeting - 11 Feb 2014
- 12.8 Peter Latham re 8 April 2014 facilitated discussion meeting – 12 May 2014, e-mail to Duncan Ambrose
- 12.9 Peter Latham re 8 April 2014 facilitated discussion meeting – 5 May 2014, e-mail to Ethie Kong
- 12.10 Peter Latham re 8 April 2014 facilitated discussion meeting – 3 Jul 2014, e-mail to Duncan Ambrose
- 12.11 Peter Latham re review of Brent CCG engagement 1 Jul 2014, e-mail to Nick Young
- 12.12 Robin Sharp re Brent CCG review of statutory duties on equality etc. 19 Jun 2014
- 12.13 Peter Latham re Brent CCG Constitution 14 Jun 2014
- 12.14 Peter Latham re Brent CCG Constitution 13 Jun 2014, e-mail to Ethie Kong
- 12.15 Peter Latham re Brent CCG Constitution 16 Jun 2014, e-mail to Joanne Murfitt (NHSE)

13 Equality Objectives and Duties

- 13.1 Public Sector Equality Duty Performance Report
- 13.2 Public Sector Equality Duty Annual Report 2013-14
- 13.3 Brent CCG Equalities Action Plan – cover report
- 13.4 Brent CCG Equality Objectives Report – action plan 2013-16
- 13.5 Brent Equality Duty Priorities and Intentions – action plan 2013-16

14 Other CCGs

- 14.1 Bristol
  - 14.1.1 Bristol CCG statement re legal challenge
  - 14.1.2 Bristol CCG Constitution
  - 14.1.3 Bristol PPI Strategy
  - 14.1.4 Bristol Planning and Engagement Strategy
  - 14.1.5 Bristol Equality, Diversity and Human Rights Strategy
  - 14.1.6 Bristol – order between parties re claim against CCG by Protect our NHS
  - 14.1.7 Bristol – Bevan Britten statement re claim by Protect our NHS

- 14.2 City & Hackney
  - 14.2.1 City & Hackney CCG: Patient Participation, Engagement and Involvement in City & Hackney 2013-14
  - 14.2.2 City & Hackney CCG Engagement Strategy
  - 14.2.3 City & Hackney CCG PPI Committee
  - 14.2.4 City & Hackney CCG Constitution

- 14.3 Dudley
  - 14.3.1 Dudley Communications and Engagement Committee Terms of Reference
  - 14.3.2 Dudley CCG Constitution
  - 14.3.3 Dudley Infographic – urgent care
  - 14.3.4 Dudley Communications-Engagement Strategy

- 14.4 Haringey
  - 14.4.1 Haringey – the CCG Network
  - 14.4.2 Haringey Patient and Pubic Expenses Policy
  - 14.4.3 Haringey Insight and Learning Programme
  - 14.4.4 Haringey CCG Equality, Diversity and Human Rights Strategy
  - 14.4.5 Haringey Engagement Strategy 2014-15
  - 14.4.6 Haringey CCG Constitution

- 14.5 Harrow
  - 14.5.1 Harrow CCG Equality and Diversity Action Plan
  - 14.5.2 Harrow CCG Constitution
  - 14.5.3 Harrow CCG Communications and Engagement Strategy

- 14.6 Herts Valley
  - 14.6.1 Herts Valley CCG PPI 'Tube Map'
  - 14.6.2 Herts Valley CCG PPI Committee – sample minutes
  - 14.6.3 Herts Valley CCG PPI Committee Terms of Reference
  - 14.6.4 Herts Valley CCG Governance Structure
  - 14.6.5 Herts Valley CCG Constitution
  - 14.6.6 Herts Valley CCG Participation Strategy (draft, Sep 2014)

14.7 Hillingdon
14.7.1 Hillingdon CCG Constitution
14.7.2 Hillingdon CCG Communications and Engagement Strategy
14.7.3 Brent, Ealing, Harrow Hillingdon CCGs Equality and Diversity Policy 2013

14.8 Hull
14.8.1 Hull CCG Constitution
14.8.2 Hull CCG Planning and Commissioning Committee Terms of Reference
14.8.3 Hull CCG Communications and Engagement Strategy

14.9 Islington
14.9.1 Islington CCG Patient Public Equality and Diversity Strategy
14.9.2 Islington CCG Patient and Public Participation Committee Terms of Reference
14.9.3 Islington CCG Constitution

14.10 Leicester City
14.10.1 Leicester City CCG Engagement and Patient Experience Strategy
14.10.2 Leicester City CCG Equality and Diversity Strategy
14.10.3 Leicester City CCG Constitution
14.10.4 Leicester City CCG Communications and Engagement Strategy
14.10.5 Leicester City CCG – Frank Donlon note

14.11 Newham
14.11.1 Newham CCG Prospectus
14.11.2 Newham CCG Governance Structure
14.11.3 Newham CCG Constitution
14.11.4 Newham CCG Engagement and Communications Strategy – presentation
14.11.5 Newham CCG Engagement Strategy 2014

14.12 Tower Hamlets
14.12.1 Tower Hamlets CCG Patient and Public Involvement Strategy 2013-14
14.12.2 Tower Hamlets CCG Prospectus
14.12.3 Tower Hamlets CCG Constitution

14.13 Vale of York
14.13.1 Vale of York CCG Constitution
14.13.2 Vale of York CCG Equality Strategy
14.13.3 Vale of York CCG Communications and Engagement Strategy
14.13.4 Vale of York CCG About Patient Opinion
14.13.5 Vale of York CCG Patient and Public Engagement Steering Group
14.13.6 Vale of York CCG – Frank Donlon note

15 Brent CCG Locality Patient Participation Groups

15.1 General documents
15.1.1 Administrative support for Locality PPGs – discussion document
15.1.2 Practice PPGs signed up to Direct Enhanced Services

15.2 Harness PPG
15.2.1 Ratified Harness Locality PPG minutes checked by NT v2 7 May 2013
15.2.2 Harness Locality PPG meeting agenda 7 May 2013 v2 final

15.2.3 Harness Locality PPG meeting minutes 13 May 2014
15.2.4 Harness Locality PPG meeting agenda 13 May 2014
15.2.5 Harness Locality PPG meeting agenda 8 July 2014
15.2.6 Harness Locality PPG meeting draft minutes 9 Sep 2014
15.2.7 Harness Locality PPG newsletter 9 Sep 2014
15.2.8 Harness Locality PPG meeting agenda 9 Sep 2014

15.3 Kilburn PPG
15.3.1 Kilburn Locality PPG agenda 3 Jul 2014
15.3.2 Kilburn Locality PPG 23 Apr 2014

15.4 Kingsbury PPG
15.4.1 Kingsbury Locality PPG minutes 3 Jul 2014

15.5 Wembley PPG
15.5.1 Wembley Locality PPG agenda 3 Jun 2014
15.5.2 Wembley Locality PPG minutes 3 Jun 2014
15.5.3 Wembley Locality PPG agenda 2 Apr 2014

15.6 Willesden PPG
15.6.1 Willesden Locality PPG minutes 9 Jul 2014 v1
15.6.2 Willesden Locality PPG agenda 9 Jul 2014
15.6.3 Willesden Locality PPG Chairman's Newsletter 7 Jul 2014

16 National Guidance on Public, Patient Involvement and Engagement
16.1 NHS, England (Procurement, Patient Choice and Competition) (No.2) Regulations 2013
16.2 NHS England: Transforming Participation in Health and Care, Sep 2013
16.3 Public participation duties (extract)
16.4 NHS England: Planning and Delivering Service Change for Patients Dec 2013
16.5 NHS England: SMART Commissioning Guides for Primary Care Commissioners
16.6 NHS England: SMART Guide to Engagement – equality and diversity

17 Brent CCG website – PPE pages
17.1 Patient and public engagement
17.2 Equality, diversity and engagement

(152 documents)

APPENDIX F

This is a comparative analysis of PPI&E and Governance Committee arrangements across Brent and 13 other CCGs. They were chosen for varying reasons of geography, demography and reported best practice. This is not intended as a statistically representative sample of all CCGs. It is intended only to illustrate the significant variety of committee arrangements that have been adopted.

Also, note that many CCGs have carried out governance reviews in 2014 and may be in the process of changing some of their committee arrangements for submission to NHS England on 1st November.

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	**CCG**	**Name/Membership of Committee/s responsible for leading PPI&E/E&D**	**Composition**	**Governance Assurance Reporting to Governing Body?** **If not, to …………………**	**Composition**
1	Brent	EDEN • CCG Governing Body Lay Member (Committee Chair) 1 • CCGE Clinical Director (Deputy Chair) 1 • Public Health Lead 1 • CCG Equality and Diversity Lead 1 • CCG Communications Lead 1 • Patient Participation Group chairs (or selected representatives) 5 • CCG Chief Operating Officer 1 • Health Watch Chair 1 • Community representatives of key health interest groups 8 • Brent Council Representative 1 **Total 21**	CCG GB Members - Lay x 1 - GPs x 1 - Execs x 1 Non-GB Execs x 2 Patient Reps – 13 LA – 2 HW - 1	Yes	CCG GB Members - Lay x 1 - GPs x 1 - Execs x 1 Non-GB Execs x 2 Patient Reps – 13 LA – 2 HW - 1
Comments	• EDEN has the dual responsibility of leading on PPI&E/E&D activity as well as providing assurance to the GB. • It is a very large group of 21, in which Patient Reps (13) have a significant majority. • Healthwatch is a member. • Brent Council is a member. • Similar only to City & Hackney CCG.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	**CCG**	**Name/Membership of Committee/s responsible for leading PPI&E/E&D**	**Composition**	**Governance Assurance Reporting to Governing Body?** **If not, to …………………**	**Composition**
1	City & Hackney	PPI Committee • Board Lay Member (Chair). • A Clinical (GP) Lead. • Programme Director responsible for PPI. • 8 Patient representatives (1 from each Programme Board). • 6 Patient representatives each representing the Patient Participation Groups in a Consortium (the "super PPG"). • 2 LINk/HealthWatch representatives • 2 Local Authority representatives. **Total 21**	CCG GB Members - Lay x 1 Non-GB - Execs x 1 - GPs x 1 Patient Reps – 14 HW - 2 LA – 2	Yes	CCG GB Members - Lay x 1 Non-GB - Execs x 1 - GPs x 1 Patient Reps – 14 HW - 2 LA – 2
Comments	• The PPI Committee has the dual responsibility of leading on PPI&E/E&D activity as well as providing assurance to the GB. • It is a very large group of 21, in which Patient Reps (14) have a significant majority. • Healthwatch City and Healthwatch Hackney are both members. • 2 x LA Reps. • Similar only to Brent CCG.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	**CCG**	**Name/Membership of Committee/s responsible for leading PPI&E/E&D**	**Composition**	**Governance Assurance Reporting to Governing Body? If not, to …………………**	**Composition**
1	Dudley	Communication & Engagement Committee • The Chair of the governing body, who will be the Chair of the Committee • 2 lay members, one of which will be appointed as Vice-Chair of the Committee • The Chief Accountable Officer • The GP holding the position of Clinical Executive for Partnerships **Total 5** In attendance: • Head of Communications • Head of Membership Development • Healthwatch Representative	CCG GB Members - GPs x 2 - Execs x 1 - Lay x 2	Yes	CCG GB - GPs x 2 - Execs x 1 - Lay x 2
Comments	• The C&E Committee has the dual responsibility of leading on PPI&E/E&D activity as well as providing assurance to the GB. • It is a very small group of 5, all GB members. • The additional 3 "attendee" members include Healthwatch. • No LA representation.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	CCG	Name/Membership of Committee/s responsible for leading PPI&E/E&D	Composition	Governance Assurance Reporting to Governing Body? If not, to …………………	Composition
1	Herts Valleys	Patient and Public Involvement Committee • One Lay Member of the Board • One GP Board Member • Director of Nursing • Chief Financial Officer • Two representatives from each of the 4 localities (including the Board patient representative) • HealthWatch Representative • GP PPI Lead • Associate Director of Communications and Engagement • Patient Engagement Manager **Total 15**	CCG GB Members - Lay x 1 - GPs x 1 - Execs x 2 Non-GB - GPs x 8 - Execs x 2 HW - 1	Yes	CCG GB Members - Lay x 1 - GPs x 1 - Execs x 2 Non-GB - GPs x 8 - Execs x 2 HW - 1
Comments	• PPIC has the dual responsibility of leading on PPI&E/E&D activity as well as providing assurance to the GB. • It is a group of 15, in which GPs (9) have a significant majority. • Healthwatch is a member. • No LA representation.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	CCG	Name/Membership of Committee/s responsible for leading PPI&E/E&D	Composition	Governance Assurance Reporting to Governing Body? If not, to …………………	Composition
1	Hillingdon	Patient and Public Involvement & Equality Committee • GP member of the Governing Body • Nurse Member of the Governing Body • Hillingdon GP • 3 Patient Representative one elected to the Governing Body (Chair) • Lay member for PPE on the Governing Body • Representative from Health Watch • 2 Representatives from the Voluntary Sector (1 from small/BME groups) • HCCG Comms and Engagement Manager **Total 11** Communications leads from THH, CNWL and LBH will be invited to attend as non speaking observers.	CCG GB Members - Lay x 1 - GPs x 1 - Nurse x 1 - Patient Reps x 3 Non-GB - GPs x 1 - Execs x 1 HW – 1 Vol Sec x 2	Yes	CCG GB Members - Lay x 1 - GPs x 1 - Nurse x 1 - Patient Reps x 3 Non-GB - GPs x 1 - Execs x 1 HW – 1 Vol Sec x 2
Comments	• PPIEC has the dual responsibility of leading on PPI&E/E&D activity as well as providing assurance to the GB. • It is a group of 11, in which patients are well represented with 3 GB members, Healthwatch and 2 Vol Socs. • No LA representation.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	CCG	Name/Membership of Committee/s responsible for leading PPI&E/E&D	Composition	Governance Assurance Reporting to Governing Body? If not, to …………………	Composition
1	Islington	Patient & Public Participation Committee • Joint Vice-Chair (Clinical) - Chair • 2 x GB GP Elected Members • GB Lay Member with responsibility for PPP • Director of Quality and Integrated Governance • GB GP Chair (ex-officio) • Chief Officer (ex-officio) **Total 7**	CCG GB Members - Lay x 1 - GPs x 4 - Execs x 1 Non-GB - Execs x 1	Yes	CCG GB Members - Lay x 1 - GPs x 4 - Execs x 1 Non-GB - Execs x 1
Comments	• The P&PP Committee has the dual responsibility of leading on PPI&E/E&D activity as well as providing assurance to the GB. • It is a small group of 7, with 6 GB members. GPs (4) are in the majority. • No Healthwatch. • No LA representation.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	**CCG**	**Name/Membership of Committee/s responsible for leading PPI&E/E&D**	**Composition**	**Governance Assurance Reporting to Governing Body?** **If not, to …………………**	**Composition**
1	Newham	Partnership Commissioning Committee • Clinical Lead with responsibility for Partnership Commissioning (Chair) • Director of Adults (London Borough of Newham) (Co-chair) • Head of Governance and Engagement (Deputy Chair) • Director for Children Services (London Borough of Newham) (Deputy Chair) • 6 x Clinical Leads for Children services, Older People, End of Life, Substance Misuse and Alcohol, Learning Disabilities, Continuing Care • CCG Board Member for PPE • Lead Director of the CSU • Director of Public Health • Head of Commissioning, Governance and Market Management for Adults. **Total 14**	CCG GB Members - Lay x 1 - GPs x 1 Non-GB - Execs x 2 - GPs 6 LA – 3 CSU - 1	Yes	CCG GB Members - Lay x 1 - GPs x 1 Non-GB - Execs x 2 - GPs 6 LA – 3 CSU - 1
Comments	• Newhamgovernance structures are particularly complex with 8 over-lapping committees: ○ Executive Committee / Audit Committee / Remuneration Committee / Quality Committee / Partnership Commissioning Committee / Mental Health Commissioning Committee / Community Commissioning Committee / Acute Commissioning Committee. • PCC is primarily a partnership committee but appears to lead at a corporate level on PPI. It has the dual responsibility of leading on PPI&E/E&D activity as well as providing assurance to the GB. • The partnership emphasis is shown by 3 x LA members. • It is a group of 14, with 7 GPs. • No Healthwatch.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	**CCG**	**Name/Membership of Committee/s responsible for leading PPI&E/E&D**	**Composition**	**Governance Assurance Reporting to Governing Body?** **If not, to …………………**	**Composition**
1	Vale of York	Patient and Public Engagement Steering Group The group has members representing patients, the voluntary and community sector, public sector organisations and the CCG.	n/a	Yes. Role is to oversee and monitor engagement, and to develop, implement, and review progress on patient and public involvement strategy.	Although the P&PE Steering Group reports to the GB, it is not clear precisely how GB gets assurance on PPI&E.
Comments	• Vale of York governance structures are notably light with only the two GB statutory committees. • There is limited information in the public domain about the P&PE Steering Group. It seems to have multi-organisational representatives as well as CCG and public members. • The organisation chart shows that the P&PE Steering Group reports to the GB, but the constitution does not describe the arrangements formally.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	CCG	Name/Membership of Committee/s responsible for leading PPI&E/E&D	Composition	Governance Assurance Reporting to Governing Body? If not, to …………………	Composition
2	Bristol	PPI, Equalities and Communications Steering Group Membership information not in the public domain	Not available	Quality and Governance Committee • The Chair of the Governing Body who chairs the Committee • Two other Member Representatives from the Governing Body • The two Lay Members (Lay Member for Patient and Public Involvement and the Lay Member for Audit and Governance) • The Chief Accountable Officer • The Director for Transformation and Quality • The Operations Director **Total 8**	CCG GB - GPs x 3 - Execs x 1 - Lay x 2 Non-GB Execs x 2
Comments	• Bristol CCG has just emerged from a legal challenge from "Save our NHS" who claimed that the PPI arrangements were inadequate to support competitive commissioning. The case was settled out of court but the CCG have not admitted liability. • The PPI, Equalities and Communications Steering Group is a sub-group of the GB Quality and Governance Committee – an integrated governance committee, excluding financial matters. • The Quality and Governance Committee of 8 is high level, including CCG Chair, Chief Officer and 4 other GB members.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	**CCG**	**Name/Membership of Committee/s responsible for leading PPI&E/E&D**	**Composition**	**Governance Assurance Reporting to Governing Body?** **If not, to …………………**	**Composition**
2	Haringey	Communication and Engagement Sub-Committee • Chair – Lay Member of the Governing Body with responsibility for PPE (the "Chair") • 2 GP members of the Governing Body (one of whom shall be the Deputy Chair) • Director of Quality and Integrated Governance • Head of Communications and Engagement • Head of Quality and Performance (Equality and Diversity) • Representative from Healthwatch • 2 patient representatives **Total 9**	CCG GB Members - Lay x 1 - GPs x 2 Non-GB Execs x 3 Patient Reps – 2 HW - 1	Quality Committee • Chair – Registered Nurse, (the "Chair") • Deputy Chair Lay Member, • Director of Quality and Integrated Governance • Head of Quality and Performance • Assistant Director of Public Health, Haringey Council • 2 GP Members • Head of Medicines Management, HCCG • Safeguarding Lead, HCCG • CSU Relationship Manager **Total 10**	CCG GB Members - Lay x 1 - GPs x 2 - Reg Nurse x 1 Non-GB Execs x 4 LA – 1 CSU - 1
Comments	• The 9 member Communication and Engagement Sub-Committee contains a balance of 3 GB members, 3 executives and 3 patient reps. • No LA representative. • The Quality Committee is an integrated governance committee, excluding financial matters. LA is represented on this committee. • Haringey also has a CCG Network with membership of up to 30 people drawn from: o PPG members (selected against transparent criteria) o Community group representatives - invited for relevance to protected characteristic or an identified collaborative issue (e.g. drug/alcohol dependence) o Local Healthwatch representation (Partner member) o HAVCO representation - the community group umbrella organisation (Partner member)				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	**CCG**	**Name/Membership of Committee/s responsible for leading PPI&E/E&D**	**Composition**	**Governance Assurance Reporting to Governing Body?** **If not, to …………………**	**Composition**
2	Harrow	Equality & Engagement Committee • Lay member - (Chair) • GP - CCG Member • GP- CCG member • Equality & Engagement Lead • Healthwatch chair (Patient experience) • Nurse Lead • HR Lead • Health Improvement Lead • Commissioning Lead **Total 9**	CCG GB Members - Lay x 1 - GPs x 2 Non-GB Execs x 5 HW - 1	CCG Executive Committee • The Chair of the Governing Body • The Clinical Directors from the Governing Body x 6 • The Accountable Officer • The Chief Finance Officer • The Chief Operating Officer • Local Nurse • All Lay Members x 2 (optional) **Total 13**	CCG GB Members - GPs x 7 - Execs x 4 - Lay x 2
Comments	• E&EC has a majority of CCG executives (5) with a broad skill mix. • Healthwatch is a member. • This committee reports to the CCG Executive Committee, which is responsible for the running of the CCG and reports to the GB. In governance terms it may be queried whether there is an appropriate level of assurance when it is routed via the executives, rather than via a separate GB assurance committee. • No LA representative.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	CCG	Name/Membership of Committee/s responsible for leading PPI&E/E&D	Composition	Governance Assurance Reporting to Governing Body? If not, to …………………	Composition
2	Hull	Planning and Commissioning Committee • 2 x CCG Board GP Members (Co-chairs) • Director of Commissioning and Partnerships • 5 x CCG Board GP Member – Programme Leads (May include the co-chairs of the Committee) • Lay Member – Strategic Change & Vice-Chair • Patient Experience and Engagement Manager • 4 x CCG Senior Commissioning Managers • Director of Quality and Clinical Governance/Executive Nurse/Quality Manager • Senior Business Intelligence Lead/Head of Business Intelligence • Public Health representative • Ambassador/Patient Champion • Head of Finance • Practice Manager **Total 18/20**	CCG GB Members - Lay x 1 - GPs x 5/7 - Execs x 3 Non-GB - Execs x 6 PH – 1 Patient – 1 PM – 1	Reporting to the Integrated Audit and Governance Committee (via/with the Quality and Performance Committee) • Lay Member – audit, remuneration and conflict of interest matters (Chair) • Lay Member – Strategic Change (Vice Chair) • CCG GP Member • CCG GP Member • Practice Manager Member of CCG Board	CCG GB Members - GPs x 2 - Lay x 2 - PM x 1
Comments	• The Planning and Commissioning Committee is a very large committee with 18/20 members drawn from a wide variety of roles. Healthwatch is not included. • There is a complex cross relationship with the Quality and Performance Committee, whereby both are accountable to the Integrated Audit and Governance Committee. This is the only totally integrated committee in our research. • It is also a very small committee with just 5 members, 3 from member practices and the 2 GB lay members.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	**CCG**	**Name/Membership of Committee/s responsible for leading PPI&E/E&D**	**Composition**	**Governance Assurance Reporting to Governing Body?** **If not, to …………………**	**Composition**
2	Leicester City	Engagement and involvement, Patient Experience and Equality and Diversity will be jointly led by the: • Chief Corporate Affairs Officer • Director of Nursing and Quality • Governing Body Vice Chair with specific responsibility for engagement • Independent lay member with responsibility for Equalities **Total 4**	CCG GB Members - Lay x 2 - Execs x 2	Executive Committee • Managing Director (Chair) • Chief Operating Officer (Vice Chair) • CCG Chair • CCG Co-Chair • Independent Lay Member x 1 • 4 x Locality Chairs • Board Nurse / Director of Nursing • Chief Finance Officer • Chief Corporate Affairs Officer • Chief Strategy Officer • Public Health Consultant **Total 14**	CCG GB Members - Lay x 1 - GPs x 6 - Execs x 6 Non-GB - PH x 1
Comments	• There does not appear to be a single committee responsible for PPI&E/E&D • As in Harrow, reporting is to the CCG Executive Committee, which is responsible for the running of the CCG and reports to the GB. In governance terms it may be queried whether there is an appropriate level of assurance when it is routed via the executives, rather than via a separate GB assurance committee. • The Executive Committee of 14 contains 13 GB members. • The Healthwatch representative on the GB is a non-voting member and acts as an advisor to the governing body, ensuring that the governing body has demonstrated due regard to its duty to involve patients, carers and the wider public in appropriate decisions about local health services.				

Category 1 = C'tee reports to CCG GB 2 = C'tee reports to ANO (Specified)	**CCG**	**Name/Membership of Committee/s responsible for leading PPI&E/E&D**	**Composition**	**Governance Assurance Reporting to Governing Body?** **If not, to …………………**	**Composition**
2	Tower Hamlets	Engagement and Communications Sub-Group (of H&WBB) • Tower Hamlets CCG • Healthwatch Tower Hamlets • Tower Hamlets Council for Voluntary Service • Tower Hamlets Health and Well-Being Forum • LBTH • Other CCGs, for example Newham and Waltham Forest	n/a	Transformation and Integration Committee • Deputy Chief Officer - Chair • Lay Member lead for Patient and Public Engagement • Clinical Governing Body Member (CCG) • Clinical Governing Body Member (CCG) • Director of Public Health (LBTH) **Total 5** In attendance • Tower Hamlets Borough Manager (CSU) • Lead for Transformation and Innovation (CCG) • Portfolio Leads from the CCG Governing Body	CCG GB Members - Lay x 1 - GPs x 2 Non-GB - Execs x 1 LA – 1
Comments	• As in Vale of York, there is limited information in the public domain about the Steering Group. It seems to have multi-organisational representatives as well as CCG and public members. • Assurance is provided by the 5-member Transformation and Integration Committee.				

APPENDIX G

Engagement strategies in selected CCGs

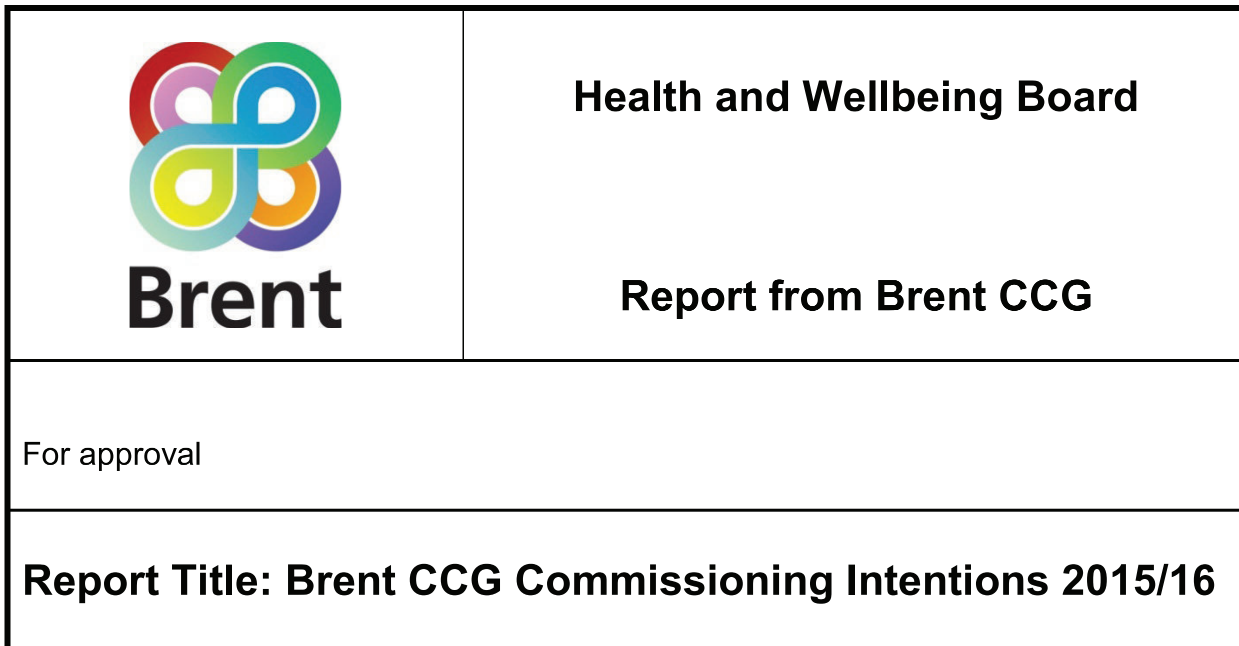
GENERAL PRINCIPLES	ANALYSE AND PLAN	DESIGN AND IMPROVE	PROCURE, MONITOR AND LEARN
Insight			
• Feeds into Joint Strategic Needs Assessment, so collaborate with local authority, social care agencies, Health and Wellbeing Board and local community groups • Describe and segment local population using routine statistics and surveys • Use existing local and national data first before commissioning special studies to fill gaps • Produce annual commissioning and engagement action plans • Signpost decisions and trade-offs	• Collate and monitor patient experience data, including CQC surveys, adult social care survey, carers survey, Friends and Family Test results, GP patient survey, online feedback via NHS Choices, Patient Opinion, Patient Reported Outcome Measures (PROMs), and MyHealthLondon (see Haringey's Insight and Learning Programme) • Commission specific surveys or other studies to fill gaps in existing knowledge (see Leicester strategy) • Develop a general engagement strategy for all stakeholders, including patients, public, clinicians, local politicians (see Haringey's Engagement Strategy 2014-15) • Build capacity – offer training to patient reps and staff (see Newham CCG)	• Focus on specific patient groups (e.g. those with long-term conditions or children) and develop a coordinated approach with other agencies (see Hull's Local Offer for Children with Special Educational Needs and Disabilities) • Work with community groups to provide self-care support (see Newham Community Prescription) • Consider needs of protected groups and consult them where appropriate (see Tower Hamlets mental health consultation) • Review strategies to personalise care, e.g. information and patient decision aids, self-management support, social prescribing (House of Care), personal health budgets (see Islington's strategy)	• Engage patients in setting quality goals, devising KPIs and monitoring these (see Tower Hamlets patient and carer evaluation) • Use NHS Constitution and relevant policy statements (e.g. National Voices narrative and care and support planning guide) to clarify quality goals and develop KPIs • Include patient-defined quality and outcome goals + KPIs in contract negotiations (see Haringey) • Include specific requirements for priority groups in contracts (e.g. learning disabilities, autism) (see Haringey) • Specify required engagement activities and outcomes in contracts (see Leicester strategy) • Carry out Equality Impact Assessments (see Tower Hamlets)
Communications			
• Adopt a plain language policy (oral and written) and train staff in its use • Recruit a lay readers group who can help ensure that all communications are well-designed, readable and comprehensible to general public • Seek Information Standard certification for all public communications • Plan and publicise meetings (including Governing Body meetings) carefully and circulate any papers well in advance • Focus on patient groups and outcomes, rather than services or processes • Be honest about conflicting interests and difficult decisions	• Build network by recruiting members / community champions (see Hull's People's Panel) • Produce newsletters and leaflets in plain English and minority languages (see Leicester's website) • Use infographics to present data for public consumption (see Tower Hamlets website) • Use website to publicise plans and invite feedback + social media + face-to-face presentations (see Hull People's Panel Survey) • Use video boxes to get people to say what they want (see Newham video box) • Offer incentives to encourage feedback via website (see Islington CCG) • Use simple web surveys to elicit feedback (see Healthvoice Islington)	• Develop a bank of patient stories (see Tower Hamlets Patient Story programme) • Use videos to stimulate discussion (see Newham Young People Speak Out) • Publicise results of quality monitoring on website • Provide feedback on response to complaints – 'You said, we did' (see Bristol CCG) • Organise 'Open Mic' events for patients/service users to speak out (see Sandwell and Birmingham CCG mental health open mic forum)	• Publicise a summary of the commissioning strategy written in plain English (see Tower Hamlets Prospectus) • Publish an annual report and forward plan on engagement activities (see City and Hackney CCG) • Provide information about the impact of engagement on the commissioning plan and outcomes – 'You said, we did' (see Haringey)

Outreach			
• Don't try to consult on everything at once – focus on a few specific priorities • Don't expect everyone with an interest to attend CCG meetings – get out of the office to meet specific groups in places where they are comfortable • Use expert facilitators and a variety of methods to obtain people's views	• Provide funding for community groups (see Healthier Hull Community Fund) • Recruit a group of volunteers to help the CCG with its engagement programme (see Hull Ambassadors) • Organise public forums, patient focus groups, and deliberative events to determine priorities and where appropriate invite clinicians, local politicians and other stakeholders to these events (see Haringey) • Organise visits to community groups and voluntary organisations (see Haringey)	• Organise joint projects with Healthwatch, CVS, PPGs or other vol orgs (see Haringey) • Engage users in reviewing pathways and designing improvements using co-production principles (see Newham Community Reference Group) • Organise proactive visits to organisations that represent protected groups (see Haringey) • Develop a Quality Alert system for providers to report problems (see Haringey) • Introduce special initiatives as pilots and evaluate them (see Newham Community Prescription)	• Develop database of patients who would like to be involved in procurements (see Newham Community Reference Group) • Involve patients in developing service specs, tender documents, including sitting on procurement panels (see Hull depression and anxiety services) • Involve patient reps in planning integrated care arrangements, including pilots and Better Care Fund (see Haringey) • Consider using participatory budgeting in specific projects (see Leicester's Community Budgets scheme)

APPENDIX H

Template for planning and assuring engagement activities

Criteria	Evidence
INSIGHT	
In what ways does this initiative respond to priorities listed in the Joint Strategic Needs Assessment and/or the Joint Health and Wellbeing Strategy?	Specify which health needs/problems this is intended to address.
What strategies are being used to inform and engage individual patients/users/carers?	Specify (e.g. written information, audio-visual materials, online information, patient decision aids, self-management support groups, education and training programmes, social prescriptions, personal budgets, etc.)
Which data sources were used to inform the case for change? Did these include information from and/or involvement of patients/local community groups?	Specify data sources (e.g. provider-level patient experience surveys, specially commissioned surveys or investigations, co-production workshops or experience-based design, informal feedback, complaints, outreach visits, national data, other)
COMMUNICATIONS	
Has the case for change and the commissioning plan been clearly stated in plain English?	Has it been checked by a lay readers group?
Were local people consulted about the commissioning plan? How were they consulted?	How was it publicised? What type of feedback was received?
Have local people been informed about the impact and outcomes of the commissioning and engagement initiatives?	Was a 'You said, we did' report produced? How was it publicised? Was it checked by a lay readers group?
OUTREACH	
Were patients/users/carers directly involved in developing the commissioning plan? Who was involved? How were they involved?	Specify which community or population groups were involved and/or consulted and how their views were sought
Were patients/users/carers directly involved in the commissioning, contracting and procurement process? How were they involved?	Specify (e.g. determining priorities, reviewing pathways, setting quality goals, determining special needs (esp. protected groups), helping to write service specs or tender documents, sitting on procurement panels, planning integrated care arrangements, carrying out equality impact assessments, developing outcome-based contracts and KPIs, etc.)
Are patients/users/carers directly involved in monitoring commissioning outcomes? How are they involved?	Specify (e.g. reviewing patient experience data and/or KPIs, informal feedback, mystery shopping, community group visits, reviewing impact on protected groups, etc.)



Brent

Health and Wellbeing Board

Report from Brent CCG

For approval

Report Title: Brent CCG Commissioning Intentions 2015/16

1.0 Summary

The commissioning intentions attached set out the framework within which Brent CCG operates. The clinical commissioning principles are clearly defined and the intentions reflect the national, North West London wide and local context that the CCG operates within. The intentions further incorporate what our patients have told us during the consultation period.

2.0 Background

2.1 The CCG's statutory commissioning functions broadly include:

- Commissioning community and secondary healthcare services (including mental health services) for:
- All patients registered with its Members; and
- All individuals who are resident within the London Borough of Brent who are not registered with a member GP practice of any Clinical Commissioning Group (e.g. unregistered);
- Commissioning emergency care for anyone present in the London Borough of Brent

2.2 The commissioning intentions set out the CCG's intentions with regard the range of services it has responsibility for commissioning across community and secondary care services. The commissioning intentions further set out how it will work collaboratively with NHS England to support improvements in primary care and ensure the continuous improvement of services it has responsibility for commissioning. Fundamentally, the CCG's commissioning intentions describe how it will achieve the shift of care to more community and out of hospital settings in line with its strategic aims.

2.3 Commissioning intentions serve as a notice to all providers of community and secondary about which services and the models of care that will be commissioned by NHS Brent CCG. The Commissioning Intentions provide a basis for robust engagement between NHS Brent CCG and its providers, and are intended to drive improved outcomes for patients, and transform the design and delivery of care, within the resources available.

3.0 The key commissioning priorities for 2015/16 are:

- 7 day working in primary and social care
- Supporting the establishment of GP provider entities in the form of localities which have become four networks across Brent
- Commissioning out of Hospital contracts at locality level, replacing practice level local enhanced services and ensuring a wider population coverage
- Increased coverage of a single GP IT system, namely Emis Web across Brent
- Establishment of a whole systems integrated care service as an early adopter with a joint commissioning approach with a view to starting in 2015/16.
- Negotiating contracts with key providers that incentivise the transformation of services and the movement of services out of hospital

4.0 Detail

4.1 Our aim is to work with our provider market to achieve the following key outcomes in 2015/16:

4.2 Acute

- The majority of our acute activity will remain at our 2 major local providers: London North West Healthcare Trust and Imperial. The merger of NWLHT with Ealing Hospitals in 2014 will have an impact on our contracts for 2015/16. LNWHT remains a financially challenged organisation.
- Brent CCG will continue to work with a wide range of other acute providers, including specialist hospitals from across London and the South East to ensure equity in standards and quality of care for Brent patients.
- The focus will remain on reducing the numbers of patients attending Accident and Emergency and the resulting emergency admissions. A number of our workstreams and initiatives are designed to support this.
- We will also continue to focus on reducing referrals to Outpatients and moving more activity to community settings as appropriate. This approach supports the delivery of the Out of Hospital Strategy.

4.3 Voluntary & Third Sector

- We will continue to work with the voluntary and community groups in Brent to support early identification of people who would benefit from care navigation, lifestyle coaching and with a particular emphasis on self-directed care across a range of mental health and long term conditions.

- We will ensure that the voluntary and community groups are integrated within the CCG commissioning strategy and work streams.

- We will ensure that the development of provider markets includes voluntary and community organisations to provide for the ethnically diverse population of Brent.

- We will make effective use of the voluntary sector to support access and engagement from the hard to reach or seldom heard communities.

4.4 Primary Care

- We will continue to align with the North West London Primary Care Transformation Programme that forms part of the Shaping a Healthier Future (SaHF) structure.
- We will continue to support the emerging GP networks to enable them to coordinate care and enhance services provided in primary care.
- Primary Care will continue to provide extended opening hours at the conveniently located hubs to offer greater choice and access for patients.
- Continue to develop the GP networks to provide out of hospital services where appropriate.

4.5 Community Services

- We will work with our community nursing service to develop collaborative approaches to service delivery leading to a more integrated model of service delivery.
- We will redesign community services as appropriate to deliver our Out of Hospital strategy.
- We will seek to implement the recommendations of the recent review of Community Services and improve quality and productivity of services.

4.6 Mental Health

- We will seek to achieve the productivity levels identified by NHS England in regard to Improved Access to Psychological Therapies (IAPT) and deliver the 15% prevalence target.
- We will continue to ensure patients are treated in the most appropriate setting through the Shifting Settings of Care Programme.
- We will work with our partners across North West London CCGs to procure CAMHS service (including for Learning Disability) and agree a urgent care pathway.
- In accordance with the Better Care Fund initiative we will strive to improve care and crisis planning for patients with mental health conditions to reduce the numbers requiring emergency admission.

5.0 Financial Implications

5.1 The developments within the commissioning intentions are designed to be financially viable, achievable within the time available and sustainable so that the CCG continues to operate efficiently and effectively.

6.0 Legal Implications

6.1 N/A

7.0 Diversity Implications

7.1 The commissioning intentions ensure that all services are commissioned based on the principles of equality and diversity to standardise access across Brent.

7.2 Services to be delivered support care closer to home as well as empowering patients and the public to look after themselves to prevent ill health and improve patient experience of care locally.

7.3 Engagement of patients, carers and service users from Brent's diverse communities is embedded throughout the commissioning cycle.

8.0 Staffing/Accommodation Implications (if appropriate)

8.1 N/A

9.0 Background papers

9.1 NHS Brent CCG Commissioning Intentions 2015-16 (attached)

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Final Commissioning Intentions

NHS Brent Clinical Commissioning Group

2015 - 2016

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Foreword

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Welcome to Brent Clinical Commissioning Group (BCCG) commissioning intentions for 2015/16.

- We intend to continue the work that we started in 2014/15 to ensure that we work collaboratively with all our partners across the health, social care and voluntary care spectrum to deliver first class services for all of our residents and deliver the strategic vision that the CCGs across North West London have set out in Shaping a Healthier Future (SaHF).
- We will also consolidate and extend the work where we have reviewed and re-commissioned a number of clinical services. This has meant that patients have begun to see improved access to GPs via the hubs as well as other services beginning to be delivered closer to their homes such as Ophthalmology, and shortly Cardiology.
- Key workstreams for 2015/16 have been based on defining our clinical priorities as well as taking fully into account what our patients have told us and are articulated in the commissioning priorities throughout this document.
- We look forward to working with all of our providers and service users during 2015/16 to deliver the best services possible.

Sarah Mansuralli
Acting Chief Operating Officer
Brent CCG

Dr Ethie Kong
Chair
Brent CCG

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Strategic Context

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The 8 CCGs in North West London, with our local authorities and other partners, are in the process of implementing wide scale changes to the way in which patients experience and access health and social care. These plans are ambitious and transformational, and the vision is set out below.

We want to improve the quality of care for individuals, carers, and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community.

This vision is supported by 3 principles:

1. People and their families will be empowered to direct their care and support and to receive the care they need in their homes or local community.
2. GPs will be at the centre of organising and coordinating people's care
3. Our systems will enable and not hinder the provision of integrated care.

Some of the key enablers to date include:

- 7 day working in primary and social care.
- Supporting the establishment of GP provider entities in the form of localities which have become four networks across Brent.
- Commissioning of Out of Hospital Contracts at locality level, replacing practice level local enhanced services and ensuring a wider population coverage.
- Increased coverage of a single GP IT system, Emis Web across Brent practices
- Establishment of a whole systems integrated care service as an early adopter with a joint commissioning approach with a view to implementation starting in 2015/16.
- Contracts with key providers that incentivise the transformation of services and the movement of service out of hospital.

We intend to build on this further during 2015/16.

Commissioning Intentions Inputs

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Commissioning Principles

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Brent CCG is currently in a strong position to radically improve health care outcomes and build on our effective health and social care partnerships. Our strength is in our member practices who have demonstrated their ability to effectively respond to the wide system changes that clinical commissioning has brought about.

Brent CCG commissioning principles for 2015/16 remain to:

- Ensure that we demonstrate and evidence equality and consistency in access to services across Brent that continues to reduce health inequalities and improve health outcomes
- Work with other commissioners where integrated commissioning will deliver innovative and effective solutions in line with commissioning strategies
- Improve the uptake of preventative services and promote self care while reducing mortality and morbidity resulting from poor long-term condition management.
- Ensuring appropriate use of commissioned services so that Brent CCG manages activity within the available budget.
- Transform services where new designs are required to improve quality and value for money
- Demonstrate full compliance with the principles of patient choice
- Ensure patients receive the right care, in the right setting by the most appropriately skilled clinician, which will improve the quality of care patients receive and reduce dependency on acute care.
- Provide a proportion of outpatient appointments in community settings, rather than in acute settings, at lower cost and higher quality, where it is clinically safe and cost effective to do so.
- Providing services designed to minimise inappropriate A&E attendances and non-elective admissions including initiatives such as urgent care centres, access to community beds, additional GP appointments and extending the range of Ambulatory Care Pathways.
- Commission services in a manner that interface effectively with GP networks
- Continue to deliver patient and public engagement that ensures meaningful public involvement in commissioning
- Commission care in line with health needs as identified within the Joint Service Needs Assessment (JSNA) and the Joint Health & Well Being Strategy

Brent’s Health Landscape - Demographics

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Brent is an outer London borough in north-west London (figure 1). It has a population of 317,264 and is the most densely populated outer London borough, with a population density of 74.1 persons/ha. The population is young, with 35% aged between 20 and 39. Brent is ethnically diverse, with 65% of its population from black, Asian and minority ethnic (BAME) backgrounds.

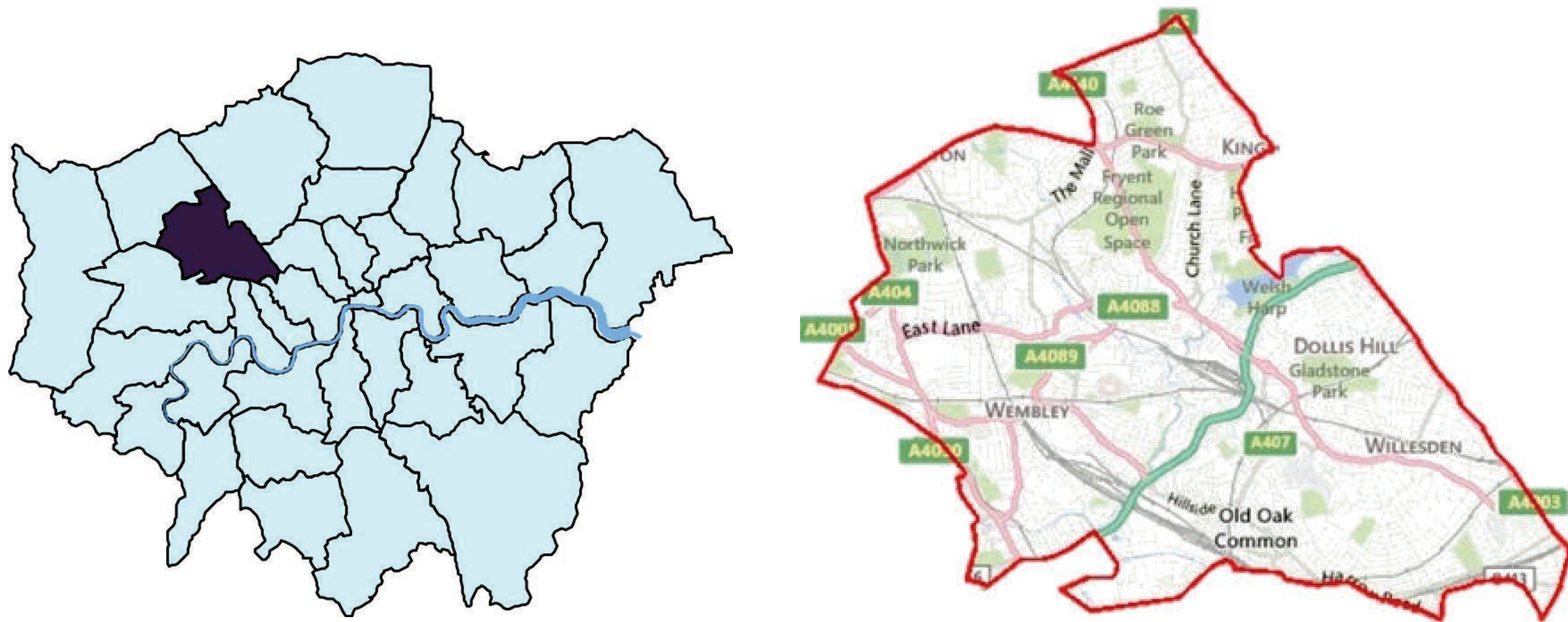

Figure 1: Brent in London and Brent map. © Crown copyright and database rights 2014, Ordnance Survey 100016969 – ONS © Crown Copyright 2014

Brent’s Health Landscape - Demographics (*continued*)

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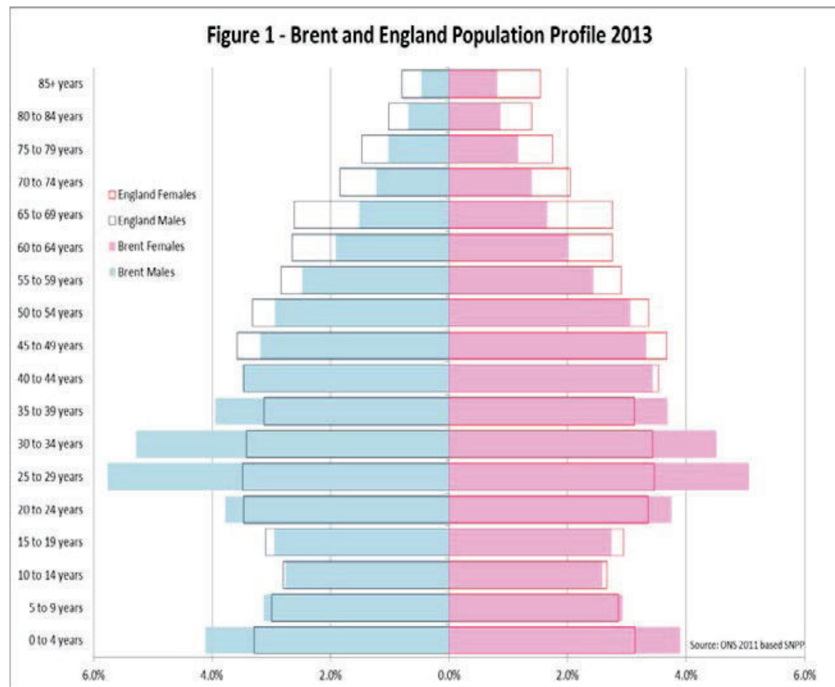
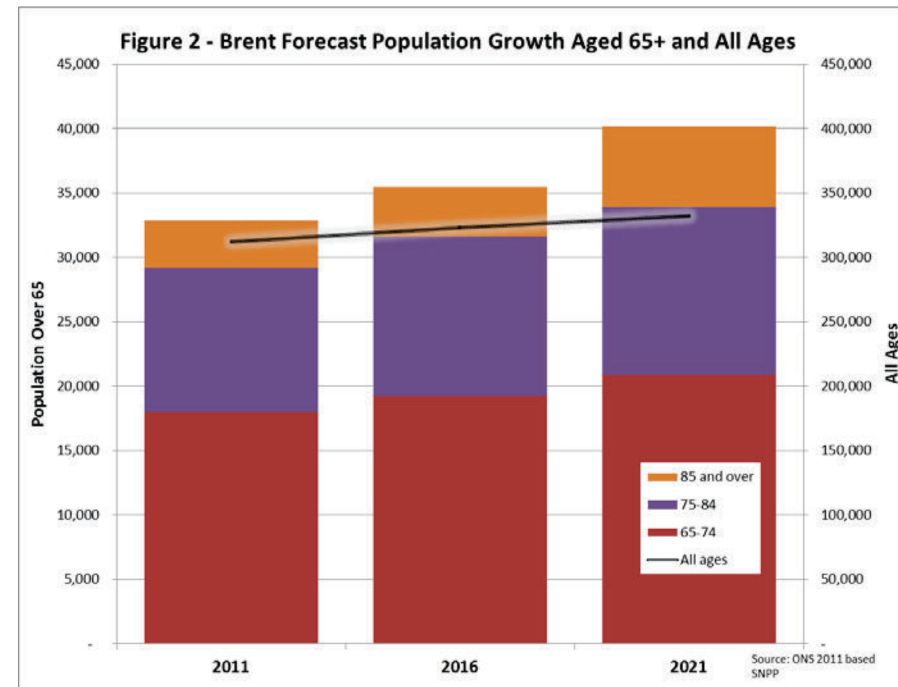
- The population of Brent is young, 44% of residents are under 30 years, above the England average, as illustrated by figure one.
- The gap in life expectancy for men varies for the most affluent and most deprived parts of the borough by 5.3 years.
- Though the population aged 65 and above will grow at a faster pace than the population at large. Between 2011 and 2021 the population aged between 65 and 74 is expected to grow by 16%, 75-84 by 16% and 85 + by 72% whilst the total population will only grow by 7%.





ONS 2011 based population projections

Brent's Health Landscape – Key challenges

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- Brent is a place of contrasts. Home of the iconic Wembley Stadium, Wembley Arena and the spectacular Swaminarayan Hindu Temple.
- Our borough is the destination for thousands of British and international visitors every year
- Brent is served by some of the best road and rail transport links in London
- The area is accustomed to the successful staging of major events such as the Champions League Final in 2011 and Olympic Games events in 2012.
- Our long history of ethnic and cultural diversity has created a place that is truly unique and valued by those who live and work here.
- Overall life expectancy is in line with the rest of London, but there are significant health inequalities within the borough
- Over 130 different languages are now spoken in our schools
- Brent is the most ethnically heterogeneous borough in the country
- The chances of 2 people in Brent being from different ethnic groups are higher than anywhere else in the country

Our population is young, dynamic and growing (311,200 according to the 2011 census)

Brent is ranked amongst the top 15% most-deprived areas of the country.

Deprivation is characterised by high levels of long-term unemployment, low average incomes and a reliance on benefits and social housing

Children and young people are particularly affected with a third of children in Brent living in a low income household and a fifth in a single-adult household.

The proportion of our young people living in acute deprivation is rising

The gap in life expectancy for men varies for the most affluent and the most deprived parts of the borough by 5.3 years

The population is relatively young with 43% of residents under 30 yrs and more than 30,000 people over 65 yrs

Brent's Health Landscape – Focus on Public Health

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There are a number of areas of on-going public health work that can help to inform and also support commissioning intentions moving forward and the priority areas are described below:

NEEDS ASSESSMENT

- Mental Health
- Substance Misuse
- Children and Young People including CAMHS
- Learning Disability
- Pharmaceutical Needs Assessment

HEALTH IMPROVEMENT PLANS

- Mental Wellbeing
- Dementia Friends
- Early years
- Obesity Strategy and Action Plan Development

LOCAL AUTHORITY COMMISSIONING

- Sexual Health
- Substance Misuse
- School nursing
- Post health check service
- Smoking cessation (GPs & CPs) chlamydia screening & IUCDs (GPs), health checks (GPs) , EHC (CPs)

Health Challenges in Brent for 2015/16 – (JSNA 2014)

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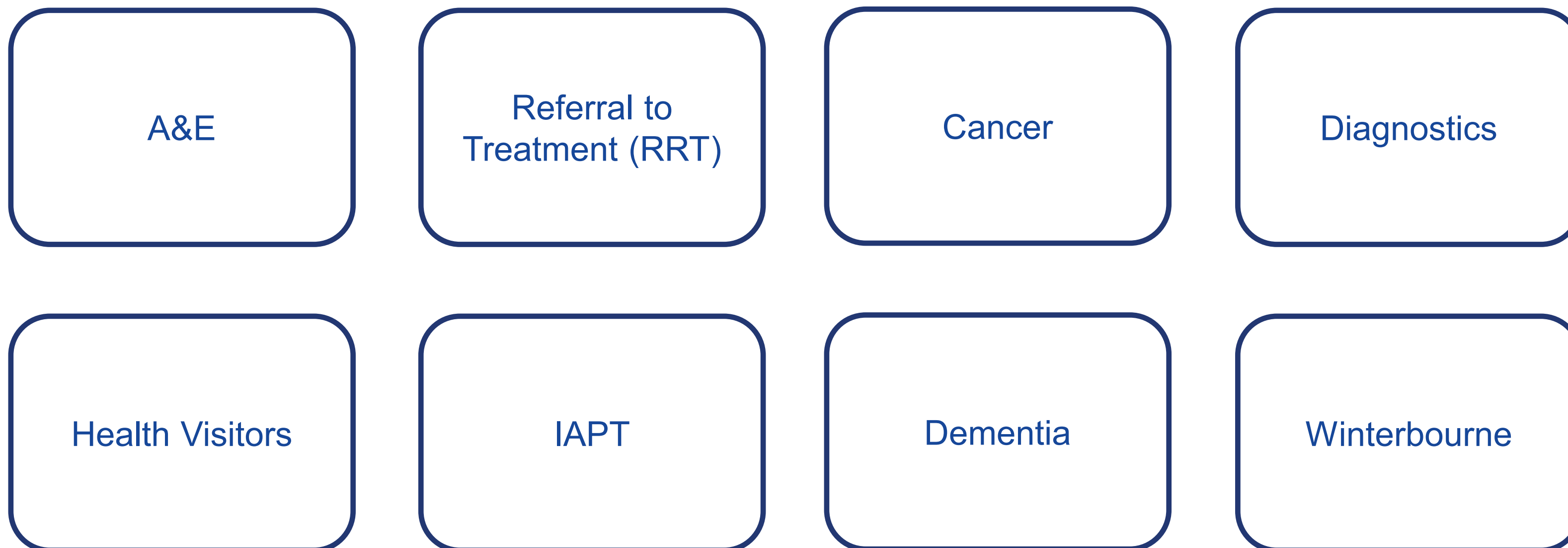
- Low birth weight in Brent in 2012 was (9%) which was worse than the national average (7.3%)
- Poor oral health amongst children under five
- Childhood obesity – In Brent, 11% of reception year pupils were obese in 2012/13 and 24% of year 6 pupils were classified as obese. Childhood obesity is the single biggest predictor of adulthood obesity and can increase the risk factors for many clinical conditions throughout the person's whole life cycle
- Adult obesity and diabetes - Obese and overweight adults put themselves at a greater risk of developing health conditions, such as type 2 Diabetes. Brent saw a 38% increase in the prevalence of diabetes between 2008/09 and 2012/13
- Increasing rates of alcohol-related hospital admissions - larger proportion of the population in Brent are high risk drinkers (7.1%) compared to the national average (6.7%).
- Tuberculosis - (TB) rates in Brent are amongst the highest in the country. This represents a crude rate of 98.3 cases per 100,000 population compared to an England rate of 15.1 per 100,000 population.
- Cancer, Cardiovascular disease,(CVD) & chronic respiratory disease – these are the main causes of premature death in Brent but generally below the England average excepting CVD which also has a low prevalence which might indicate under diagnosis. These also reflect the variation in life expectancy across the borough.
- High levels of many long-term chronic conditions which are often related to poor lifestyles, relative deprivation and the ethnicity in the community.
- Mental health –The prevalence of severe and enduring mental illness in Brent is 1.14% of the population which is above both the London and England averages
- Dementia - Projections suggest that there will be a 32% increase in the numbers of people over 65 with dementia. There are rising levels of dementia amongst older adults in line with the national trend.
- Adults with autism and learning disabilities- between 2014 and 2030, the number of adults aged 18 to 64 with ASD in Brent is predicted to rise by 10%
- Physical disability and impairment- By 2030, the number of people aged 18 to 64 who will have a moderate physical disability will increase by 12% from 2014
- Hearing impairment - There are a high number of people living in Brent with hearing impairment aged at under 75 and over 75. This is again prevalent in certain ethnicities and in areas of deprivation.

National Priorities - NHS England 8 Focus Areas

NHS England is an executive non-departmental public body of the Department of Health. NHS England oversees the budget, planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012.

NHS England work with NHS staff, patients, stakeholders and the public to improve the health outcomes for people in England and have indicated that they wish CCGs to prioritise these 8 issues in 2015/16.



Collaborative Working - North West London

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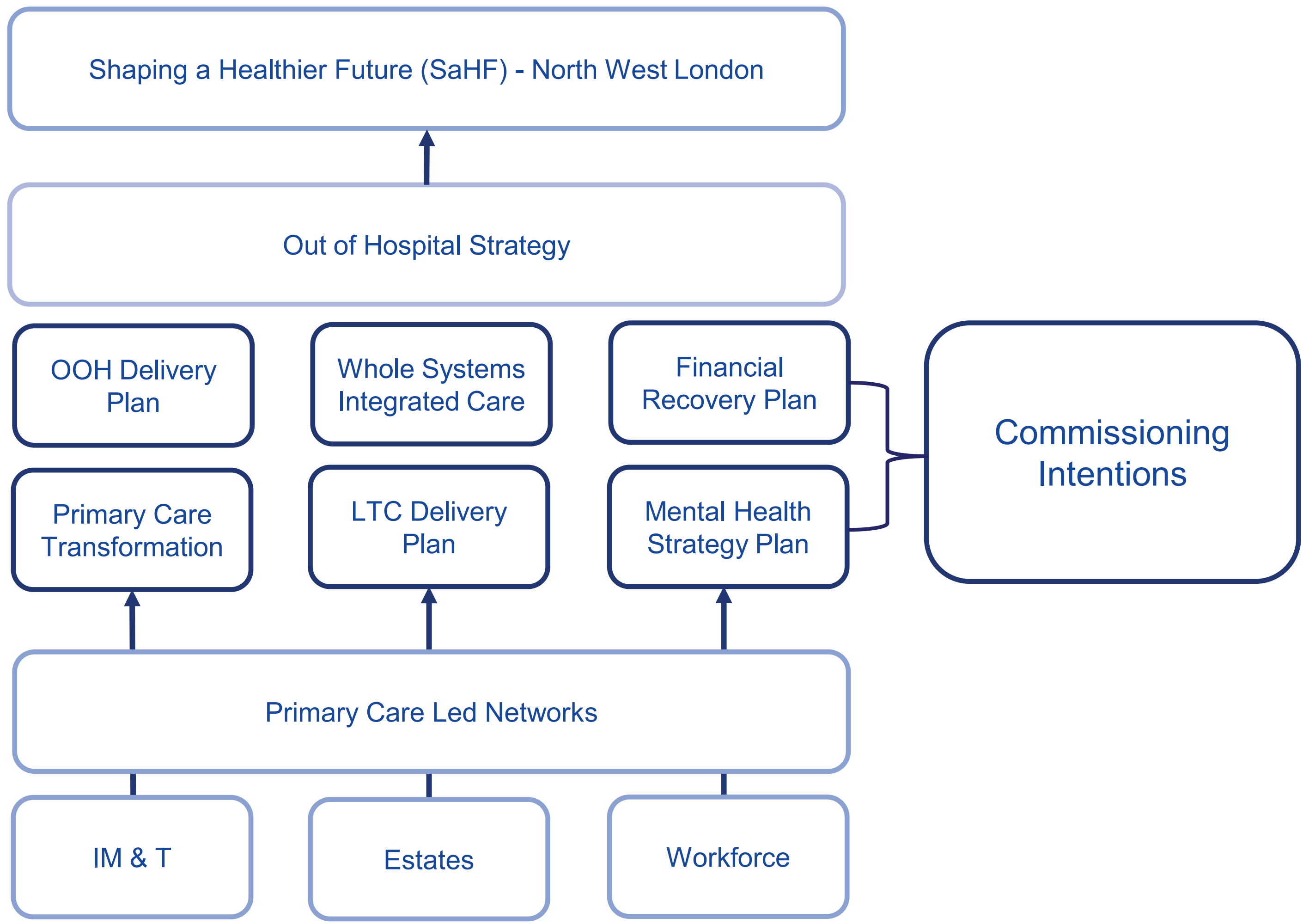

Shaping a Healthier Future (SaHF)
Acute Reconfiguration

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The NWL acute reconfiguration programme will centralise the majority of emergency and specialist services to deliver improved clinical outcomes and safer services to patients. North West London's vision is changing the existing hospital landscape of nine hospitals, re-configured to provide five Major Acute Hospitals. The agreed SaHF programme will oversee, in partnership with patients and stakeholders the re-development of:

Support of the Secretary of State (Oct 2013) followed a review by the Independent Reconfiguration Panel to deliver the following changes to priority services in 2014/15:

- Transition of services from the Emergency Unit at Hammersmith Hospital
- Transition of services from the A&E at Central Middlesex Hospital
- All Urgent Care Centres (UCCs) moved to a common operating specification, including a 24/7 service

Quality

NW London's clinicians developed a set of clinical standards for Maternity, Paediatrics, Urgent and Emergency Care in order to drive improvements in clinical quality and reduce variation across NW London's acute trusts. These standards, along with London Quality Standards and national Seven Day Service Standards, will underpin quality within the future configuration of acute services.

Seven Day Standards

North West London is committed to delivering seven day services across the non-elective pathway by March 2017, based on the national clinical standards, in order to improve the quality and safety of services and to support emergency care flow. In 2014/15 the baseline of delivery against the Seven Day standards has been established and a NWL prioritisation has been agreed to guide the sequencing of Seven Day standard achievement through until March 2017. As of April 2015/16, all Acute Trusts will meet the following 7 day standards:

- **Time to first consultant review**: All emergency admissions must be seen & have clinical assessment by a suitable consultant asap but at the latest within 14 hours of arrival at hospital.
- **On-going review**: All patients on the AMU, SAU, ICU and other high dependency areas must be seen & reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate.
- **Diagnostics**: Hospital inpatients must have scheduled seven-day access to consultant-directed diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology.

Shaping a Healthier Future (SaHF)
Acute Reconfiguration Cont'd

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Seven Day Standards Cont'd

In addition, Acute Trusts will be expected to produce quarterly patient experience reports that compare feedback from weekday and weekend services.

Over the course of 2015/16, Acute Trusts will work towards achieving the following seven day standards:

Multi-Disciplinary Team Review

All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

Shift Handover

Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

Seven Day Discharge Pathways

All providers across primary, community and social care will work towards seven day discharge pathways - i.e. that support services, both in the hospital and in primary, community and mental health settings must be available to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

Planning Arrangements

The acute reconfiguration is dependent on significant take-up of existing and new out of hospital services being delivered locally by all CCGs to ensure that patients only go to hospital when they need to. The programme has also been undertaking contingency planning for the potential transition of Maternity and Paediatrics services at Ealing Hospital.

Outline Business Cases (OBCs) for all sites and an Implementation Business Case (ImBC) will be developed, aligned with the clinical vision and centrally reviewed to ensure the solution for NWL remains affordable. OBCs for all hospitals are expected to be approved by NHSE, NTDA, DH and HMT in 2015/16. Following approval, a full business case is to be developed to allow the redevelopment of sites to continue.

Shaping a Healthier Future (SaHF)
Primary Care Transformation

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A number of drivers have combined to create a pressing need to transform access to General Practice in NW London:

Patient Expectations

A survey of NWL patient priorities found seven of the top ten issues related to improved access.

SaHF Programme

With The Independent Reconfiguration Panel Report requires GP practices to move towards a 'seven day' model of care to support changes to acute services.

Contractual Drivers

With effect from Apr 14, GMS contractual arrangements have been amended to reflect an increased emphasis on improved access to General Practice.

Financial Drivers

A consistent, system-wide access model to reduce costs for both commissioners (reduced service duplication) and providers (more efficient use of resources).

Though it may be part of the solution, expanding capacity alone will not improve access to General Practice, due to several reasons:

Funding

It is financially unsustainable for every GP practice in NW London to operate 8am – 8pm, 7 days a week.

Workforce

There are not enough GPs and nurses in NW London for every GP practice to operate 8am – 8pm, 7 days a week.

New Demand

Likely that increasing the number of appointments would cater for unmet need instead of re-distributing existing demand.

More of the Same

Still wouldn't give the public their desired appointments (e.g. doesn't make use of new technology to offer different types of appointment or make bookings convenient).

Any strategy for widening access to General Practice must therefore comply with four overarching goals:

System-wide Reconfiguration

Provision of additional appointments outside of core hours is unlikely to lead to sustainable improvements to access. To ensure service delivery reflects patient need, we need to think about seven day working across General Practice in its totality.

Financially & Operationally Sustainable

A new model must be affordable and deliverable. In the long-term this probably means no net increase in cost or workforce.

Meet Patient Expectations

A new model must deliver the type of appointments patients want, when they want them.

Reconfigure Supply & Demand

Though patient choice should be respected, every effort should be made to ensure patients receive care appropriate to their clinical condition, requiring mapping capacity to clinical need.

Shaping a Healthier Future (SaHF) Transformation

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Prime Minister's Challenge Fund

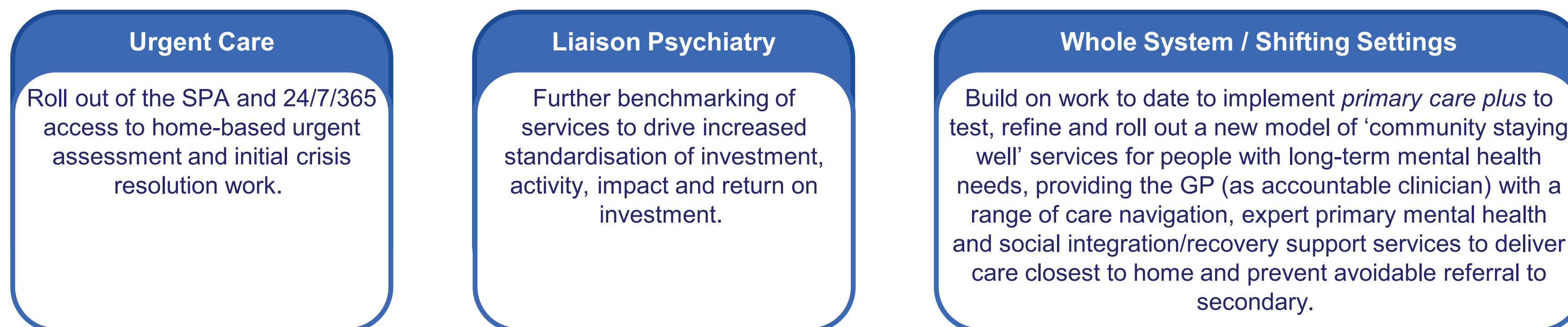
NW London were awarded funding through a successful application to the Prime Minister's Challenge Fund. This is now a significant enabler to deliver NWL's vision for a transformed primary care landscape in allowing, through a combination of NWL and NHSE funding:

- Extending GP access & continuity in the short term (by end of 2014/15)
- Putting the right support in place to nurture & grow GP networks (2014/15 and beyond)

The Challenge Fund will focus on outcomes around Urgent, Continuity & Convenient Care to ensure that patients have access to General Practice services at times, locations and via channels that suit them seven days a week.

Mental Health

In 2015/16, CCGs wish to see continued implementation of Shaping Healthier Lives 2012-15, core initiatives including:



In 2014/15, the Board has sponsored development work streams in Dementia, Learning Disability, Perinatal Mental Health and IAPT. CCGs will wish to see providers of service, implement the key pathway, models of care and quality standards that emerge from these work programmes. Regarding CAMHS OOH, CCGs will be commissioning a new provider of service, following that service review, due to be complete early Autumn 2014.

The Board commenced review of the extant strategy, Shaping Healthier Lives, in December 2013. A new vision statement was agreed in March 2014, reflecting a much broader, recovery and prevention Mental Health and Well-being Strategy, required for 2015 onwards. This is currently under development and agreement across the 8 CCGs and LAs, Metropolitan Police, both mental health NHS provider Trusts, Third Sector, Users and Carers. CCGs will issue a tender to take this programme of work forward and will wish all providers to be engaged in development and delivery in 2015/16.

Summary of Brent CCG Commissioning Priorities

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Acute & Primary Care

- Work with our Local Trusts to ensure the delivery of national standards ie: RTT 18 weeks, A&E 95% seen in 4 hours and Cancer access and treatment targets.
- Develop and implement new referral pathways with a Brent wide peer review system to ensure referrals are appropriate in several specialities including ENT, Gastro, Urology, T&O & Spinal,
- Continue to review the Internally Generated Referrals in line with the NWL agreed policy
- Deliver the QIPP programme for 15/16 by collaborative working across the local health economy
- Deliver the Wave 2 OP in community settings for MSK, Rheumatology & Gynaecology per the agreed timetable
- Promote integration across services and agencies to truly improve outcomes for Brent residents including delivery of the Better Care Fund Initiatives and Integrated Care (Unplanned Care)
- Implement the recommendations from the Community Beds Review (Unplanned Care)
- Review STARRS service to maximise productivity and reduce hospital attendances/admissions/readmission Implement the recommendations following the Ealing ICO review to deliver productivity improvements
- Continue the work to improve the treatment of Long term conditions eg: Diabetes
- Delivery of the various Better Care Fund schemes to reduce emergency admissions
- Whole Systems Integrated Care – there will be capitated budgets in shadow form during 15/16
- Cancer – all providers will be expected to meet the NICE, National CWT and London Model of Care standards during 15/16. This will include access to diagnostics and implementation of the new NICE initiatives for 15/16.
- Robust and challenging contract metrics to be agreed to improve acute performance and efficiency

Mental Health

- Working with relevant stakeholders continue to promote the concept of self care
- Continue to progress towards the IAPT target of 15% by ensuring that the investment is utilised appropriately
- Delivery of Better Care Fund schemes

Ealing Integrated Community Organisation (ICO)

- Implement the recommendations and findings from the recent review,, this will include the right to market test

The Provider Market for Brent CCG 2015/16

Brent
Clinical Commissioning Group

Acute

- The majority of our acute activity will remain at our 2 major local providers: North West London Hospital Trust (NWLHT) and Imperial. The merger of NWLHT with Ealing Hospitals in 2014 will have an impact on our contracts for 2015/16. NWLHT remains a financially challenged organisation.
- Brent CCG will continue to work with a wide range of other acute providers, including specialist hospitals from across London and the South East.
- The focus will remain on reducing the numbers of patients attending Accident and Emergency and the resulting emergency admissions and our workstreams and initiatives are designed to support this.
- We will also continue to focus on reducing referrals to Outpatients and moving more activity to community settings as appropriate. This approach supports the delivery of the Out of Hospital Strategy.

Voluntary & Third Sector

- We will continue to work with the voluntary and community groups in Brent to support early identification of people who would benefit from care navigation, lifestyle coaching and with a particular emphasis on self directed care across a range of mental health and long term conditions.
- We will ensure that the voluntary and community groups are integrated within the CCG commissioning strategy and workstreams.
- We will ensure that the development of provider markets includes voluntary and community organisations eg: IAPT
- We will make effective use of the voluntary sector to support access and engagement from the hard to reach or seldom heard communities.

The Provider Market for Brent CCG 2015/16 (*continued*)

NHS Brent Clinical Commissioning Group

Primary Care

- We will continue to align with the North West London Primary Care Transformation Programme that forms part of the Shaping a Healthier Future (SaHF) structure.
- We will continue to support the emerging GP networks to enable them to coordinate care and enhance services provided in primary care.
- Primary Care will continue to provide extended opening hours at the conveniently located hubs to offer greater choice and access for patients.
- Continue to develop the GP networks to provide out of hospital services where appropriate.

Community Services

- We will work with our community nursing service to develop collaborative approaches to service delivery leading to a more integrated model of service delivery.
- We will redesign community services as appropriate to deliver our Out of Hospital strategy.
- We will seek to implement the recommendations of the recent review of Community Services and improve productivity within the existing contract.
- Where productivity improvements cannot be achieved we will reserve the right to selectively test the market in specific areas.

Mental Health

- We will seek to achieve the productivity levels identified by NHS England in regard to Improved Access to Psychological Therapies (IAPT) and deliver the 15% prevalence target.
- We will continue to ensure patients are treated in the most appropriate setting through the Shifting Settings of Care Programme.
- We will work with our partners across North West London CCGs to procure CAMHS service (including for Learning Disability) and agree a urgent care pathway.
- In accordance with the Better Care Fund initiative we will strive to improve care and crisis planning for patients with mental health conditions to reduce the numbers requiring emergency admission.
- We will continue to ensure our providers deliver and maintain productivity and efficiency improvements

Shared Intentions
BHH Collaborative Working

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Brent CCG will continue working with partners at neighbouring CCGs on shared programmes of work to maximise the use of skills and capacity across BHH federation. A summary of shared projects across Brent, Harrow and Hillingdon CCGs is shown below with detailed commissioning intentions on subsequent slides or as indicated.

Tri-Party Clinical Projects	Overview
Continuing Care & Personal Health Budgets	Implement findings of audit report and redesign process so it is consistent across BHH.
IAPT	Joint negotiation with NHSE over 15% prevalence target and also opportunities for shared procurement. (see Mental Health commissioning intentions)
CAMHS	Collaborative commissioning across NWL (8 CCGs) and negotiation with NHSE regarding benefit share for Tier 4 admission avoidance (see Childrens commissioning intentions)
Psychiatric Liaison	Collaborative commissioning for 2015/16. (see Mental Health commissioning intentions)
Spinal Pathway	Pathway development led by Hillingdon for agreement by individual CCGs (see Planned Care commissioning intentions)
Medicines Management including Medication Incidents	Collaborative work across all three MMTs to look for efficiency opportunities.
Integrated Nursing	Common model of care across community nursing.
GP IT Systems	Providers to be committed to interoperability

Continuing Healthcare

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Scope

Continuing Healthcare is volatile , unpredictable and operates as a demand led service. There is an urgent need to manage the increasing demand and ensure commissioning of appropriate services for the age range and care groups. We need to determine how long existing patients will stay in service, the number of patients that are likely to be still in care after a period of time and associated costs as well as work with Public Health to determine local demographic trends and patterns.

NHS Funded Continuing Health Care (CHC) is the statutory NHS service for the assessment and provision of non- hospital care to those with on-going health needs. Funded Nursing Care (FNC) is the element of NHS Funded nursing care provided to those with nursing care needs outside of hospital settings. CHC and FNC are statutory responsibility of CCGs. Provision is for all adults and children across all care groups and eligibility for CHC is based on an individual's assessed health needs.

Need

- Marked increase in individuals assessed and their care moving from FNC into CHC
- Increased elderly population with on-going care needs assessed as a primary healthcare need
- Reduced lengths of stay of patients in hospital (particularly elderly frail and non-weight bearing patients) is resulting in this cohort meeting the CHC threshold and requiring intensive packages of care to reduce the risks of re-admissions
- Increased numbers of patients being discharged from Acute Trust with higher levels of need assessed as a Primary healthcare need
- Aging population and people living longer as a result of better medicine and new developments in medical technology

Commissioning Priorities

- Ensure sufficient management and operational capacity to be directed at CHC assessments and reviews
- Review the capacity and skill mix of the team and structure this to better reflect the needs of the service
- Implement more efficient contract management of providers so as to avoid additional costs being claimed for
- Develop more effective joint working arrangements with the Local Authority through agreed operational policies and joint training
- Training of Care home staff as part of the overall CCG strategy – ICP
- Develop a local commissioning framework for Continuing Healthcare
- Demand planning, market analysis and protocols for managing the market,
- Ensure compliance with the National Framework
- Scope and assess the extent to which personal budgets can help reduce the costs

Impact

- Delivery of high quality services at the lowest possible cost
- Improved protocols and associated arrangements with the Trusts and the Local Authority around management of Delayed Transfers of Care to
- Market engagement – Identification of supply and market opportunities and development of strategies stimulate the market
- Better procurement and contract management and rationalised provider contracts at present these are in excess of 300 separate provider contracts over 500 Individual patient contracts

Personal Health Budgets (PHBs)

NHS Brent Clinical Commissioning Group

Scope

- In 2009, the Department of Health launched a national pilot programme to look at the viability of personal health budgets in England (Department of Health, 2009). The pilot programme involved over 70 primary care trusts and covered a range of long-term conditions (chronic obstructive pulmonary disease, diabetes, long-term neurological conditions, mental health and stroke), NHS continuing health care, maternity care and end of life care, with 20 sites involved in an independent, in-depth evaluation. The evaluation concluded that personal health budgets are cost-effective (with certain caveats) and thus supported a wider roll-out.

Need

- Following this recommendation, the government confirmed its intention that, as of April 2014, individuals in receipt of NHS continuing health care funding will have the right to request a personal health budget. This will include an extension of the programme to cover children with special educational needs and disabilities, who will be able to have an integrated budget across the NHS, social care and education.

Commissioning Priorities

- As of 2015, clinical commissioning groups are expected to be able to offer a personal health budget to anyone with a long-term condition who could benefit. For commissioners, personal health budgets offer a new tool to support self-management and care planning, in line with the Government's mandate to the NHS to place greater emphasis on patients as partners in the management of long-term conditions.
- Brent CCG has been working toward an agreement in principle with work now commencing to review processes to reach an arrangement with local partners to implement and manage Personal Health Budgets.

Impact

- Offers patients choice of care and treatment and enables more self care to be delivered locally for anyone that is eligible.

Medicines Management

Scope

- To support effective medicines optimisation for Brent residents so that they get the most out of their medicines. This requires health and social care professionals, patients and carers working together in an integrated way.

Need

- Some practices need more support than others to prescribe more cost-effectively, and the pharmaceutical advisors ensure resources are directed to the appropriate practices. Evidence-based advice is provided so that patient receive high quality, safe, effective and rational medicines

Commissioning Priorities

- Roll out the pilot started in 2014/15 to optimise services for patients in nursing or residential care homes in conjunction with the Integrated Care Pathways Service (ICP)
- Improve the interface transfer of prescribing with secondary care, community and mental health trusts by agreeing shared care protocols for certain medicines
- Implement the NWL wide protocols for drugs and improve the contract management of acute prescribing
- Review the amount of repeat prescribing to ensure appropriateness
- We will support providers to improve systems for safe transfer of information on patient medication at admission and discharge

Impact

- Realisation of the QIPP savings whilst maintaining quality prescribing.
- Implementation of cost-effective evidence based medicine.
- Improvements in the practice repeat prescribing systems / processes with a view to reducing medicines wastage.

Informatics

NHS
Brent
Clinical Commissioning Group

Scope

- The 8 CCGs across North West London are committed to achieve greater integration of care through greater integration of information about patients between GPs and providers, and across the provider network.

Need

- Information Technology is a key enabler of Brent CCG's clinical strategies for 2015/16 and therefore the CCG intends to place a heavy emphasis on IT in the CQUINs for the year, as for 2014/15.
- The objective is to implement three layers of clinical information exchange where at least one of the following is in place in any setting of care:
  Level 1 - Access to and two way information exchange within a common clinical IT system and a shared record between the GP and the care provider.
  Level 2 – Where Level 1 is not possible, ensuring systems are interoperable and in full conformance with the current Interoperability Toolkit (ITK) standards
  Level 3 - Where neither of the above is relevant or feasible then the Summary Care Record is enabled, available and accessible.

Commissioning Priorities

- Implementation of the NHS number as a unique identifier across NHS & Social Care
- Implement an EMIS (GP IT system) data sharing module across the GP networks in Brent
- The NWL Information sharing protocol to be signed off by all organisational partners
- Delivery of NWL diagnostic Cloud by all providers
- Agreement for open access (APIs) across all systems
- Brent CCG is seeking to achieve Level 2 for clinical information in 2015/16

Impact

- Better integration and coordination of services and treatment
- Enabling providers to provide more timely and accurate information
- GPs to receive electronic information about the patients' treatment, investigations and discharge

Community Services & Integrated Nursing

Brent
Clinical Commissioning Group

Scope

- Brent CCG is committed to increasing capacity in community and intermediate care services effectively across the transforming system.

Need

- The residents of Brent have changing health needs, as people live longer and live with more chronic and lifestyle diseases – putting pressure on social and community care
- 2. Under our current model of care, we cannot afford to meet future demand. We need to have more planned care, provided earlier to our population in settings outside of hospital.
- This should provide better outcomes for patients, at lower cost.

Commissioning Priorities

- Implementation of the EICO review recommendations for the future provision of quality community services
- Align integrated nursing model to GP networks and other key strategic initiatives
- Align STARRS rapid response service and early supported discharge to Better Care Fund (BCF) Avoiding Unnecessary Hospital Admissions
- Providers (social and health) will work together, with the patient at the centre, to proactively manage people with long term conditions, the elderly and end of life care out of hospital.
- Continued development of planned care pathways that ensure wherever possible care is delivered outside of a hospital setting. Patients will have access to services closer to home.

- **Impact**

- Better integration and co-ordination of services and treatment for patients
- Reduction in emergency admissions
- Reduction in readmissions

NHS Brent CCG's Vision for Quality

Brent
Clinical Commissioning Group

Brent CCG's 'vision for quality' is every person deserves a quality and safe experience wherever they are cared for in NHS services, and our ambition is to work with the providers of services to continually improve in order to achieve our objective.
Our local framework for quality is informed by national policy for delivering quality and patient experience, and is set against three main drivers:

- Planning for high quality services
- Developing and commissioning high quality services
- Assuring the services we have commissioned deliver a quality service

Brent's quality strategy outlines the framework for ensuring that quality is at the heart of everything we do. It is built around the priorities identified by Brent Clinical Commissioning Group for commissioning high quality healthcare services for its residents in 15/16, with our quality strategy covering:

Quality Governance
The Governing Body has agreed an quality assurance structure for identifying, monitoring and challenging quality in the organisations we commission services from. Good quality information is a pre-requisite to understanding current services, for gaining improvement and planning future services. It supports our role to commission the right services and best possible care for our residents.

Quality Assurance
We take responsibility for Quality Assurance by holding providers to account for delivery of contractual obligations and quality standards. We also take responsibility for working closely with providers to ensure service delivery continually improves and they have in place processes to drive this continual improvement including the adoption and sharing of innovation. We have a system of quality assurance and early warning processes in place which provides information about the safety, effectiveness and patient experience of services we commission. This system enables us to be proactive in identifying early signs of concerns and take action where standards fall short.

Patient Experience

Using the guidance from The Department of Health's '*Building on the Best: Choice, Responsiveness and Equity in the NHS* (DH, 2003)' and their Patient Experience Framework, we will monitor elements that are critical to the patients' experience of services we commission.

Quality Improvement & Learning
We are committed to improving quality by sharing lesson learnt, best practice and to utilise this information to inform commissioning decisions at each stage of the cycle.

NHS Brent CCG's Vision for Quality (*continued*)

NHS
Brent
Clinical Commissioning Group

Quality Goals
Our priorities build on national policy, our commissioning strategy, and areas of higher risk and identified concerns. We have set ourselves three specific quality goals for the lifetime of our strategy:

- Compliance with National NHS Constitution expectations
- Delivery of local quality improvement objectives
- Delivery of a quality team operational work plan

For 2015/16, Brent intends to consolidate and build upon its 2014/15 work by:

- Continuing to broaden and diversify PPE links to ensure there are robust ways in which patient's views and experiences are collected and used to improve care. "You said – We did"
- Work with the BHH Federation commissioning team to further improve the quality of reporting, the use of intelligence and the implementation of improvement.
- Ensure implementation of the key recommendations from the Francis Report.
- Maintain effective relationships with the Area Team of NHS England, the NHS Trust Development Authority, the Care Quality Commission (CQC) and Public Health England (PHE) to ensure information sharing and co-ordinated responses to concerns.
- Continue to 'champion' the ambition of the CCG to provide the highest quality care for patients.
- To maximise the input from the restructured shared quality team, improving capacity and strengthening the local focus.
- Working with the Chairs and PPI leads on planned shared areas of work embracing opportunities for shared learning.
- Monitor the impact on quality of QIPP and investment initiatives.

Better Care Fund Plan

Brent
Clinical Commissioning Group

Scope

- To develop whole systems anticipatory care management services and episodic care models across the local population groups, ensuring person centred and coordinated care.
- To improve the quality of care and empower people to maintain independence through health and social care integration:
- To reduce the use of residential care and enable people to remain healthy and independent in the community.
- To deliver a whole system response aimed at reducing hospital admission, the length of time a patient has to stay in hospital if they are admitted, and more planned and proactive care, based in the community.

Need

Whilst the population of Brent is young, age is a significant determinant of the likelihood of an unplanned admission to hospital.. From our JSNA an 80 year old is almost 8 times more likely to be admitted as an emergency than a 20 year old. Once in hospital, patients aged 65 and over, stay longer. In Brent, 35% of emergency admissions are for patients aged 65 and over with 55% of bed days used by this group. This is caused by longer recovery times, infection and delayed discharges. 13% of emergency admissions of patients over 65 are for conditions which can be better managed in a community, primary care or outpatient setting.

Commissioning Priorities

- Keep the most vulnerable well in the community – commission proactive care to support better management of long term conditions and prevent acute exacerbations in health.
- Avoid unnecessary hospital admissions – commissioning provision that supports patients in the community ensuring that acute exacerbations don't necessarily result in admissions to hospital. Rapid responses through primary care networks and in reach into A&E departments
- Ensure effective multi agency hospital discharge - Reduce re-admissions and lengths of stay by reducing the number of delayed bed days associated with complex discharges and ensuring our acute capacity is maintained through minimising the number of delayed transfers of care.
- Implement 7 day working to ensure that urgent and emergency care providers develop plans for the 10 clinical standards, seven days a week. The ten clinical standards will improve quality and reduce variation in clinical outcomes (within hours from out of hours and weekends).

Impact

- Integrated care plan that puts the patient's perspectives at the centre of planning and care delivery and contributes to improved patient experiences, better care and support outcomes, service user satisfaction and potentially more cost effective care.
- Co-ordinated care planning of health, social care, well-being and enablement through a person centred approach to meet the full spectrum of needs and integrated Rapid Response Service –a range of services in place to prevent patients and service user from being admitted to hospital settings where appropriate. Short-term multi-disciplinary care delivered to support patients to remain in the community which in turn reduces admissions and the length of time people stay in hospital and also enables a more proactive care approach to managing patients in the community
- Integrated Discharge - working collaboratively to assess patients to ensure that discharge planning and transfer of care to community settings is seamless and timely.
- Recovery Focused Mental Health so that care is provided in an integrated and coordinated manner and early intervention support is extended to improve the quality of care for individuals with serious mental illness; including the provision of employment and secure housing for people recovering from mental health issues.

Unplanned Care

NHS
Brent
Clinical Commissioning Group

Scope
There are a range of services that contribute to the whole systems approach to unplanned care, these include primary and community care, admission avoidance, services for children, services provided by London Ambulance Service and those commissioned by NHS England and Public Health England.

Need
The number of patients attending our major providers (notably NWLHT, Imperial, THH, RFH and CNWL) for unplanned care continues to rise as does the number of patients admitted.

Commissioning Priorities

- Work closely with NWLHT to drive up performance and ensure that more patients are seen and treated to meet the national standard of 95% in 4 hours.
- The Remedial Action plan developed in 14/15 will be fully implemented including:
  - Real time reporting of discharge summaries onto all primary care systems
  - Ensure that A&E can view patient primary care records
  - Implement an agreed assessment pathway whereby patients are admitted if clinically appropriate
  - All acute providers to ensure rapid access to diagnostics in A&E to support 4 hour target
- Implement the findings from the community beds review including provision of additional neurological rehabilitation beds and seek to permanently commission community beds at Willesden to provide additional capacity
- Hospital at Home service to be re-launched from April 2015 and provided by STARRS to enhance the current provision of community based services
- Increase the use of the Ambulatory Care Unit by adding a further 10 pathways during 2015/16 and improve utilisation by Brent GPs
- Develop a robust strategy for the development of community based nursing and therapy services to support Brent CCG vision for local health care services and promote 7 day working
- The CCG expects providers to implement a clinical tool e.g.MCAP to enable review and determine appropriate care levels based on best practice
- NHS 111 will be the subject of a NWL wide procurement
- Implement across acute and community contracts the unplanned care elements of the National 7 day service standards
- Review the Home Oxygen service to understand the current pathway and define any new pathway requirements. Appropriate use of this service can reduce the instances of avoidable hospital admissions.

Impact

- Increased available bed capacity
- Reduce number of delayed transfers of care
- Reduce length of stay in acute setting
- Reduction of inappropriate attendances/admissions
- More patients seen and treated in 4 hours

Cancer

NHS
Brent
Clinical Commissioning Group

Scope

In 2015/16 quality requirements for cancer have been refined to provide clarity on actions to reduce variation. All cancer services will be commissioned in line with the requirements of NICE Improving Outcomes Guidance and NICE quality standards (QS), (QS56), the London Model of Care for cancer services and the National Cancer Survivorship Initiative (NCSI).

Need

- The CCG recognise the pressures and demands on cancer's services and therefore will work towards increasing awareness, screening and early diagnosis of cancer.
- The CCG will seek to improve quality of primary and secondary care in relation to cancer - by working to secure improvements in cancer services, focusing on national and local priorities

Priorities for 2015/16

- Quality requirements for cancer have been refined to provide clarity on actions to reduce variation.
- A number of services will be commissioned to support the earlier diagnosis of cancer in line with the Pan London Early Detection pathways, such as prostate cancer , colorectal cancer , ovarian cancer, lung cancer services , breast cancer etc.
- Services will be commissioned in line with the new cancer pathways as well as to support the management of patients with a family history of breast cancer.
- Some services will be commissioned to manage the consequences of anti-cancer treatment (late effects). Specifically services for lymphoedema and services for psychological and physical sexual related problems.
- Maintain the holistic approach to cancer care and care plans by ensuring that multi disciplinary teams are effective

Expected Impact

- Help people live well for longer – preventing ill-health, and providing better early diagnosis and treatment of cancer
- Reduce the variation in the access to cancer services across Brent – although the premature mortality from Cancer is below London average for Brent there is variation across the Borough.

Palliative Care

NHS
Brent
Clinical Commissioning Group

Scope

Palliative care includes all adults, irrespective of diagnosis, who are in the end of life phase of their disease process.

Need

- Only 11% of those who may need a plan have one identified on the Coordinate My Care (CMC) system
- Brent has a younger than average population. However as a deprived area and with a high influx of migrant people the population faces end of life issues at an earlier age than most of the UK. Poorly managed long term conditions, failure to present early with cancer symptoms and failure to attend follow up appointments places a higher than average number of people into coping with later stages of illness at an earlier time.

Commissioning Priorities

- To improve the standard to support more patients to achieve their preference of dying outside of hospital
- To work with GP networks to support member practices with End of Life Care

Impact

The aim is to reduce dependence on secondary care during this phase of care and as a result fewer patients should have emergency admissions into hospital.

Planned Care - supporting Out of Hospital strategy

NHS
Brent
Clinical Commissioning Group

Scope

- Planned care covers those services and treatments which are not carried out in an emergency, often those which patients are referred to by their GP.
- Brent CCG is committed to transforming local planned care services in order to deliver high quality, personalised care, which enables patients to see the right person, in the right place, at the right time.

Need

- Services that provide patient-centred, effective but affordable services in, and wrapped around, local communities, for example in health centres, GP surgeries and in community settings rather than just in hospitals.
- Strengthening primary care and community services and supporting patients to participate in decisions about their own care empowering them to self-care where safe to do so.

Commissioning Priorities

- Deliver Specialist Multi disciplinary Community Musculoskeletal (MSK) service.
- Deliver Community Consultant led Gynaecology service.
- Introduce revised pathways across a range of specialties with particular emphasis on areas where there are issues with meeting the 18 week referral to treatment target. This includes ENT, Urology, Spinal, Dermatology, Gastroenterology & Paediatrics.

Planned procedures with a Threshold (PPwT) and Individual Funding Requests (IFR)

- Deliver the planned changes to existing PPwT policies
- Implement new policy developments
- Endorse and implement the changes to PPwT/IFR governance processes

Impact

- Supporting our hospitals and surgical teams to deliver the best outcomes for those who do need their services
- Reducing waiting times by streamlining services and removing delays at every stage of the patients journey to ensure everyone can be seen within 18 weeks

Long Term Conditions

Scope

Supporting adults with long term conditions, including patients with COPD and asthma, Stroke, Cancer and Inflammatory Bowl Disease (IBD).

Need

Brent has a higher than average number of patients with LTCs. Variation in the quality of care provided and lack of integration between services is leading to lower than expected prevalence rates and poorer health outcomes for patients.

Commissioning Priorities

We will place greater emphasis on self-management of long-term conditions in community settings through greater use of the Expert Patients Programme and health coaching for patients.

We will seek to commission integrated care pathways and services for patients with respiratory conditions and stroke that provide care closer to home in an integrated way.

We will seek to increase the number of patients with LTC that have a care plan under ICP and reduce the number of A&E attendance and Emergency Admissions by LTC patients.

We will seek to implement, in shadow form, a model of whole systems integrated care for patients aged 65 plus with one or more long term conditions. This model will be delivered via our GP networks on an incremental basis.

Impact

Through our work, we will reduce variation in the care provided, improve the quality and range of services that are closer to where patients live, and improve health outcomes for patients with LTC. More patients will be better able to manage their own care, reducing demand on local acute services and clinicians.

Primary Care - supporting Out of Hospital strategy

Brent
Clinical Commissioning Group

Scope

These commissioning intentions cover all the activities that Brent CCG is involved in, relating to primary care, including the commissioning of community health services. We will further work collaboratively with NHS England to support improvements in primary care. We will shift care to more community and out of hospital settings in line with national priorities. We will work to reduce reliance on urgent care, moving to a more anticipatory and integrated model of care across services in order to improve patient outcomes and achieve best use of resources. We will provide patient centred, co-ordinated care and GP-patient continuity.

Need

Increasing demands, demographic changes and fewer resources on healthcare services mean that services provided in primary care, and particularly those offered by GPs are under severe pressures. Our aim is to ensure that local people can continue to receive an improved level of service from primary care provision.

The CCG will work to promote integrated working between primary and community services not only to provide sustainable solutions to the issues around workforce, but also to ensure that patients receive better health care experiences and improved outcomes. This also aligns with Brent CCG's networks involved in the early adopter Whole Systems Integrated Care pilot and the work we are leading on jointly with Local Authority partners to deliver the Better Care Fund plan.

Commissioning Priorities

- Commission more Out of Hospital services from GP networks
- GP Hubs/Access - to continue to provide extended opening hours at conveniently located hubs to offer greater choice and access
- Organisational Development and Education - to develop networks so that these can provide out of hospital services where appropriate
- Seek to provide Paediatric phlebotomy in a local setting (age 2-12)
- GP performance, - to enable practices to develop improvements plans to address their performance needs and improve patient experience
- Deliver the reconfigured the Brent wide referral system to streamline services
- These are in addition to those priorities already articulated elsewhere in this document including delivery of Prime Minister's Challenge Fund, Out of Hospital Developments, Implementing improved Pathways, Mental Health (Shifting Settings of Care), Planned Care, Shaping a Healthier Future.
- Work with GP practices who are outliers in utilisation of GP UCC, A&E and Emergency Admissions to ensure that patients receive care in the

Impact

- To meet the required national and local outcomes including:
- Reducing Attendance at Emergency Departments and managing referrals
- Preventing people dying prematurely
- Enhancing quality of life for people with Long Term conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and Caring for People in a Safe Environment and Protecting Them From Avoidable Harm
- Ensuring that there is a responsive, timely and accessible service that responds to different patient preferences and access needs

Children & Young People

NHS
Brent
Clinical Commissioning Group

Scope

Commission a range of high quality, effective, integrated children's services, embedding integrated commissioning arrangements for children and young people

Needs

A quarter of the population of Brent is under the age of 20 years and 91% of the school children are from a Black or minority ethnic group. A reported use of drugs, alcohol and smoking amongst our young people remains a high priority. Given our dynamic demographic make-up we are focused on building on existing work to further reduce risk-taking behaviour amongst young people and support those young people with complex health needs, including mental health problems. to stay well in the community. There is a need to commission fully integrated health and social care models of care for children and young people in Brent.

Commissioning Priorities

- CAMHS – work with NHSE to review the care pathway for access to Tier 4 services for children and young people. Commission a cohesive and integrated care pathway across health and social care, which includes community based services where appropriate and ensuring robust transition plans for children moving into adult services. We will deliver provision that supports best outcomes for children and young people with emotional and mental health conditions.
- Review unplanned admissions and avoidable emergency department attendances by children and young people.
- Children Looked after – develop and implement robust care pathways for Children Looked After. Ensure systems for collating and reporting timely and accurate data on all CLA assessments and reviews of Brent Children
- Community Nursing Teams – Develop integrated children's nursing teams to include health visitors, practice and nurses, community paediatric nurses to manage complex children's conditions in the community
- Therapy Services – we will review Brent CCG's current community Paediatric services to reflect that there is sufficient capacity to meet therapeutic needs
- Special Education Needs and Disability (SEND) – we will meet our statutory duties and implement SEND requirements and review the associated impact on health commissioning
- Personal Health Budgets - developing a local policy for implementing Personal Health Budgets for children and young people, enabling them to create their own care plan and decide on the health and wellbeing outcomes they want to achieve, in agreement with a health care professional
- Work with the Local Authority's education services to develop an integrated plan for children with complex care needs to support them to remain in family settings where possible and to support children at high risk of admission to stay in the community.
- Ensure inclusion of safety quality standards in contract schedules

Impact

- Integrated health and social care pathway to enable a holistic approach to supporting children and young people with complex care needs
- Improved health outcomes for all Brent Children and Young People
- Robust care plans in place to deliver the most appropriate treatment by the right clinician at the right time, with clear pathways in and out of secondary, primary and community care.

Mental Health and Learning Disabilities

Brent
Clinical Commissioning Group

Scope

These commissioning intentions cover adults and older adults learning disabilities and mental health services in Brent. It includes health, social care, 3rd sector, Primary and secondary care mental health services, GP networks, jointly commissioned and jointly funded services. The areas covered include mental health placements, mental health productivity, Shifting settings of care, IAPT, and Winterbourne .

Needs

Mental health remains the single largest cause of morbidity within Brent affecting one quarter of all adults at some time in their lives and is a key priority of our commissioning intentions. We recognise the need to promote mental wellbeing in our communities and address the stigma and lack of awareness around mental illness that is often present in many of our diverse communities. We have a responsibility to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them1

Commissioning Priorities

- Mental Health Placements – to continue to review care packages and provide advice, support and clinical interventions to mental health and Learning disabled service users, matching complex patients to appropriate settings of care closer to home.
- Mental Health Productivity – achieve a 2% financial reduction linked to the use of routine clinical outcome monitoring, and supporting recovery and self-management
- Shifting Settings of Care – Reduce activity in out-patient follow-up by secondary care. Facilitate the move of patients in mental health secondary care settings to primary care services who have low level acuity symptoms, developing shared prescribing protocols and depot administration.
- Older Adults inpatient activity - to commission and design a specialised integrated health and social care team home treatment team , enhancing the existing team to enable and support more elderly individuals to be cared for at home, addressing high costs relative to in-patient settings.
- Mental health Urgent care & Dementia support – reduce the number of non-elective admissions and re-admissions to physical health wards for people with mental illness and commission appropriate support services and models of care e.g. support teams. Redesign care pathways to have better links with A&E LPS, substance misuse service, dementia services and GPs to ensure Crisis Plans are supported and management is pro-active (including carer support, and support for people with personality disorders
- IAPT - Invest to increase capacity, whilst developing new ways of removing barriers to access with specific target of BAME communities who have traditionally not been known to access IAPT services
- CAMHS - Commission a revised CAMHS out-of-hours service (following the review in 14/15), develop and implement IAPT service models for children, and support the wider CAMHS review in 2015/16
- Learning Disabilities – commission services locally and ensure that people remain in their communities whilst reducing reliance on inpatient care for individuals with a learning disability
- Winterbourne - Review and develop clear pathways for people with a learning disability and a mental illness (Winterbourne View Review phase two)

Impact

- Improve quality of service for people with mental health problems
- Reduction in activity in out-patient follow-up by secondary care
- Prevent older people with mental health problems being admitted to acute care as appropriate
- Improved care-pathways and coordination across CAMHS providers and more efficient use of specialist resources o support the needs of children who are Looked After by the Local Authority, and children with learning disabilities
- Commissioning of more bespoke options to manage people with learning disabilities and challenging behaviours.

Carers

NHS
Brent
Clinical Commissioning Group

Scope

To create and sustain a positive environment that enables carer to be supported in the caring role for as long as is possible. improve the improve the quality of life and the health and well being of carers and ensure that carers receive modern, responsive, high quality cost effective care. To ensure That carers have choice and control over the services they receive and to ensure that these are equitable and accessible.

Need

We need to develop joint working with GP's and health professionals to recognise and support family carers in their practices and avoid hospital admissions for those they care . We need to be able to improve carers access to health services and other health Promotion initiatives. There is a need for services that reduce the negative effect of caring to be developed to support carers with coping mechanisms and support and encourage them to stay independent and healthy.

Commissioning Priorities

- Support carers to identify themselves as carers at an early stage and be informed of relevant local support for them in Brent.
- Involve carers in planning the individual care packages of those for whom they care.
- Enable those with caring responsibilities to fulfil their educational and employment potential by links to educational and career support in Brent.
- Provide respite grants that allow carers to have a break from their caring duties.
- We will support carers to have integrated and personalised services including ensuring that carers are identified, recognised and respected by all agencies and are involved in the design and delivery of services
- Providing timely accessible and relevant information to all carers
- Providing training for key professionals in health and
- Provide referral routes to IAPT (Improving Access to Psychological Treatment), which enables them to gain psychological support around anxiety and stress.
- Work proactively in partnership with Brent Council to provide an integrated model of support for carers that addresses both their health and social needs.
- Supporting Carers to remain physically well.
- Integrate health and social aspects of support to carers in a coordinated manner that increases their wellbeing

Impact

- Improve quality of carers experience in attaining support in Brent
- Increase the number of carers accessing psychological intervention.
- Bring a more integrated care plan to the support offered to carers.
- Promote both mental and physical health to carers

NHS Brent CCG QIPP & Investment 2015/16

NHS
Brent
Clinical Commissioning Group

Key areas to focus:

QIPP Plan

- Forecast modelling for 15/16 include savings brought forward from 14/15 FYE, plus new ideas generated throughout the fiscal year both from the additional work undertaken by Atkins and within Brent CCG.
- There are also some new schemes added as innovation and ideas that have and will subsequently emanate from the commissioning intentions.
- Target budgets include gross savings of £18.5m (£5.6m re-provision), to achieve net savings of £12.9m.
- The majority of savings are targeted at the main providers in the acute setting (NWLHT and Imperial) with other schemes in mental health (CNWL) and community (Ealing ICO).
- Work will continue to ensure delivery of Brent's QIPP target is sustained.
- There is clearly a need for continuing discussions with providers around these QIPP schemes, these will take place during the normal contracting process.

Investment Plan

- The value of existing QIPP schemes, planning assumptions relevant to Brent's strategic goals and corporate objectives, plus control total has enabled capacity for an investment plan in 15/16.
- Investments implemented in the forthcoming year will be targeted to help achieve QIPP savings in future years.
- Plans for investment currently identify a provision of £8.7m (£3m recurrent / £5.7 non-recurrent), with an overall budget to be confirmed.

- **Until final budgets are confirmed in March 2015 these QIPP figures remain draft and will subject to change during contract negotiations with providers.**

Brent CCG Draft QIPP Plan 15/16 - summary

NHS
Brent
Clinical Commissioning Group

Brent CCG Draft QIPP Plan 15/16	*2015/16*		
	Gross QIPP	Reprovision	Net QIPP
	£'000	*£'000*	*£'000*
1. QIPP 14/15 Brought Forward			
a. Original Schemes	*(8,872)*	*2,208*	*(6,664)*
b. Additional Schemes	*(2,417)*	*0*	*(2,417)*
c. Other	*(786)*	*0*	*(786)*
2. QIPP 15/ 16 - New Schemes	*(4,785)*	*1,385*	*(3,400)*
Total	***(16,860)***	***3,593***	***(13,267)***
Gap to Identify			
QIPP Plan 15/16 target	***(18,478)***	***5,624***	***(12,853)***

Draft QIPP 15/16 - Schemes b/f

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Project Name	Start Date	Description	Gross Savings	Re-provision	Net Savings
Wave 1 Outpatients : Ophthalmology	22/09/14	New preferred provider for outpatient services to replace most acute outpatient services, offering improved care in community settings with better outcomes at a reduced cost to deliver Brent's OOH Strategy.	(666)	552	(114)
Wave 1 Outpatients : Cardiology	02/02/15	New preferred provider for outpatient services to replace most acute outpatient services, offering improved care in community settings with better outcomes at a reduced cost to deliver Brent's OOH Strategy	(2,194)	1,415	(779)
DMARD	01/01/15	To provide a community based service for patients on DMARD therapy, including monitoring and follow up via a service that is convenient whilst remaining clinically safe.	(300)	101	(199)
Endoscopy	01/09/14	To introduce a faecal calprotectin stool test to prevent the need for flexible sigmoidoscopy for patients with inflammatory bowel disease. The pathway aims to reduce referrals to secondary care.	(198)	40	(158)
Outer ICP (BCF)	01/04/14	Deliver person-centered coordinated care, involving primary care, acute, social care, MH and community services, with an aim to proving a coordinated, seamless approach enhancing the patient's experience.	(1,020)	0	(1,020)
Anticoagulation	01/10/14	A community network based service for patients on anticoagulation therapy. Monitoring (10/12 follow up visits) within PC settings with less reliance on secondary care for patients initiated on high risk drugs.	(91)	0	(91)
Very Short Stay Emergency Admissions	01/07/14	Agree a local tariff for zero or one day LoS emergency admissions and reduce the number of these admissions.	(100)	0	(100)
C2C Referral Management	01/10/14	To review and reduce internally generated referrals.	(375)	0	(375)
Circulation (BNP)	01/01/15	To assist GPs to implement serum natriuretic peptide (Serum NP: either BNP or NTproBNP) testing, with potential to rule out heart failure with 98% accuracy.	(66)	0	(66)

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Draft QIPP 15/16 - Schemes b/f

Project Name	Start Date	Description	Gross Savings	Re-provision	Net Savings
MH Repatriation : FYE 14/15	01/04/14	The placement efficiency programme provides advice, support and clinical interventions to MH and LD placement cases to match complex patients to appropriate settings of care.	(300)	0	(300)
HIV : Review Non-secondary Care Services	n/a	To review the existing Mildmay service to identify contract efficiencies by mapping the referring pathway to enable the CCG to deliver a reduced 3 year rolling average in 15/16 to provide more localised services.	(50)	0	(50)
Community ICO	n/a	To deliver contract efficiencies by working with providers toward local efficiencies based on the opportunities indicated by national and local benchmarking data.	(485)	0	(485)
STARRs (BCF)	01/04/15	Review STARRS service to maximise productivity and to help reduce hospital attendance figures and avoid re-admissions with more patients being supported at home during their health crisis period.	(1,816)	0	(1,816)
Mental Health CNWL : Productivity	01/04/15	1.5% Efficiency savings across all service lines without affecting front line service delivery or patient care in order to: • Decommission early intervention psychosis team • Tender the CAMHS support • Possibly re-procure the entire MH service • Move care into alternative settings	(700)	0	(700)
Falls Service	01/04/15	To identify those at risk of falls, bone fractures and osteoporosis. This will lead to a reduction for both NHS costs i.e., conveyance, attendance and admission costs, as well as a reduction in social care costs.	(511)	100	(411)
		Total	**(8,872)**	**2,208**	**(6,664)**

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Draft QIPP 15/16 - Additional Schemes b/f

Project Name	Start Date	Description	Gross Savings	Re-provision	Net Savings
Referral Standardisation	01/04/14	Focus on top 6 specialties to increase referrals with periodic peer reviews of GP referrals by allocated consultant to maximise opportunity to deliver care in alternative settings. Stretch on original RFS scheme and equates to a reduction of 2 referrals per practice per month.	(450)	0	(450)
Repeat Prescribing	01/10/14	Community pharmacists to support practices to carry out reviews, particularly for patients taking multiple medications. Focus on waste and work with nursing homes to reduce reliance on fortified supplements.	(203)	0	(203)
Continuing Healthcare - Review of Cases 14/15	01/10/14	Case reviews for high cost cases, adults and children. Faster reviews, challenging cases to reduce and rationalise. Anticipating will be undertaken in more timely basis.	(200)	0	(200)
Diagnostics	01/04/15	Optimise GP use of pathology; in some areas diagnostics that have been undertaken in primary care are being duplicated in secondary care. Pathology protocols to be developed to optimise usage.	(120)	0	(120)
Stroke : Early Discharge	01/04/15	6 and 12 month reviews for stroke patients undertaken outside the acute hospital setting.	(105)	0	(105)
Contract Management: Acute Metrics	01/04/15	To review and monitor acute metrics to ensure targets are achieved.	(750)	0	(750)
Contract Management : Maternity Acuity	01/04/15	There is a maternity audit agreed by the CCGs and NWLHT using PbR principles and guidelines. Currently NWLHT are some 15% away from national predicted average and it is envisaged that this audit will reflect a lower acuity than currently being paid for in contract. Target reflects a small proportion of the c3,000 Brent deliveries a year at NPH. Opportunity to review acuity has arisen due to new maternity tariff.	(94)	0	(94)
Contract Management : Excess Bed Days (BCF)	01/04/15	Improving process of discharge, will be identified as part of STARRS review and as part of the Community Beds Review. Social worker investment in System resilience funding. Challenge is to improve the excess bed days in elderly medical exacerbated by delays in discharge and in transferring patients to step down/up beds or nursing homes.	(150)	0	(150)
Urology : Redefine Referral Criteria	01/04/15	Urology referrals have increased by 30%. Clinicians are meeting on 8th October to re-define the referral criteria.	(300)	0	(300)

NHS
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Draft QIPP 15/16 - Additional Schemes b/f

Project Name	Start Date	Description	Gross Savings	Re-provision	Net Savings
Contract Management : Harrow / Brent UCC	01/04/15	NPH UCC enhancing its range of services offered to deliver the Harrow QIPP target. Brent CCG patients will also benefit from this enhanced service delivery resulting in fewer patients referred onward to A&E and ultimately reduced hospital admissions (although savings on fewer hospital admissions are captured elsewhere in Brent QIPP).	(45)	0	(45)
		Total	**(2,417)**	**0**	**(2,417)**

Draft QIPP 15/16 – other b/f

Project Name	Start Date	Description	Gross Savings	Re-provision	Net Savings
Commissioning Support	n/a	Seek to reduce spend and deliver some services at a BHH or local level.	(786)	0	(786)
		Total	**(786)**	**0**	**(786)**

Draft QIPP 15/16 - New Schemes

NHS
Brent
Clinical Commissioning Group

Project Name	Start Date	Description	Gross Savings	Re-provision	Net Savings
Wave 2 Outpatients : Gynaecology	01/08/15	Re-commission and deliver outcome-based service for specialisms, offering improved care in community settings with better outcomes at a reduced cost.	(1,600)	1,360	(240)
Wave 2 Outpatients : MSK	n/a	Re-commission and deliver outcome-based service for specialisms, offering improved care in community settings with better outcomes at a reduced cost.	0	0	0
Alcohol Admissions	01/04/15	Seek to reduce the number of alcohol admissions and agree appropriate methods of support and care via a potential service.	(102)	25	(77)
MH Repatriation : FYE 15/16	01/04/15	The placement efficiency programme provides advice, support and clinical interventions to MH and LD placement cases to match complex patients to appropriate settings of care.	(864)	0	(864)
GP Prescribing (Efficiencies)	01/04/15	Implement cost effective evidence based prescribing across all practices in Brent, resulting in appropriate use of the prescribing budget whilst working closely with localities and practices to support improvement in prescribing.	(943)	0	(943)
Continuing Healthcare - Review of Cases 15/16	01/04/15	Case reviews for high cost cases, adults and children. Faster reviews, challenging cases to reduce and rationalise. Anticipating will be undertaken in more timely basis.	(300)	0	(300)
DTOC (BCF)	01/04/15	Implement the recommendation of a community beds review to improve processes, particularly around discharge delays.	(169)	0	(169)
MH Reduced Acute Admissions (BCF)	01/04/15	Seek to reduce the number of acute admissions and agree appropriate support services and models of care e.g. support teams.	(296)	0	(296)
Ambulatory Care Pathway (Tariff)	01/04/15	Introduce a further 10 pathways in 15/16 (30 in total) and agree appropriate tariff for these admissions based on ward attender or outpatient procedure tariff.	(141)	0	(141)
Reducing Readmissions (mitigations)	01/04/15	Seek to reduce the number of readmissions into secondary care.	0	0	0
Spinal Pathway Redesign	01/04/15	Design and introduce a pathway in community settings at a reduced cost.	(100)	0	(100)
Phlebotomy (age 2-12)	01/10/15	Seek to agree a reduced tariff from outpatient attendance, e.g. ward attender. Also introducing Paediatric Phlebotomy across networks in Brent	(100)	0	(100)

Draft QIPP 15/16 - New Schemes

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Project Name	Start Date	Description	Gross Savings	Re-provision	Net Savings
Community ENT	01/10/15	Design a community ENT service for dizziness and vertigo, micro-suction for wax, hearing aid battery replacement and glue ear etc.	(75)	0	(75)
Adult Malnutrition	01/04/15	Review of oral nutrition supplement prescribing; implement NICE clinical guidance for nutritional support and seek to reduce malnutrition.	(95)	0	(95)
		Total	**(4,785)**	**1,385**	**(3,400)**

Glossary of Terms

NHS
Brent
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Acronym	Full Description
BCF	Better Care Fund
BHH	Brent, Harrow and Hillingdon CCGs
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CLA	Children Looked After
EOLC	End of Life Care
HENWL	Health Education North West London
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICO	Integrated Care Organisation
ICP	Integrated Care Programme
IFR	Individual Funding Request
IM&T	Information Management and Technology
LA	Local Authority

Glossary of Terms *(continued)*

NHS
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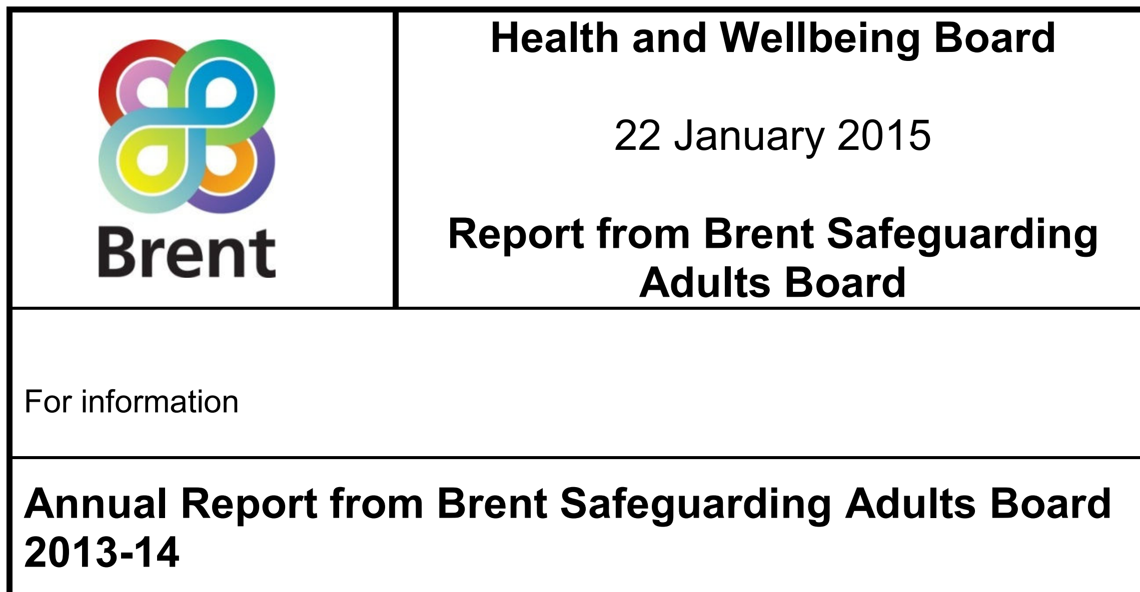
Acronym	Full Description
LBB	London Borough of Brent
LTC	Long Term Conditions
MDT	Multi-Disciplinary Team
NHSE	NHS England
NWL	North West London
NWLHT	North West London Hospitals Trust
QIPP	Quality, Innovation, Productivity and Prevention
PPwT	Planned procedures with a threshold
SaHF	Shaping a Healthier Future
STARRS	Storm Term Assessment, Rehabilitation and Re-ablement Service
WSIC	Whole Systems Integrated Care



Health and Wellbeing Board

22 January 2015

Report from Brent Safeguarding Adults Board

For information

Annual Report from Brent Safeguarding Adults Board 2013-14

1.0 Summary

1.1. The Director Adult Social Care and Independent Chair of the Adults Safeguarding Board will present the Board's Annual Report for 2013-14. This report reviews the work carried out by the partnership in 2013-14, provides analysis of the safeguarding statistics collected for that period and outlines priorities for the Board in 2014-15.

2.0. Recommendations

2.1. The Health and Wellbeing Board is asked to:

2.1.1. Note the large increase in alerts (from 748 in 2012-13 to 1208 in 2013-14) and referrals (from 314 in 2013-14 to 370 in 2013-14, up by 18%) received and investigated by the Safeguarding team during the period.

2.1.2. Also note and comment on the priorities for SAB identified within the report. Specifically the SAB intends to re-establish sub groups so as to widen membership and secure full participation from statutory agencies to drive continued improvement in relation to safeguarding across the sector.

2.1.3. The SAB intends to be in a position to publish a strategic plan in the first quarter of 2015-16 setting out how it will work to further develop multi-agency safeguarding work for adults in Brent.

3.0. Detail

3.1. Please see attached the full report which details what action each partner took to address the priorities of the Board and the impact this had for local residents.

3.2. The Safeguarding Adults Board identified six priorities for 2013-14 the first two of which considered types of abuse. The Board aimed to reduce

financial abuse (which decreased over the period by 13%) and also sought to reduce avoidable pressure ulcer incidents. Unfortunately this proved difficult to measure due to inconsistencies regarding definitions and reporting requirements. It is noted however that, neglect or acts of omission continue to be the leading category of types of abuse and a high proportion of these are from incidences occurring in services arranged or commissioned by Adult Social Care. This will remain therefore a key area for the SAB to continue to monitor in 2014-15, but it should also be noted that awareness raising and training will have had a significant impact on the cases reported and investigated by the Safeguarding Team.

3.3. The remain priorities were to improve processes and multi-agency working to effect a culture change aimed at improving quality in commissioned care and support services and making Brent safer. The report goes into each of these in detail, setting out what the priority means and highlighting case studies to demonstrate how interventions are effective.

3.4. The Board has focused this year on improving processes to ensure greater accountability to the wider community, through our safeguarding conference in February 2014, during which the Board set the priorities for the year. The Board has also worked to implement ‘Making Safeguarding personal’ achieving recognition from the Local Government Association that the work it has done to date, specifically with user groups to secure feedback, puts us at a ‘silver medal’ status. This programme is designed to ensure that the processes employed by the partner agencies reflect the outcomes individuals wish to achieve and minimise the risk that safeguarding becomes process driven.

3.5. The Board has also overseen a comprehensive training programme and a Brent wide campaign to raise awareness of abuse and what actions to take to report this. This campaign received national attention and has resulted in a rise in alerts, demonstrating its effectiveness. The main impact of this can be measured by the large increase in alerts sent into the team for investigation. This demonstrates that the message, that ‘safeguarding is everyone’s responsibility’ has reached a wider audience than previously. However the conversion rate from alert to referral (i.e. when a matter that has been referred is assessed to within the Safeguarding team’s remit for investigation) remains a key performance indicator alongside their feedback rate to those who submit alerts so that awareness campaigns regarding safeguarding work can be targeted more effectively.

3.6. However, there are still areas where we need to do more and the report details in the final section the priorities for 2014-15, specifically how it will take forward work on pressure care, further develop transparency and accountability to local residents and look to new areas of need such as safer recruitment.

4.0. Financial Implications

4.1. Brent Council has already committed to the continued funding of the SABs work. Discussions continue within the Task and Finish Care Act group regarding wider contributions from relevant partners.

5.0. Legal Implications

5.1. Presently there are no statutory requirements to have a Safeguarding Adults Board. From April 2015, following implementation of the Care Act 2014, the Local Authority will be required to establish a SAB, publish a strategic plan and an annual report and undertake Safeguarding Adults Reviews where an adult at risk has died and it appears there are lessons that should be learnt about how agencies work to protect vulnerable adults. The Brent Safeguarding Adults Board currently undertakes all of these functions, so there is a strong base on which to revise the work to ensure it is Care Act complaint from April 2015.

5.2. In addition, both the Police and CCG must contribute to the work of the Board, but it is agreed that to be effective the SAB in Brent will draw from a much wider membership. Each partner agency represented on the Board will be required to appoint a Designated Safeguarding Adults Manager and set out how it will contribute towards the work of the Board.

5.3. It is widely recognised that the Board fulfils an important function for all agencies involved. Specifically it is able to demonstrate Brent Council and key partner agencies are fulfilling statutory obligations to meet the needs of adults at risk in their area. It also ensures that all agencies responsible for providing protection and support to adults at risk are working effectively together to drive continued improvement.

6.0. Diversity Implications

6.1. None

7.0. Staffing/Accommodation Implications (if appropriate)

7.1. None

8.0. Background papers

8.1. The Brent Safeguarding Adults Board Annual Report 2013-14
8.2. The Care Act Guidance: Chapter 14

Fiona Bateman
Independent Chair, Brent Safeguarding Adults Board

Phil Porter
Strategic Director, Adults
phil.porter@brent.gov.uk

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Welcome to our annual report. I was appointed as Independent Chair in September 2014 and chaired my first Brent Safeguarding Adults Board meeting in October. My role as an Independent Chair is to support continual improvement in the work of all agencies responsible for providing protection and support to 'adults at risk' in Brent.

I am grateful for the work already undertaken by Brent Safeguarding Adult Board's previous Chair, Phil Porter, who has guided the board to date. The board achievements over the past year have attracted significant national and local press coverage. Some highlights include Mencap's Disability Hate Crime Awareness Project and Brent Council's Abuse. See it. Stop it! campaign both featured in this report.

The board works hard at continually identifying areas for improvement and evaluating what we do well. This year we are changing how we do things so we can keep you up to date with where we are at throughout the year. We will update on our priorities throughout the year. I look forward to an exciting year ahead for the board and hope you find this Annual Report interesting.

Fiona Bateman

Independent Chair

Brent Safeguarding Adults Board

TEXT BOX: The board works hard at continually identifying areas for improvement and evaluating what we do well.

What is Brent Safeguarding Adults Board?

Brent Safeguarding Adults Board (BSAB) is a multiagency group working together. The board is made up of people who have an active interest in the well being of vulnerable adults. Each agency is committed to being proactive part in changing things for the better in Brent for vulnerable adults. The board meets six times a year.

Current Independent Chair: Fiona Bateman

Brent Safeguarding Adults Board

Brent Council:

Adult Social Care,

Children and Families Department,

Housing Department,

Legal services (advisory)

Community Safety Brent

Clinical Commissioning Group

Metropolitan Police Brent

Mencap

The Probation Service

North West London Hospital Trust

London Fire brigade

London Ambulance Service

Ealing and Harrow Hospital Trust

Care Quality Commission

Central and North West London Foundation

Trust

Healthwatch

Brent Local Safeguarding Children Board (LSCB)

About the board

The focus for the board in 2013-14 was to ensure effective and collaborative leadership in safeguarding activity across the statutory, voluntary and private sectors. At the BSAB Safeguarding Conference in February 2014 the board consulted widely on the priority areas on which to focus and identified a number of key priorities. Details of the work undertaken to address those are set out later in this report. In addition the board has identified its key priorities for the remainder of this year at the end of this report.

P. 4. Together we aim to raise awareness and promote action in the prevention of abuse of vulnerable adults.

p. 5. Making Safeguarding Personal

The term 'safeguarding adults' covers everything that assists an adult at risk of abuse or neglect to live a life that is free from such harm and which enables them to retain independence, well-being, dignity and choice. It is about listening to people who are at risk about how they would like agencies to support them to live free from abuse and neglect as well as promoting good practice for responding to concerns on a multi agency basis.

Brent Safeguarding Adult's Board is built on the foundation of Making Safeguarding Personal, approaching our work with vulnerable adults from their perspective. Putting the person who is being abused or at risk of abuse at the centre of everything we do.

Being person-centred means that we listen to vulnerable adults carefully, focusing on supporting them to decide what is best for them and helping them to achieve

their goals. Responding to the needs of individuals enables us to continue to reflect and review what we do and how we do it.

The Board is a partnership of senior officers from local statutory and voluntary agencies. It coordinates strategic decision making across the agencies, provides advice regarding safeguarding responsibilities and develops quality assurance measures to ensure all partner agencies' practices are effective at identifying and stopping abuse for those at risk. The Board also leads on raising awareness and promoting action in the prevention of abuse of vulnerable adults.

Members of the Board remain responsible for their operational core responsibilities but work collectively to implement agreed improved safeguarding practice to promote the wellbeing of adults in Brent.

Where a vulnerable adult is being abused Brent Council's Safeguarding Adults Team will lead an investigation and intervene, drawing on support from BSAB member agencies, to stop the abuse.

TEXT BOX: Where a vulnerable adult is being abused we will investigate and intervene to stop the abuse.

P.6. What does the Safeguarding Adults Team look like?

In 2011 Brent Council reconfigured Adult Social Services into teams which follow a customer's journey. As part of the restructure our Safeguarding Adults Team was created, allowing other teams to focus on their core business while ensuring there was a clear focus in the department on Safeguarding Adults.

The Safeguarding Adults Team provides a central point of contact for all safeguarding concerns relating to adults in Brent. The team reviews every alert made to it and investigates cases whenever it believes an adult who may need care and support is at risk of or may be experiencing abuse or neglect.

The views and wishes of the adult are central to the safeguarding process and the Safeguarding Team work in partnership with the alleged victims, family, carers, professionals and relevant others to optimise the safety and wellbeing of adults who are at risk of harm.

The team works in accordance with Protecting Adults at Risk: London multi agency policy and procedures to safeguard adults from abuse.

The creation of the Safeguarding Adults team does not detract from the underlying ethos in the department, that 'safeguarding is everyone's responsibility', but it does ensure there is a clear lead on safeguarding investigations and a coordinated response between all relevant partner agencies.

The team comprises of the following staff –

A Safeguarding Adults Team Manager who has overall responsibility for the operational running of the team and the development of safeguarding adult processes within Brent Council.

A Deprivation of Liberty Safeguards Safeguarding Adults Manager who is responsible for ensuring all referrals sent to the team related to Deprivation of Liberty Orders are progressed in accordance with legislation and policy and the safety and wellbeing of the adult is optimised. They also lead on the development of Deprivation of Liberty Safeguards processes in Brent.

4x Safeguarding Adults Managers – They are responsible for screening all the safeguarding concerns that are sent to the team and deciding what action needs to be taken. They lead on the safeguarding investigations, ensuring protection plans are in place to keep people safe and the appropriate processes are followed in accordance with legislation and policy. They also lead on developing the safeguarding process within Brent Council and raising awareness of the process with relevant agencies throughout Brent.

3x Safeguarding Investigators – They visit victims, alleged perpetrators and relevant others to obtain their views, optimise their safety and gather information related to the investigation. They carry out urgent and planned visits dependent on the level of risk. They present their investigation findings to the Safeguarding Adults Manager or a multi-agency meeting where an outcome and action plan is agreed.

4x Safeguarding Liaison Officers – They provide support to the Safeguarding Adults Manager, gathering information and carrying out tasks to make sure any new safeguarding alerts are progressed appropriately. They provide support with administrative tasks in the team. They also visit alleged victims and perpetrators of harm to obtain their views, optimise their safety and gather information related to the investigation.

P. 7. Safeguarding adults – the priorities

The Safeguarding Adults Board sets out clear priorities to address each year. The priorities are identified from data analysis of the work undertaken by the Safeguarding Adults Team. For a detailed report and information on the comparative data for the UK please go to: www.brent.gov.uk/xxxxxxxxxxxxxxxxx

The priorities for 2014 were:

- **Reducing financial abuse and ensuring a more effective multiagency response**
- **Reducing avoidable pressure ulcer incidents**
- **Improving processes and procedures to embed high quality standards**
- **Changing practice and policy: making Brent safer**
- **Improving multi-agency working, including board effectiveness**
- **Changing culture – commissioning for quality What is Financial Abuse?**

Financial abuse is where a vulnerable adult is the victim of theft, fraud or is being pressured to give money to other people. The Safeguarding Adults Team work closely with Board member agencies, including the Police and the Office of the Public Guardian to investigate allegations of financial abuse and seek redress. Betty's case provides an example of financial abuse and how agencies working together can support and protect vulnerable adults.

Betty

A case illustrating stopping financial abuse – Voiceability Advocacy

Raising alerts

Betty was referred to the safeguarding team for alleged financial abuse. Betty was not sure where her money was going. Carers had some concerns and raised a safeguarding alert. The investigation identified Betty's friend Ted as the alleged person to have caused harm. As a single person without any relatives in the community Betty was referred to the advocacy service, Voiceability

P.8 Jenny the advocate Jenny, an advocate from Voiceability, was able to work together with Betty throughout the investigation. As someone who previously had been assessed as unable to manage finances it was important to establish how Betty managed now.

Action

Betty had previously had a stroke and her ability to communicate had been affected. Noticing the communication difficulty, Jenny referred Betty to speech and language therapists for an assessment. With the help of speech and language therapy it was identified that Betty did have the capacity to manage her finances on a day-to-day basis. The issue was Betty's ability to make herself understood by others and not her capacity to manage her finances.

Results

The Safeguarding Adults Team was able to identify her friend Ted as the perpetrator and remove the risk of further abuse.

Jenny made sure that Betty's voice was heard and her wishes taken into consideration. Jenny was also able to pick up on eyesight problems and arrange a visit to the opticians. The focus always remained on Betty's wishes whilst ensuring legal information was obtained in case of prosecution. Working together enabled Betty to have her needs met, stop the abuse and more forward.

Reducing avoidable pressure ulcer incidents

Many people who are frail and have restricted mobility are at risk of developing sores on the points of their body which receive the most pressure. These are known as pressure sores and are sometimes called bed sores or ulcers. Pressure sores start with skin discoloration but, if left untreated, they can become very deep and infected; in the worst cases they can be life threatening. With management and

care, pressure sores can be avoided in most cases. Sometimes pressure ulcers are an indicator of poor care or neglect and a safeguarding alert needs to be raised. Monitoring the number of pressure ulcers enables the Safeguarding Adults Board to address any concerns raised in the standard of care provided in care homes and hospitals.

The Safeguarding Adults Board has put in place a preventative strategy to reduce avoidable pressure ulcers. Staff across care homes and hospitals receive training on how to identify risk and prevent pressure ulcers.

The training has resulted in an increase in referrals for 2013/2014 to 15 cases, up from 13 reported in 2012/2013 (increased by 15%). This has led to the setting up of a multi-agency group looking to work directly with providers to improve practice so as to improve the quality of life for all patients in those settings. More details on outcomes are set out later in this report.

Improving Processes and Procedures

As part of the making safeguarding personal programme the Safeguarding Adults Board places the vulnerable adult at the heart of investigations. The Board seeks to ensure that processes continue to work effectively to achieve the Board's key objectives. For example, the Board must make sure communication between agencies is open and that information is shared with the consent of the person at risk or when it is necessary to protect the vulnerable adult. The Board's focus is on what person wants to achieve as an outcome at the end of the investigation, so it is important to confirm that the processes supports the person, rather than the adult's needs becoming overridden due to process. In 2013-14 the Board wanted to ensure that the process for safeguarding was responsive to the needs of individuals and that investigations were completed in a timely manner. Our data shows that during this periods all alerts were screened within 24 hours of receiving them, with the majority of referrals requiring full investigation being concluded within 25 day time-frame.

Page 9

Raising Alerts and Working Together

The Board is committed to working with its partners in the voluntary sector. Brent Mencap is represented on the Board and works closely with partner agencies, including by providing useful challenge, to ensure that vulnerable adults are supported to be safe in the community.

There was a safeguarding incident involving a vulnerable adult called 'Adam', which Mencap alerted the safeguarding adults team to. The perpetrator was also a vulnerable adult. During the course of the investigation it was discovered that reporting systems did not allow allegations to be recorded against an alleged perpetrator case notes. The issue raised led to the Mencap and the safeguarding adults team to hold regular tracking meetings with the police lead so that the risk to possible victims and alleged perpetrator's could be considered and effective protection put in place. Additional case audits were implemented to monitor how this worked in practice and this has now led to a positive change in practice.

P. 10. Improving multi-agency working, including board effectiveness

The Board carries out multi-agency case audits and uses this information alongside the statistical data from Adult Social Care Outcomes Framework (ASCOF)* and the Safeguarding Adults Return, as well as other audit tools, to ensure that work it has undertaken is effective and increases the flow of communication across services to tackle abuse.

* http://ascof.hscic.gov.uk

Audits on ten percent of safeguarding cases

As part of improving multi-agency working the Board undertook Case Audits to ensure communication and processes between agencies are optimised. Aiming to streamline processes to reduce disruption to the vulnerable adults who require safeguarding interventions.

Understanding the needs of staff and our customers is an on-going process. By checking on ten percent of all safeguarding alerts raised we are continually building a picture of the needs of vulnerable adults in Brent. This enables us to ensure that communication pathways are working well and change anything that seems to be an issue. We can also begin to see if there are any 'hotspots' in the borough, highlighting areas of potential abuse or risk that we need to target.

Training

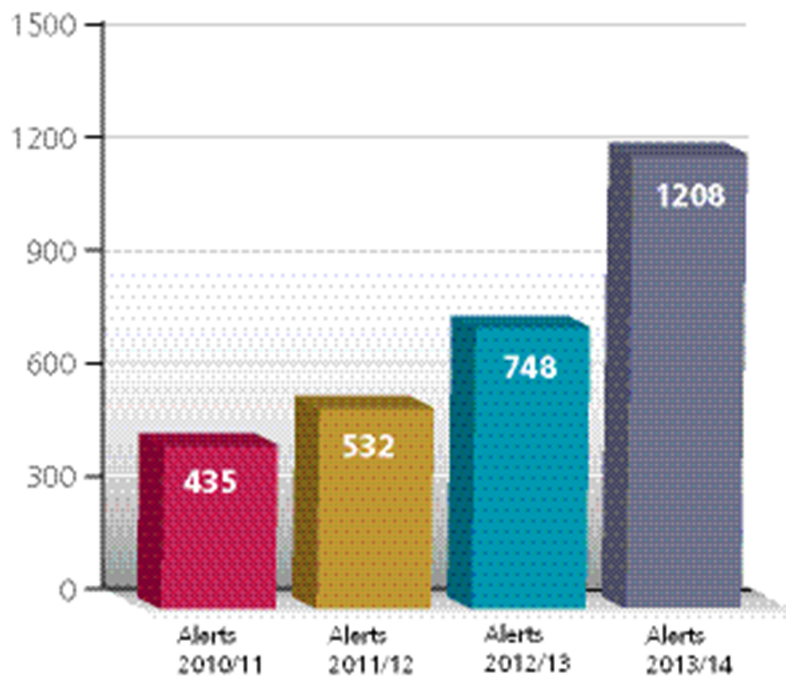
Additionally through training and awareness raising we are able to promote best practice, improve multi-agency working and ensure vulnerable people are at the heart of what we do.

Throughout 2013 and 2014 we have we have been working hard to increase awareness within staff and communities of how to identify abuse or risk of abuse. Our multi-agency training programme has delivered 92 courses to a total of 1,001 staff across health, social care, housing and recovery teams attending the courses.

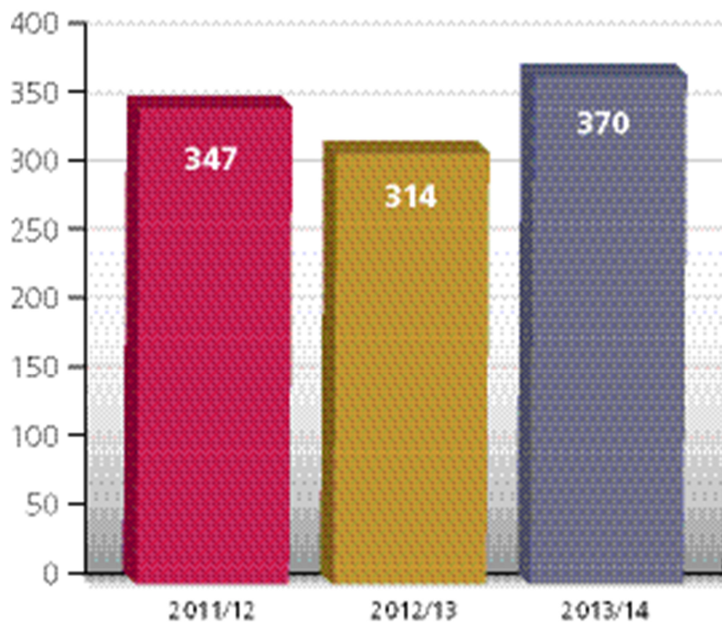
The London North West Healthcare NHS Trust reports that safeguarding adults is an integral part of staff induction and regular mandatory updates. There is increased safeguarding level 3 training, with compliance 88 per cent. Further dementia training focuses on the provision of patient focused care to improve both patient outcomes and experience. PreVent trainers have been introduced supporting a rolling educational programme across the trust. Key staff have been trained such as those working in Accident and Emergency (A&E), Security, Chaplains and the Site Management team. Safeguarding training now fully incorporates Domestic Violence and Learning Disabilities.

This appears to be having a positive impact on the numbers of safeguarding alerts raised. This is good news for vulnerable adults in Brent, as we continue to raise awareness and tackle institutional abuse. The increase in alerts is a positive result demonstrating that people are now recognising when abuse is happening and they are confident to raise an alert.

We have seen an increase in alerts:



and an increase in referrals



Just under half (172 or 46 percent) of the 370 referrals are in respect of people in the service group of Physical Disability, Frailty and Sensory Impairment. The proportion relating to Learning Disability, 82 (22 percent) and Mental Health, 86 (23 percent) are very similar to national figures. The lowest representation is for those defined as Other Vulnerable People, 29 (8 per cent) and Substance Misuse, one.

A quarter of cases for 2013-2014 were inconclusive. We have set targets for 2014-2015 to lower this to ten percent.

Just over a third of concluded referrals were substantiated. Brent set itself a target in the Brent Safeguarding Adults Board Annual Report for 2012/13 to reduce the number of cases defined as Inconclusive for 2013/14. The percentage defined as Inconclusive has risen from 23% for 2012/13 to 25% for 2013/14. As such this has remained a key performance indication for the Safeguarding Adults Board to monitor each quarter to ensure improvements. The Safeguarding Adults Team also received support, including access to legal advice, investigation technique skills training and were restructured during the year in order that they would have a dedicated investigator resources over and above the Safeguarding Adults Manager role to improve outcomes of investigations.

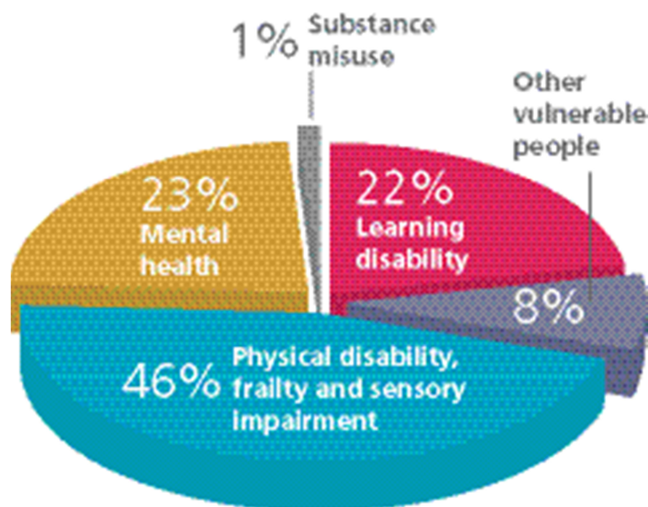
A full programme of continuing training and development is scheduled for 2014-2015:

www.brent.gov.uk/xxxxxxxxxxxxxxxxxx .

Changing culture – commissioning for quality

Commissioning across all services requires contractual arrangements to include level 2/3 safeguarding training for all staff. Where there are any concerns with commissioned services, immediate plans are put in place to closely work with addressing the issues and minimising risk. These plans are then monitored and reviewed by the multi-agency subgroup comprising Clinical Commissioning Group (CCG), Brent Council's safeguarding team, Brent council's Contract Monitoring and Commissioning Team and the Care Quality Commission (CQC). Quarterly reports are presented to the board to ensure operational standards are maintained.

Types of referral:



P. 12 Spotlight on projects and campaigns

Brent Mencap Hate Crime Awareness Project 2013-4

Brent Mencap's Hate Crime Awareness Project, funded by the Trust for London, started in April 2013. Key tasks were prepare, advertise and run training sessions and workshops on hate crime against people with a learning disability. The key audiences for these sessions are people with learning disabilities, their carers and support workers and the police.

What Mencap did

All except one of the training sessions have been run jointly with at least one assistant trainer with learning disabilities. The work has included training and preparing the assistant trainers.

Four training sessions have been delivered to police in Brent, to 64 police officers. A fifth session was planned, but postponed on the day, because of a serious crime requiring intense policing. The sessions to date have been delivered to police in Brent (although the officers come from a variety of locations). Training sessions have been arranged to take place in Ealing during the forthcoming year.

Five workshops have been delivered to people with a learning disability, reaching 43 people, plus eight staff members and attended by the four police officers who contributed to the workshops.

Two workshops have been delivered to support workers, reaching 12 members of staff.

A session was delivered to a special school assembly for anti-bullying week, reaching approximately 90 young PWLD and 15 staff members.

Staff from the hate crime project and other Mencap staff have ensured that the message that hate crime should always be reported is embedded in other Mencap activities, including visits by the transport safety police, community police and officers from the fire services.

P.14 Brent Council's Abuse. See It. Stop It! publicity campaign

The success of Brent Council's Abuse. See it. Stop it! campaign raised awareness of adult abuse and how to raise alerts across the borough. Featured in The Guardian, local press, on billboards and leaflets in public places, the campaign ran throughout 2013-2014, highlighting that safeguarding is everyone's responsibility.

Hoarding and self-neglect

This year, the Board's new initiatives targeted people who self-neglect and/or hoard. Hoarding can cause increased risk of fire in the home. Along with the fire service we have been providing information and home visits to people who hoard.

Forced marriage

The council's legal team has been working together with the police to tackle the issue of forced marriage, improving connections to work collaboratively to prevent and reduce the incidences.

The Patient Passport

A Patient Passport provides immediate and important information for doctors, nurses and administrative staff in an easy–to-read form, promoting a positive experience for people with learning disabilities going into hospital.

Ealing and NWLHT NHS Trust has trialed the Patient Passport and successfully rolled it out during 2013/14. The Learning Disabilities Nurse fully supports staff and patients in the ward areas.

NHS England/Association of Directors of Adult Social Services audit

All health agencies represented on the Board and Brent Council have completed the statutory audit tool to test how embedded the safeguarding culture is within their organisations.

When looked at as whole, this is evidence that safeguarding responsibilities are well understood across those agencies. There remains work to be done to further embed good practice, but the agencies and Brent Safeguarding Adults Board now have clarity on how to better support staff to continually improve safeguarding outcomes. (link to more detailed information here).

BSAB/Health and Well Being Board

There is now an agreed protocol between the Safeguarding Adults Board and the Health and Well Being Board. (link to protocol)

Where we are currently represented

The Safeguarding Adults Board is represented at the following meetings/organisations:

• Healthwatch Brent

• The Drug and Alcohol Treatment Partnership

Board

• The Substance Misuse Reference Group

• Carers Forums

• Working Families Group (Brent)

• The Safeguarding Unborn Children Group

• Multi-Agency Risk Assessment Conference

(MARAC)

• Multi-Agency Public Protection Arrangements

(MAPPA)

• Self-neglect and Hoarding Group

• LSCB

• Community Safety Partnership

Deprivation of Liberty Safeguards and The Mental Capacity Act

The Mental Capacity Act 2005 provides a framework for making decisions on behalf of people who don't have the mental capacity to do so for themselves. Deprivation of Liberty Safeguards (DoLS) procedures are designed to protect vulnerable adults who can't make decisions about treatment or care, who need to be cared for in a restrictive way. For example, some people who have dementia, a mental health problem (but are not detained under the Mental Health Act 1983) or a severe learning disability and need to be supervised in their daily activities so as to keep them safe from harm.

The aim of the safeguards are to:

- make sure people can be given the care they need in the least restrictive way. This means following good practice in care homes and hospitals
- prevent decisions being made to suit the home or hospital rather than the needs of the person receiving care
- provide safeguards for people in receipt of restrictive care to ensure regular reviews of their care
- provide the rights to challenge unlawful detention against the person's will.

Best Interest Assessors

Best Interest Assessors (BIAs) assess people to find out whether a deprivation of liberty is in the best interests of the person. If the authorisation is to be granted, the BIA ensures the least restrictive option is in place. They act independently from those responsible for deciding and funding the care required for a vulnerable adult.

Brent DoLS Authorisations 2013-2014

In 2013-14 a total of 18 applications were submitted for authorisation of a deprivation of liberty under these Safeguards, this is a slight increase from the previous years. This resulted in 19 full Best Interest Assessors (BIAs) assessments being completed, as one required two assessments in the year when their deprivation period was extended. The majority of those requiring care that amounted to a deprivation of liberty received this care in residential placements and, in line with national comparators for that period, most deprivation of liberty authorisations were granted to provide care to older people. As the second table demonstrates, deprivations of liberty were authorised in only 12 of the 18 applications and, for a further 4 adults deprivations were in place for under one month. In only two cases where the circumstances such that deprivations were authorised for over one year.

The table below show the number of referrals by provider type and customer group

	Older People	Learning Disabilities	Mental Health	Physical Disabilities
Hospital	4	1		1
Care / nursing home	8	4		

The table below gives us information on how long people are deprived of their liberty in Brent

Not granted	Less than 2 weeks	2 – 4 weeks	4 weeks – 2 month	2 – 3 months	3-6 months	6- 12 months	Over a year
6	2	2	2	4			2

A case decided in March 2014 by the Supreme Court explained more clearly situations where deprivation of liberty will occur. This now requires Local Authorities or the Courts to put in place legal authority if a person requiring care is, because they lack mental capacity, unable to agree to the care and living arrangements and where the care they require amounts to constant supervision and/or they would not be free to leave those arrangements.

The DOLS procedure only applies where it is necessary to put in place care that would limit personal freedom and it is proportionate to restrict their liberty in order to protect a person from harm. The change in case law will mean that many more people will benefit from the additional assessments undertaken and, where applicable, advocacy support available to ensure that the care they receive is in line with their best interests. In addition, now, if an individual is likely to be subject to restrictions for over a year statutory bodies are under strict legal requirements to review those arrangements regularly and, if necessary, refer cases to the Court of Protection. This ensures that their care is arranged in a way that promotes their best interests.

The change in the law has had a national impact and put pressure on qualified BIAs. In response to this increased pressure the council is training two further BIAs. Other key SAB partners, such as Brent Clinical Commissioning Group and Central and North West London (CNWL) have given a commitment to train a BIA.

The Board continues to play a key role in the strategic oversight of both the management of the DOL Safeguards but also in highlighting the changes in practice required as a result of the changing case law.

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What's next? 2014-15 and beyond

In April 2015 the Care Act will, for the first time, place the responsibility for safeguarding adults at risk on a statutory footing and require Brent Council (working with relevant partners including the Police and CCG) to establish a Safeguarding Adults Board. The new responsibilities will need to be interpreted within the pre-existing wider legal and cultural framework of obligations owed to vulnerable individuals to ensure that our response to their needs as a board is proportionate and effective. They must also reflect the local issues identified within the detailed audits undertaken during the course of this year. To this end the Brent Safeguarding Adults Board has identified a number of priorities:

1. A Care Act 'Task and Finish' group will review the governance and reporting arrangements of the board to ensure that it is accountable to all the relevant agencies and closely linked to other strategic partnerships to minimise duplication.

The group will also review the membership, work plans and structure of the BSAB sub groups so that the work that these groups undertake is transparent and feeds directly to the work of the main board.

2. The BSAB hopes to encourage genuine participation from across the sector, but specifically from service users and carers in the work of the sub groups so that the voice of these groups better informs decisions of the board.

3. The Board will look to develop a system for commissioning and contracting for safeguarding and Mental Capacity Act training that is monitored for quality assurance across all agencies using the Training Competency Framework already agreed by the board to promote and ensure a shared understanding between all agencies of the standard, monitoring and operational expectations for training. Again this should increase opportunities of access for BSAB member agencies and, more widely, to GPs, the voluntary and private sector providers for good quality, consistent training which should improve practice and reduce risk of abuse and neglect.

4. The Board has adopted an agreed audit tool and will ensure it is completed by the member agencies to demonstrate that safeguarding is recognised as a core function

of their work. The BSAB will devise and continue to review an action plan arising from this audit to ensure that all relevant partners have policies in place, which are widely understood and applied by practitioners, to address known safeguarding risks. It will also look to develop an agreed method for collecting quantitative data to collate key performance indicators from all relevant partners so as to better understand BSAB member agencies' safeguarding practice in the area.

5. Safer recruitment: The BSAB hopes to work with local and national agencies to review practices, including the advice and information that is available to service users and their carers. This is to ensure that they are able to buy care and support services with confidence and so that employers understand their duties to check a person's suitability to work with adults at risk or report concerns regarding a person's suitability to work with vulnerable people where these arise.

6. Continue to focus on pressure sores and tissue viability work, including monitoring the effectiveness of the Tissue Viability Nurse (TVN) post in reducing avoidable pressure sores in the community and raising awareness of good preventative practice in this area of healthcare provision.

With special thanks to LIFT for input and consultation on improving accessibility to our annual report.

www.liftpeople.org.uk

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