
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.

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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- The EDEN strategy is out-of-date and insufficiently detailed.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 engagement¹
- 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 law² 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

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 England³ 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

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.

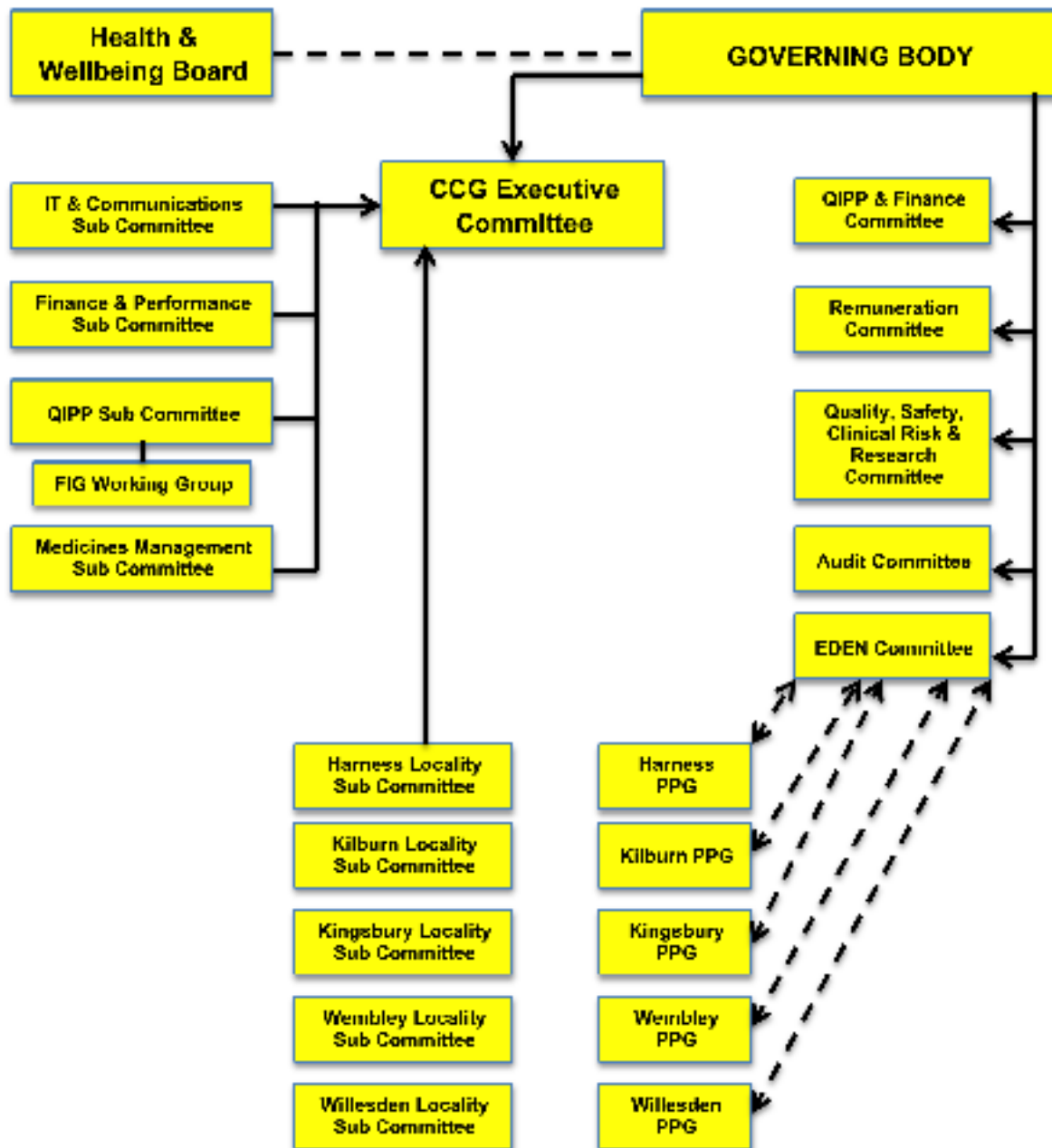
Review team recommendation: The CCG should allocate a defined budget to support its engagement activities, including insight, communications, outreach and governance arrangements. It should make substantive staff appointments to lead these activities.

6. GOVERNANCE STRUCTURE AND CONSTITUTION

ORGANISATIONAL CHANGES

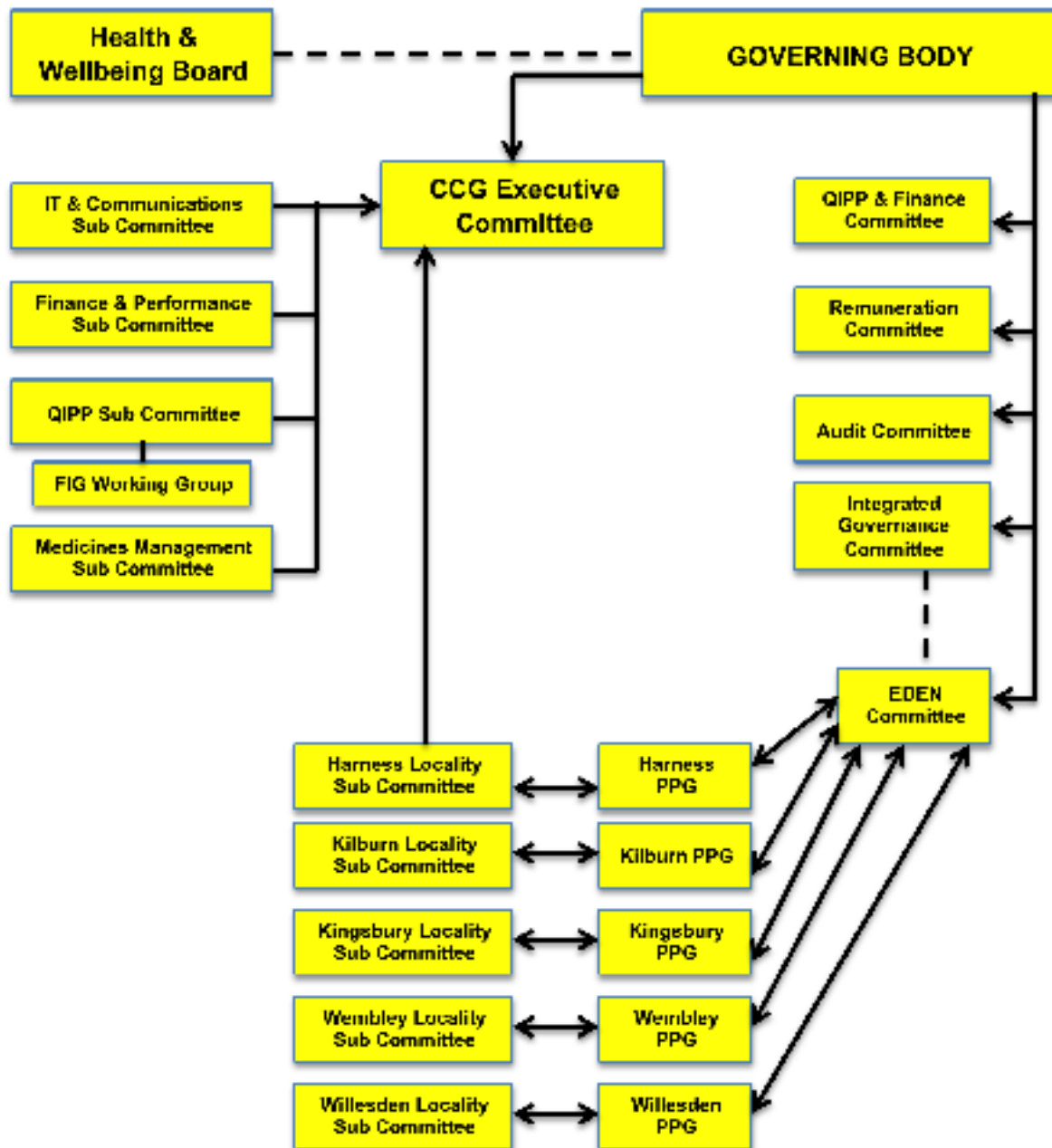
All of the above, when added to the Governing Body's concerns described earlier about the EDEN Committee's lack of effectiveness in giving assurance, creates a compelling case for, at least some change, and probably for radical change in Brent CCG's patient and public engagement structures and governance 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



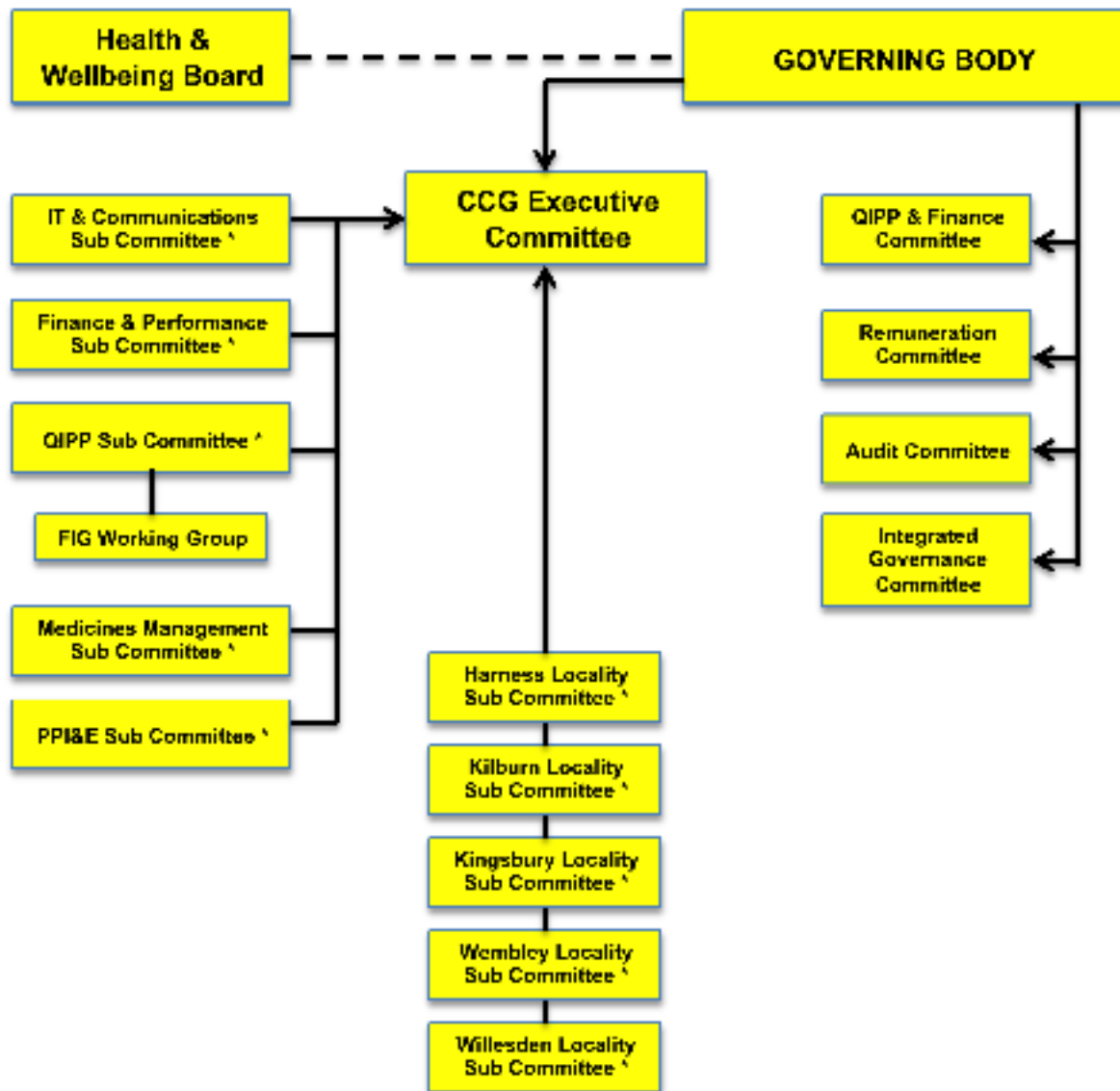
The chart above describes our understanding of the current position. It differs from the organisational chart in the CCG's current Constitution because we were told that the original plans had evolved somewhat since that was published. For example, the original version showed dotted lines between the 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

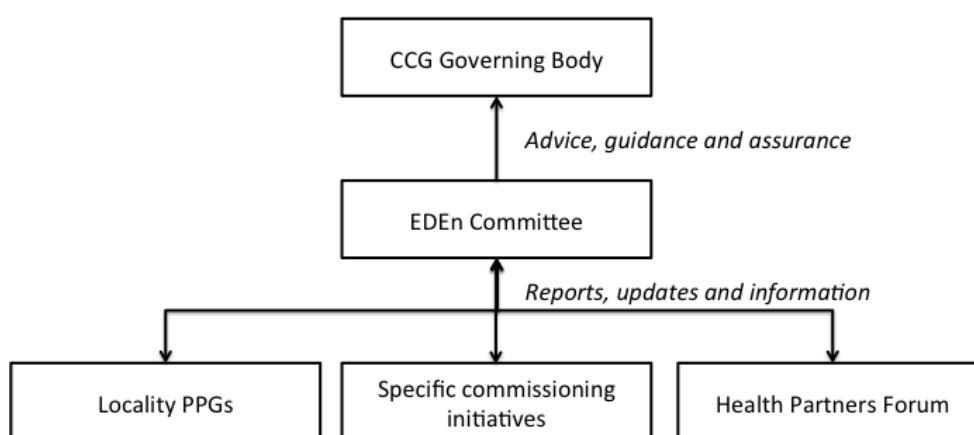


Figure 1: Public and patient engagement structures within the EDeN Strategy

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 an 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

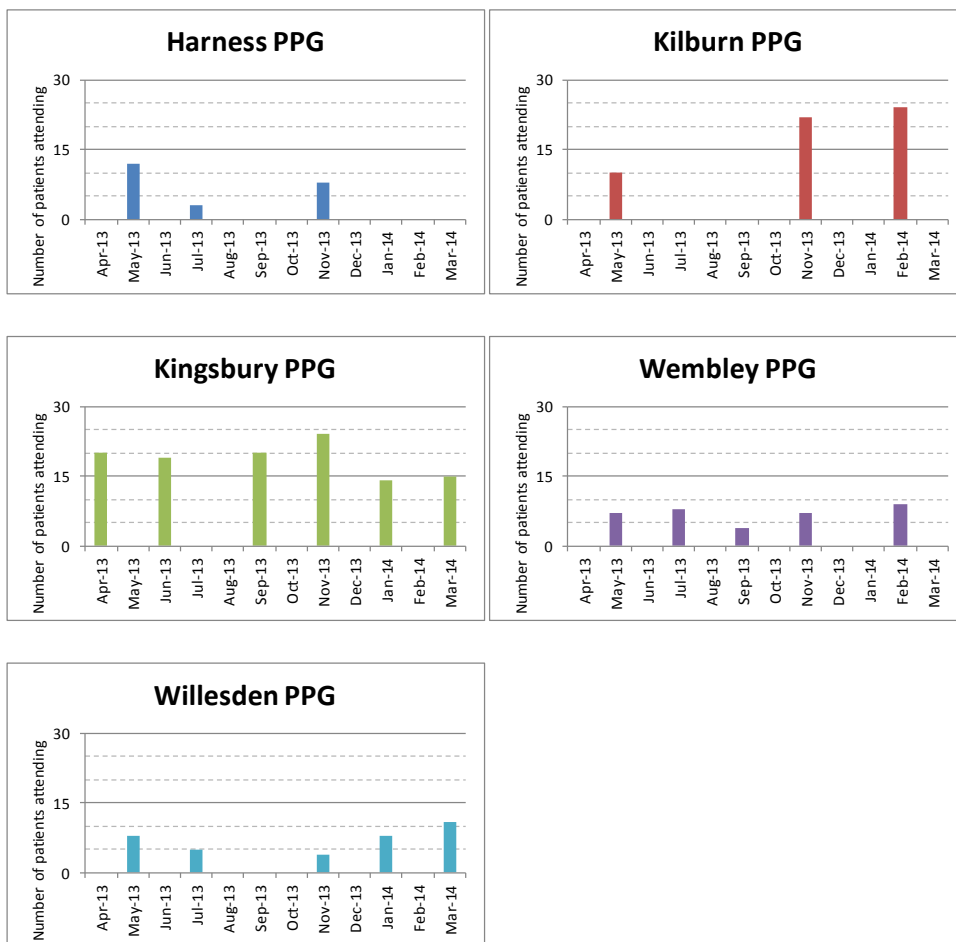
- **The Governing Body are asked to retain the current EDEN Committee until completion of the review, and new management arrangements are put in place subject to the principles for interim monitoring arrangements being put in place and adhered to.**

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

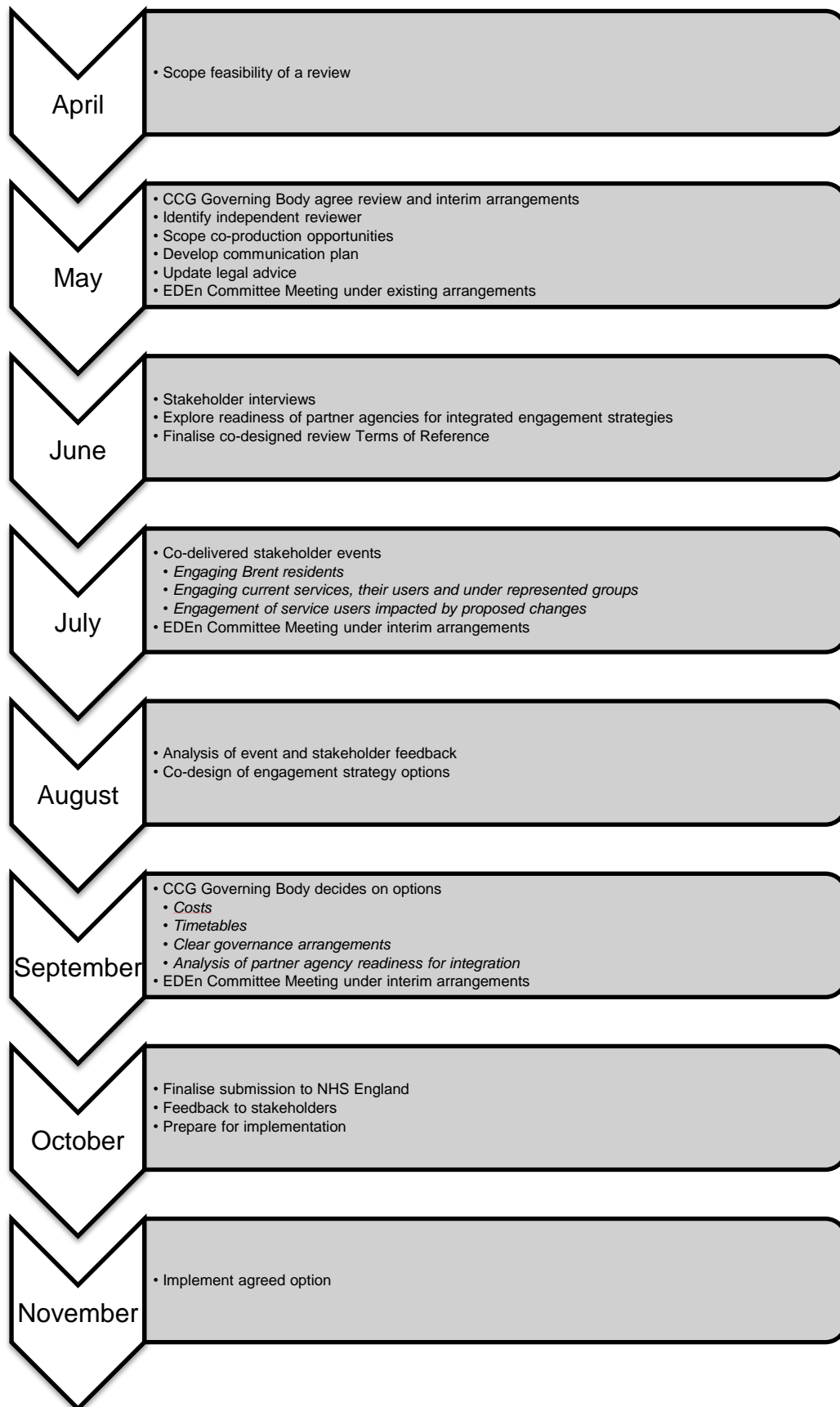
a) Locality PPG frequency and attendance levels 2013/14



b) Locality PPG service discussions 2013/14

	Locality PPG Service discussion on agenda 2013/14					Total of all PPGs
	HARNESS	KILBURN	KINGSBURY	WILLESDEN	WEMBLEY	
Services on agenda for discussion 2013/14	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		
<p>What works well</p> <ul style="list-style-type: none"> Effectiveness of the committee Good strategy Strong links with Locality PPGs through the chairs Commitment and effort by patient representatives 	<p>What works less well</p> <ul style="list-style-type: none"> 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 	<p>What needs to change</p> <ul style="list-style-type: none"> 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		
<p>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.</p>		
Locality PPGs		
<p>What works well</p> <ul style="list-style-type: none"> CCG support to LPPGs – induction, training, information sharing LPPGs as legitimate representatives of patients Role and influence of LPPGs Role/influence of LPPG Chairs 	<p>What works less well</p> <ul style="list-style-type: none"> 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 	<p>What needs to change</p> <ul style="list-style-type: none"> 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		
<p>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.</p>		
Commissioning Specific Initiatives		
<p>What works well</p> <ul style="list-style-type: none"> 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 	<p>What works less well</p> <ul style="list-style-type: none"> 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 	<p>What needs to change</p> <ul style="list-style-type: none"> 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

consultation events	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> • 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
Review Team comments		
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.		
Health Partners Forum		
<p style="text-align: center;">What works well</p> <ul style="list-style-type: none"> • Attendance, feedback all very positive • Food 	<p style="text-align: center;">What works less well</p> <ul style="list-style-type: none"> • Same faces / same issues/ always the same / nothing changes • Too stage managed 	<p style="text-align: center;">What needs to change</p> <ul style="list-style-type: none"> • Less formal presentations, more focused topic-specific work
Review Team comments		
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.		
CCG culture and behaviour		
<p style="text-align: center;">What works well</p> <ul style="list-style-type: none"> • CCG individuals' commitment • CCG open style 	<p style="text-align: center;">What works less well</p> <ul style="list-style-type: none"> • 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 	<p style="text-align: center;">What needs to change</p> <ul style="list-style-type: none"> • 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
Review Team comments		
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.		

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 Public 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 “attende” 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 <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Newham governance structures are particularly complex with 8 over-lapping committees: <ul style="list-style-type: none"> ○ 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ PPG members (selected against transparent criteria) ○ Community group representatives - invited for relevance to protected characteristic or an identified collaborative issue (e.g. drug/alcohol dependence) ○ Local Healthwatch representation (Partner member) ○ 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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			
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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			
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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

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| <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • 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) |
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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 <u>individual</u> 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.)