



Health and Wellbeing Board

Thursday 6 October 2016 at 7.00 pm

Boardrooms 5 & 6 - Brent Civic Centre, Engineers Way,
Wembley, HA9 0FJ

Membership:

Members

Councillor Hirani (Chair)	Brent Council
Councillor Butt	Brent Council
Councillor Colwill	Brent Council
Councillor McLennan	Brent Council
Councillor W Mitchell Murray	Brent Council
Carolyn Downs	Brent Council
Phil Porter	Brent Council
Dr Melanie Smith	Brent Council
Gail Tolley	Brent Council
Dr Sarah Basham	Brent CCG
Rob Larkman	Brent CCG
Dr Ethie Kong	Brent CCG
Sarah Mansuralli	Brent CCG
Julie Pal	Healthwatch Brent

Substitute Members

Councillors:
Denselow, Mashari and
Southwood

For further information contact: Tom Welsh, Governance Officer
0208 937 6607 tom.welsh@brent.gov.uk

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The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item	Page
1 Declarations of interests	
Members are invited to declare at this stage of the meeting, any relevant personal and prejudicial interests and discloseable pecuniary interests in any matter to be considered at this meeting.	
2 Minutes of the previous meeting	1 - 6
3 Matters arising	
4 Sustainability and Transformation Plan (STP) Update: Brent & North West London	7 - 22
The purpose of this report is to provide the Health and Wellbeing Board with update on the progress of the development of the Sustainability and Transformation (STP) at North West London level and locally in Brent.	
5 Update on the development of an Accountable Care Partnership	23 - 28
This paper updates the Brent Health and Wellbeing Board on forms of Accountable Care Partnership (ACP) and local work to progress towards this model of service provision and delivery.	
6 A common Public Sector Estates Strategy in the London Borough of Brent	29 - 32
The Board are requested to consider the scope of a consultant's project brief, in order to commission a common public sector estate strategy, with a first phase project looking at both Brent and the local Health estate.	
7 STP Governance - Establishment of a Brent STP Delivery Board	33 - 40
This report looks at the development of a Sustainability and Transformation plan (STP) Delivery Board and the governance arrangements that would need to be put in place.	
8 Brent Children's Trust Update	41 - 46

This report follows two smaller updates - heard at the 7 June 2016 Health and Wellbeing Board, focussing on the '*giving every child the best start in life*' and '*helping vulnerable families*' priorities - and provides a broader summary of the Brent Children's Trust (BCT0 work programme and actions of the BCT sub-groups from April to September 2016.

9 Healthwatch Brent Update: Patient experience of phlebotomy services, and the self-directed support of residents living with mental health conditions 47 - 110

This report presents the findings of three action research projects funded through the Community Chest prepared by Healthwatch Team (Phlebotomy Services in Brent); Brent User Group (Self-directed Support – A Survey) and Brent Centre for Young People (A mental health needs assessment of young Irish people at Lynton Close).

10 Any other urgent business

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

Date of the next meeting: Tuesday 24 January 2017



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

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

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MINUTES OF THE HEALTH AND WELLBEING BOARD Tuesday 7 June 2016 at 7.00 pm

PRESENT: Councillor Hirani (Chair), Dr Ethie Kong (Vice Chair), Dr Sarah Basham (Assistant Chair, Brent Clinical Commissioning Group), Councillor Butt (Leader, Brent Council), Councillor Colwill (Brent Council), Sarah Mansuralli (Chief Operating Officer, Brent Clinical Commissioning Group), Ian Niven (Head of Healthwatch Brent), Phil Porter (Strategic Director, Community and Wellbeing), Dr Melanie Smith (Director of Public Health, Brent Council) and Gail Tolley (Strategic Director, Children and Young People, Brent Council)

Also Present: Councillors Chohan and Hoda Benn and Julie Pal (CEO of CommUNITY Barnet)

Apologies were received from: Councillors McLennan, W Mitchell Murray, Downs and Larkman (Chief Officer, Brent, Harrow and Hillingdon Clinical Commissioning Groups)

1. **Declarations of interests**

None declared.

2. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 22 March 2016 be approved as an accurate record of the meeting.

3. **Matters arising**

None.

4. **Sustainability and Transformation Plan (STP)**

The Board considered the report on Brent Council and Brent CCG's plan to drive a genuine and sustainable transformation in patient and resident experience and health outcomes over the next five years. Matthew Hannant, Director of Strategy and Transformation for NW London introduced the plan by stating that it was regarded as one of the better plans for improvement. It was important that all stakeholders were signed up to it by the 30 June submission date even though it now appeared this would represent a work in progress submission date that would form the basis of conversations with the NHS.

Kate Lawrence, Brent STP Project Manager, submitted a presentation to the Board outlining the progress made to date and the five local and nine shared NW London

priorities contained within the plan. She outlined the next steps in developing Brent's local STP and STP delivery plan.

In answer to a question regarding how the needs of children were covered in the plan, Matthew Hannant explained that whilst priority 3 was the only one that specifically mentioned children by reference to giving them the best possible start, all the other priorities encompassed the care of children. Discussion took place on the redesign of Central Middlesex Hospital for it to meet the priorities set out in Shaping a Healthier Future. Again, in addressing how the needs of children were to be met, it was explained that the provision of a good primary care facility would provide the main interface for children. It was suggested that articulating an incremental approach towards some of the big ticket items that would take the full five years to achieve would provide greater re-assurance that progress was being made along the way.

It was agreed that that an officer with responsibility for the needs of children should be invited to future STP meetings.

Referring to the list of engagements set out in the presentation, Dr Kong stated that this did not include all the activities that were already taking place which would demonstrate inclusion of all communities. The Chair and Councillor Butt expressed the view that there was a need to reach out to sections of the community which were not currently engaged so that there was a greater awareness of the work being done. One suggestion was for an on-line survey to be developed. It was agreed that Healthwatch would carry this out.

The request was made for the presentation to be circulated to all members of the Board.

RESOLVED:

- (i) that the progress made to date at a Brent and NW London level in terms of developing the NW London Sustainability and Transformation Plan (STP) be noted, as well as the anticipated next steps with regards to developing the Brent STP and STP Delivery Plan;
- (ii) that particular note be made of:
 - The NW London and Brent emerging priorities for the next five years
 - The proposed local Brent STP and Delivery Plan content and focus
 - The proposed status of the final Brent Local STP and Delivery Plan as the overarching strategic plan for Brent.

5. Health and Social Care Integration Prioritise for 2016/17 / The Brent Better Care Fund (BCF) submission for 2016/17

The Board received the report presenting a summary of recent submissions to NHS England for year 2 of the Better Care Fund (BCF) work based on the first year of using the Better Care Fund administered by NHS England. The report also presented a high level summary of the BCF schemes which it was believed would have the biggest impact in 2016/17

Duncan Harper (Interim Integration Programme Director for Brent Council and Brent CCG) introduced the report. He reported that informal feedback from NHS England had been encouraging but there were some questions to address. Duncan Harper explained to members the four schemes it was believed would have the greatest impact.

It was noted that the alignment within teams had improved under the BCF1 scheme and that work was being undertaken to ensure housing featured in the scheme BCF3. It was felt that this scheme needed to be broadened to include reference to the Sustainability and Transformation Plan. It would also be important to ensure the work of partners under the scheme BCF4 was co-ordinated and mutually supportive.

RESOLVED:

- (i) that the report be noted;
- (ii) that the 2016/17 priority areas for health and social care integration be endorsed.

6. **Health and Wellbeing Board stocktake**

Phil Porter (Strategic Director, Community Wellbeing) introduced the report which reflected on the changes that had happened over the last 12 months and sought decisions on changes going forward.

It was noted that reference to the Ofsted inspection in paragraph 4.4 of the report should have been to the 'Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board'. It was felt that there should be a quarterly update from the Children's Trust to the Board.

Regarding membership of the Board it was noted that the Council's Chief Executive was a member but that the post of Strategic Director, Regeneration and Growth no longer existed and so should be deleted. It was felt that standing invitations to meetings of the Board should be extended to an Adult Social Care provider and a GP provider. Although not a member of the Board, members felt that attendance by NHS England was important. With reference to the role of the Fire Brigade, Phil Porter undertook to discuss where its engagement would be most effective.

RESOLVED:

- (i) that events be reduced to one a year focusing on the Board's current priorities, with quarterly formal board meetings and, if required a further development meeting to follow up on the public engagement work and other board requirements;
- (ii) that the revised membership set out in section 6 of the report, as amended at the meeting be agreed;
- (iii) that a firm proposal for a strategy be agreed at the next meeting of the Board.

7. Children's Trust update:

7.1 Giving every child the best start in life

Gail Tolley (Strategic Director, Children and Young People) explained that the update paper only provided information on progress since the last update had been presented but, as endorsed by Dr Sarah Basham, a lot of work had been undertaken. Dr Basham felt that a fuller report on the work of supporting children could be presented to a future meeting of the Board in order to focus on the direction of future work in this area.

7.2 Helping vulnerable families

Phil Porter (Strategic Director, Community Wellbeing) introduced the update by saying that it was the intention to report more fully to the next meeting of the Board. The Chair asked that this include how this priority area linked to the work within schools and children centres.

8. Healthwatch report - plan for year and annual report or highlights for last year

The Board considered the report presented by CommUNITY Barnet, the organisation commissioned by Brent to deliver the local Healthwatch contract, which summarised progress to date and set out plans for the year ahead. Julie Pal, CEO of CommUNITY Barnet introduced the report and outlined the proposed priorities for Healthwatch Brent.

In answer to a question regarding the level of work undertaken on Female Genital Mutilation, it was explained that this had been limited during 2015/16 and so was ongoing into 2016/17. It was acknowledged that it was important for Healthwatch Brent to get direct feedback from the women affected by this practice.

Julie Pal confirmed that whilst evaluating the patient experience, her organisation would also take account of the provider's view. It was agreed that as and when Healthwatch Brent produced reports on the issues it had identified as its priorities they would be sent to the Chair of the Health and Wellbeing Board who would determine where else they should be sent.

As part of the process undertaken by Healthwatch Brent in determining its priorities it was agreed that this should include how the priorities linked-in with the work of the Health and Wellbeing Board.

RESOLVED:

- (i) that the progress made by Healthwatch Brent in delivering the contract be noted;
- (ii) that the principles informing the priorities for Healthwatch Brent in 2016/17 be endorsed and an update be presented to the next meeting of the Board setting out the finally agreed priorities and providing a scope supporting each one.

9. **Any other urgent business**

None.

The meeting closed at 8.45 pm

K HIRANI
Chair

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Health and Wellbeing Board

6 October 2016

Report from the Chief Operating Officer of Brent Clinical Commissioning Group and the Strategic Director of Adults and Community Well Being Brent Council

For information / decision/ noting

Wards Affected:
ALL

Sustainability and Transformation Plan update

1.0. Summary

- 1.1. The purpose of this report is to provide the Health and Wellbeing Board with update on the progress of the development of the Sustainability and Transformation (STP) at North West London level and locally in Brent. The report further details the five main delivery areas for Brent which translates into five big ticket items, i.e. deliverables that will have the greatest impact in addressing the health and care triple aim described in the Five Year Forward View.
- 1.2. The Brent STP represents Brent's overarching 5-year strategy and implementation plans to improve health and well-being, the quality of services provided and achieves financial sustainability. It is a triangulation of existing plans, plus new initiatives where gaps in existing plans have been identified and where we believe a different approach to joint working can make a real difference to people in Brent.
- 1.3. It is proposed that the Brent STP will be the overarching strategic plan for Brent. The STP has to reflect and respond to three gaps: Health and Wellbeing, Care and Quality and Finance and Efficiency. Therefore, it makes sense that these sections reflect updated health and wellbeing priorities and Better Care Fund (primarily focused on Care and Quality) priorities. However, it is important to note that this is an evolving process and will be further informed by future engagement and consultations with our communities and key stakeholders.
- 1.4. There are tangible benefits for areas with good STPs, ambitious STPs will attract transformation funding from NHS England.

2.0. Recommendations

2.1.1 The Health and Wellbeing Board is requested:

- i) To note the progress on the development of the NW London and Brent Sustainability and Transformation Plans.
- ii) To endorse the five big ticket items as below for Brent whilst acknowledging that this is an evolving process and will be further adapted to reflect the outcomes of our engagement and consultation process.

- Self- care and Prevention
- New Models of Care
- Joining up frailty services
- Improving outcomes and wellbeing for children and adults with mental health needs and
- Improving Acute Services and Quality of life - Central Middlesex Hospital

3.0. Detail

3.1. Principles and approach

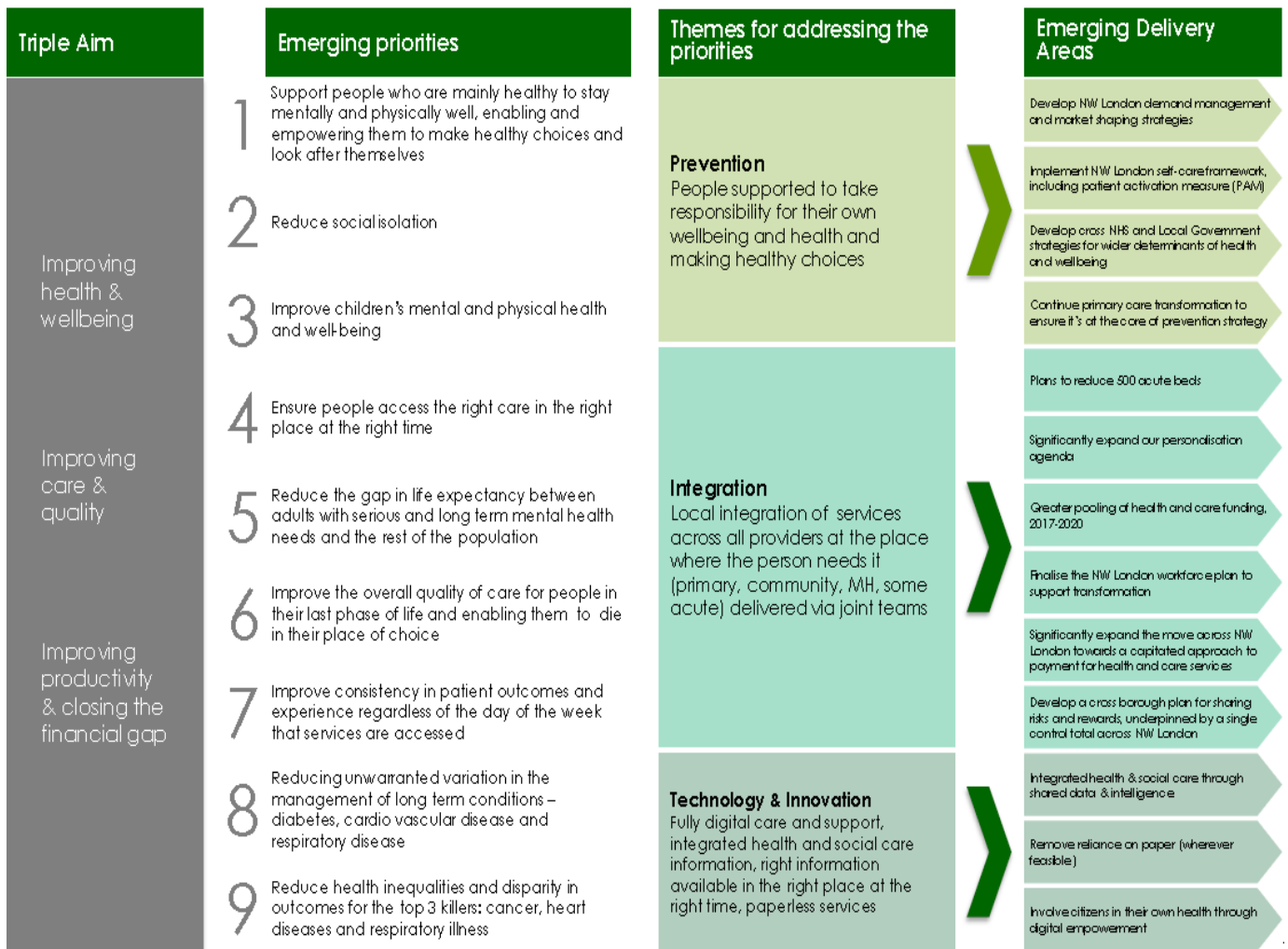
3.1.1 In order to support the development of a plan as ambitious as the STP, it is critical to some key principles are agreed so that everyone involved works together in the same way. In addition to those adopted by NW London, Brent included:

- make decisions based on a population or whole NW London system view (rather than an individual organisation or area view);
- maintain trust and transparency, and raise any issues that may be encountered;
- recognise that Brent has both local deliverables and as part of the NW London footprint;
- recognise that work will go on between meetings in order to progress within timescales and commit to making best efforts to attend all meetings; and
- each member is responsible both for representing their respective organisation view and for cascading back outcomes from the Planning Group

3.1.2 The NW London STP takes a population segmentation approach to understand the changing needs of our population. This approach is at the core of how we intend to collectively design services and implement strategies around these needs.

3.2 NW London Emerging Priorities and Delivery Areas

3.2.1 The emerging NW London priorities are a consolidation of local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. They seek to address the challenges described by the 'as-is' picture and deliver the vision and 'to-be' ambitious using an evidence-based, population segmentation approach.



3.2.2 The emerging NW London priorities are designed to address the triple aim of the Five Year Forward View. These priorities map to the core themes for addressing the challenges across the NW London system and emerging delivery areas. have been influenced by Brent priorities, which have been derived from our Health and Wellbeing Strategy and our Joint Strategic Needs Assessment. This local intelligence highlights the changing needs, challenges and issues facing our population.

3.3 Brent's Priorities and Deliverables

3.3.1 The Brent Plan has five delivery areas these being:

- DA1 – Radically upgrading prevention and wellbeing
- DA2 – Eliminating unwarranted variation and improving Long Term Condition (LTC) management
- DA3 - Achieving better outcomes and experiences for older people
- DA4 – Achieving better outcomes for children and adults with mental health needs
- DA5 – Ensuring we have safe, high quality sustainable acute services

Two Councils (Hammersmith & Fulham and Ealing) oppose the delivery of Area 5 because of the direct impact of the changes in their boroughs. All Councils, at the time of writing, support all other delivery areas.

3.3.2 It should be noted that the draft plan includes a commitment to close the social care funding gap (£17m in Brent by 2020) and also to invest £110m in prevention. These two financial commitments are to be strongly welcomed.

3.3.3 The Brent specific health and well-being gaps have been identified as:

- Common mental health disorders (CMD): large numbers and projected to increase - in 2014, an estimated 33,959 people aged 18 to 64 years were thought to have a CMD
- Severe and enduring mental illness: affects 1.1% of the population
- Mental well-being: the percentage of people with depression, mental health issues or other nervous disorders in employment is 23% also lower than both the England rate (36%)
- Significant and growing challenges to provide housing which potentially further undermine mental wellbeing
- Childhood obesity: Brent is in the worst quartile nationally in terms of the % of children aged 10-11 classified as overweight or obese – 38%
- Diabetes: by 2030 it is predicted 15% of adults in Brent will have diabetes
- Long Term Conditions: 20% of people have a long term condition
- Dementia: prevalence of dementia in people aged 65 years and over is 2,225 (2016) (and 80% of prevalence is diagnosed)
- STIs/HIV: 1,404 STIs per 100,000 population compared to 829 in England
- Health-related behaviour: physical inactivity: worst in West London; nutrition: 47% get 5 a day; tobacco use; alcohol; take up of immunisations

3.3.4 Brent's priorities are based on our understanding of changing needs and our vision for care and support in 2020. We will work to achieve this vision and address the triple aims through the following:

Health & Wellbeing

- Wellbeing is seen in its widest sense. It is not just about healthcare but wider factors such as employment, housing, and lifestyle. Brent will be a Dementia-Friendly Borough.
- Mental and physical health is given equal importance and will be considered holistically at the point of care.
- A significantly strengthened approach to prevention will improve the health status of Brent on a medium to long-term basis.
- Joining up health promotion, self-care and non-statutory support across the continuum enables people, including those with LTCS, to make decisions, take actions & manage a broad range of factors that contribute to their health & wellbeing on a day-to day basis.

Care & Quality

- An integrated workforce plan is in place to develop skills, enable flexible use of staff across settings of care, improve workforce planning, and support local recruitment and retention, including of local Brent residents.
- Primary care providers are better equipped through a new federation and model of care to provide more care in the community.
- An Accountable Care Partnership will be accountable for the end-to-end care and outcomes of a population group, i.e. people aged 18 or over with one or more long term conditions who are at risk, in need or unstable.
- There will be a concentration of acute hospital services to develop centres of excellence. These will achieve higher clinical standards and more efficient care delivery. Central Middlesex will be redesigned as a H&WB Centre, including urgent care.
- Expanded provision of early interventions for people with mental health problems and reduced reliance on inpatient care.
- An integrated approach to commissioning (and providing) services locally, including Nursing Care Homes, improving quality.
- A unified Frailty and Older People's Care model will stitch together existing services and models into a single pathway that ensure older people receive high quality and timely acute care and active support to maintain independence.

- Brent CCG and Council will minimise the impact of changing demographics through the cumulative impact of the initiatives outlined in the Brent STP, and ensuring that best practice is achieved across all service areas in Brent.
- Reduced acute and residential care demand will be achieved through a range of initiatives, including: new EOLC pathways; effective case management of people with complex needs; reduced variation in the management of LTCs (including Right Care); enhanced care in Nursing Homes; implementation of 'discharge to assess' models as part of the WLA integrated discharge initiative; and implementation of a unified Frailty and Older People's Care model.
- Providers will achieve and maintain financial balance by implementing internal financial recovery plans, including the redesign of CMH, reductions in Length of Stay, reduced reliance on agency staff, and Carter Review recommendations.
- A strong delivery focus will be required to ensure the Brent STP is fully implemented on time.

3.3.5 From the above the local STP Group has identified **five 'big ticket' items**. e.g. those that will have the greatest impact on closing the gaps and that can be only be delivered fully from working as a collective. These are described below:

- l) **Prevention and Self-Care**, which reflects the need for a step change in behaviour across the system to manage demand, which includes building on current initiatives:
- making Every Contact Count (MECC) – i.e. use every opportunity to achieve health and wellbeing, and involve systematic promotion of benefits of healthy living;
 - workplace based Health Promotion programme - i.e. adapted version of London Healthy Workplace Charter for small businesses in Brent; contracts issued with workplace health and wellbeing as a 'social value' requirement;
 - widen the scope of SIBI - SIBI currently delivers a 2nd tier service, but the service can be re-aligned to support 1st (signposting and advice, with links to existing services) and 3rd tier patients (intensive support for short periods (6weeks to 3 months) using multi-agency approach;
 - self-Care as part of Whole Systems Integrated Care and

In addition it is proposed to focus on

- Alcohol
- Smoking and tobacco
- Self-care: PAM (Patient activation measure) and DPP (diabetes prevention programme)

The levels of alcohol related admissions in Brent are significantly above the national average. However there are few referrals to alcohol treatment services from health care professionals (the majority of people entering the treatment system are self or family referred). A priority will be to improve the pathway to treatment from health and social care. An outline business case has been submitted to the NWL STP programme for seven day alcohol care teams in Northwick Park, for an increase in assertive outreach and to support a step change in screening and brief interventions (to address the very large numbers of people who while not dependent on alcohol, are drinking at levels which risk harming them). The outcome of this is awaited.

The London Clinical Senate has recently called clinical services to increase their efforts to address smoking through their CO4 initiative. NWL public health teams have supported an outline business case to NWL STP programme to support the implementation of this, for example through routine monitoring of exhaled carbon monoxide (CO) by clinicians ("would you like to know your level?"). Particular emphasis will be placed upon improving the smoking cessation offer for mental health service users who are more likely to smoke and on encouraging clinicians in Brent to ask about the use of tobacco generally to reflect the use of shisha and chewing tobacco.

'Patient activation' describes the knowledge, skills and confidence a person has in managing their own health and health care. NHSE is promoting the use of patient activation measures (PAM) as a means of tailoring health services support to enable patients to self care. In Brent the use of PAMs will be introduced into WSIC.

NHSE has commissioned a pilot diabetes prevention programme which offers those at high risk of diabetes intensive support to reduce their modifiable risk (primarily through increased physical activity and improved nutrition). With Harrow and Hillingdon, the CCGs and public health teams are preparing a bid to access this service.

- II) **New Models of care**, which reflects the need to eliminate unwarranted variation and improving LTC management which includes:

Re-confirming the original vision for Whole Systems Integrated Care (WSIC) building on the work done with primary care to fully integrated Primary Care Transformation plus community based acute prevention and discharge services, social care, housing and voluntary services into a single pathway.

The focus for 16/17 is to move to New Models of care to improve quality, experience and outcomes for patients with LTCs and their carers whilst reducing the costs to the system. The plan is to improve the productivity and efficacy of health and care teams, increase the capacity and capability within multidisciplinary teams, embed new interventions and roles, and overcome barriers to integrated working between different professionals, teams and services.

This will be through a “New Provider Model” – delivery and performance led and managed by a partnership of providers who form an Accountable Care Partnership (ACP). The ACP will be responsible for planning and managing care with a defined budget and set of outcomes for which they are jointly accountable.

The scheme has the following objectives:

- move from reactive care to proactive care through better planning, prevention and management;
- move from fragmented care to coordinated and integrated care;
- moving from professionally led care to a model of support to self-care and self-management – with personal goal based care plans;
- achieve continuity of care through the relationship between the patient, their carers(s) and their own GP; and
- deliver care at the appropriate time and in the appropriate setting – out of hospital wherever possible.

III) **Joining Up Frailty Services** – which reflects the need to have in place a proactive and integrated community and hospital based solutions to support discharge and maintain or reduce the overall number of Delayed Transfer of Cares (DTCs) in Brent. This includes a range of 16/17 Better Care local schemes including:

- integrated rehabilitation and reablement service;
- joint commissioning of step down residential and nursing beds;
- single point of access to community provision across London Northwest Health NHS Trust;
- West London Alliance level hospital discharge project, where a single local authority will be the lead for each hospital. (e.g. Brent Council would be the lead local authority for Northwick Park Hospital and take on all discharges for Hounslow, Tri-borough and Ealing residents before the end of this winter)
- Targeted support from housing;
- 7 day working by social care to support discharges at weekends (live from Dec 15)

- improve the quality of care in local nursing home provision – including development of the workforce and
- increase capacity locally of nursing care provision

IV) **Improving outcomes and wellbeing for children and adults with mental health needs** – recognising that mental health and wellbeing has the same focus as physical health and wellbeing.

Build on the work done to integrate health and social care mental health teams – implement a recovery focused care management approach through integrating health, social care, housing and employment pathways with a strong peer support focus so people can live independent lives including the following work streams:

- community map and navigation to reduce social isolation
- day service hub for people with specialist mental health interventions with peer led daily activity programmes that promote recovery and independence;
- extended GP appointments and primary care mental health services; crisis care
- alternative to inpatient care and post discharge support services – reducing no. of people in inpatients units and residential care and moving into independent housing with support as required and
- build on the work done to improve diagnosis, assessment and support for People with Dementia, community solutions for people with Dementia, e.g. specialised Dementia Care and make Brent a Dementia friendly borough.

Promote, protect and improve our children and young people’s mental health and wellbeing through a Comprehensive Children and Young People’s transformation plan underpinned by objectives of resilience, prevention and early intervention, a system without tiers and care for the most vulnerable, work force development. These objectives will be achieved through dedicated children and young people work streams

V) **Improving Acute Services and Quality of life - Central Middlesex Hospital** – recognise the significant impact we could have by working together in a one public sector estate model and deliver an exemplar of the approach at Central Middlesex Hospital:

- redevelop the Central Middlesex Hospital (CMH) site into a Brent Health & Well-Being Centre providing a range of local services (including the Urgent Care Care)

- broaden the scope of existing discussions to take in the wider CMH site, to include the new nursing home and extra care facility opposite in order to do two things: 1) focus on the place shaping opportunity to make this a better place to live and work, and 2) make very strong links between the acute and primary services at CMH and the social care facilities to ensure high quality services.

3.3.6 It is to be noted that the big ticket areas for Brent are still evolving and will need to be further updated as greater focus and clarity is obtained following future consultation and engagement events.

3.3.7 The STP for Brent will be supported through three key enabler work streams Estates IT and Workforce development.

3.4 NHS England Feedback

3.4.1 Following submission of the draft STP on 30th June, representatives from NW London met with NHS England on Thursday 14 July where the draft document was well received. We have recently received feedback to support the October submission. Overall NHSE were “very impressed” by our commitment to system-wide working and noted that our proposals have great potential to deliver the Five Year Forward View and provide a route to sustainably improved services for patients. While impressed by our vision, NHSE did identify that delivering our vision at scale and pace will be challenging.

3.4.2 NHSE identified a number of areas for us to focus on to develop the final plan, these areas include:

- further detail on our plans for primary and wider community services and how these will impact on hospital based activity
- further detail on our plans for engagement with local communities, clinicians and staff and a clear narrative which articulates the benefits for proposed changes to the public
- further detail on our provide productivity proposals
- updated plans for mental health following the publication of the Forward View for Mental Health
- year on year financial trajectories
- finalise the development of the Business Case for submission to NHSE Investment Committee (IC)
- finalise the proposal to implement the new model of care at Ealing Hospital including an affordable capital proposal for approval by the IC
- a clearer articulation of the impact on quality of care as a result of our plans
- making links with neighbouring STPs that could provide opportunities or obstacles to your planning

3.5 STP Governance and Monitoring

- 3.5.1 Going forward, in order for us to work together across the system to deliver the transformation set out in the STP, we need to develop an effective governance approach at the NWL level and in Brent.
- 3.5.2 At the NWL level, the process this far has been overseen by The Strategic Planning Group (SPG) which is a forum for a wide range of system leaders (primarily senior managers and lay partners) from across the system. This is spearheaded by a Leadership Group comprising Dr Mohini Parmar (Chair), Claire Parker, Rob Larkman (both CCG accountable officers), Tracey Batten (CEX Imperial) and Carolyn Downs (CEX, LB Brent). The NW London programme has established a Joint Health and Care Transformation Group which will have representation from across local government and health, including commissioners, providers and lay representatives. The purpose of this group will be to oversee the development of the STP and its delivery, and its first meeting was scheduled for 22 September. The purpose and membership of this group was discussed at the NW London Strategic Planning Group (SPG) in July resulting in an agreement that a smaller representative group was required to provide oversight. There will be governance groups established at NW London level to oversee the mobilisation and delivery of the 5 Delivery Areas. There will be four councillors on the joint board and four council officers, these being Cllr Sachlin Shah (Vice Chair), Cllr P Copthorne (Hillingdon), Cllr R Robotham (Westminster), Cllr S Curran (Hounslow), Carolyn Downs (CEX Brent), Michael Lockwood (CEX Harrow), Charlie Parker (CEX Westminster), Liz Bruce (DASS Tri-Borough).
- 3.5.3 In Brent the STP will be overseen by a Delivery Board which will report in to the Health and Wellbeing board. A detailed paper on the Brent STP governance structure is being presented separately at this meeting.
- 3.5.4 The STP challenge is significant, and the NW London and Brent governance structures relatively new, and so there remains a commitment to review and improve structures as the full NW London STP is finalised, whilst ensuring we keep a clear focus on implementing Brent specific priorities aligned to the NW London STP. The degree to which these structures can continue to deliver a shared perspective on the challenges, co-production of the solutions, clear accountability and effective monitoring of progress and impact will be a crucial test as STP develops.

3.6 Engagement

Beyond the involvement of lay partners in the core groups, the programme has also undertaken a number of patient and public engagement activities,

including hosting 22 face to face engagement events across all eight boroughs to help co-design the local plans. These events have included workshops, seminars and public meetings and have been very popular with providers, patients, clinicians, Healthwatch, lay partners, carers and their families.

In Brent three street events have been planned over September and early October to reach out to different sections of the community and engage with them on our big ticket areas.

3.7 Next Steps

- 3.7.1 NW London is required by NHS England to submit our final plan on 21st October (although this date is still provisional). Feedback from NHS England, local governance boards and from the public and staff engagement described above is being incorporated to help develop and shape the final plan. The submission will include a chapter on Brent STP.
- 3.7.2 Our intention is to receive and incorporate feedback in September to enable final plan by organisations in early October ahead of the final submission. Between now and the October submission there will be a number of engagements with NHSE London as plans are finalised.
- 3.7.3 NW London has already committed to delivering a series of outputs for 2016/17 through the draft STP. The programme teams have been proactive in identifying opportunities to accelerate delivery to ensure that we meet the ambitions set out in the draft plan, and the STP programme team will continue to measure and support this.
- 3.7.4 In addition, the programme is finalising 17/18 deliverables and benefits, and aligning these deliverables to the 17/18-18/19 planning round and two year contracts.
- 3.7.5 Brent will continue to build and strengthen local relationships, throughout the STP development process, supported by a shared understanding of strengths and challenges faced as well as a clear ambition for 2020, and a set of concrete steps to get there.
- 3.7.6 Progress has commenced on the establishment of local working groups to progress key STP work streams. The governance underpinning delivery will be formalised at this meeting of Health and Well Being Board.
- 3.7.7 Detailed review and analysis of the suggested financial opportunities in the Brent context are being used to inform project initiation documents to be agreed across partners
- 3.7.8 There will need to be ongoing collaboration and input to the NW London SPG and Delivery Boards to ensure alignment and opportunities are maximised.

4.0. Financial Implications

- 4.1. Approximately £12m of net savings are required each year to close the CCG financial gap over the next five years. The Council will have a £17m gap by 2020 without applying the Council tax precept and £9m if Brent applied the precept year on year up to 2020. LNWHT provides services to three key commissioners, and therefore only a proportion of its 'gap' is directly associated with Brent; similarly with CNWL. This signals a significant finance and efficiency gap which needs to be addressed through quality, innovation, productivity and prevention initiatives across the system rather than within individual organisations.
- 4.2 The transformation required to close the Health & Well-Being and Care & Quality gap in Brent will enable closing the Finance & Efficiency gap. The STP provides the opportunity to think and work fundamentally differently across local government, the NHS and the wider public and voluntary and community sector. The aim being to respond to the significant financial challenges by working collectively to develop new integrated models of prevention and care which can transform the way services are delivered, reduce duplication, and minimise infrastructure costs. In summary, Brent will close the finance and efficiency gap over the next five years by:
- Brent CCG and Council will minimise the impact of changing demographics through the cumulative impact of the initiatives outlined in the Brent STP, and ensuring that best practice is achieved across all service areas in Brent.
 - Reduced acute and residential care demand will be achieved through a range of initiatives, including: new End of Life Care pathways; effective case management of people with complex needs; reduced variation in the management of Long Term Conditions (including Right Care); enhanced care in Nursing Homes; implementation of 'discharge to assess' models as part of the WLA integrated discharge initiative; and implementation of a unified Frailty and Older People's Care model.
 - Providers will achieve and maintain financial balance by implementing internal financial recovery plans, including the redesign of CMH, reductions in Length of Stay, reduced reliance on agency staff, and Carter Review recommendations.
 - A strong delivery focus to ensure the Brent STP is fully implemented on time.
- 4.3 The STP and associated funding to support local, regional and sub-regional transformation is critical to the health and care economy. Without collective agreement and a plan to address the finance and efficiency gap both health and quality of care will continue to deteriorate. There remain residual gaps for

both CCG and Council, and therefore (a) existing opportunities must be maximised, and (b) further opportunities will be required in order to ensure that the CCG and Council continue to provide high quality services to a growing Brent population.

- 4.4 New care models will be enabled by a new provider model. In 2014 Brent developed an ambition for a health and care system where delivery and performance is led and managed by a partnership of providers who form an Accountable Care Partnership (ACP). Providers work together to plan and manage care, ensuring funding flows to where it is needed most by working within a defined budget to achieve a shared set of priorities and outcomes. This was known as an Accountable Care Partnership (ACP), reflecting the need to break down barriers between health and care and reshape provision around patient, service user and carer needs.
- 4.5 The Five Year Forward View (FYFV) and new contracting frameworks provide real opportunity to progress. Brent plans for an ACP align well to the Multi-speciality Community Provider (MCP) model from the FYFV and this is the model we will pursue. We have already made good progress and are facilitating partnerships between Primary Care, Community, Mental Health, Social Care, Acute, the voluntary sector and others.
- 4.6 Brent GP Networks have recently developed a joint venture meaning they can mobilise to provide services at scale and in common and work together to continuously improve quality and make decisions on resource allocation and performance as a partnership. This provides the foundation on which partnerships with other at scale providers can be built. As an MCP the providers would be commissioned to deliver end to end care with functions and governance focused on outcomes and on clinical and financial accountability.

5.0. Legal Implications

The provisions of the Care Act 2014, accompanying Regulations and Guidance must also be born in mind in the development of the proposed Sustainability and Transformation Plan.

6.0. Diversity Implications

The STP aims to address the whole health and care system to enable a rebalancing towards prevention, early intervention; supporting independence and wellbeing. It aims to engage and empower the diverse communities of Brent and the wider health economy across NW London to deliver clinical outcomes and patient experiences.

7.0. Staffing / Accommodation Implications (if appropriate)

N/A

Background Papers

Background papers are available on request.

STP Submission 30th June

Contact Officers


Name: Phil Porter

Job Title: Strategic Director of Adults and Community Wellbeing
Brent Council

Name: Sarah Mansuralli

Job title: Chief Operating Officer
Brent Clinical Commissioning Group

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	<p>Health and Wellbeing Board 2016</p> <p>Report from NHS Brent Clinical Commissioning Group</p>
<p>For information</p>	
<p>Report Title: Update on the development of an Accountable Care Partnership</p>	

1. Introduction

- 1.1 This paper updates the Brent Health and Wellbeing Board on forms of Accountable Care Partnership (ACP) and local work to progress towards this model of service provision and delivery.
- 1.2 'ACP' is the term we use in North West London (NWL) to describe a group of providers jointly accountable for the planning and management of care and delivery of a set of shared population outcomes within a defined budget, for which they are held collectively accountable.
- 1.3 The ACP model developed drew on example and evidence of similar integrated care systems and provider models in place in Europe, USA and New Zealand. There are many models – with the Accountable Care Organisation (ACO) the most prevalent; however they all share a minimum set of characteristics – defined population, outcomes based contracts, capitated budget with risk/reward share agreements with commissioners.
- 1.4 An ACP is therefore a provider model designed to support the delivery of integrated health and social care – a partnership between providers offers opportunities to align objectives, overcome fragmentation in delivery systems and organise care around patient and carer needs (not service or geographical boundaries).
- 1.5 The commissioner role in developing an ACP model is to identify the challenges the partnership is being asked to overcome (and translate these into meaningful outcomes) and to consider how we might use contracting and payment mechanisms to incentivise joined up working and shared accountability, and ensure funding flows to where it is needed most in the system.

1.6 Below we summarise our work to date in Brent for the Health & Wellbeing Board:

- Background
- What model are we seeking for Brent?
- Progress to date
- Next steps for commissioners and providers
- Conclusion

2. Recommendations

2.1 The Brent Health and Wellbeing Board are asked to:

- Note the progress made towards an ACP/MCP in Brent.
- Confirm that the direction outlined in the report is appropriate and affirm organisational commitment.
- Agree the need for development of a detailed scope and plan
- Provide any initial comment on this and other next steps outlined - which will need to be undertaken during the period covered by the STP (2016/17-2020/21).
- Provide direction on any key messages that need communicating to Brent residents.

3. Background

3.1 The ACP model was first designed by commissioners, providers and lay partners in NWL under the Whole Systems Integrated Care programme (WSIC) – an NHSE ‘Pioneer’ programme for integrated care. Work commenced in 2014 by CCGs, Local Authorities and Providers and was expected to deliver within a 5 year timeframe.

3.2 The concept of jointly accountable provider partnerships as key to delivery of integrated care outcomes is now widely used and accepted in national policy. NHS England (NHSE) ‘Vanguard’ sites are developing these models. The Five Year Forward View (FYFV) notes *‘decisive steps to break down the barriers in how care is provided’* will be taken and presents new provider models as a way to overcome the ‘traditional divide’ in health and between health and social care. This is also reflected in Sustainability & Transformation Plans (STP) and national planning guidance.

3.3 Two new models (configurations of providers) are presented – essentially national versions of an ACP model – and a legal and contractual framework is being developed for each. The two models are:

- **Multispecialty Community Provider (MCP)** - a primary care led provider model based around the GP registered list. The MCP would develop out of hospital teams to deliver proactive care to people with complex needs and chronic conditions. The workforce ‘wrapped around’ primary care might include nurses, therapists, pharmacists, psychologists, social workers and potentially consultants (for example geriatricians). More outpatient consultations and ambulatory care could be delivered in out of hospital settings, community-based diagnostics and treatment could be expanded and out of hours care could be managed differently.

There is also an emphasis on partnership with the voluntary sector and on self-care. The MCP would eventually be asked to take delegated responsibility for a capitated budget.

- **Primary and Acute Care Systems (PACS)** – this builds upon the lead/prime provider model by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services. Where primary care is unable to deliver sufficient capacity hospitals will be permitted to open their own GP surgeries and registered lists with Foundation Trust investment supporting expansion of new style primary care. Again, a PACS could eventually take delegated responsibility for a capitated budget.

3.3 In either case, new provider models must deliver expanded and strengthened primary, out of hospital care and integrated care. They are frameworks through which we might achieve key outcomes e.g. moving beyond single unconnected 'episodes' of care to models that address a full range of needs, new career pathways and workforce models, improving quality and reducing variation, managing demand, reducing duplication/streamlining processes and achieving a financially sustainable system.

4. What model are we seeking for Brent?

- 4.1 The model of care designed under WSIC envisioned multidisciplinary teams wrapping around patients and carers in primary and community settings to deliver a proactive and coordinated end to end care pathway for adults with LTCs.
- 4.2 To achieve this primary care staff need to become adept at working with and securing input from different partners within a multidisciplinary team, operational managers must design and implement policies and procedures that work across traditional boundaries and leaders must develop a model of management and governance through which they effectively support and hold each other to account. The codesigned model aligns most closely to an MCP, however local areas will need to adapt and tailor these frameworks.
- 4.3 The MCP model is well suited to models of community based care for those with complex or chronic long term conditions. The MCP offers a framework through which to integrate a range of providers / services across health and social care. The 'whole systems' model of case management for adults with LTCs could evolve using the MCP framework. The MCP requires significant 'horizontal' integration – and learning from the last 18 months suggests this is challenging to deliver, with a large number of providers at the table, complex contracting and potentially complex leadership and governance structure. However, if delivered successfully with buy-in from stakeholders, an MCP is perhaps more likely to deliver partnership working, out of hospital outcomes & joint accountability.
- 4.4 The PACS model may be more suited to a new integrated urgent and emergency model of care. It may be easier to implement - working with a smaller number of large providers and a simpler financial model and operating model; however, it risks feeding demand for traditional hospital based care and our complex acute landscape

in Brent (with 4 acute trusts delivering services to Brent patients) could present implementation and delivery challenges not found in other areas of NWL.

- 4.5 Commissioners should revisit questions of function and form with providers and stakeholders as national contract templates become available. The draft MCP framework has already been released (with full contracts due to be released soon).

5. Progress to date

- 5.1 In 2014/15 and early 2015/16 there was a lack of partnership working between Brent GP Networks. Separate WSIC contracts were held (LTC care planning and case management) and 'shadow ACP' meetings were hosted by individual GP Networks. This made it extremely difficult for other partners to engage efficiently and effectively and jeopardised the development of a consistent offer to patients and carers.
- 5.2 Commissioners agreed a single contract for 16/17 aligned more closely to the strategic objectives of WSIC and Primary Care Transformation - which requires primary care providers to work together and develop the infrastructure / capability for at-scale 'accessible', 'proactive' and 'coordinated' care.
- 5.3 In response primary care providers formed a new joint venture - *Brent Care Ltd*. This primary care 'federation' represents the first stage of the 'horizontal' integration required for an MCP model. It means primary care can mobilise to provide services at scale and in common, make decisions on resource allocation and monitor quality and performance as a partnership.
- 5.4 *Brent Care Ltd* also offers a single route through which partners such as Social Work, IAPT and the voluntary sector might align.
- Social Work colleagues from the local authority Support Planning and Review team are now attending weekly/monthly multidisciplinary meetings.
 - IAPT are building relationships & seeking to participate in weekly multidisciplinary meetings.
 - Three local voluntary sector organisations (Living Well, Sufra, Mencap) have been subcontracted to provide Care Navigators and support the development of self-care and social prescribing within the model of care. CVS Brent is also involved, providing a 'front door' to the wider voluntary and community sector.
- 5.5 There is significant work to do, but important steps have been taken. WSIC is a platform on which providers can develop commercial relationships, come together to shape and manage multidisciplinary teams and develop a shared leadership and governance model, as a precursor to a more formal ACP/MCP model.
- 5.6 The CCG and Local Authority have committed to this model as part of Sustainability & Transformation Plan (STP) and are working closely together to explore a roadmap for Brent. There is work underway in the NWL Local Services team.

6. Next steps for commissioners and providers

- 6.1. The provider landscape in Brent is complex and we have to date lacked the bottom-up push for an ACP seen from providers in other areas of NWL. Our 'roadmap' to an ACP must therefore utilise and align to 'business as usual' commissioning, market shaping and systems leadership activity.
- 6.2. There is no additional funding to deliver the transformation required (with the exception of any STP funding that may be allocated); so we must align wider commissioning and contracting to deliver 'accountable care' objectives. Joint commissioning plans need to reflect an agreed scope, timetable and key messages to the market.
- 6.3. The end state for an ACP/MCP is a single contract and budget for a specific population defined by the GP registered list, with the provider partnership accountable for end-to-end care and inclusive of all functions required to deliver that. This requires a clear scope.
- 6.4. There has been high level exploration of scope, but further definition of outcomes and benefits sought, and mapping of services, pathways, activity, spend is required. Early example of MCP procurement (for example Dudley) seek a provider partnership to deliver multi-disciplinary teams that support people within homes and communities, enhance individual independence, prevent unnecessary admissions and facilitate prompt discharge. Once further defined, a Brent scope will need to be tested, communicated and agreed.
- 6.5. The Brent Community Services Review will be the vehicle through which we determine options to secure better integration between primary, community, social care and mental health services, as well as refine the scope of an ACP/MCP model.
- 6.6. It may be helpful to consider a local diagnostic for the provider market in Brent, examining the baseline position against key skills provider partnerships would need to deliver, for example:
 - Planning and design of services,
 - Internal 'procurement' capabilities e.g. subcontracting & due diligence
 - Effective operating models and management frameworks
 - Access to & use of data for quality and performance monitoring
 - Governance processes - to allocate funds effectively and hold partners to account.
- 6.7. It may also be helpful to review implications for our commissioning cycle and processes across the CCG and Local Authority. The release of the MCP contract provides a next step for commissioners - it enables use of a formal process of competitive dialogue, or a mix of collaborative and competitive procurement, to procure end to end pathways. It also provides a framework through which we might shape the market (shaping a partnership and formally identifying providers who want to deliver this model).

Contact officer:

Sarah McDonnell, Assistant director primary care, NHS Brent CCG

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Health and Wellbeing Board

6 October 2016

Report from the Strategic Director of Strategic Director Community Wellbeing (LB Brent) & the Chief Officer (Brent CCG)

For information & comment

Wards Affected:
ALL

A common Public Sector Estates Strategy in the London Borough of Brent

1.0. Summary

- 1.1. The Board are requested to consider the scope of a consultant's project brief, in order to commission a common public sector estate strategy, with a first phase project looking at both Brent and the local Health estate, with Members asked to consider and confirm the questions in 3.9 of this report.

2.0. Recommendations

- 2.1. That the Board review the attached Project Brief, titled "A common Public Sector Estate Strategy in the London Borough of Brent – aligning Health and Local Authority Estate Holdings to facilitate delivery of a more integrated and customer focused service" and consider the questions in 3.9 of this report.
- 2.2. To approve a tender exercise, with an update to the Board upon receipt of tender returns.

3.0. Detail

- 3.1 The Cabinet Office, One Public Estate Programme's aims are to encourage and facilitate increased local public partnerships, through provision of seed funding to enable a strategic and collaborative approach to service delivery and estate planning in order to delivery improved outcomes for customers.
- 3.2 The key objectives of the One Public Estate Programme are:
 1. To deliver more integrated and customer focused services, through co-location, delivering efficiencies and more customer focused.
 2. To create economic growth, enabling release of land and property to stimulate growth, regeneration, new homes and jobs.
 3. To reduce running costs of central and local government assets.
 4. To generate capital receipts, through the release of land and property.

3.3 Brent in partnership with the local Clinical Commissioning Group (CCG), along with other public sector partners has made an application under the current phase of the OPE programme, with a number of projects identified and a strategic vision that says:

“Our aim is to have a common Public Sector Estates Plan that is driven by each Public Sector Partners service needs”.

3.4 The OPE opportunity fits very well with the NHS’s Estates and Technology Transformation Fund (ETTF), which is making £1bn of investment over 4 years to support the development of primary care estate. Investment is aimed at ensuring the estate supports new ways of working (including extended access and management of patients with long term conditions), introducing the use of technology to improve care delivery, develop training practices, and establish a sustainable primary care service for the future.

3.5 The ETTF programme as we understand it is over-subscribed, with the NHS encouraging local CCG’s to work with their local authorities to find local solutions to complement existing programmes.

3.6 Locally the Strategic Service Delivery Plan (SSDP) concluded that three locality based out of hospital hubs were required to enable the delivery of transformed models of care across the Borough. The location of the Hubs was identified as Central Middlesex Hospital, Willesden Centre for Health and Care and the Wembley Centre for Health and Care, however these may well be reviewed as part of the Strategic Transformation Plan (STP) and possibly on further development of OPE opportunities.

3.7 From Brent’s perspective, the OPE opportunity the ETTF and SSDP, fit with Brent’s Borough Plan objectives, that aim to build local partnerships that provider services that are finely tailored to local needs. It aims to create a better place, increasing the supply of good quality homes and new affordable housing, while improving lives by supporting enterprise, creating jobs, and helping people into work and fair pay.

3.8 To facilitate delivery of the Borough Plan, Brent’s Property Strategy/Strategic Property Plan 2015-019 builds on these themes by using and maintaining assets to support service delivery, promoting community resilience through community asset transfer, maximising value with a focus on revenue, and promoting investment and acquisition to support regeneration, housing and planning for new schools.

3.9 To deliver the common local Public Sector Estates Plan vision, Brent officers working with the local CCG have developed a project brief, (see Appendix A), to be used for the purposes of commissioning a professional property consultant. Specifically the Board are requested to consider the following questions:

1. Is the vision correct and are the objectives correctly defined?
2. Are there any comments on the background?

3. Is the approach correct?
4. Have the constraints been correctly and fully identified?
5. As per the financial implications (section 4), Members are asked to confirm the preferred funding approach?

4 Financial Implications

- 4.1. Brent's OPE application has requested £30,000 towards the co-ordination of a data capture exercise and to undertake the public sector and health review, feedback from the OPE team suggests that their view is that this work may overlap with other elements of the Brent application and is at risk of being taken out.
- 4.2. In view of the doubts as to OPE providing initial funding for this project, and as there are clear synergies in what both Brent and the CCG are looking to achieve, a joint funding approach with Brent and Health sharing the cost, or matching any OPE funding that may be received should be considered.
- 4.3. Successful OPE bids are dependent on a clear demonstration of deliverables in terms of service transformation, homes, and new jobs, and identifying these deliverables is a required outcome from the project. The fact that both Brent and Health have made an initial financial commitment will also demonstrate both parties commitment to the OPE process. With outcomes clearly identified, and the OPE appetite for Health based projects, follow on applications to OPE stand every chance of success.
- 4.4. There is a OPE funding round at the end of October and at regular intervals thereafter.
- 4.4. The actual cost of the consultant's commission will be determined following a tender exercise.

5 Legal Implications

- 5.1. In respect of the proposed consultant commission, legal advice will sought on the technical aspect of a joint commission and if this is not possible Brent or Health may need to be named as lead client in a contract with the consultant, with side agreement detailing roles and responsibilities and funding arrangements.

6 Diversity Implications

- 6.1. Equality analysis will be required on programme and project basis.

7 Staffing / Accommodation Implications (if appropriate)

- 7.1. To be determined on a programme and project basis.

Background Papers

Appendix 1. Project Brief.

Contact Officers

Sarah Chaudhry
Head of Property
Brent Council

Sue Hardy
Head of Strategic Estate Development
Brent, Harrow, Hillingdon and Ealing CCGs

Phil Porter, Strategic Director of Community Wellbeing, LB Brent

Rob Larkman, Chief Officer, Brent CCG

Health and Wellbeing Board

06 October 2016

Report from Phil Porter, Director of Adult Social Services, and Sarah Mansuralli, Chief Operating Officer NHS Brent CCG

For decision

Wards Affected:
ALL

STP governance – Establishment of a Brent STP Delivery Board

1.0. Summary

- 1.1. To deliver the STP, robust governance arrangements need to be put in place. The proposal is to use the successful Children's Trust model and form an STP Delivery Board that would report to the Health and Wellbeing Board. The group would have a number of sub-groups which will deliver specific work streams within the STP, when possible building on existing groups, and otherwise forming new groups. It will also link to enabler work streams that will underpin the delivery.

2.0. Recommendations

- 2.1. The board agrees to the governance arrangements in section four, pictured in appendix one.
- 2.2. The board agrees the proposed terms of reference for the STP delivery board

3.0. Background

- 3.1. The Sustainability and Transformation Plan (STP) is a five year plan NHS led initiative for residents to be well and live well. It is delivered at regional level, so for Brent is delivered at North West London level. There are two parts to Brent's STP, the overarching North West London objectives, and the local objectives. The paper, "Update on NWL and Brent STP" has details about this.
- 3.2. These objectives will be delivered over five years. Brent has developed a plan for the first year, concentrating on five big ticket items. These five big ticket items will be delivered through delivery areas. The big ticket items and related delivery areas are:

- Prevention and self-care; Radically upgrading prevention and wellbeing
- New models of care- Eliminating unwarranted variation and improving Long Term Conditions (LTC) management
- Joining up frailty service; Achieving better outcomes for older people
- Improving outcomes and wellbeing for children and adults with mental health needs;
- Improving acute services and quality of life (Central Middlesex Hospital) Ensuring we have safe, high quality sustainable acute services

3.5 The Better Care Fund (BCF) began in 2014/15; its aim is to transform local services so that people are provided with better integrated care and support, by managing local pressures and improving long term sustainability. The BCF is delivered at a local level as a collaboration between local councils and CCGs. It has been used to inform the development of the local STP and is included in the delivery areas:

- Whole systems integrated care
- Integrated rehabilitation and reablement service
- More effective hospital discharges
- Nursing care home market changes

3.6 The Health and Wellbeing Board is responsible for delivering both the BCF and the STP. To do this, robust strategy and governance must be developed.

3.7 The Children's Trust, a strategic group overseeing the agenda for children, including delivering the Health and Wellbeing Strategy objectives relating to children and young people, has been a successful group. It is proposed that a similar group is created, with strategic oversight for delivering the STP.

4.0 STP governance arrangements

4.1 An STP Delivery Board will be set up. The STP Delivery Board will make connections between pieces of work, monitor and oversee delivery, and unblock obstacles that get in the way of efficient delivery. The group would learn from the successful Children's Trust, and would follow a similar set up procedure, starting with a core membership which can be built as the group develops. The group will have membership from both Brent Council, and NHS Brent CCG, and will also include the chairs of the sub-groups. It will be co-chaired by Phil Porter, Strategic Director Community Wellbeing, Brent Council, and Sarah Mansuralli, Chief Operating Officer, NHS Brent CCG. The group would report to the Health and Wellbeing Board, and have oversight of five sub-groups that would be responsible for delivering different areas of the STP. The sub-groups will change annually according to the priorities for that year. The STP Delivery Board will determine the sub-groups and work streams.

- 4.2 The chairs of the sub-groups are responsible for the delivery of the work streams. The chairs must evidence that the delivery plans are developed through co-production and engagement with key stakeholders and our communities. They are expected to report any issues to the STP delivery board.
- 4.3 This year, to ensure delivery in all areas of the STP as well as other priorities, the proposed sub-groups are outlined.
- 4.3.1 Prevention/self-care:** This will oversee the delivery of prevention and wellbeing delivery area and will be chaired by Dr Melanie Smith, Director of Public Health, Brent Council. There is a self-care group in existence that will feed into this group, and link to the existing patient engagement group (BEES), the Brent Advice Matters partnership, and the self-care clinical working group. The alcohol and tobacco work will be delivered by a revised DAAT group, which will extend to include secondary care membership.
- 4.3.2 Local services:** This will oversee delivery of the BCF objectives, Whole systems integrated care, Integrated rehabilitation and reablement service, More effective hospital discharges, and Nursing care home market changes, and will be chaired by Helen Woodland, Operational Director Social Care, Brent Council. There is a BCF steering group that oversees delivery of the four BCF groups, currently in existence. The BCF steering group will become the Local Services group and the set-up will slot into these proposed governance arrangements.
- 4.3.3a Mental wellbeing group:** This is the health and wellbeing priority for the year, as well as both a local and NWL STP priority. It will oversee the delivery area achieving better outcomes for children and adults with mental health needs. The proposed chair for this group is Stephanie Bridger, Divisional Director for Adult Mental Health Services and Learning Disability Services, Central and North West London NHS Foundation Trust. This is a new group. There is already a like-minded working group that reports into the NWL STP group. This Like-minded group will broaden its scope to deliver the local STP work streams. It will link to the mental wellbeing board, and the learning disabilities and TCP group. It will also link to a children's group currently in existence, the Children and Young People's Mental Health and Wellbeing Transformation Group which will deliver the young people's mental health and wellbeing work stream. As mental health is such a broad topic a separate group to deliver the learning disabilities work stream will be set up.
- 4.3.3b Learning disabilities/Transforming Care Partnership (TCP):** This group will oversee the delivery of the transforming care partnerships objectives, and the learning disabilities agenda. Sheikh Auladin, Deputy Chief Operating Officer, NHS Brent CCG
- 4.3.4 Unified frailty services:** This is a new group that will oversee the delivery of this area, achieving better outcomes and experiences for older people. It combines the older people elements within the BCF work streams so will report into local services, as it does in the North West London STP. James Walters, Divisional General Manager, London North West Healthcare NHS Trust will chair this group

- 4.3.5 Central Middlesex Hospital Redevelopment Group:** This will oversee the redevelopment of the Central Middlesex Hospital (CMH) site into Brent Health and Wellbeing Centre providing a range of local services including Urgent Care. This group will be chaired by Ralph Elias, Head of Planning Operational Lead, London North West Healthcare NHS Trust.
- 4.4 To underpin the work of the delivery groups, there will be enabler work streams including IT, one public estate, and workforce. Working groups for these will link to the STP Delivery Board.
- 4.5 Currently, lay members are not proposed in the membership of the working groups, but it is explicit in the delivery board terms of reference that nothing will be signed off or progressed without evidence of co-production (with professionals and the public).
- 4.6 The draft terms of reference are in Appendix two.

Background Papers

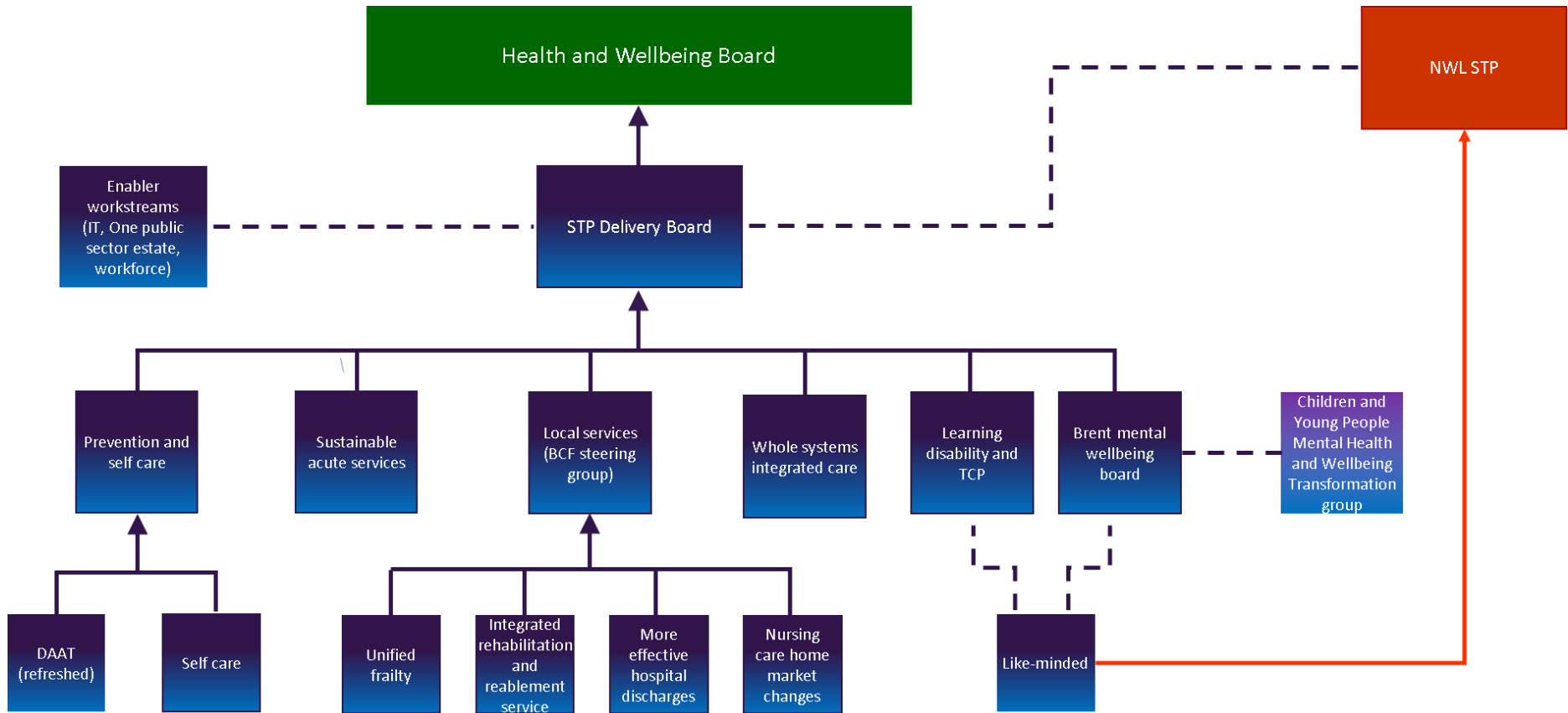
Background papers are available on request.

Contact Officers

Phil Porter, phil.porter@brent.gov.uk

Sarah Mansuralli, sarah.mansuralli@nhs.net

Appendix one



DRAFT TERMS OF REFERENCE

Sustainability and Transformation Plan Delivery Board

1. Purpose

- 1.1 The purpose of the Sustainability and Transformation Plan Delivery Board is to provide system wide leadership and accountability for the delivery of Sustainability and Transformation Plan (STP) in Brent.
- 1.2 The Brent STP will be the overarching strategic plan for Brent. The STP reflects and responds to the three gaps: Health and Wellbeing, Care and Quality, and Finance and Efficiency.

2. Governance

- 2.1 The STP Delivery Board will report to, and is accountable to the Health and Wellbeing Board, It will report to the Brent Health and Wellbeing Board through its Chair(s) and will develop a two way relationship with the Health and Wellbeing Board.
- 2.2 The STP Delivery Board will have oversight of six sub-groups that would be responsible for delivering different areas of the STP. The sub-groups will change annually according to the priorities for that year. The STP Delivery Board will determine the sub-groups and work streams.
- 2.2 The STP delivery board will have close working relationships with the enabler work streams, and the STP NWL Board.

3. Responsibilities

- 3.1 To own the delivery of the STP big ticket items and related delivery areas in Brent. For 2016/17, these are:
 - Prevention and self-care; Radically upgrading prevention and wellbeing
 - New models of care; Eliminating unwarranted variation and improving Long Term Conditions (LTC) management
 - Joining up frailty services; Achieving better outcomes for older people
 - Improving outcomes and wellbeing for children and adults with mental health needs;
 - Improving acute services and quality of life (Central Middlesex Hospital); Ensuring we have safe, high quality sustainable acute services
 -
- 3.3 To oversee and challenge progress and pace of delivery of all the work streams being delivered by the sub-groups
- 3.4 To ensure that the delivery plans from individual sub-groups are approved on the basis of evidenced co-production and engagement with stakeholders and the public.
- 3.5 To receive progress updates, including risks and issues, from sub-group chairs and to support the resolution of barriers and issues.
- 3.6 To monitor the achievement of agreed benefits and to lead corrective actions where benefits are not being achieved against the plan.
- 3.7 To escalate as appropriate, risks, issues and barriers which are preventing timely delivery of agreed schemes. Escalation may be within member organisations or collectively to relevant governing boards.

- 3.8 To oversee the development of a health and social care system which has a strong focus on prevention, early intervention, and self-care.
- 3.9 To oversee the development of a system which commissions and provides different models of integration, innovation and transformation to deliver care that enhances resilience and independence of our communities.
- 3.10 To take an economy wide approach to managing difficult issues and where appropriate to use freedoms and flexibilities available to maximum advantage locally and challenge the system where barriers exist and seek solutions at the necessary level.
- 3.11 To understand the total NHS and Local Authority resources and direct those resources to support transformation as required. This will include advising and informing the Health and Wellbeing Board on targeting of transferred NHS resources from acute to community settings.
- 3.12 To quality assure communications and engagement activity across the schemes and to assure itself that any changes to the system reflect the views and experience of local people and users of services.
- 3.13 To oversee service development and a culture change to deliver integration, innovation and transformation.

4. Membership

- 4.1 The group will have membership from both Brent Council, and NHS Brent CCG, and will also include the chairs of the sub-groups. It will be co-chaired by Phil Porter, Strategic Director Community Wellbeing, Brent Council, and Sarah Mansuralli, Chief Operating Officer, NHS Brent CCG.
 - Phil Porter, Strategic Director Community Wellbeing, Brent Council
 - Sarah Mansuralli, Chief Operating Officer, NHS Brent CCG
 - Helen Woodland, Operational Director Social Care, Brent Council
 - Sheikh Auladin, Deputy Chief Operating Officer, NHS Brent CCG
 - Dr Melanie Smith, Director of Public Health, Brent Council
 - Preeti Sheth, Integrated Care Programme Director, Brent Council and NHS Brent CCG
 - Stephanie Bridger, Divisional Director for Adult Mental Health Services and Learning Disability Services, Central and North West London NHS Foundation Trust
 - James Walters, Divisional General Manager, London North West Healthcare NHS Trust
 - Ralph Elias, Head of Planning Operational Lead, London North West Healthcare NHS Trust
 - Others as appropriate and agreed with the board chairs

5. Frequency of meetings

- 5.1 The meetings are to be held every two months.

6. Conflicts of interest

- 6.1 The board will adopt the Brent CCG policy and addendums for the management of conflicts of interest.

7. Review

- 7.1 The Brent STP Delivery Board Terms of Reference will be reviewed annually to reflect the STP priorities. The date of the next review is: September 2017

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 Brent	<p style="text-align: center;">6th October 2016</p> <p style="text-align: center;">Health and Wellbeing Board</p>
<p>For information Wards Affected: ALL</p>	
<p>Update Paper: Brent Children's Trust</p>	

1. Introduction

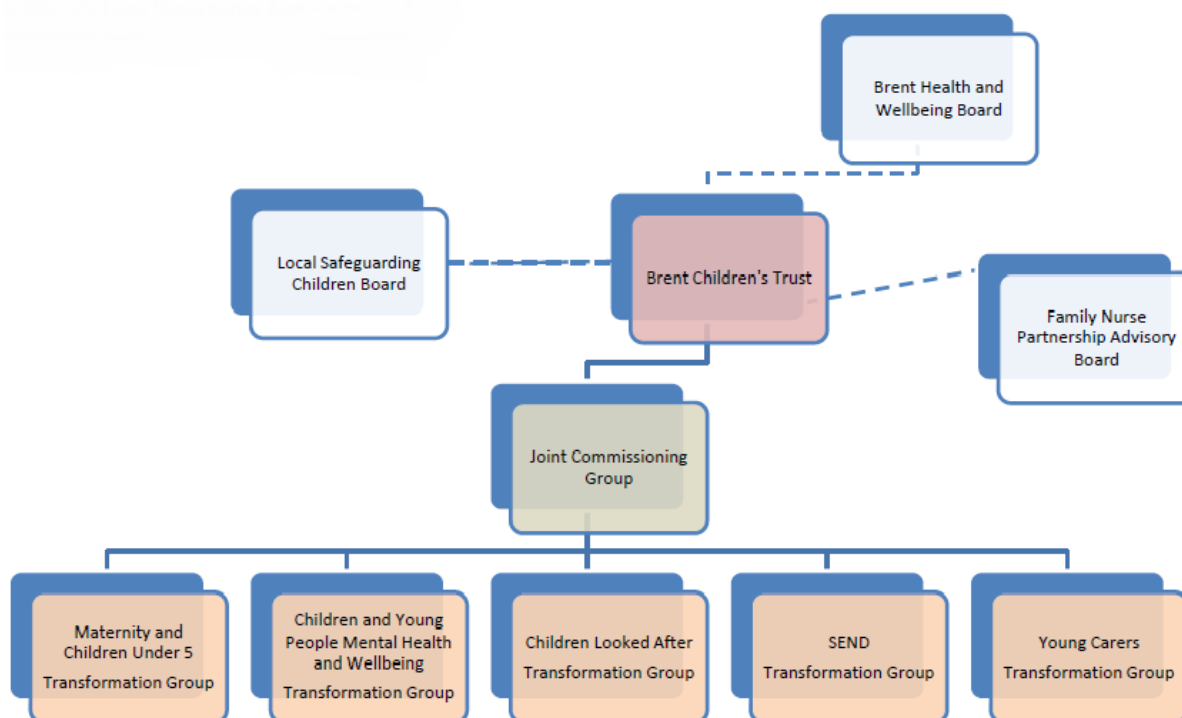
- 1.1. The Brent Children's Trust (BCT) is a strategic body that encompasses a local partnership of key partners. The primary functions of the BCT relate to collaborative working, commissioning and joint planning, in ensuring that resources are allocated and utilised to deliver the maximum benefits for local children and young people.
- 1.2. The BCT has a strong relationship with the Brent Health and Wellbeing Board and Local Safeguarding Children Board. Through the Children's Joint Commissioning Group (JCG), the BCT is linked to five transformation groups tasked with taking forward specific priorities at a more operational level. This structure is outlined in the diagram at 3.1.
- 1.3. This report follows two smaller updates - heard at the 7 June 2016 Health and Wellbeing Board, focussing on the '*giving every child the best start in life*' and '*helping vulnerable families*' priorities - and provides a broader summary of the BCT work programme and actions of the BCT sub-groups from April to September 2016.

2. Recommendations

- 2.1. The Health and Wellbeing Board is asked to:
 - Note the work of the Children's Trust from April – September 2016

3. Structure

- 3.1 The diagram below provides an overview of the governance arrangements of the BCT, JCG and five Transformation Groups.



4. BCT Work Programme

4.1 A 2016/17 BCT work programme was agreed in March 2016. BCT meetings are held on alternate months to progress the work programme, which remains flexible throughout the year to ensure oversight of and address challenges in the children and young people's landscape. All BCT agendas also include standing items to receive feedback from and provide steer to the JCG. A summary of the work of the JCG and its sub-groups is provided from 5.1.

4.3 Since April 2016 the BCT work programme has covered the following areas as non-standing items:

Children and Young People's Mental Health and Wellbeing (linked to STP)

- The BCT has continued to support and inform the progress of the CCG led CYP Mental Health and Wellbeing Transformation Plan through ongoing dialogue and action around its eight priorities:
 - 1) Needs assessment – BCT members committed to contributions from their areas to the Anna Freud Centre asset based needs analysis for Brent, including completion of online surveys and focus group attendance. The needs assessment is due to be completed in September.
 - 2) Supporting co-production – including maximising engagement opportunities and targeting specific groups and communities using jointly established CCG and Brent Council principles.
 - 3) Workforce development and training – competitive tender awarded to Anna Freud Centre, workforce assessment report now published.
 - 4) Specialist Community Eating Disorder Service for children – CNWL service is now open, Northwick Park Hospital site is not yet open.
 - 5) Redesigning pathways – to be progressed on completion of needs assessment (priority 1) and supported by priorities 2 and 3.

- 6) Enhanced support for learning disabilities and neurodevelopment disorders - to be progressed on completion of needs assessment (priority 1) and supported by priorities 2 and 3.
- 7) Crisis and urgent care pathways – awaiting needs assessment and findings from Out-Of-Hours pilot. Will also consider Single Point of Access CNWL business case, ‘new models of care’ work by NHS England and ‘child house’ models for safeguarding.
- 8) Embedding ‘Future in Mind’ – including improved joint commission arrangements through agreed joint funding of CAMHS commissioner from 2017/18.

Preparation for Joint Targeted Area Inspections (JTAI)

- In response to the January 2016 introduction of JTAI framework - which assesses the effectiveness of joint working of local authorities, health, the police, probation and youth offending in an area to identify, support and protect vulnerable children and young people – the BCT have been monitoring JTAI activity across other boroughs and reviewing guidance materials in preparation for a Brent inspection; the date of which is not yet known.
- The BCT has remained sighted on the changing deep dive themes of the inspections (pre-September this was ‘*child sexual exploitation and children missing from home, care or education*’ post-September it changed to ‘*domestic abuse*’) to consider the best response to different requirements.
- The BCT Chair and the Independent Chair of Brent LSCB have scheduled a separate forum with other key JTAI stakeholders to ensure coordination across all relevant Brent bodies.

Health Visiting and School Nursing Service alignment

- The BCT has discussed options and provided steer for the post 31/03/17 delivery arrangements of aligned Health Visiting and School Nursing Services.
- A separate task and finish group, including soft market testing, was encouraged to move forward with additional input from CCG and other stakeholders.
- On 15/08/16 Cabinet agreed the BCTs preferred commissioning option, which is 0-19s Health Visiting and School Nursing Service incorporating a weight management programme.

Scrutiny arrangements

- Following the October 2015 Ofsted SIF inspection, which had criticised Brent’s then Scrutiny arrangements as not being effective, a new model was introduced from 18/05/16. The BCT has discussed the model with the lead officer for the new Community and Wellbeing Scrutiny Committee; which primarily (though not exclusively) encompasses children and young people areas.
- Feedback from BCT members included requests for full follow through in response to the Ofsted findings, scrutiny items that offer solutions to corporate objectives, more efficient protocols for data requests, and the offer for Scrutiny Members to attend and observe BCT meetings (or similar).
- On 3rd November a Scrutiny awareness session about the work of the Children’s Trust and LSCB has been planned for Members.

- Updates and discussions with lead scrutiny officers has been added to the BCT work programme as a standing 6-9 monthly item to support stronger BCT/Scrutiny links and communication.

Collaborative working and information sharing

- The BCT has continued to work collaboratively with other strategic Boards, including Brent LSCB, as well as key partners such as the Healthy London Partnership (HLP).
- The LSCB Business Plan 2016-19 and Section 11 audit were presented to the BCT to ensure shared oversight of priorities, which has helped to identify areas for joint working.
- The BCT has developed closer links with the HLP, including opportunities for BCT to influence the content of the HLP data-packs and the promotion of HLP toolkits in Brent.

Local area SEND inspection planning

- In preparation for an anticipated SEND inspection the BCT have considered its scope, methodology and key questions.
- An exemplar inspection timetable has been developed and shared with CCG.
- The SEND Board / Transformation group are reviewing TORs to ensure best representation and attendance.
- A stakeholder map has been developed and received BCT feedback.
- The BCT have planned resources for the preparation and management of the inspection, including identifying a nominated, dedicated person for both Brent Council and Brent CCG.

4.4 Key work programme non-standing items to be heard at upcoming BCT meetings include the following:

- CCG commissioning intentions analysis;
- Children's JSNA review;
- LSCB annual report;
- National Childhood Obesity Action Plan response;
- Young Carers update report;
- CYP Participation Strategy monitoring report; and
- Troubled Families programme report - which is now scheduled as a six-monthly BCT item to give stronger grip of the '*helping vulnerable families*' priority.

Updates on these items will be included in future BCT to Health and Wellbeing Board papers.

5. Children's Joint Commissioning Group and Transformation Groups

- 5.1 As a standing item the BCT receives updates from and provides steer to the Children's JCG; which meets every two months to progress the Joint Commissioning Framework and consists of the Chairs of the five Transformation Groups, Brent CCG Children's Commissioner, Brent Council Children's Commissioner, and other key stakeholders.

- 5.2 In July the JCG increased its membership to include the CVS Brent Chief Executive Officer. The JCG plans a central role for CVS Brent over the next two to three years, which includes developing the local market prior to tendering for new and revised children's services. CVS Brent will help to structure this development, enable smaller organisations to work together and join-up, help to establish lead organisations in joint delivery partnerships and assist in areas of due diligence and minimum requirements to remove barriers to quality bids for service delivery. Other key workstreams will include leading on and coordinating joint engagement, which will be aligned with and inform commissioning opportunities identified by the JCG.
- 5.3 The JCG has established links with Brent's new Commissioning and Procurement Board to ensure that the work of the JCG complements and feeds into the corporate vision. This has included an in-depth discussion of the Brent Social Value policy (presented by the Head of Procurement) and the opportunity to feedback on the development of social value measures that will better align with Children's priorities. JCG membership now also includes the Children's Category Manager (for Brent / Harrow joint services) to ensure stronger procurement oversight.
- 5.4 In September a live 'contracts map' document was agreed by the JCG. The map currently provides details of all Local Authority contracts and agreements for Children's services - and will be adding the same content for CCG and Public Health services. The map groups services into the following broad categories:
- SEN Placements
 - Inclusion Services
 - English as an Additional Language (EAL) Projects
 - LAC Services
 - Health and Wellbeing Services
 - Family Support Services
 - Early Help
 - Services commissioned by other Departments / Agencies that benefit children (in development)
- The map includes the value, purpose, start date, end date and notice periods for all services and will be used by each transformation group to identify links and opportunities for new delivery models.
- 5.5 The JCG has directed the development of Plans on a Page (POPs) by each Transformation Group. The POPs are high level documents that detail the key outcomes and objectives of the individual working groups. Progress towards the objectives and related challenges and opportunities are discussion items at each JCG meeting.
- 5.6 Based on the findings of the contracts map and POPs detailed above the JCG has developed a draft Roadmap product. The purpose of the roadmap is to identify and clearly state the areas where the LA and CCG can link up over the next two to three years to deliver together. The roadmap will be finalised over the next few months - confirming the areas to be taken forward for joint delivery - and shared with partners and stakeholders.

5.7 The Transformation groups have continued to progress BCT and JCG priorities at an operation level. A selection of their key achievements and ongoing challenges are outlined below:

Maternity and Children under five Transformation Group

- Engagement of all the main maternity units at which Brent women give birth (only about half of Brent mothers give birth at units within the Borough).
- Agreement of shared priorities for partners as: obesity (including maternal), oral health, breastfeeding, immunisation.
- Promotion of childhood obesity training for front line health, social care and early years staff (funding secured from Health Education England)

Children Looked After Transformation Group

- Two permanent LAC nurses recruited.
- Successful consultation on the Brent Pledge for Children in Care.
- The group are looking into arrangements for ensuring smoother transitions into adulthood for care leavers.

SEND Transformation Group

- A Joint Strategic Action plan has been compiled.
- The group are taking steps towards pooling budgets to buy equipment for children with SEN.
- Therapy services (including Speech and Language and Occupational) have been identified as areas to develop joint commissioning options.

Children and Young People's Mental Health and Wellbeing Transformation Group

- Joint YOS-CAMHS post recruited to.
- Joint LA / CCG CAMHS commissioner post to be funded from 2017/18.
- Upon completion the group will be taking forward the findings of the Anna Freud Centre needs assessment and developing recommendations for Health and Wellbeing Board agreement.

Young Carers Transformation Group

- Successful consultation and engagement to develop new Young Carers leaflet to promote increased awareness.
- Development of new ways to identify young carers including new assessment form and linking with schools.
- The group are now looking at ways to set up and deliver a range of activities identified and requested via the engagement process.

Health and Wellbeing Board 6 October 2016

Report from Healthwatch Brent

For endorsement

Wards Affected:
ALL

Healthwatch Brent update:

Patient experience of phlebotomy services and the self-directed support of residents living with mental health conditions

Author: Julie Pal – CEO CommUNITY Barnet

1.0. Summary

- 1.1. Healthwatch Brent is the independent voice through which Brent residents can share their experiences of using health and social care services.
- 1.2. CommUNITY Barnet is commissioned by the London Borough of Brent to deliver the local Healthwatch contract.
- 1.3. The contract commenced from 1 July 2015 for an initial period of 12 months and then extended for a further 12 months. This report presents the findings of three action research projects funded through the Community Chest prepared by Healthwatch Team (Phlebotomy Services in Brent); Brent User Group (Self-directed Support – A Survey) and Brent Centre for Young People (A mental health needs assessment of young Irish people at Lynton Close)
- 1.4. The reports are attached as appendices for reference.

2.0. Recommendations

2.1. The Health and Wellbeing Board is asked to:

- Note the progress Healthwatch Brent has made in delivering the contract
- Note the contents of the reports for information.

3.0. Context

- 3.1. Healthwatch Brent works with 11 of Brent's charity, voluntary and community organisations.
- 3.2. It is delivered by a Brent-based central core team, a partnership of Brent based voluntary and community organisations and a team of volunteers.
- 3.3. The work programme of Healthwatch Brent aligns to all five priorities of the Brent Health and Wellbeing board namely:
 - Giving every child the best start in life
 - Helping vulnerable families
 - Empowering communities to take better care of themselves
 - Improving mental wellbeing throughout life
 - Working together to support the most vulnerable adults in the community
- 3.4. Healthwatch Brent is delivered on a Hub and Spoke model. The Hub is the first point of public access and delivered by the core team located in Wembley. The Spokes consist of two groups – the Healthwatch Brent Advisory Board whose role is to support the core team and shape the work programme around the needs of Brent residents. Membership of the Healthwatch Brent Advisory Board includes Age UK Brent, Brent User Group; Brent Patient Voice, Mosaic LGBT Young People's Group; Community Health Action Trust.
- 3.5. The Promotion and Reach Partners with their strong and vibrant networks are able to cascade messages from Healthwatch Brent to local residents. The partners include: Ashford Place, Brent Carers' Centre, Elders' Voice, Jewish Care, Brent Mencap.
- 3.6. Our strategic priorities for Healthwatch Brent include:
 - Encouraging greater participation in health and social care
 - Collecting evidence of increasing engagement with those residents from under-represented communities
 - Demonstrating that Brent residents feel more able to express their views and to report they are listened to
 - Showing how Healthwatch Brent has been able to make a constructive contribution to support and enable informed decision making through the representation of the authentic voice
 - Healthwatch Brent offers value for money
 - That Healthwatch Brent service offers added value
- 3.7. As part of our delivery, Healthwatch Brent committed £20,000 to establish a Community Chest which aimed to increase the capacity of local organisations to provide evidence based reports from less heard communities, increasing public awareness of Healthwatch Brent and increasing the number and range of views we gather. We created two grant programmes:

- 3.7.1 Large Grant Programme (maximum £3,000) to fund activities to support good practice or identify the needs of a service group. These applications were required to provide clear evidence of need and had to be approved by the Advisory Board.
- 3.7.2 Small Grants Programme (maximum £600) would raise awareness of the role of Healthwatch Brent. Applications have been approved by the Healthwatch Brent team.

4.0. Brent phlebotomy report

4.1 As a response to concerns raised at Healthwatch Brent's public meeting in October 2015, Healthwatch Brent looked into the phlebotomy service and patient experience.

4.2 Surveys and interviews with patients and professionals were carried out.

4.3 Key findings included:

- patients being largely unaware that they could have their blood tested at alternative GP practices (40% said their practice did not offer this);
- patients were generally satisfied with the phlebotomy service – 83% rated it as good;
- some patients show signs of isolation and might be frequenting clinics to overcome loneliness
- there was a mixed experience of waiting times in acute settings
- In GP practices waiting times for booking appointments varied according to how they were booked – patients booking at a GP reception were given their appointments more quickly
- At the GP practices that offered online booking of blood test appointments, patients were not necessarily aware of this service

4.4 The following recommendations were made:

For Commissioners:

- To commission voluntary schemes to address social isolation and tackle loneliness

For acute providers:

- at Northwick Park Hospital - to identify ways waiting times can be shortened, and to clearly communicate with patients
- to refer more patients to Central Middlesex Hospital Phlebotomy Clinic

5.0. Self directed support

- 5.1 Brent mental health User Group (BUG) carried out this research using the Community Chest funding as anecdotal evidence indicated that individuals using mental health services in Brent are utilising and benefitting from self-directed support in a range of creative and imaginative ways to meet their social care needs.
- 5.2 A survey was circulated to everyone who had made successful applications for self-directed support between 2013 and January 2016. Key staff in Brent's mental health services were interviewed. Analysis of anonymised data from Brent's self-directed support database was used.
- 5.3 Self-directed support was seen as positive overall, but some changes could be made, ensuring the individual would get they thought was right for them.
- 5.4 Recommendations from the report include:
- Ensure that staff maintain the ethos of self-directed support, enabling individuals to use direct payments in ways that they feel will meet their social care needs
 - Individuals need to have more choice about their personal assistants and staff need to work with them to ensure they feel in control of their relationship.
 - Staff need to work with individuals to enable them to identify and utilise personal assistants to do what they feel motivates them as opposed to what staff think will motivate people
 - Individuals need to be actively involved in measuring their progress; flexibility to meet individuals changing needs also needs to be incorporated
 - The role of personal assistants needs to be distinct from that of staff in specialist mental health services
 - Where individuals are using personal assistants via agencies, the role of the agency needs to be clear

6.0. Financial Implications

- 6.1. There are no financial implications as all costs are within the current agreed contract.

7.0. Legal Implications

- 7.1. Healthwatch Brent was established through the Health and Social Care Act 2012 to give users of health and social care a powerful voice both locally and nationally and formally launched in 2013 as an independent charity.
- 7.2 From 1 July 2015 its services have been delivered as an arms-length department of Community Barnet (CB) a charity and company limited by guarantee.

7.3 Financial and contract accountability remains with CommUNITY Barnet's Board of Trustees and delegated through the Chief Executive Officer to the Head of Healthwatch.

7.4 The contract is expected to run until 30 June 2017.

8.0. Diversity Implications

8.1. The reports presented reflect Healthwatch Brent's commitment to equalities and believes that they support Brent Council in meeting its Public Sector Equality Duty as defined in Section 148 of the Equality Act 2010.

9.0. Staffing / Accommodation Implications (if appropriate)

9.1. None for the purposes of this report.

Background Papers

Background papers are available on request.

Contact Officers

Julie Pal

CEO CommUNITY Barnet

Julie.pal@communitybarnet.org.uk

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Phlebotomy Services in Brent

July 2016

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GLOSSARY OF TERMS

CCG	Clinical Commissioning Group
CMX	Central Middlesex Hospital
GP	General Practitioner
HOSC	Health Overview and Scrutiny Committee
ICE	Integrated Clinical Environment
LNWHT	London North West Healthcare Trust
NPH	Northwick Park Hospital
PCT	Primary Care Trust
RCA	Root and Cause Analysis
TDL	The Doctor's Laboratory

INTRODUCTION

Healthwatch Brent is an independent local organisation, and part of the national network led by Healthwatch England, established under the Health and Social Care Act 2012. Healthwatch is the independent voice of local people to get the best out of their health and social care services, to enable residents to contribute to the development of quality health and social care services, and to provide information on local services in Brent. It was formed in April 2013.

We listen to people's views about Brent health and social care services. We listen to individuals of all ages and from all of Brent's communities. We visit community groups, public events, hospitals and health and social care venues to tell local people about Healthwatch. We listen to what they say about health and social care – the good and the bad. If there are concerns about the quality or safety of services, or there are unmet needs, we feedback patients' experiences, to local commissioners and decision makers, in order to improve the service.

The Community Outreach Team of Healthwatch was swift to build upon existing positive contacts and a range of outreach sessions in a variety of venues were arranged. In October 2015, Healthwatch Brent held a public meeting. The aim of the event was to raise awareness of Healthwatch's role, and how people could get involved. A number of local residents shared their experience with us about phlebotomy services, with some individuals saying that their 'test results were lost, so I was asked to do the test again'. In response to this and other similar local feedback, Healthwatch Brent designated phlebotomy services as a priority area for research.

Note: All responses of individuals, who took part in our research, are anonymous except for those who have explicitly provided consent.

EXECUTIVE SUMMARY

Purpose: Why we are looking into phlebotomy services

At Healthwatch Brent's public meeting in October 2015, concerns were raised about phlebotomy services, and Healthwatch Brent were asked to look into the service and the patient experience. There was no clarity on whether the services were provided directly by GP services or secondary/acute care providers. Some concerns had been raised about the performance of this service in Brent Clinical Commissioning Group (CCG) report about the quality and risk management of handling phlebotomy and pathology results (Update, Brent and Harrow PCT, 2013), which further prompted us to explore the service further.

In 2013, a Root and Cause Analysis (RCA) highlighted the factors behind these concerns and was carried out by a multi-disciplinary team. The analysis emphasised the importance of communication, and how it differs among providers, which should guide commissioners to invest in building capacity in having a more robust approach in phlebotomy services between primary and acute care providers.

Healthwatch Brent talked to patients who lived in Brent and who had a blood test in the past six months, either at GP or hospital settings. Feedback from patients in Brent revealed mixed experiences with the service. However, overall, patients value the contact and rapport they develop, with clinicians, during their visit to the phlebotomy clinics, confirming the vital role that professionals play in the lives of patients on a daily basis.

Aim

- To learn about the patient experience with phlebotomy services in Brent

Objectives

- To learn about the patient journey with GP-based services
- To learn about the patient journey with hospital-based services
- To learn about the reasons for requesting repeat blood tests
- To learn about what patients need and suggest for service development and improvement

Methodology: How we made our findings

A mixed methodology of interviews and survey was used to inform our findings including:

- Face-to-face survey with patients who attended phlebotomy services between January and May 2016. Seventy patients responded
- 10 professionals, from primary and acute care settings, provided service information to Healthwatch Brent including:
 - 5 GP Practice Managers
 - 4 professionals from London North West Healthcare Trust (LNWHT)
 - 1 professional from Brent CCG

Findings:

Key themes emerged:

1. Individual's experience:

- Patient awareness of alternative services: Approximately 38% of patients (41% from hospital; 35% from GP clinics) surveyed do not know that they can have their blood test

at an alternative GP practice. Around 40% claim that their GP practice does not offer this option.

- Patient's self-care and clinical follow-up: Patients who receive regular follow-ups from their clinician tend to be aware of their health condition and attend their test appointment when requested by their clinician.
 - Patient satisfaction: Around 83% of patients rate the phlebotomy service either at their GP practice or hospital, as good. GP patients would like to see faster information about their test results, and quicker access to appointments. Hospital patients would like to have less waiting time at the drop-in service.
 - Some patients, while having a blood sample taken, had experienced pain, discomfort, and on occasion, bruising.
2. Community picture:
- Some patients show signs of social isolation, which may be a key factor in frequenting health or phlebotomy clinics to overcome loneliness.
3. Service provision:
- Some patients believe that hospital care is more holistic than less-resourced GP services, which have led them to frequent hospital phlebotomy clinics rather than their GP.
 - Mixed experiences with waiting times for a blood test, at the hospital drop-in service, may largely depend on the patient in-flow in a given venue at a given time, where Central Middlesex clinic may have capacity to see more patients at the phlebotomy clinic.
 - The waiting time for booking appointments for a blood test at a GP practice may vary depending if patients make an appointment on the phone or at the reception. Phone booking seems to take longer to make, while patients are given appointments more quickly at the GP reception. GP patients in larger clinics report facing longer waiting times for an appointment.
 - Booking an appointment for a blood test online is available at some GP practices, and patients may not necessarily be aware of the service.

Recommendations

A. For commissioners

- To commission voluntary schemes to explore how the incidence of social isolation can be addressed, and to identify support for community cohesion and to tackle loneliness among patients who visit health services frequently.

B. For acute providers

- To explore the waiting times at the Northwick Park clinic in order to identify ways that this can be shortened and/or clear communication is provided for patients so they understand why this may be the case.
- To consider ways that more patients can be referred to Central Middlesex Hospital phlebotomy clinic.

C. For primary care providers

- To promote the option of attending alternative GP practices for blood tests, specifically among GP patients who may have to wait for a blood test for longer than 5 days.
- To inform patients as to when test results will be made available.

- To identify ways to improve the patient experience when making appointments on the phone.

D. For all providers

- To ensure the provision of refresher guidance and information to patients on how to reduce the incidents of pain, discomfort, and bruising after a blood test. Additionally, patients could be advised that the test may result in discomfort or bruising.

E. For individuals and communities

- To ask your GP, phlebotomist, or clinician involved in your blood test for help and guidance when you are in need of advice on how to reduce the incidents of pain and discomfort of finding a vein or how to reduce the likelihood of developing a bruise after a blood test.

METHODOLOGY

Healthwatch Brent followed a collaborative 360 approach, working in partnership with GP practices, London North West Healthcare Trust (LNWHT), and Brent CCG. Healthwatch Brent sought the views and feedback from GP practice managers and hospital service managers, and equally from patients. Information was collected as follows:

- *Patient survey*: This is an in-house survey developed by Healthwatch Brent to learn about the patient experience. Seventy patients took part in the face-to-face survey; 29 GP-based respondents, and 41 hospital-based respondents. The survey was presented at:
 - 3 Brent GP practices in Kilburn, Wembley and Willesden
 - Northwick Park and Central Middlesex Hospital phlebotomy clinics
- *Practitioner interviews*: An in-house semi-structured interview was held to learn about the phlebotomy and pathology current practice, from the point of referral to reporting results to the requesting clinician and to patients. The interviews were held either face-to-face or over the phone with:
 - LNWHT Pathology Manager
 - The Doctor's Laboratory (TDL) Laboratory Manager
 - Five GP Practice Managers including Chichele Road Surgery, Law Medical Group Practice, Gladstone Medical Centre, Alperton Medical Centre, and Harness Harlesden Medical Centre
- *Literature review*: Healthwatch Brent looked into the following:
 - Brent CCG Phlebotomy Service Specifications 2014-2017 for primary care, provided by Brent CCG¹.
 - Family and Friends Test results for Northwick Park phlebotomy services obtained from LNWHT, for the month of October 2015².

Note: All responses of patients who took part in our report are anonymous.

¹ Provided by Brent CCG Primary Care Project Manager on 13 June 2016

² Provided by LNWHT on 19 January 2016

BACKGROUND

Definition: Phlebotomy and pathology

The National Association of Phlebotomists defines phlebotomy or blood testing or taking as “...the practice of obtaining blood from a vein, and will often be an additional skill for Healthcare professionals”³. This can be carried out by a phlebotomist, a healthcare assistant, a nurse, a doctor or other health professionals. In the UK, there is no entry requirement or qualification to become a phlebotomist, however, training-on-the-job is usually provided by employers⁴.

Once a blood sample is taken from a patient, the sample is transferred to a pathology laboratory. In the NHS, pathology⁵ is defined as “...the study of disease, its causes and progression...Every time [one gives] a blood, stool, urine or tissue sample, it is analysed by a pathologist, [who] looks for abnormalities within samples ... to help with the early detection of potentially fatal conditions” or for research purposes to find a cure.

Phlebotomy in Brent

In 2014, Brent CCG commissioned phlebotomy services in accessible community GP practices, to make health services available in the local area. Brent service providers deliver 190,000 blood tests in 58 GP practices, 2 walk-in clinics in Sudbury and Burnley (Brent CCG Service Specifications Phlebotomy, 2014-2017), and also a drop-in service at Northwick Park and Central Middlesex hospitals.

Current service provision

a. GP or community-based services

Healthwatch Brent had interviewed five GP practice managers in Brent, from both small and larger practices, where their patient population may range from 2,500 to 15,000. The interviews focussed on how the service is being delivered at GP practices.

From April 2014, around 58 Brent-based GP practices provide phlebotomy services either on their premises or in an alternative GP practice in the local area. Six other practices are part of a local GP network where they share resources to increase patient access to primary care services at a convenient time and location for patients⁶. Some GP practices run the phlebotomy service five days per week, while others offer it on a weekly basis. GP practices that offer the service weekly or exclusively in an alternative GP practice often inform the patient to book an appointment directly with the alternative GP practice. Test results are returned electronically to the patient’s GP on a system called ICE (Integrated Clinical Environment). According to LNWHT pathology management, some GPs may submit requests to the laboratory for tests manually, not electronically, which may delay the process of reporting results. GP compliance with ICE requests are monitored by LNWHT pathology management on a monthly basis.

³ www.phlebotomy.org/faq Retrieved on 10 May 2016

⁴ www.healthcareers.nhs.uk/explore-roles/clinical-support-staff/phlebotomist Retrieved on 10 May 2016

⁵ www.nhs.uk/NHSEngland/AboutNHSservices/pathology/Pages/pathology-services-explained.aspx Retrieved on 10 May 2016

⁶ Information provided by Brent CCG Primary Care Project Manager, on 13 June 2016

Opening hours generally are from 8am to 12pm, after which a courier collects the blood samples at or after 2pm to transfer them to the laboratory located at Northwick Park Hospital, on a daily basis. According to TDL pathology management and GP practice managers, results are usually reported back, the next day or on the second day, to the GP who requested the blood test, however, this may vary occasionally based on the type of the blood test requested.

b. Hospital-based services

LNWHT provide phlebotomy services at Northwick Park and Central Middlesex hospitals. During the three-hour visits that Healthwatch Brent carried out to the hospital sites in Northwick Park, 90 patients were seen during the visit; and in Central Middlesex, 60 patients were seen during the visit. The average number of patients seen per day may vary, based on whether a number of hospital departments would refer their patients on any given day for specific blood tests. The opening hours are from Monday to Friday, 8am to 4pm. It is a drop-in service.

A private company, TDL, is the pathology provider where they analyse all blood samples, and other tests, since December 2012. They are based at Northwick Park Hospital.

Pathology incidents

In 2012, pathology incidents and concerns were raised by a number of Brent and Harrow GPs. The concerns raised included missing samples, spurious results, and pathology results received by GPs had a different format than previously experienced; and the pathology provider, at the time, failed to report on or to flag some abnormal results, which may cause a clinical risk (RCA, 2013).

Between January and March 2013, a comprehensive Root-and-Cause Analysis (RCA) report (RCA, March 2013; Update on Investigation, May 2013)⁷ was chaired by a Brent GP, to look into these pathology incidents. The report outcomes were presented to the Health Partnerships Overview and Scrutiny Committee (HOSC), after which an action plan was put in place. The plan was overseen by clinicians and managers from three commissioning bodies (Brent CCG, Harrow CCG, and LNWHT).

The RCA report (2013) identified seven causes as to why these incidents took place, during the period of transition from PCT to CCG:

- No measures taken by PCT to mitigate risks (in transition and implementation)
- IT system set-up had technical issues resulted in producing different formats of results
- Equipment stability was malfunctioned
- The transition from PCT to CCG has affected the Shared Drive, and the electronic and paper records
- Lack of clinical engagement in the process (no grass roots GPs; used same clinicians, too thinly spread)
- Poor reporting and communication structure in both PCTs (Brent and Harrow)

⁷ Update on the Investigation into incidents involving the Pathology Service for Brent and Harrow PCTs 23rd May 2013. <http://democracy.brent.gov.uk/documents/s17282/pathology-update.pdf>. Retrieved on 10 May 2016

- Laboratory staff needed familiarisation with equipment and systems, and customisation of system to meet the end-user’s clinical needs

The storage, transportation and delivery times of the courier service provider were also reviewed, to support the transfer of the samples between GP practices and the laboratory.

FINDINGS

A. Patient journey

There are two types of patients taking a blood test (phlebotomy):

- *GP patients:* When a GP refers a patient for a blood test, they usually have the test in a community-based centre, either at their GP practice mainly, or a local health centre.
- *Hospital patients:* When a hospital clinician refers a patient for a blood test, they usually have their blood taken either at Northwick Park Hospital or Central Middlesex Hospital, on a drop-in basis.

All blood samples are sent to a laboratory in Northwick Park Hospital for analysis (pathology). Although phlebotomy and pathology are distinct disciplines from one another, both services are part of the blood testing circle:

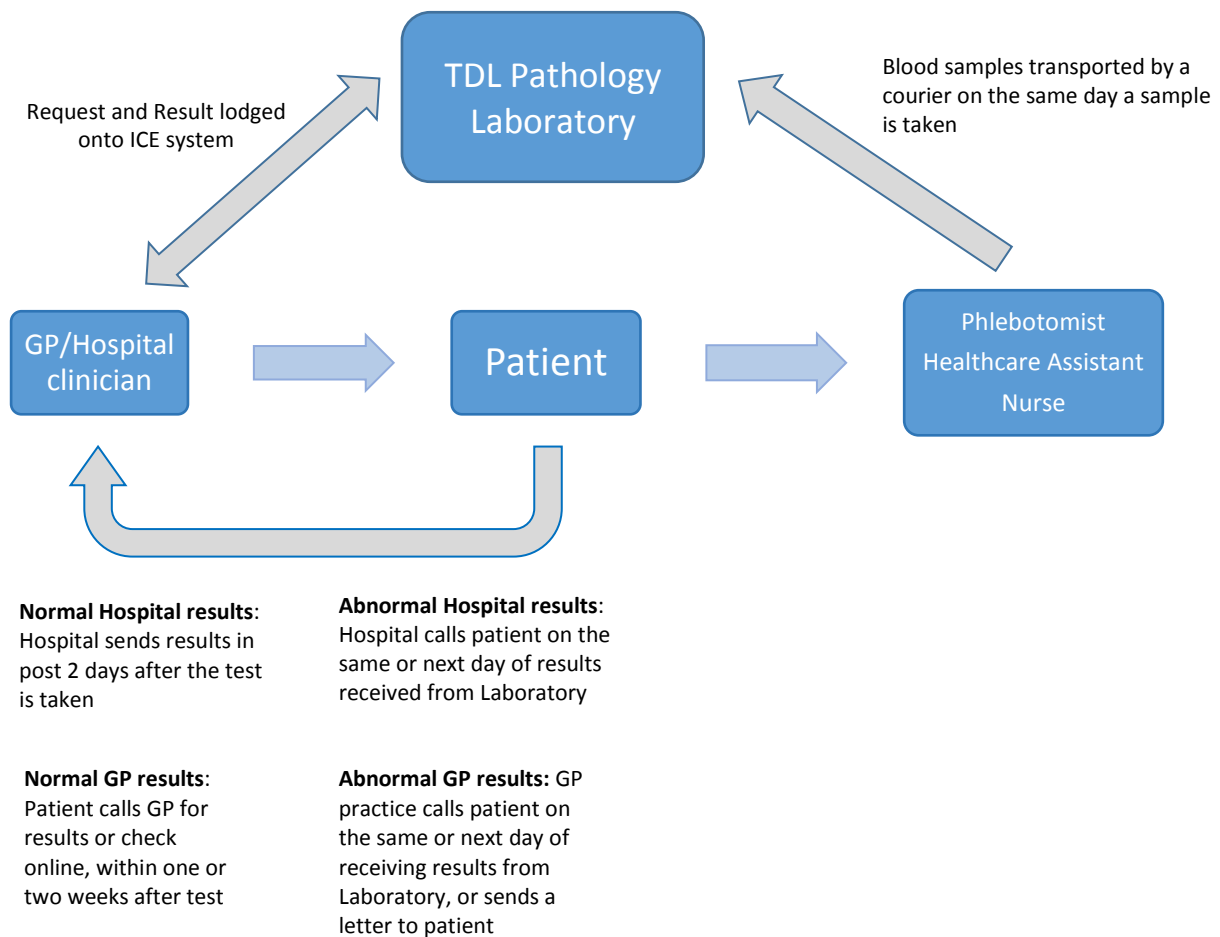


Figure 1. Patient Journey in Phlebotomy (based on patients' survey)

B. Patient experience

Healthwatch Brent looked into the patient's feedback from two sources:

1. Family and Friends Test (FFT)

In October 2015, 5 patients responded to FFT at Northwick Park clinic⁸, and provided the following feedback:

- Staff are caring, helpful and friendly
- The drop-in ticketing system is well-received
- A long wait at the drop-in service
- An overcrowded waiting room raises the concern for infections from other patients
- Not enough parking places

2. Healthwatch Brent Survey

The following findings are based on the feedback provided by patients from Healthwatch Brent survey, which look into the patient journey in GP and hospital settings.

	GP patients	Hospital patients
Waiting times for a blood test	10-15 minutes	Up to 2 hours
Access to making appointments	42% appointments made available within 2-5 days 21% appointments booked on the same or next day 12% booked more than 5 days	Drop-in service Mon-Fri 8am to 4pm
Venue location	GP practice or an alternative practice	Northwick Park or Central Middlesex Hospitals
How to book appointments	59% at the GP reception/drop-in 25% On phone	Ticketing system at a drop-in service
Medical care	GPs provide long-term care including regular health checks and follow-up	Clinicians may recognise more issues facing a patient, and therefore provide holistic care, and GPs are less likely to provide comprehensive care.
Result reporting	Normal results are patient-led Abnormal results are practice-led. Patients report that normal results are available within one-two weeks after the test.	Normal and abnormal results are hospital-led. Patients report that they receive a yellow booklet in post two days after the test if the results are normal. If results are abnormal, hospital calls patients.
Awareness of phlebotomy appointments at an alternative GP practices	25% are aware of the service 75% do not know or affirm that the service is unavailable	18% are aware of the service 82% do not know or affirm that the service is unavailable

⁸Information provided by Ward Matron, Northwick Park and Central Middlesex, LNWHT on 19 January 2016

C. Overall feedback from patients

1. Hospital patients

What is working well?

- Staff are helpful, friendly, and competent
- Regular reminders and check-ups
- Care is holistic at the hospital
- A quick process and short wait for a blood test, at Central Middlesex clinic
- Clinic facility includes drinking water
- Signage helps to get around the hospital

What is not working well?

More frequently received feedback

- Long wait which can go up to two hours at Northwick Park clinic
- Some phlebotomists are unable to find a vein and patients have experienced pain or discomfort as a result

Less frequently received feedback:

- Results only sent upon appointment with consultant which may be scheduled weeks or months after taking a blood test
- Location is not locally accessible
- Results can take too long to be sent to patients
- Chairs at Northwick Park are hard and cold to sit on
- Coordination between Northwick Park and St Mark's Hospital can be improved when referred from one unit to another and when making appointments
- Car parking is expensive
- No advanced technology for diabetes test

2. GP Patients

What is working well?

- Caring and helpful staff
- Choice of available appointment slots
- Regular reminders and check-ups
- Clinical capability in taking blood samples (i.e., "it doesn't hurt")
- Short waiting time on the day for appointments

What is not working well?

More frequently received feedback

- Difficulty to get through to the practice on the phone to book an appointment for a blood test
- It can take up to one month to have a GP appointment

An individual feedback

- One patient reports receiving wrong information given about their condition which resulted in a visit to A&E and a repeat test

"Everything here is professional"

– A patient at Northwick Park

"I came here...to do this test, and I was surprised that they don't have a gadget...like for diabetes to do the test as it is easier...but generally they are very nice staff"

– A patient at Central Middlesex

"Phlebotomists appear inexperienced. Fiddle around looking for veins..."

– A patient at Central Middlesex

"I was feeling unwell, and I didn't know why. So I went to the GP...I was given a 6-month course of tablets for iron. They sent me a letter about this, and it was good, and they were checking with me regularly"

– A GP patient

"They don't always answer [the] phone. Sometimes [I] have to wait for up to a month for an appointment"

– A GP patient

Note: from patients' feedback, there seems to be no evidence of lost results, and only one repeated test was found, as stated in the section above.

ANALYSIS

A. Individual's experience

- *Patient awareness of alternative services:* Around 42% of GP patients report having an appointment available within 2-5 days, and 12% had an appointment available more than 5 days. GP patients highlight that generally some appointments were made as per the patient's request, and other appointments were made available within one week or more due to the non-availability of earlier appointments at the patient's GP practice. Approximately 38% of all patients (41% from hospital; 35% from GP clinics) surveyed do not know that they can have their blood test at an alternative GP practice. Around 40% claim that their GP practice does not offer this option. Hospital patients claim that they cannot have their blood test in the community as the test is available at the hospital clinic only, and not at their GP practice.
- *Patient's self-care and regular follow-up:* Patients who receive regular follow-ups from their clinician report to be aware of their health condition and attend their test appointment when requested by their clinician. Regular follow-up may empower patients to have less hospital visits and to manage their health more independently and in the community.
- *Patient satisfaction:* Around 83% of patients rate the phlebotomy service either at their GP practice or hospital as good. GP patients would like to see faster information about their test results, and quicker access to appointments. Hospital patients would like to have less waiting time at the drop-in service. Consistent feedback was provided from both GP and hospital patients that the long-standing dedication from the health professionals is appreciated. Patients emphasise that the staff's caring and supportive attitude is what makes the valuable difference to their care experience.
- *Patient's confidence in clinical competence:* Patients recognise that some phlebotomists or health care assistants may need further support to develop their clinical expertise and confidence in administering blood tests. Some patients report experiencing pain and discomfort while having their blood taken.

B. Community picture

- *Social isolation:* While carrying out the face-to-face survey in phlebotomy clinics, a number of patients, during their contact with Healthwatch, shared personal challenges and family issues openly. Most of these patients were older people or single adults. Sharing their experiences with a stranger seems to be urged by a feeling of loneliness and social isolation; an opportunity for connecting with other individuals is often appreciated, and therefore, a patient's frequent visits to a health clinic could be mainly driven by a sense of isolation, and an innate need to connect with another human being.

C. Service provision

- *Hospital holistic care:* Patients appreciate the holistic care and regular contact they receive from the hospital. For example, a number of patients report to have attended for a blood test, but then they had other checks as they were deemed necessary by hospital professionals at the time, including knee pain, kidney problems besides other issues. This feedback was consistent among hospital patients. Having the reassurance of receiving

holistic care, and having a good relationship with one's hospital consultant, may explain why patients, if they have the option, prefer to attend the phlebotomy clinic at hospital rather than locally in the community.

- *Hospital waiting times and resources:* Mixed patient experiences, with waiting times for a blood test, at the drop-in hospital service may have been impacted by the patient in-flow at any given day. Patients attending Central Middlesex clinic appear to report shorter waiting times, compared to Northwick Park clinic. CMX may have capacity to have more patients seen at the phlebotomy clinic. For example, one patient reports having to go to NPH clinic, which is a long journey for her. She says that the professional designated for tests like hers is available at Northwick Park only, and that she would benefit from having her test at CMX.
- *GP service access:* There seem to be variations in patient experience having access to GP appointments for blood tests. This may vary depending on how the patient makes their appointment; patients who make an appointment on the phone claim that they are more likely to experience difficulties getting through to the practice, and to be given an appointment within 2-5 days; while patients who make an appointment at the reception may get their appointment on the day or next day. Some patients, from smaller practices, report that they get drop-in appointments with easy and quick access on the day, where practices also share phlebotomy resources with other GP practices. Some patients, from larger GP clinics, claim that they have a longer waiting time for a blood test appointment.
- *Online GP services:* In some practices, online services are increasingly becoming available, including booking appointments or checking test results. However, GP patients tend to mostly make their appointment for a GP or a blood test either at the reception or over the phone which may require resources. Booking a blood test online may be available, and patients may not be aware of the service.

RECOMMENDATIONS

A. For commissioners

- To commission voluntary schemes to explore how the incidence of social isolation can be addressed, and to identify support for community cohesion and to tackle loneliness among patients who visit health services frequently.

B. For acute providers

- To explore the waiting times at the Northwick Park clinic in order to identify ways that this can be shortened and/or clear communication is provided for patients so they understand why this may be the case.
- To consider ways that more patients can be referred to Central Middlesex Hospital phlebotomy clinic.

C. For primary care providers

- To promote the option of attending alternative GP practices for blood tests, specifically among GP patients who may have to wait for a blood test for longer than 5 days.
- To inform patients as to when test results will be made available.
- To identify ways to improve the patient experience when making appointments on the phone.

D. For all providers

- To ensure the provision of refresher guidance and information to patients on how to reduce the incidents of pain, discomfort, and bruising after a blood test. Additionally, patients could be advised that the test may result in discomfort or bruising.

E. For individuals and communities

- To ask your GP, phlebotomist, or clinician involved in your blood test for help and guidance when you are in need of advice on how to reduce the incidents of pain and discomfort of finding a vein or how to reduce the likelihood of developing a bruise after a blood test.

CONCLUSION

Individuals who attend phlebotomy services at their GP practice in the community appreciate the convenience and the long-term relationship they have with their GP. Hospital patients appreciate the rapport they develop with their hospital consultant, and the provision of holistic care for various health issues. Individuals, whether attending community or hospital services, generally value building a long lasting relationship with their clinician, who is able to recognise them by their first name, and to make them feel valued and cared for. Most of the feedback provided by the patients in the survey emphasises the value of long-term investment in staff development and recruitment of experienced and competent professionals, who are also caring and supportive of the patient's needs. It would be useful to work in partnership with patients, keeping in mind, that investing in relationship-building between patients and professionals is what would provide good care and healthy communities on the long-term. Further research is needed to explore a sustainable approach to reinforcing self-care, community cohesion, championed by both health and social care authorities, as well as by the local community.

REFERENCES

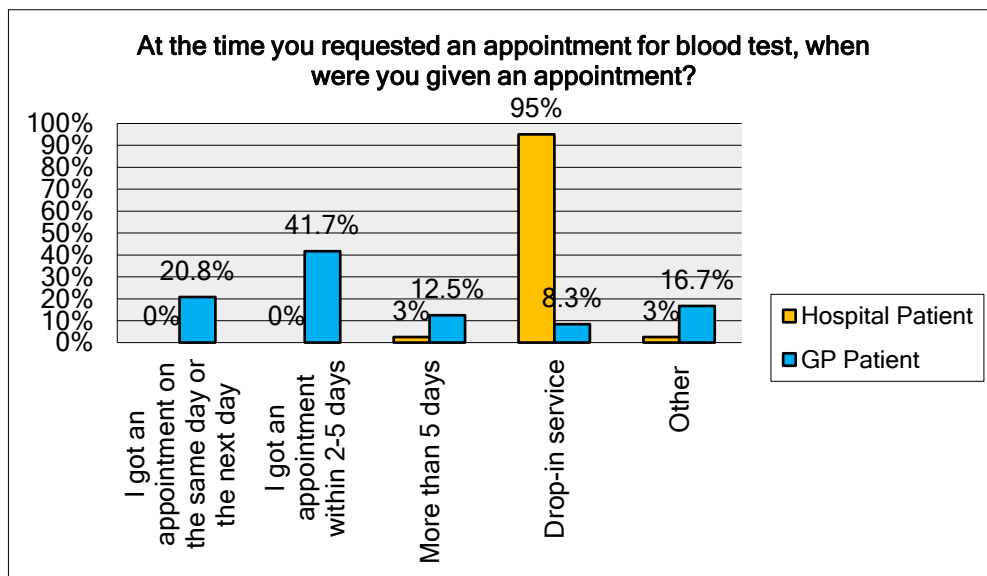
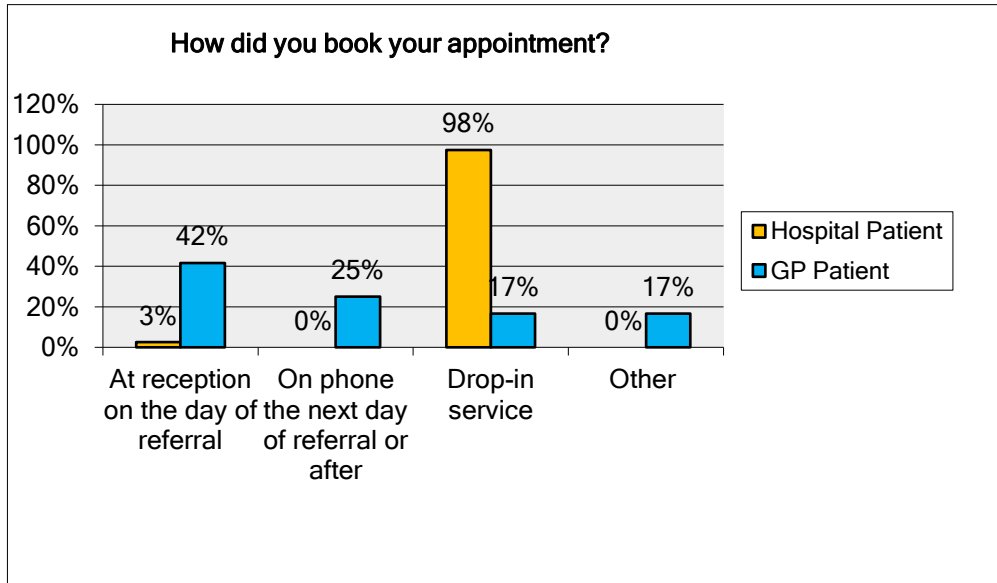
- Brent CCG Adult Phlebotomy Service Specifications 2014 (Primary Care)
- National Association of Phlebotomists, www.phlebotomy.org/faq. Retrieved on 10 May 2016
- NHS Health Careers, phlebotomist's role, www.healthcareers.nhs.uk/explore-roles/clinical-support-staff/phlebotomist Retrieved on 10 May 2016
- NHS, pathology services explained, www.nhs.uk/NHSEngland/AboutNHSservices/pathology/Pages/pathology-services-explained.aspx. Retrieved on 10 May 2016
- Update on the Investigation into incidents involving the Pathology Service for Brent and Harrow PCTs 23rd May 2013. Retrieved on 10 May 2016
- Pathology Contract Tests and Report of Results: Root Cause Analysis Investigation Report, NHS Brent, March 2013
- Pathology Service - Incidents and Investigation: Health Partnerships Overview and Scrutiny Committee, 11th June 2013. Retrieved on 10 May 2016.

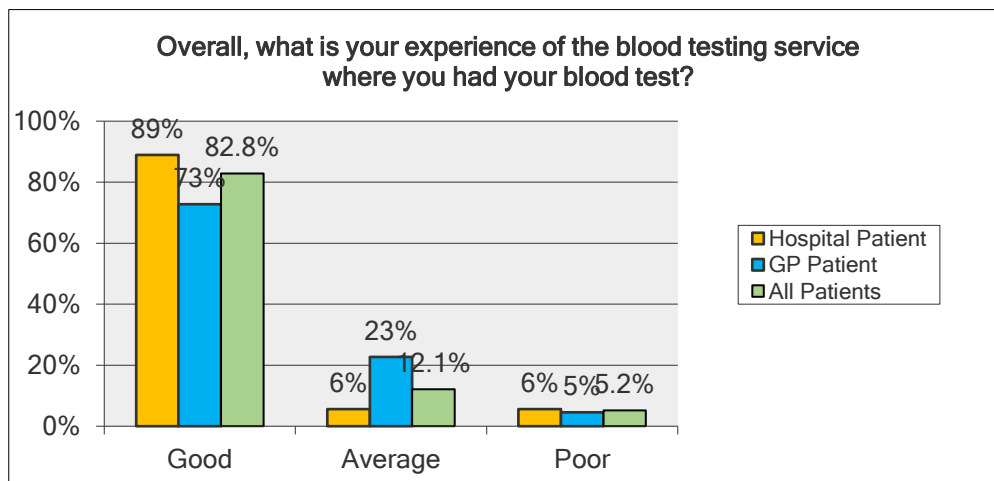
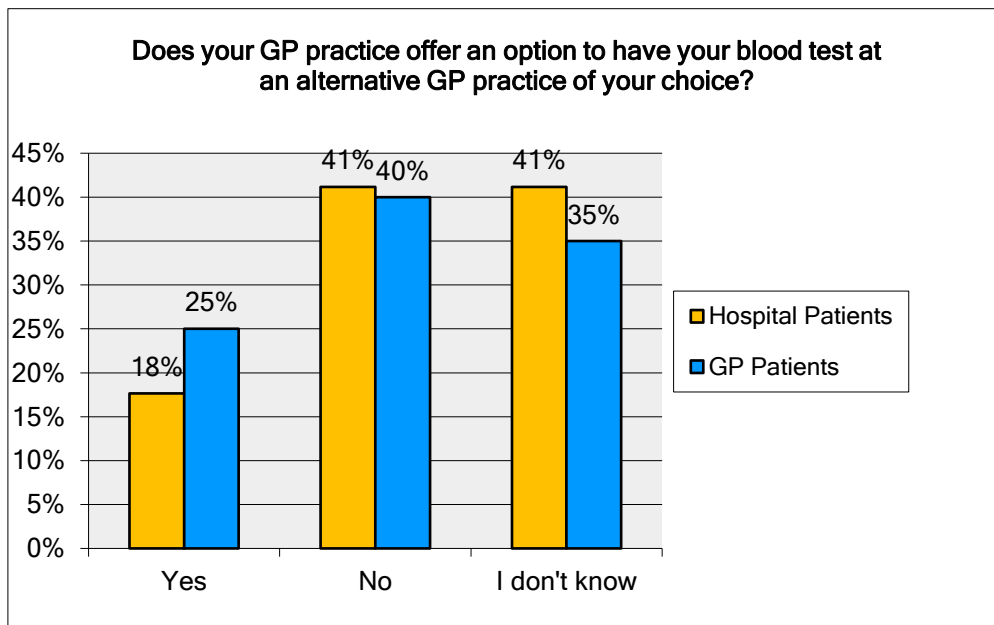
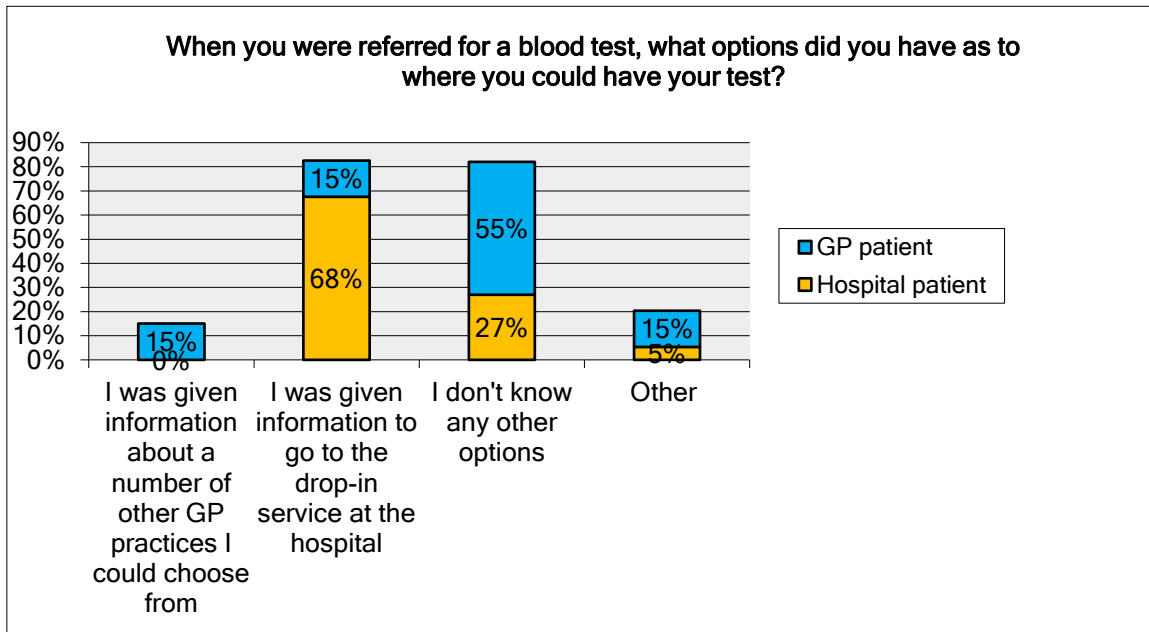
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- The Doctors Laboratory (TDL)

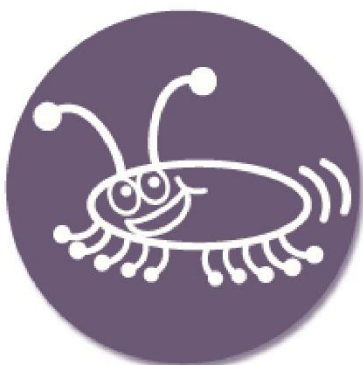
APPENDIX
Graphs





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Self directed support **A Survey**



carried out by BUG
Brent Mental Health User Group

Commissioned by Healthwatch Brent

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INTRODUCTION

EXECUTIVE SUMMARY

Use of self-directed support by people using mental health services in Brent

Healthwatch Brent's Community Chest funding to enable local community organisations to undertake research has presented this opportunity as anecdotal evidence has indicated that individuals using services in Brent to deal with mental health issues are both utilising and benefiting from their use of self-directed support in a range of creative and imaginative ways to meet their social care needs. As highlighted by the National Audit Office indicators specific to personalised commissioning in the DH's Social Care Outcomes Framework measure take-up rather than user outcomes and there has been little systematic analysis to date of the relationship between use and benefits for individuals using direct payments.

While this research report for Healthwatch Brent includes a summary of feedback from individuals using self-directed support in Brent who responded to the survey carried out by Brent Mental Health User Group and brief information about the analysis of people's use of self-directed support between 2013 and January 2016 via Brent's mental health services, full detail is included in *Report on use of self-directed support by people using services to deal with mental health issues, BUG, August 2016*. Information from interviews with key staff is incorporated throughout.

Progress in relation to use of self-directed support by people using mental health services

Evaluations carried out since the introduction of direct payments highlighting that individuals using mental health services were making significantly less use of direct payments than other groups have resulted in a number of pieces of work to increase uptake. Both experience to date in Brent, including that incorporated in this research report, have highlighted continuing barriers which need to be addressed to embed systematic use of direct payments to meet the social care needs of individuals using mental health services. Addressing key issues and recommendations made – incorporating the views of individuals using services and staff in service providers – will facilitate improvement in future. Learning from existing projects and work to facilitate use of personalisation and self-directed support will strengthen use.

Brent's Health and Wellbeing Board achieving its strategic objectives

Systematically facilitating use of self-directed support by individuals using services to deal with mental health issues will significantly contribute to Brent's Health and Wellbeing Board achieving its strategic and key objectives. This is the case particularly in relation to improving mental wellbeing – including for people with a serious mental illness – and working together to support the most vulnerable adults in the community, including by facilitating individuals' developing their own self-management in the community. Embedding use of self-directed support by people using services to deal with mental health issues will also facilitate improving integration of health and social care services and greater focus on identifying and meeting individuals' social care needs, including via robust and ongoing assessment.

Use of self-directed support facilitates both meeting individuals' social care needs and addressing the social determinants of health. Information included in this research presents an opportunity for partners included in Brent's Health and Wellbeing Board to provide leadership

locally, giving strong messages and support to – and involving – both commissioners and service providers as well as people using services and carers.

Transformation of health and social care services

Use of self-directed support is part of the transformation of health and social care services – incorporating personalisation, prevention and self-management. Inclusion in local Transformation and Sustainability Plans required by The Five Year Forward Plan presents an opportunity to give a profile to and clear messages about the expectation that use of self-directed support by people using services to deal with mental health issues is systematically embedded locally.

Focus on outcomes

The current mental health strategy and outcomes frameworks for health, social care and public health all highlight the expectation of both commissioning organisations and service providers that staff enable individuals to identify the outcomes they want to achieve from using services – and facilitate their achieving them. Use of self-directed support by individuals using services to deal with mental health issues is an integral part of this approach to meet people’s social care needs and enable them to improve different aspects of their wellbeing – the principle on which the Care Act is based.

Expectations of secondary specialist mental health services

Focus on transformation of health and social care services, including via the requirement placed by commissioners on statutory service providers to create service development and improvement plans (SDIPs), creates an opportunity to embed and measure use of self-directed support for people using services to deal with mental health issues in staff’s practice.

Shifting the culture in specialist mental health services and shifting settings of care

Specialist health and social care services need to replace the traditional, chronicity approach with a wellbeing and recovery approach of which use of self-directed support is an integral part. Senior management needs to have a clear vision and strategy to achieve this significant change, give clear messages and provide strong leadership to ensure that staff are aware of expectations. Recent redesign of community mental health services provides an opportunity, including to give clear information to individuals using services and carers about ways that staff will work with them to enable them to utilise specialist services and move away from them having achieved the outcomes they want to – so shifting settings of care.

Partner organisations need to adopt a clear process and provide information, including about the facts about self-directed support to both all staff and people using services and carers. Comprehensive training needs to be provided to all staff and use of self-directed support needs to be incorporated in supervision and team and reflective practice meetings as well as facilitating staff sharing examples while avoiding creating a ‘menu’ in order to maintain creativity and imagination. Staff also need to incorporate use of self-directed support in comprehensive health and social care assessments and care planning on an ongoing basis. Ways of systematically embedding feedback from both people using services and staff about outcomes of using self-directed support need also to be created. Services need to engage with barriers experienced

particularly by people using mental health services, including by utilising work already carried out to address risk and safeguarding in relation to personalisation^{1,2}.

Use of self-directed support also has the capacity to challenge inequalities and stigma, normalising and engaging with individuals' own motivations, not least because such a high proportion of people from black and minority ethnic communities have accessed direct payments locally which has often not been the case in other areas. Recent work has highlighted that individuals often experience greater satisfaction with services and improved wellbeing when using direct payments.

Effective use of resources

Self-directed support can often make more effective use of reducing resources as solutions are most often low cost with high impact as well as enabling individuals to reduce their use of and reliance on secondary, specialist mental health services, including by enabling people to leave hospital, re-engage with their communities and rebuild their lives.

Co-production with individuals using services and independent evaluation

Co-production has been a strong feature of facilitating use of self-directed support by people using services in Brent to deal with mental health issues and this needs to continue. Utilising expertise of user groups and enabling individuals using direct payments to be actively involved in showcasing their experience and benefits needs to be incorporated locally. Facilitating individuals to support and share information with each other enables others to take positive risks and so overcome barriers. Building on the evidence base created by this work, independent evaluation including the views of both individuals using services to deal with mental health issues and staff needs to be actively facilitated.

¹ Mitchell W and Glendinning C (2007) A review of the research evidence surrounding risk perceptions, risk management strategies and their consequences in adult social care services for different groups of service users, University of York Social Policy Research Unit

² SCIE Report 36: Enabling risk, ensuring safety: Self-directed support and personal budgets (Sarah Carr, SCIE, Nov 2010)

METHODOLOGY

BUG produced a questionnaire, incorporating both information about the research and a monitoring form to see whether individuals of different age groups, ethnicities, genders, sexualities, those with physical and/or learning disabilities were accessing self-directed support, had different experiences and/or ideas for improvement. This is included as Appendix 1.

This survey was circulated on behalf of BUG by Brent's Personalisation Peer Support Worker to all those who had made successful applications for self-directed support between 2013 and January 2016. People could complete and return a survey anonymously, talk to a member of BUG staff or be visited at home together with staff – though speaking separately and confidentially. Five people completed and returned surveys while two contacted BUG saying they were not aware they were using direct payments³.

BUG's Director interviewed key staff in Brent's mental health services – provided by a partnership between Central and North West London (CNWL) Foundation Trust and Brent council – as well as offering staff across the service the opportunity to give their input – and Brent council. Staff from two agencies which provide a significant number of personal assistants as well as the independent organisation that provides practical support to individuals employing their own personal assistants were also interviewed⁴.

A further opportunity to enable individuals who have accessed self-directed support to make their input was created via a drop-in session at Patidar House. Two people gave their input via phone and three people came to the drop-in session⁵.

Additionally, BUG analysed anonymised information about all applications made to Brent's Self-Directed Support Panel between 2013 and January 2016⁶. A summary of information is included about how 247 individuals have utilised – and benefited from – their use of self-directed support as well as about their identities while full detail is included in the separate, more detailed report produced for slightly different audiences by BUG⁷.

³ Surveys completed and returned to BUG and phone calls received, February 2016

⁴ Interviews carried out by BUG with key staff from different organisations, June 2016

⁵ Input given by individuals using services via phone and drop-in session, June 2016

⁶ Analysis of information about applications made to Brent's Self-Directed Support Panel between 2013 and January 2016, May 2016

⁷ Report on use of self-directed support by people using services in Brent to deal with mental health issues, BUG, August 2016

BACKGROUND

Aims of the Research

This research has been carried out by Brent Mental Health User Group (BUG) on behalf of Healthwatch Brent as part of its Community Chest scheme that enables community groups to apply for funding to carry out research locally. The aims of the research were to:

- gather information from individuals about how they have benefited from use of self-directed support, any difficulties they encountered and their ideas for improvement in future
- gather information from relevant staff about their experiences of self-directed support, any difficulties and ideas to resolve issues raised
- present an overview of how individuals using secondary specialist mental health services in Brent have utilised self-directed support between 2103 and January 2016 and how they have benefited
- raise key issues and make recommendations for the future based on information gathered and other knowledge

Who Carried Out the Research

Brent Mental Health User Group (BUG) is one of the oldest independent user groups in the country, set up by local people from different communities using mental health services. All staff have experience of using services in a range of ways to deal with mental health issues. The organisation works with individuals from different communities using services to enable them to get actively involved in their own recovery – including via developing their knowledge and self-management – and to access peer support both directly via staff as well as taking part in regular events and workshops. BUG also enables individuals to get involved in designing and improving health and social care services in a range of ways.

BUG works strategically and operationally with staff in Brent’s health and social care services in order to improve different aspects based on the aspirations, experiences of and involvement of individuals as well as providing wellbeing and recovery training to staff. BUG also facilitates individuals’ involvement in local commissioning by working with both NHS Brent Clinical Commissioning Group (CCG) and Brent council.

About self-directed support and work to increase the uptake of direct payments

Self-directed support is the generic term⁸ used to describe the different approaches used to meet individuals’ social care needs in different local authority areas in England, incorporating a personalisation approach. What is common, however, is that self-directed support is paid as ‘direct payments’ and this is therefore the term that has been used in legislation, projects to increase uptake, research and targets.

History of direct payments legislation and work to increase uptake

Brief details are included below about the history of legislation that introduced use of direct payments and work since to increase their uptake by different groups of people as well as to

⁸ Think Local, Act Personal (30 national partners committed to change in social care working with NHS England) 2011

introduce the personalisation agenda. More detail is included in *Report on use of self-directed support by people using services in Brent to deal with mental health issues, BUG, August 2016*.

- 1997 Direct payments introduced (*Community Care (Direct Payments) Act 1996*)
Local authorities given a power, rather than duty, to make payments for working age disabled people to have more control and choice in meeting their social care needs.
- 2000/2001 Use of direct payments extended to older people and in 2001 to parents of disabled children and carers⁹.
- 2003 The *Health and Social Care Act 2001* made it mandatory for local authorities to make direct payments to individuals who wanted to and were able to manage them with or without support¹⁰.
- 2004 Comprehensive evaluation carried out by HASCAS into use and benefits of direct payments in five national mental health pilot sites as part of the National Social Inclusion Programme, Direct Payments¹¹.
- 2005 Joseph Rowntree Foundation's New Directions Project had discussions with over 250 individuals using mental health services and staff working in integrated mental health and social care organisations to build on the research undertaken by HASCAS. Its main aim¹² was to identify and address common concerns in order to identify what needed to happen for direct payments to be successfully implemented for this group.
- 2005/2006/2007 Legislation introduced to take forward the personalisation agenda and transform adult social care¹³
- 2006 Since experience – and research – was highlighting that individuals using services to deal with mental health issues were not accessing direct payments, their consistent use was incorporated in *Ten High Impact Changes for Mental Health Services*¹⁴.
- 2006 Specific project introduced by CSIP¹⁵ alongside that to increase the use of direct payments by people with learning disabilities together with the charity In Control.
- 2009 Provision extended to enable both people who were considered to lack 'mental capacity' to have someone appointed to receive direct payments on their behalf as well as those subject to mental health legislation to access direct payments¹⁶.

⁹ Carers and Disabled Children Act 2000 which inserted new section 17A into the Children Act 1989

¹⁰ Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2003 since replaced by the Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009

¹¹ Evaluation of 5 mental health pilot sites, Spandler and Vick, Health and Social Care Advisory Service (HASCAS), 2004 on behalf of National Social Inclusion Programme Direct Payments, Care Services Improvement Partnership (CSIP)

¹² New Directions, Joseph Rowntree Foundation, 2005

¹³ Independence, Wellbeing and Choice, Department of Health, 2005; Our health, our care, our say, Department of Health, 2006 and Putting People First: A shared vision and commitment to the transformation of adult social care, DH, 2007

¹⁴ Ten High Impact Changes for Mental Health Services, Department of Health, CSIP, 2006

¹⁵ Direct payments for people with mental health problems: A guide to action, CSIP, 2006

¹⁶ Community Care, Services for Carers and Children's Services (Direct Payments)(England) Regulations 2009

- 2012 MP Norman Lamb, Care Services Minister – in relation to reform of health and social care integration – which gave a deadline of April 2013 for local councils to have offered personal budgets to all eligible users of social care services was quoted as saying: *‘I don’t want to see any evidence of [care] plans being signed off by the service user and described then as a personal budget if they haven’t had any real involvement in it. I don’t want a target achieved that turns out to be meaningless. I want real empowerment for people’*.¹⁷
- 2014 Care Act¹⁸ introduced. Its ‘wellbeing principle’ aims to put individuals’ wellbeing at the centre of provision, facilitate greater choice and focus to a greater extent on prevention rather than crisis. Carers can now also access self-directed support to meet their identified social care needs. New criteria introduced against which individuals’ identified social care needs are assessed to ensure eligibility. Duty placed on local authorities to offer personal budgets.
- 2014 Use of personal health care budgets has been developed to facilitate a personalisation approach in health provision. Work has been done to develop use of personal health care budgets and integrated health and social care budgets, including by the Integrated Personal Commissioning (IPC) Programme¹⁹.
- 2016 National Audit Office research²⁰ highlights that indicators specific to personalised commissioning in the Department of Health’s Adult Social Care Outcomes Framework measure take-up rather than user outcomes. From December 2015 the Health and Social Care Information Centre has published a more detailed dataset that facilitates some analysis of this relationship.

Approach to self-directed support

In some areas local authorities created a Resource Allocation System (RAS) which assigns ‘points’, based on assessing individuals’ social care needs – incorporating self-assessment – to create an annual ‘indicative budget’. Individuals can either use the budget in its entirety in the ways that they feel will meet their social care needs, use existing provision or a combination. Utilising this approach, individuals have access to ‘personal social budgets’, paid as ‘direct payments’. Individuals’ needs were also assessed against local authorities’ different Fair Access to Services (FACs) criteria based on the organisations’ resources. Local authorities are responsible for carrying out financial assessment for any sums above £500 to ascertain whether individuals need to contribute to the cost if they have savings, for example.

When payments are made as direct payments, individuals are responsible for managing and making payments, often via use of a pre-paid card loaded up with agreed funding by the local authority and used to make payments as well as for recordkeeping and feeding back.

Where individuals are employing personal assistants (PAs) they become employers and so responsible for all aspects of employment. Individuals can employ friends or family as their PAs – though not their partners – as long as they do not live with them, or via agencies or direct

¹⁷ Interview with David Brindle, The Guardian, Wednesday 24th October 2012

¹⁸ Care Act (England) 2014

¹⁹ Getting serious about personalisation in the NHS, Think Local, Act Personal, September 2014

²⁰ Personalised commissioning in adult social care, National Audit Office, March 2016

recruitment. Where individuals directly employ PAs they can use independent organisations to, for example, run payroll, organise appropriate insurance, help to manage the relationship and resolve any difficulties. Costs charged by these organisations need to be incorporated in the cost of the personal social care budget and any application. Clearly, where individuals are using PAs via agencies, these organisations charge an hourly rate and manage all aspects of employment.

Ethos of self-directed support

The aim of self-directed support is that it should enable individuals to meet their social care needs in creative and imaginative ways, based on their aspirations and what motivates them, as opposed to staff's opinions about what will improve different aspects of their wellbeing. As a result, there is no menu but instead individuals should be enabled to design their own support, based on what they feel will improve their lives and their wellbeing and move towards recovery. It is intended to be driven by individuals as opposed to being service-driven - *'As a general principle, local councils should aim to leave choice in the hands of the individual by allowing people to address their own needs as they consider best, whilst satisfying themselves that the agreed outcomes are being achieved.'* **Direct payments for people with mental health problems: A guide to action, Department of Health, 2006**

Approach taken in Brent

In common with other areas, the resources for self-directed support are held by the local authority. While Brent council social services directly facilitates access to self-directed support for older people and people with learning disabilities, responsibility for facilitating access by individuals using services to deal with mental health issues is devolved to Brent's mental health services provided by Central and North West London (CNWL) Foundation Trust.

Brent council did significant work to create a resource allocation system but abandoned it some years ago. As a result, indicative budgets are not created though direct payments for older people and people with learning disabilities are facilitated via assessment and creation of a care plan with a social worker. Once the system has been put in place there is no further involvement of staff until an annual review is triggered, there are difficulties or individuals' needs change, though Brent council is currently considering more regular reviews. Self-directed support paid as direct payments up to £250 a week – using pre-payment cards – is approved by team managers.

Approach taken in Brent in relation to individuals using services to deal with mental health issues

In recognition of the fact that there are significant barriers to individuals using services to deal with mental health issues utilising self-directed support, in 2012 Brent's Head of Mental Health Services set up a Self-Directed Support Panel. BUG's Director was involved both to incorporate co-production with individuals using services to deal with mental health issues as well as their significant knowledge and expertise about self-directed support.

This panel met every two weeks and created the system for applications for self-directed support to be made by any staff in Brent's mental health services on behalf of people using services, having developed them together. The panel's terms of reference included ensuring the ethos of

self-directed support, providing advice and information to staff, working with staff to develop applications within the ethos of self-directed support and reviewing individuals' use of and benefit gained based on the outcomes they had identified they wanted to achieve. The panel also worked with staff to facilitate their ensuring that dependency was not created but instead that use of PAs, for example, enabled individuals to develop their skills in different ways to enable them to move away from services as well as that applications were based on what motivates individuals themselves as opposed to what staff thought they should be addressing.

The panel, chaired by the lead occupational therapist for Brent working in the acute service, also included BUG's Director and service managers from both Brent's recovery and rehabilitation teams. Individuals were welcome to come to panel meetings together with staff to make their case as well as to share how they felt they had benefited which a number chose to do. Initially administrative support was provided by an administrator in the rehab service.

Following restructure within CNWL in 2013, the new Peer Support Worker for Personalisation based in the recovery team worked with some individuals to develop their applications – including by using the self-assessment tool developed by Brent council when working towards use of a resource allocation tool (RAS) – booking in staff to make applications to each meeting and ensuring reviews took place. While one administrator took notes and updated the database, another was responsible for progressing payments using Brent council's systems.

Following review in January 2014 by senior managers from CNWL and Brent council, it was decided the panel would continue to deal with and review applications up to £250 a week, above which applications would be made to a newly-created social care panel. It was also intended to include team managers from across the service in the panel to facilitate their involvement. During 2015 the chair of the panel was replaced by Brent's lead social worker, the two community mental health team service managers alternated at panel meetings and BUG's Director continued as part of the panel. While involvement of the Peer Support Worker for Personalisation continued, an administrator was responsible for processing payments.

While direct payments should ideally be paid direct to individuals using services, in some cases this represented a barrier for people using services to deal with mental health issues. As a result, the panel took a pragmatic approach – enabling payments to be made direct to providers on presentation of invoices though one-off purchases were always made using pre-paid cards. However, a recent project by Brent council to ensure that direct payment targets are being met has highlighted that only use of pre-paid cards contributes. As a result, successful applications for self-directed support have not been logged in this way by the local authority as pre-paid cards had not been used. The local authority is therefore aiming to replace existing systems with use of pre-paid cards for all individuals accessing self-directed support.

The Self-Directed Support Panel was disbanded by Brent council in May 2016. BUG's Director is no longer involved and applications up to £250 a week are approved by team managers while those above this sum go to the social needs panel.

FINDINGS

The 12 individuals who responded via phone, completing and returning surveys or who came to the drop-in session gave a range of responses. Individuals are of a range of age groups, genders and ethnicities with the majority being from black and minority ethnic communities. The majority of people have used services for a significant number of years and had heard about use of self-directed support largely from staff who worked with them on an ongoing basis. While some people felt that staff had taken control and made specific suggestions about how they might use self-directed support, they did not necessarily disagree with their suggestions. Others felt that staff had worked with them to enable them to think about how use of self-directed support could meet their social needs and about what motivated them and a number of people talked particularly about how useful it had been working with the Peer Support Worker for Personalisation.

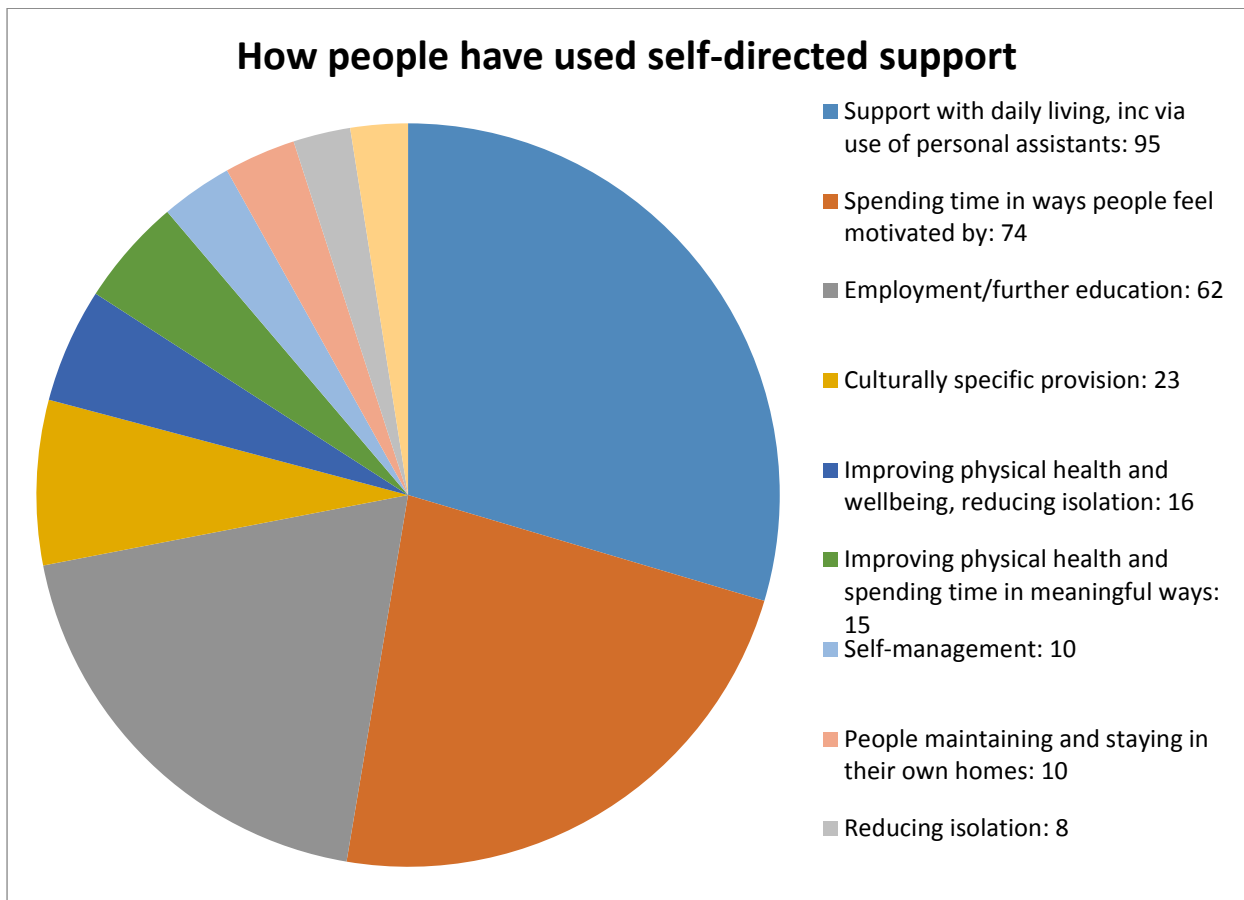
People were clear about what they wanted to achieve from their use of self-directed support and felt that they had achieved what they wanted to overall, though one wasn't sure why their gym membership had been stopped and two were having difficulties with delays and lack of information about what was happening with other applications they had made. People talked about feeling that they had achieved more than they had expected to, including regaining their sense of identity, building their confidence, seeing that they are capable individuals and feeling more motivated and that they are spending their time in ways they enjoy, motivating them to look after themselves better as well as to take positive risks to try new things. People felt that individuals' experiences of using self-directed support would be improved if staff worked with them in relation to what motivates them, the process was clear and effective and staff kept in touch to let them know about progress.

ANALYSIS

The following information is based on anonymised detail in the database used by Brent's Self-Directed Support Panel. A total of 357 applications for self-directed support were made during this period. While 335 applications were agreed – including by 14 people who made more than one, one-off application – 22 were refused on the basis of lack of information, not being appropriate for self-directed support as their focus was health provision, what people needed eg cookers and fridges being accessed via other means or not appropriately meeting individuals' social care needs and three were not progressed as people's circumstances changed, for instance, because they had gone into hospital.

Of the total of 335 applications agreed, 175 were one-off and 160 for ongoing provision. Of those who made one-off applications, one person additionally has learning disabilities.

Of those who made applications for ongoing provision, 10 people are additionally living with physical health conditions such as diabetes, difficulties with memory, arthritis and hyperthyroidism; 8 have physical disabilities – including two who were disabled short-term by accidents; 7 are older – two of whom have been diagnosed with dementia – four are living with a range of physical health conditions while four people additionally have learning disabilities. Examples are given below of how self-directed support has been utilised by individuals.



Identities of these individuals

Since 298 of those included here are from a range of black and minority ethnic communities, this indicates that individuals of a range of ethnicities are accessing self-directed support which is very positive. People are of a range of age groups. More men than women are using self-directed support and information was not systematically included about individuals’ physical and/or learning disabilities or sexualities.

RECOMMENDATIONS

Key issues and recommendations incorporated here are based on experience to date, analysis of anonymised information provided about applications made between 2013 and January 2016, feedback from individuals who gave their views as part of this survey and particular staff from Brent’s mental health services, Brent council, agencies providing personal assistants to individuals and local organisation that provides practical help to people using direct payments.

Who Has Accessed Self-Directed Support to Date

It is clear from the anonymised data about individuals who have made successful applications between 2013 and January 2016 that self-directed support is being accessed by people of a range of ages, ethnicities and genders, faiths and by those with physical disabilities. Since lack of access to direct payments by people from black and minority ethnic communities has

consistently been highlighted in different pieces of research, it is particularly positive that so many people who have traditionally been excluded are using them.

People who also have learning disabilities – and dementia – are also utilising self-directed support. It does seem, however, that a significantly larger number of men have utilised self-directed support. In addition, information included raises questions about whether lesbians and gay men and those who identify as transgender are accessing self-directed support.

1. Attention needs to be paid by staff to ensure that individuals of all genders and sexualities in particular are accessing self-directed support.

How Self-Directed Support Has Been Used

Again, from the information included about how people have utilised – and are utilising – self-directed support it is clear that it is being used to enable people to get back into education; into employment; to develop their social lives and social networks; to improve their physical health and wellbeing; to help manage physical disabilities and illnesses; to develop their daily living skills and maintain and/or stay in their own homes; to spend their time in ways that feel meaningful for them as well as to reduce isolation; to re-engage with their families and friends and cultures; and to develop their self-management.

People are being enabled to particularly make one-off applications to spend their time in creative and imaginative ways which enable them to move towards recovery and improve their sense of wellbeing in a range of ways.

1. Ensure that staff maintain the ethos of self-directed support, enabling individuals to use direct payments in ways that they feel will meet their social care needs.

Use of Personal Assistants

A significant number of people are using personal assistants (PAs) though the majority are provided via agencies. While this has some advantages for individuals – it can represent a barrier to appropriate matching and to their being or feeling in control of the relationship which is the intention.

1. Individuals need to have more choice about their personal assistants (PAs) and staff need to work with them to ensure they feel in control of the relationship. People need to be enabled to use guidelines to consider when employing personal assistants produced with individuals using services to facilitate greater control over their relationships with PAs.

In Brent, a PA Finder database of people who want to work as PAs is being developed by the organisation funded to support individuals to employ PAs directly and to manage their direct payments generally.

2. Attention needs to be paid to ensure this meets individuals' needs.

PAs are currently largely enabling people to manage at home – doing laundry, cleaning, shopping and looking after themselves – while fewer are using PAs to develop their social lives and social networks; to spend their time in ways that feel meaningful to them; and to get involved in the community.

3. Staff need to work with individuals to enable them to identify and utilise PAs to do what they feel motivates them as opposed to what staff think will motivate people.

Individuals' use of PAs has been set up during this period with the intention that the number of hours they have worked each week has reduced as people have developed their confidence and abilities – and/or wanted to spend their time in other ways, including in order to avoid creating dependence.

4. Individuals need to be actively involved in measuring their progress, reducing the number of hours that PAs support them in order to avoid creating dependency as they develop their confidence, ensuring their needs continue to be met. Flexibility to meet individuals' changing needs also needs to be incorporated.

Experience has indicated that mental health service staff can struggle with the notion that PAs role is not intended to be either an extension or duplication of theirs.

5. The role of PAs needs to be distinct from that of staff in specialist mental health services as opposed to duplicating it. Individuals need to be the drivers of their relationship with PAs.

The relationship between individuals, PAs employed by agencies and staff in mental health services is complex.

6. Where individuals are using PAs via agencies, the role of these agencies needs to be very clear. Individuals' control of the relationship with their PAs needs to incorporate control of information that PAs have and with whom they are comfortable this is shared. Staff in mental health services need to be clear they are not the employer but have facilitated the provision and need to ensure that individuals have identified the outcomes they want to achieve and that use of PAs is enabling them to do so, systematically reviewing this.

How People Have Benefited From Use of Self-Directed Support

While considerable information was included in the anonymised data provided to BUG as well as gathered from individuals and specific staff who took part in the survey about how people have benefited from use of self-directed support, information has not been routinely gathered from individuals.

1. Make it a requirement that both individuals utilising self-directed support and staff systematically feedback on how people have benefited from use of direct payments in future. Staff need to work with people to enable them to identify the outcomes they want to achieve via use of direct payments and to be actively involved in ensuring they are meeting these outcomes.

It is very clear that people have significantly benefited from their use of self-directed support, including in ways they had not anticipated. People have increased their confidence in their own abilities as well as developed their ability to manage and improve their lives and take risks to try new things and recognise their potential.

People have also been spending their time in ways they enjoy and feel motivated by, so improving their sense of wellbeing, and often motivating them to manage other aspects of their lives. While some individuals using direct payments have done so in order to develop their self-management which has been successful, use of self-directed support in different ways has achieved this outcome for others too.

A significant number of people have both taken part in further education courses as well as been able to move towards and gained employment.

A number of people have also been enabled to leave the mental health unit, including after quite long stays, and to rebuild their lives via use of particularly PAs. However, this is also a function of Brent Council's Reablement Team.

2. Access to Brent Council's Reablement Team by people using mental health services needs to be clarified.

Gathering and Analysing Qualitative and Quantitative Information

While information included in this survey has focused to a greater extent on qualitative information which is very useful to develop a picture of individuals' use and experience of using direct payments, it would also be useful to regularly analyse quantitative data. In order to do so both hard and soft targets need to be measured, so, for example, individuals' reduced use of or reliance on any aspects of mental health services.

1. Creation of a system to enable and analyse the relationship between use of and benefit to individuals of direct payments – incorporating recommendations from the National Audit Office's recent research – needs to be prioritised locally, including via co-production with individuals using services to deal with mental health issues and their user groups.

Individuals and Staff Reporting How People Have Benefited From Use of Direct Payments

The fact that so few individuals – and staff in Brent's mental health services – responded to BUG's invitation to share their experiences of use of self-directed support and ideas for

improvement in future is of considerable concern. While it can be difficult to extrapolate the reasons for this, it is worth considering the possibilities that individuals are not aware that they are using self-directed support, have not been sufficiently involved in discussions or are worried that they may lose this resource if they give their input.

It is also the case that BUG surveys have consistently shown that individuals are not used to measuring their progress or what they have changed or achieved as a result of using services which needs to be addressed, including since this is an expectation of services of NHS England, Public Health England and the National Institute of Clinical Excellence (NICE).

1. Staff need to recognise the importance of feeding back on their own and individuals' experiences of using direct payments. This needs to be built into staff's practice in future, not least to ensure that individuals are both identifying and then achieving the outcomes of using services that they want to.

Systematically Facilitating Access to Direct Payments

Everyone who uses services to deal with mental health issues should have access to direct payments to meet their social care needs.

1. Staff need to recognise the importance of their facilitating individuals' access to self-directed support. Staff have a crucial role to play in championing use of self-directed support, sharing examples and information about benefits with each other as this will help practitioners see the value of giving control to individuals using services and to take a pragmatic approach to risk-taking, comprehensive crisis planning and developing positive risk-taking plans, incorporating use of advance statements.

Addressing Barriers to People Being Enabled to Utilise Self-Directed Support

The fact that take-up of direct payments by people using mental health services has been consistently lower than other groups of people who can also utilise self-directed support has been addressed in a range of ways over the years by strategic statutory organisations. This includes the Department of Health in its cross cutting outcomes mental health strategy for people of all ages and associated outcomes frameworks including that in relation specifically to meeting individuals' social care needs which aims to enable local authorities in particular to measure progress achieving its outcomes.

There are a significant number of barriers to individuals using services to deal with mental health issues accessing direct payments which have been recognised over the years by, for example, the Department of Health. Some of the issues raised here are reflective of the national position.

Lack of Focus on Individuals' Social Care Needs

While mental health services have comprised integrated health and social care for some years, the fact that individuals' experience is that these services continue to have a tendency to focus on health to a greater extent has been consistently raised in BUG surveys.

1. Staff need to ensure that they carry out comprehensive health and social care needs assessments on an ongoing basis.

Staff's Beliefs about People's Abilities

Where mental health services continue to use the traditional, chronicity approach, staff can struggle to believe that individuals using those services are capable of deciding for themselves their needs and how they can utilise self-directed support to meet those needs. This has been raised as an issue by staff themselves, for example, in wellbeing and recovery training and workshops in relation to self-directed support and needs to be addressed.

1. Staff need to challenge their assumptions about individuals' abilities and enable them to develop their use of direct payments using reframing skills and positive risk-taking.

People's Own Beliefs about Their Abilities

Individuals using services have also expressed a lack of belief in themselves during workshops designed to facilitate people gaining information about and developing use of self-directed support.

1. Workshops need to continue to be provided – including individuals talking about their experiences of using self-directed support and how they have benefited as hearing from their peers could facilitate people developing their confidence and feeling more prepared to take a risk themselves. Staff also have an important role to play in instilling confidence in as well as sharing information with people using mental health services.

Individuals' Concerns about the System

People have expressed concerns about using pre-paid cards as this is unfamiliar and requires their being actively involved in making payments and recordkeeping.

1. Individuals need to be given clear information about and provided with support to use pre-paid cards.

Staff Wanting a Menu from Which to Select

Staff are most used to using specific interventions when working with individuals using services to deal with mental health issues. Conversely, direct payments are intended to be driven by individuals themselves, based on what they feel motivates them and outcomes they want to achieve to meet their social care needs. Staff need to bear this in mind when working with people to develop their individual use of direct payments.

1. In order to be creative and imaginative, staff need to share examples and information with individuals about how others have used direct payments while avoiding creating a 'menu' from which people are supposed to select.

Staff's Approach to Individuals' Use of Self-Directed Support

Staff continue not to routinely enable individuals to access direct payments.

1. It needs to be made clear to staff that individuals using services to deal with mental health issues not only have a right to access direct payments but that enabling people to do so is part of staff discharging their duty in relation to social care defined by the Care Act. Staff need to talk about use of direct payments on an ongoing basis – throughout the time people are using specialist mental health services – incorporating its use in care planning. The Trust needs to address the fact that it may help if this is linked into its information system.

Myths about Self-Directed Support

Despite detailed information having been produced by Brent's Self-Directed Panel in relation to use of self-directed support - circulated to all teams and discussed at team meetings – myths about individuals' eligibility, how self-directed support can be utilised and use of self-directed support generally have continued.

1. Clear messages need to be given by commissioners to service providers and by providers to staff about the use of self-directed support by individuals using services to deal with mental health issues.

Difficulties with Brent Council's Systems

Staff working in mental health services, those from agencies providing PAs to individuals and people themselves raised concerns about considerable, ongoing difficulties with payments being made – initially as well as ongoing. As well as a number of individuals having missed the opportunity to take part in further education courses, agencies are having to continue paying PAs they employ to ensure that they continue working with individuals.

1. Brent Council's systems need to be clear, function effectively and staff in Brent's mental health services and Brent council need to both recognise the importance of and be enabled to process payments immediately in order to avoid delays. As well as a need for a clear process that is communicated, the system needs to build in flexibility so people can easily change how they use direct payments based on their needs, so, banking hours when they use fewer PA hours to enable them to use more when necessary, avoiding a protracted process. This approach with other groups of people needs to be replicated with people using mental health services.

An issue currently being addressed is that there is no system to enable people using pre-payment cards who have been overpaid by the system to repay funds.

2. The system needs to be as flexible as necessary to meet individuals' needs using direct payments as opposed to individuals meeting the system's needs.

Acknowledging People's Changing Needs

Experience to date has indicated that, where individuals have used mental health services, there is an assumption that only staff from these services will provide assessment, for example.

1. Individuals not being able to access specialist assessments in relation to physical and/or learning disabilities needs to be addressed. Additionally, the fact that people's primary needs may no longer be in relation to mental health needs to be recognised.

Changing the Culture

While some progress towards change has been made, mental health services do continue to use the traditional, chronicity approach – characterised by staff 'managing risk and care'. This represents a barrier to achieving consistent use of self-directed support by individuals using services to deal with mental health issues.

1. Service providers need to replace this approach with all elements of a wellbeing and recovery and personalisation approach which is consistent with national expectations of services.

Staff need to be provided with comprehensive wellbeing and recovery training such as that designed and run successfully by BUG for some years, based on the approach developed together with people using services, carers and clinicians from a range of disciplines by National Institute for Mental Health England (NIMHE). Staff need to work with people as unique individuals in the context of their lives, in equal partnership, facilitating their identifying what they feel will enable them to improve all aspects of their wellbeing and move towards recovery. Staff's practice needs to incorporate a strengths-based approach – recognising and building on people's strengths and engaging with their intrinsic motivations as opposed to trying to create artificial motivations. As well as using reframing skills to challenge negative assumptions about individuals and turn them into opportunities to get to know and work with them as individuals, staff also need to use a positive risk-taking approach, enabling individuals to stretch themselves and try new things in order to achieve their potential.

Use of self-directed support needs to be incorporated, including to facilitate a personalisation approach, enable individuals to address all aspects of their wellbeing, develop their self-management and utilise community resources. Individuals who took part

in the survey talked about how use of self-directed support had enabled them to regain their loss of identity as well as having developed a sense of purpose in life.

Focus on Meeting Individuals' Social Care Needs

Staff in mental health services do not focus sufficiently on people's social care needs.

1. Staff need to focus to a greater extent on enabling individuals to both identify and meet their social care needs, utilising self-directed support. Service providers need to use this approach in order to meet their duties under the Care Act. Focus on identifying and achieving outcomes of using services – including to achieve the ambition that all eligible users have a personal budget – is incorporated in the adult social care outcomes framework utilised alongside the frameworks for both the NHS and public health. The 2015-16 version outlines its future development, in particular considering the implications of the Care Act and measures included are used to monitor the Department's progress in meeting its equality objectives.

Enabling Individuals to Identify and Achieve Outcomes

Staff are not used to focusing on outcomes.

1. Staff need to focus on enabling individuals to identify outcomes they want to achieve from using services – and achieve their goals, including via use of self-directed support. This is an expectation of services incorporated in NHS England's broad strategy for health and care improvement, detailed recommendations on how to deliver this within the London context as well as the independent Mental Health Taskforce report in which 20,000 people took part of create a 10-year implementation plan for this strategy to transform mental health and social care services. This implementation strategy in particular highlights the need to increase the uptake of direct payments by people using mental health services.

Strategically Addressing Difficulties and Barriers

Experience to date has indicated significant difficulties strategically addressing barriers on an ongoing basis.

1. Identified barriers need to be systematically strategically addressed.

Clear Strategy and Messages from Senior Management and Co-production

Use of self-directed support has little profile in Brent's mental health services.

1. Senior management in CNWL as well as well as Brent's mental health services need to give a high profile to and prioritise use of direct payments. They also need to develop a clear strategy and implementation plan for as well as give clear messages to all staff about the expectation that they facilitate individuals' access to and use of direct payments. Co-

production with people using services – and organisations’ representing them – those involved in their support network – and their representative organisation needs to be central to this work.

Information and Workshops for Staff and People Using Services

Information produced and circulated has not necessarily been engaged with by staff – or passed onto individuals using services.

1. Clear information needs to be circulated amongst staff about use of self-directed support, including the process used, and their understanding regularly checked. The factsheet already produced could continue to be utilised here. Written information needs to be supported by provision of workshops for staff.

Similarly, information needs to be routinely given to individuals using services about use of self-directed support – including about the process to get access. Workshops also need to be provided to individuals.

Ensuring all Staff Enable People to Utilise Self-Directed Support

While a few staff working in CNWL’s rehabilitation service and in acute services have enabled people to access self-directed support, the majority are from the community teams.

1. All staff working in Brent’s mental health services need to recognise that they have a role in facilitating individuals’ access to and use of direct payments.

Building Use of Self-Directed Support into Staff’s Practice

Use of self-directed support is not routinely incorporated in staff’s practice.

1. All staff need to recognise that individuals can utilise self-directed support. Team managers need to incorporate discussion of progress in managerial supervision, team meetings and reflective practice groups. This will enable staff to share information and examples with each other, building their knowledge and confidence and challenging negative assumptions and misinformation. Recent redesign of Brent’s community mental health services presents an opportunity to build in discussion and facilitation of use of direct payments in regular contacts with care coordinators.

Enabling Individuals to Routinely Meet with the Personalisation Peer Support Worker

Access to the Peer Support Worker for Personalisation based in one of the community mental health teams is limited.

1. Learning from experience of the benefits of individuals meeting with Brent’s personalisation peer support worker to develop use of direct payments – including to

identify what they feel motivated by – people should routinely be enabled to meet with this member of staff when they start to use mental health services as well as ongoing.

Individuals Being Actively Involved in Their Use of Self-Directed Support

People's response to this research has indicated that they are often not aware they are using self-directed support.

1. Experience to date has indicated the importance of people using services leading to a greater extent as opposed to staff deciding what will motivate them. People also need to be actively involved in their use of self-directed support.

Creating Opportunities for Individuals to Meet Each Other

People do not have many opportunities to meet each other.

1. Opportunities need to be created for individuals using direct payments to meet and gain peer support from each other, sharing their experiences and finding ways of resolving any difficulties.

Cost of Self-Directed Support

There is often an assumption that use of self-directed support is more costly, the opposite is true, particularly where this replaces other provision.

1. Cost benefit analysis of direct payments, including based on savings as a result of individuals having been enabled to stay out of hospital or reduce their reliance on secondary specialist mental health services needs to be carried out.

Developing the Local Evidence Base

Evidence of benefit and outcomes achieved has not been gathered until now.

1. Developing a system to routinely gather information about individuals' use of direct payments, experiences and benefits from both staff and people using services will facilitate the development of this local evidence base. The National Audit Office's recent research highlighted this need as information gathered on outcomes has focused on meeting targets as opposed to qualitative information and any analysis of the relationship between use and benefits of direct payments. It also highlighted the fact that local surveys have more usually gathered information about people's negative experiences and generally not used surveys such as those produced by the In Control charity. Qualitative information should also be gathered by independent user groups.

Developing Use of Personal Health Budgets and Integrated Health and Social Care Budgets

There has been little progress locally in developing use of these personal budgets.

1. Health and social care commissioners and partners involved in developing personalised commissioning and use of self-directed support in its broadest sense need to incorporate learning from these pilots locally and take risks to develop this approach.

Shifting Settings of Care

While the aim is to enable individuals to utilise specialist mental health services for the shortest possible time, there is a belief that individuals' use of self-directed support can represent a barrier to 'discharging' people from these services. At the same time, individuals often either have continuing social care needs when they move away from specialist mental health services or have social care needs when using primary care services.

1. These issues need to be addressed.

Commissioning and Accountability

As mentioned previously, use and benefits of using self-directed support for individuals using services to deal with mental health issues currently have a low profile in Brent.

1. There are a number of ways in which accountability either does or could apply to use of direct payments as well as opportunities to strengthen their use. The recently formed Mental Health Strategic Partnership Board, chaired by Brent council, should incorporate use of direct payments in its work and any workstreams, including co-production with people using services to deal with mental health services and their user groups.

Brent council's Overview and Scrutiny Committee could also be utilised to ensure that service providers are enabling individuals using services to deal with mental health issues are routinely accessing direct payments.

The same applies to Brent's Health and Wellbeing Board to which the Mental Health and Wellbeing Transformation – and Implementation Boards – report, including in relation to the North West London LikeMinded Mental Health and Wellbeing Strategy and work to transform mental health services. The LikeMinded team incorporates co-production with Mad Alliance – an independent group of individuals using services to deal with mental health issues and carers. The North West London Mental Health and Wellbeing Transformation Board has a particular remit to strengthen mental health services addressing individuals' social care needs and social determinants of health.

It is also reasonable to expect that NHS Brent CCG's Local Sustainability and Transformation Plan incorporates use of personal social care budgets, health budgets and integrated health and social care budgets.

Learning from Relevant Work

Opportunities to learn from relevant work is sometimes not taken advantage of.

1. Healthy London Partnership – comprised of 32 London CCGs and NHS England – is working on enabling people using self-directed support in different ways to manage this using online tools as well as doing considerable work in relation to social prescribing to facilitate commissioners utilising this personalisation approach, including to enable individuals to avoid having to use statutory provision to meet their needs. Brent’s health and social care commissioners and partners involved in developing use of direct payments need to link in with this project, both in order to influence and utilise it – and incorporating co-production with people using services and their independent user groups and carers and their representative organisations.

CONCLUSION

Both information included in this report and the process of carrying out the research indicates that considerable attention needs to be paid locally to enabling people using services to deal with mental health issues to access and utilise self-directed support. It is very clear that people have considerably benefited from their use of self-directed support and this needs to be built on locally.

This applies to service providers and commissioners and partners will need to work effectively together – including with individuals using services and carers – and their organisations to address key issues and implement recommendations in the report.

ACKNOWLEDGEMENTS

As ever, our thanks go to those individuals using self-directed support who have taken the time to give their input as part of this survey. Similarly, thanks to the staff who took part in order to improve both take-up of self-directed support as well as the experiences of both individuals using services and staff in future

APPENDIX

Survey about Experiences of Using Self-Directed Support in Brent

About this survey and whose views we want to gather

This survey is being carried out to find out about the experiences of people who have made successful applications for self-directed support in Brent.

So you might have been able to get money to buy a piece of equipment – like a musical instrument or laptop – go to the gym, do a course, spend your time in ways you enjoy... or maybe you have a personal assistant who supports you with your daily living and/or to develop your social life. It doesn't matter what you use this money for, we really want to hear your views.

And we want to hear what you thought both about the information you got from staff and of the process of making the application – both good and bad – as well as how it felt to work with staff to make your application. Very importantly, we really want to hear what you think would improve the experience in future.

How can you give your views

You can complete and return this questionnaire without putting your name on it. You don't need to put a stamp on the envelope if you return it to BUG's Freepost address at: **Brent Mental Health User Group, Freepost RTRT-EHCH-BJBC, Dephna House, 7 Coronation Road, London NW10 7PQ**. Or you can get a Word or pdf version to complete by e-mailing BUG on info@brentusergroup.com.

If you would like to go through the questionnaire with a member of BUG staff, you can do this either on the phone (we can call you back so you don't pay for the call) or face-to-face. Just ring Lynn at BUG on 020 8964 8650 to organise a time to talk or meet.

We are also happy to come and visit you with any member of staff who comes to see you at home. We just need to know the name of this member of staff so we can organise it with them. Of course, if we did come to see you at home we would make sure that we talked privately – rather than in front of the member of staff, if this is something that is important to you.

We are more than happy to talk to you on the phone using Typetalk if you are Deaf or have a hearing impairment. Or we can organise a British Sign Language (BSL) interpreter if you want to go through the questionnaire face-to-face.

If you want to talk to us using your first language we can organise an interpreter using LanguageLine on the phone. You just need to phone and tell us which language you want to use.

Or maybe you would like to get together with others who also use self-directed support to give your views. If you do, then just ring BUG on the phone number above or e-mail us on info@brentusergroup.com. If there are a number of people who would like to do this we can organise it. We need your completed questionnaire back by: **Thursday 11th February 2016**.

Don't forget to also complete the attached monitoring form so that we can see whether people of different ethnicities, genders, sexualities, age groups, faiths and who have physical and/or learning disabilities have had differing experiences or ideas for improvement as well as to make sure that we have gathered the views of different groups of people using self-directed support.

We have also included a contact sheet at the end of the questionnaire to enable you to get feedback about this survey and/or would like to be added to BUG's mailing list in order to get involved in future or take advantage of other services offered. We really want to hear about your experiences and ideas for improvement in future.

What will happen to the information you give us

Information you give us will be separated from any personal information you give us such as your name and contact details and used only in the ways you have asked us to. Your views will be combined with others in a report and will be used to improve how self-directed support is accessed by individuals using services to deal with mental health issues in future.

So nothing you say will be attached to you personally. You can feel free to say what you want about your experience. This is too good an opportunity to really make a difference and make sure your voice is heard so don't miss out!

Survey about experiences of using self-directed support in Brent

As well as lots of space to tell us both about your experiences to date and ideas for improvement, we have also included some options for you to select – so the questionnaire shouldn't take too long to complete.

About your use of services to deal with mental health issues

1. Roughly how long have you been using mental health services? (please tick below)

- 6 months to a year
- 1-2 years
- 2-5 years
- 5-10 years
- more than 10 years (please give details)

About which staff in Brent's mental health services told you about self-directed support

2. Could you tell us which staff talked to you about self-directed support?
(Some options are included from which to select as many as you want)

- staff at Park Royal Centre for Mental Health (*on Shore, Pond or Pine wards or Caspian or Tasman wards – please circle which ward/s*)
- staff in Brent’s Home Treatment Team (*that enables people to stay out of hospital and/or to leave hospital more quickly*)
- staff in the Early Intervention Service
- staff in the Assertive Outreach Team
- staff in the community team (*which includes care coordinators; welfare and employment workers; occupational therapists that work with people to develop daily living skills; peer support worker...*)
- staff in the rehabilitation service (*rehab houses where staff provide support in your shared house*)
- other (*please give details*):

Information about self-directed support

3. Where did you hear about self-directed support?

(some options are given below from which to select as many as you want)

- from staff in Brent’s mental health services who work with you on an ongoing basis, for example, care coordinator or mental health support worker
- from Brent’s peer support worker in the community team
- from Brent Mental Health User Group (BUG) – for example, from going to a workshop or a BUG Information and Participation Day
- other (*please give details*):

4. How did you hear about being able to use self-directed support?

(some options are given below from which to select as many as you want)

- staff in Brent’s mental health services told you about it
- from a BUG workshop and/or Information and Participation Day
- from an information sheet produced by BUG on behalf of Brent’s Self-Directed Support Panel
- from someone else using services who has accessed self-directed support
- other (*please give details*):

5. Could you give us a sense of what information you were given about self-directed support and how you could use it? *(some options are given below to select as many as you want)*

- staff told you that you could use it in a particular way (*could you give details?*):
- staff worked with you to find out what you need and how you could use self-directed support to meet those needs
- staff talked to you about what you feel motivates you and then how you
- could use self-directed support in the way/s you wanted to

other (*please give details*):

6. Could you tell us what you felt about how staff worked with you to develop your application?

(some options are included below for you to select as many as you feel apply to you)

- you felt staff had particular ideas about how you could use self-directed support
- you agreed with staff's suggestions *or*
- you weren't sure you agreed with staff's suggestions
- you talked with staff about what you need and staff made suggestions *or*
- you talked with staff about what you need and you decided how you wanted to use self-directed support
- you felt that your application for self-directed support was developed with you at the centre – with staff being imaginative and creative
- you were invited to the Brent Self-Directed Support Panel to talk about your application *or*
- you were told you had to go the panel meeting to talk about your application
- you felt staff told you about what was available and you chose which service you wanted to use – using self-directed support
- you were involved in doing research, for example, about model of laptop or where to buy particular equipment – or a particular service you might want to use
- other (*could you tell us more?*):

7. Could you tell us about your experience of using self-directed support?

(some options are given below for you to select as many as you want but do add your own information too)

- staff supported you to use the money in the ways you wanted to
- staff checked with you to make sure that you were getting what you wanted from self-directed support
- staff enabled you to think about how you were benefiting from use of your original application and think about how you could develop use of self-directed support in future
- staff didn't really seem to know much about it
- staff took control
- staff enabled you to access another service such as Penderel's if you are employing your own personal assistant – rather than employing a personal assistant via an agency (*could you tell us about your experience if you have used Penderel's?*):
- other (*could you tell us more?*):

8. Could you tell us what you felt about how staff worked with you to develop your application?

(some options are included below for you to select as many as you feel apply to you)

- you felt staff had particular ideas about how you could use self-directed support
- you agreed with staff's suggestions *or*

- you weren't sure you agreed with staff's suggestions
- you talked with staff about what you need and staff made suggestions *or*
- you talked with staff about what you need and you decided how you wanted to use self-directed support
- you felt that your application for self-directed support was developed with you at the centre – with staff being imaginative and creative
- you were invited to the Brent Self-Directed Support Panel to talk about your application *or*
- you were told you had to go the panel meeting to talk about your application
- you felt staff told you about what was available and you chose which service you wanted to use – using self-directed support
- you were involved in doing research, for example, about model of laptop or where to buy particular equipment – or a particular service you might want to use
- other (*could you tell us more?*):

9. Could you tell us about your experience of using self-directed support?
(*some options are given below for you to select as many as you want but do add your own information too*)

- staff supported you to use the money in the ways you wanted to
- staff checked with you to make sure that you were getting what you wanted from self-directed support
- staff enabled you to think about how you were benefiting from use of your original application and think about how you could develop use of self-directed support in future
- staff didn't really seem to know much about it
- staff took control
- staff enabled you to access another service such as Penderel's if you are employing your own personal assistant – rather than employing a personal assistant via an agency (*could you tell us about your experience if you have used Penderel's?*):
- other (*could you tell us more?*):

What you wanted to achieve by using self-directed support

10. Could you tell us what you feel you wanted use of self-directed support to enable you to do?
(*please tick as many as you feel apply to you*)

- stay out of hospital
- reduce contact with staff in mental health services generally
- avoid use of drugs and/or alcohol
- reduce isolation
- stay in contact with family and friends
- develop your social life and social network
- take part in daily activities that enable you to move towards recovery and improve your sense of wellbeing
- get involved in activities which connect you to your culture

- support you in your first language
- spend time in ways that feel meaningful for you and that you enjoy
- get back into work
- get back into education
- live independently, including by managing physical disabilities or illnesses
- maintain your home or tenancy
- manage your life, including carrying out practical tasks
- improve your physical health
- lessen feelings or symptoms such as thoughts or feelings that are intrusive
- maintain your motivation
- develop your coping strategies and self-management, for example, by going to self-help groups

Please tell us about anything else that you wanted to achieve from using self-directed support:

11. Do you feel you have achieved what you wanted to?

- Yes
- no
- to an extent

Could you tell us more?

Achieving what you wanted to via use of self-directed support

12. Could you tell us what you applied for to enable you to achieve your goals?

(some examples are given below for you to select as many as you want to but do add your own information too)

- equipment eg laptop, camera, musical instrument...
- materials
- further education course
- anything that enables you to move towards employment (could you give details?):
- going to the gym
- help to maintain your home
- help with practical, daily tasks in order to manage your life
- funding to enable you to spend your time in ways that are meaningful to you and enable you to improve your wellbeing and move towards recovery (could you give details?):
- funding to enable you to take part in daily activities to improve your social life (could you give details?):
- funding to enable you to develop your life, including by linking into cultural activities (could you give details?):

- employed a personal assistant to help you manage your life in different ways (either through an agency or directly employing someone) (could you give details?):
- develop your coping strategies and self-management

Please add anything else that you want to about what you applied for:

Improvements to your life

13. Could you tell us how you feel use of self-directed support has enabled you to improve your life?
(a few examples are included below for you to select as many as you want to but do please add your own information too)

- you have been able to develop your skills and abilities
- you have developed confidence in your own abilities
- you have developed your communication and relationships with others
- you feel you have greater control of your own life
- you have been able to try new things
- you have recognised what you are able to do, so, recognised your potential
- you are able to live independently
- you have been able to improve your sense of wellbeing
- you have been able to develop your own management of your mental health issues and your life generally
- you have been able to improve different aspects of your life

Could you tell us more here about how using self-directed support has helped?

Could you tell us about any other ways you feel your life has improved, including anything you didn't expect?

About the process of making your application for self-directed support

14. Could you tell us what you felt about the process of making your application for self-directed support?
(some options are included below for you to select as many as you want to and do add your own information too)

- it felt clear
- you felt involved
- the member of staff you worked with kept you up to date with progress
- you felt you had to wait ages for your application to go to the Self-Directed Support Panel
- once your application was agreed it seemed to take ages to receive the money

- there were problems with you receiving the money
- other (could you tell us more here?):

If you did have problems with receiving the money, could you tell us about them here?

Improving experience of self-directed support

15. Could you tell us what you feel would improve experiences of self-directed support in future?

(some options are included below for you to select as many as you want and do add your own information too)

- everyone being told about self-directed support when they start to use mental health services
- everyone using services being able to meet with a peer support worker to develop use of self-directed support
- staff knowing more about the process of making an application for self-directed support
- staff being able to give clear information about the aims of self-directed support, for example, that it is intended to be personalised to individuals and enable you to achieve what you want to – and be creative and imaginative
- staff being more creative and imaginative
- staff being able to offer examples and suggestions – based on what you feel you need
- staff being more confident about self-directed support
- having clear information about use of self-directed support
- having information about how others have used self-directed support
- use of self-directed support being discussed each time your care plan is reviewed
- use of self-directed support being talked about constantly
- being able to meet with others who are also using self-directed support
- being kept informed throughout the process
- being able to sort out any problems with receiving money once the application has been agreed

Could you tell us what else you think would improve the experience of using self-directed support?

Any other comments

Please make any other comments that you would like to about your use of self-directed support

Thanks a lot for completing this survey. Don't forget to also fill in the monitoring form attached and return your questionnaire by Thursday 11th February 2016 to BUG's Freepost address on the covering information sheet.

- South East Asian (eg Chinese, Vietnamese, Malaysian, Thai)
- Asian British
- Middle Eastern
- Black Caribbean
- Black African
- Black British
- Turkish
- Greek
- White European
- Eastern European
- White British
- Irish
- Jewish
- Mixed race

Please use this space to tell us how you describe your ethnicity, if you want to:

Faith

A few examples of different faiths are included here so please tick which is appropriate to you – though do add your own information if you want to:

- Agnostic
- Atheist
- Buddhist
- Christian
- Hindu
- Jewish
- Muslim
- Rastafarian
- other (please give information):

Life experiences you have had to deal with

We have given a few examples below but it would be useful if you could give some idea here of particular life experiences you have had to deal with which you feel have contributed to your mental health issues, eg:

- racial abuse or harassment
- homophobic abuse or harassment

- abuse of any kind (including as a child)
 - anti-woman abuse
 - domestic violence
 - homelessness (including as a result of lack of safety where you live)
 - using drugs and/or alcohol
 - other (please say what):
-
-

Contact sheet for individuals

Information you give here will be separated from the detail you have given in your completed form and used only to send you feedback from the completed survey – or to contact you in the way that you have said you want to be contacted.

Name:

Contact details:

(you could give your address and/or e-mail address, depending on how you would prefer to be forwarded feedback from this survey – and contacted in future)

E-mail address:

Please tick below as appropriate

- I would like a copy of the completed survey
- I would like to be added to BUG's mailing list

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