



## Report from London: Patient Voice

### Scrutinising NHS England (London)'s Public and Patient Engagement 2016 - 17

May 2018

Supported by



Chair's foreword	3
Corporate Leadership and Governance	6
Corporate Leadership and Governance Recommendations	6
Primary Care	9
GP Commissioning	9
GP Commissioning Recommendations	10
Dental, Optometry and Pharmacy Commissioning	11
Dental, Optometry and Pharmacy recommendations	12
Specialised Commissioning	13
Introduction to Specialised Commissioning	13
Patient Voice in Specialised Commissioning	14
Child and Adolescent Mental Health Services	15
South London Transformation Plan	16
Neo-natal Services	17
Specialised Commissioning Recommendations	17
Public Health, Armed Forces Health, and Health in the Justice System	18
Public Health - Immunisation & screening:	18
Public Health - Screening:	19
Public Health Recommendations	19
Armed Forces Healthcare	19
Health in the Justice System	20
Summary and next steps	22
Interviews and evidence list	24

## **Chair's foreword**

London: Patient Voice's review of NHS England (London)'s 16/17 engagement with patients and public has been undertaken and delivered in record time.

We recruited six new members in February 2018 and completed this review in May. For new colleagues, getting to grips with NHS England (London)'s (NHSEL) activities, finding the appropriate people to talk to, understanding the challenges the organisation faces and the ways it listens to the Voice of the Patient has presented colleagues with a steep learning curve.

What we have found is a continuation of the processes that were identified in our first two reports. There is a strengthening of organisational awareness of the benefits of seeking out and listening to what service users, carers and the wider London community have to say about how health services are designed and delivered.

Better engagement with Patient Voice leads to better designed services, which in turn can lead to earlier diagnosis of disease, better compliance with treatment regimes, better outcomes, less waste of time and resources and, so important in the context of financial pressures, cost savings.

Since our last report, awareness has matured and commitment has deepened. Patient and Public Voice (PPV) has become more than simply something required by statute and is starting to be thought of as an important management and improvement tool in the same way as Human Resource (HR), Quality Assurance and budget management.

With this acknowledgment has come the challenge of how best to recruit, use and support the large cohort of willing lay representatives who give up many thousands of hours each year attending boards, panels and meetings to offer the patient perspective on proposed changes to services and the commissioning of new ones.

In this review we have made recommendations that we hope will further embed PPV in the organisation, make the management and support of PPV more consistent and more transparent and emphasise that PPV should be one element of a partnership of equals with clinicians and commissioners.

We started our work at a very busy time in the commissioning/budget cycle so we are especially grateful to NHS staff who made time to talk to us while delivering to tight deadlines; to those who patiently explained the more esoteric and obscure aspects of commissioning and to the open handed and enthusiastic support from all staff. In our next review we hope to focus more on PPV reps themselves and will be looking to NHSE(L) colleagues to facilitate this.

I would also like to thank the PPV reps who gave time to speak to us, to Insight to Impact Consulting Ltd for excellent project support and to my London: Patient Voice colleagues for all their hard work, enthusiasm and commitment.

Over the next few years NHSE(L) will continue to respond to the challenges of budget pressures, increasing incidence of co-morbidities, diabetes and obesity, an ageing population and the recommendations of Sustainable Transformation Partnerships.

Patient Voice will continue to be an important ingredient in ensuring that NHSE(L) continues to deliver for Londoners.

David Winskill,

Chair, London: Patient Voice

May 2018

## Aims and Methodology

Following a London-wide recruitment process in December 2017 and January 2018, six new members were recruited to London: Patient Voice (L:PV), to work alongside the existing Chair. They attended training sessions, read previous L:PV reports and started work scoping out and planning their first review.

This review took a slightly different approach to previous work and focused on directly commissioned services (Primary Care, Public Health and Specialised Commissioning). Members were divided into four work strands:

- Corporate leadership and governance;
- Primary Care;
- Public Health (Screening and Immunisation, Health in the Justice System and Armed Forces Health);
- Specialised Commissioning.

Each of the strands:

- Reviewed whether L:PV's previous recommendations had been responded to;
- Scrutinised NHS England (London's) (NHSE(L)) own self-assessment (Participation and Engagement Report) published in November 2017;
- Developed key lines of enquiry, and identified those people that they wanted to interview;
- Interviewed key NHS England Staff and where possible Patient and Public Voice (PPV) Partners.

This report focuses on these areas and gives a commentary on what L:PV has observed.

## Timetable of review

December 2017	Insight to Impact Consulting Ltd appointed following a competitive tendering process.
December 2017- January 2018	Recruitment and appointment of L:PV members.
February 2018	Research and meeting preparation
March and April 2018	Interviews across the four strands - with staff and some Patient and Public Voice Partners.
11th May 2018	Review and recommend L:PV team session.
End May 2018	Final report with recommendations (this report) submitted to NHS England
11th June 2018	L:PV Chair and Insight to Impact Consulting Ltd attend PPV Accountability Group to report on this report

# Corporate Leadership and Governance

**L:PV members: David Winskill, supported by Su Turner**

Following our recommendations in the last report, we were keen to discover how public and patient voice had been further embedded in the corporate culture and practice of NHS England (London).

L:PV met with NHSE(L)'s Director of Nursing, and Head of Quality, and regional lead for Patient and Public Voice (PPV) to explore corporate ownership of PPV, and also how far colleagues view PPV as a corporate resource which can support service improvements and better commissioning decisions.

Overall, L:PV is pleased with the more focused level of corporate ownership that NHSE(L) are achieving. Much has been done to respond to the comments and the recommendations in our previous reports.

A direct reflection of L:PVs recommendations is the commitment to improving recruitment practices and training of patient and public representatives. Work has been done on trying to achieve consistent and more open recruitment processes.

It has also been good to see the results of all the hard work of NHSE(L) in offering training to 100s of existing PPV representatives, as well as better induction for new representatives.

We feel that there is a tangible and ongoing commitment at Executive Board level to improve and facilitate ways that patients and the public are involved in commissioning decisions.

To reflect and further embed this continuing commitment to PPV, we set out a number of recommendations under the following headings:

## **Corporate Leadership and Governance Recommendations**

London: Patient Voice (L:PV) is pleased with the increasing level of corporate ownership that NHS England (London) are achieving with regards to patient and public participation. To further improve this commitment, we recommend that:

- *The role of the in-house Patient and Public Voice Champion, and the Accountability Group is reviewed, redefined and re-launched*
- *Patient and public voice should be made an integral part of the quality assurance processes.*

## **Training**

L:PV is pleased with the roll-out of training to PPV Partners since our last report. We now feel that this could be enhanced by encouraging commissioners, clinicians and PPV reps to develop a mutual understanding of the benefits, obstacles to and opportunities offered by listening to patient and public voices.

We recommend that NHSE(L):

- *Considers arranging development opportunities to involve commissioners, clinicians and patient and public voice partners. This could include whole-board team development and joint training sessions on understanding the impact and opportunities offered by patient and public voice involvement.*
- *Holds specific patient and public voice training for Chairs of Boards. We recommend that a Charing Skills Programme is developed and offered to all Chairs to ensure that they are equipped for their role in involving and supporting the voices of public and patients.*

To further develop the skills of PPV reps, tackle the isolation of PPV reps and encourage the sharing of good practice we recommend that you:

- *Consider establishing a mentoring scheme; utilising the skills of the more experienced public and patients partners in supporting newer ones.*
- *Develop a specific training module about the London health landscape and economy, inequalities and structures. This should be made available for patient and public, and staff induction.*

## **Ladder of participation**

We discussed with several PPV Partners the opportunities that they have had to influence service change. An emerging theme was that they felt that the 'big decisions' were taken upstream of the meetings they attended, so their ability to influence was limited. Few said they had been involved in more upstream activities such as co-design or co-production.

We recommend that:

- *The Patient and Public Accountability Group is asked to do a piece of work to look at the feasibility and appropriateness of moving towards co-design, and / or engagement at an earlier stage of the commissioning cycle.*

## **Sharing Good Practice**

L:PV found that the composition of patient and public voice in London tends to be characterised by many highly motivated and experienced lay representatives. Much has been done nationally to promote the role of PPV, We also noted how fragmented and inconsistent patient and public voice is in parts of London. We have mentioned earlier how

PPV reps report feeling isolated and unaware of the bigger picture and what colleagues elsewhere are doing and how they are doing it.

We therefore recommend:

- *That NHSE(L) should consider taking a lead role in how best practice can be spread across all health agencies and providers.*
- *Consider opportunities to bring together PPV Partners either virtually or face to face, to share their experiences and good practice examples.*
- *Provide clear feedback with specific examples to PPV partners to assure them of how their input has made a difference in the commissioning of all services.*

### **Social Media**

Good work continues to be done using social media to canvass public opinion, accessing responses and reactions in real time. However this is still limited to a few commissioning streams, notably Public Health Immunisation (see later):

- *It is recommended that the Patient and Public Accountability Group (or Engagement Leads Group) explore how the benefits offered by social media could be best used in other areas and consider setting up an advisory panel of lay representatives to look at messaging and targeting to seldom-heard groups.*

### **Recruitment**

L:PV feels that the vibrant and active patient and public constituency we found is something to celebrate.

However, we were unable to find a single register or people bank that brings together the entirety of PPV engagement activity. Such a register could be used to ensure that PPV representatives are more representative of the populations of London, and that all PPV vacancies and training opportunities are better circulated.

Whilst the Involvement Hub is used to recruit patients and the public, during our research, only two positions were advertised.

We recommend:

- *Establishing a People Bank that contains details of all PPV Partners and the details of the panels, boards and projects they are engaged with.*
- *Ensuring that the Involvement Hub is established and advertised as a resource for the recruitment of PPV partners.*



## Primary Care

**L:PV members: Jane Allberry, Brigitte Shallow and David Winskill**

### GP Commissioning

*London: Patient Voice* (L:PV) met NHS England London's (NHSE(L) Head of Procurement and held a teleconference with The Sustainable Transformation Partnership (STP) and Alternative Provider Medical Service (APMS) Lead for NW and SE London.

Because of changes in responsibilities since 2016/17, we had difficulty locating some of the key people we wanted to talk to. We did not manage to speak to the people in NHSE(L) responsible for engagement with patients and the public in monitoring GP contracts and generally engaging with service users about improving local GP services. However, we obtained contacts towards the end of this review and will follow these up in our next review.

One of the major challenges L:PV had in this strand was to understand where the responsibility lay for managing and ensuring PPV. As the new (and complex) arrangements for GP commissioning bed in, we intend to do a more rigorous investigation for the 2017/18 report.

Since our last review, commissioning arrangements have changed considerably. Generally, commissioning of GP services has been delegated to Clinical Commissioning Groups (CCGs) and so, moving forward, we need to look at how far Clinical Commissioning Groups have engaged with the public and how far NHS England (London) have assured themselves of adequate and effective engagement.

Following the two previous L:PV reports NHS England (London) made a number of commitments to improve patient and public engagement in GP services. In March 2016, NHS England produced a comprehensive guide "The Framework for Patient and Public Participation in Primary Commissioning".

We found that

- As a result of the difficulties outlined above, we were unable to find any evidence about how far this Framework was being used.
- We could not find out whether other recommendations were implemented, particularly the promised Communication Strategy to inform every GP's Patient Participation Group of emerging strategies and re-provision of services or the commitment to engage with the Healthy London Partnership using their Panel of patients to discuss development and re-provision of services.

Anecdotally, we are aware that excellent engagement with patients and the public at local level in the development of services was not uncommon. But, this falls short of a broad

engagement on monitoring how far GP services are meeting their contract requirements and also for NHSE(L) to be able explicitly to show how they have engaged – and where that engagement has brought about changes - in general GP services commissioning.

We were impressed by the centrality to successful commissioning attached to the role of PPV by the Head of APMS Procurement. A vigorous champion of the added value that it can bring in improving services, he has been working with PPV for nearly a decade across a range of Primary Care services. He spoke of the unique perspective that PPV can bring to aspects of commissioning such as access, hours of opening, information, range of services and (especially important in London) languages.

The example set out in the NHSE(L) report about engaging with patients and the public when GP services are re-procured under the APMS contract is a good one. We investigated further how these re-procurements worked and were impressed by the thorough and effective way patient and public views were sought. We were conscious though that, once a new APMS contract was awarded, there was not such a standard system (which we could be confident was being implemented) for engaging patients and the public in monitoring it.

## **GP Commissioning Recommendations**

Our specific recommendations for GP Commissioning are that:

- 1. Patients and the public in London should be provided with a clear statement of opportunities to engage in the commissioning of GP services, and advice about how to get involved, and what they are able to influence.*
- 2. NHSE(L) should, in future report on how they have fulfilled their statutory duties for engaging with patients and the public in commissioning services, set out clearly how they have done this for all GP services (not just re-procurement of services under the APMS contract), what evidence they have that patients and the public have been engaged effectively, and some examples of what difference the engagement has made.*
- 3. While it is good news that going forward NHS England is assessing CCGs about how far they have engaged with patients and the public, we want to see evidence that CCGs are being assessed specifically on their engagement on the commissioning of GP services - because this is an area of such great importance to local populations and an area where NHSE(L) has delegated its responsibilities and so must assure itself that CCGs are meeting the requirements on their behalf.*

*For our 2017/18 report, we intend to research:*

- How far NHSE(L) is meeting its PPV responsibilities for GP commissioning; and*
- By talking to representatives of CCGs, Healthwatch and local GP Patient and Participation Groups, how this might be improved.*

## Dental, Optometry and Pharmacy Commissioning

*London: Patient Voice* met with the Commissioning Manager for Dental, Optometry and Pharmacy; together with four Patient and Public Voice (PPV) Partners who sit on the Dental, Optometry and Pharmacy Services Patient Leadership Board (DOPLB). The Board is very well established having started in November 2014 as the Dental Patient Advisory Board. In July 2015 Pharmacy and Optometry were added and the name was changed to the Patient Advisory Board. In March 2017 the Board changed its name to the Patient Leadership Board.

We were very pleased to see such an example of good practice and the commitment of the lay members who were kind enough to give their time to meet us. There was evidence of diversity (ethnicity, age and gender) amongst the members who included a person with a Learning Disability. A very aware and thoughtful group, they spoke of the difficulty of engaging and retaining younger people.

We recognised that much of the success of the Board is due to having a long standing dedicated relationship/project manager who receives open handed support from senior management. We were given examples of the good work that goes into ensuring full involvement by the members.

### Example of good practice

*It is difficult to provide documents in the Royal Mencap Society's "Easy-read" format, so the Commissioning Manager offers a pre-meeting with the board member with a Learning Disability to take him through the papers ahead of the meeting. Further, to improve accessibility, all officers making presentations at meetings are asked to use images, large print and avoid tiny graphs and dense data.*

*This is much valued and allows the board member to better engage and contribute to the activities and discussions of the board.*

The arrangements in place for this member could also provide a model for recruiting and supporting other PPV reps with a learning disability in other commissioning areas.

Board members who cannot attend meetings are invited to make comments by e-mail, patient surveys, etc. Also, to facilitate attendance and reduce workload, they have reduced the frequency of meetings to four times a year. Board members are actively engaged between meetings on various work-stream projects.

We asked for examples of PPV engagement and were told about how patients had engaged on the development of new arrangements for community dental service and for a new dental nurse triage system via NHS 111.

Board members confirmed that they felt supported and fully engaged. All are able to contact the relationship manager (who they described as extremely helpful) at any time outside the meetings.

However, DOPLB members were concerned that policies, proposals and plans seemed quite often to have been fully formed “up-stream” by the time they are asked for their views. Therefore they felt they had only marginal influence over direction and overall strategy, their influence being limited to "softening the edges" but not fundamentally able to change things.

The Board members also felt that the three areas Dentistry, Optometry and Pharmacy are very large and quite overwhelming for them and so perhaps it might be better to have three separate groups for the different areas or to be subgroups of a combined Board. They did seem to feel confident to challenge, but were not convinced it made a difference, although any questions asked and challenges they raised were minuted.

The Lay Board members were able to add agenda items if they wished and issues which were more relevant to other groups were passed on as required. Although there was evidence of good engagement in this area, there seemed to be a sense of constraint between legal requirements, e.g., procurement rules that identify certain stages where PPV can be engaged and where the rules do not permit it, and the expectations of lay members to be involved throughout the commissioning cycle, i.e., review, development of specification, procurement, and post award monitoring.

Several Board members said that they would like feedback on how their work had resulted in changes and improvements to services and outcomes. PPV invest a great deal of time in this work and so it is important that they feel it is worthwhile, valued and makes a real difference.

### **Dental, Optometry and Pharmacy recommendations**

Our specific recommendations for Dental, Optometry and Pharmacy commissioning, are:

- 1. NHSE(L) should consider ways of reducing the burden on PPV partners including the use of sub-groups for the three areas under its remit.*
- 2. Consider ways in which PPV partners can be engaged more fully throughout the commissioning cycle.*
- 3. Consider allowing one of the Patient Leadership Group to sit on the senior board, to address lack of strategic connection*
- 4. Provide clear feedback with specific examples to PPV partners to assure them of how their input has made a difference in the commissioning of DOP services.*

# Specialised Commissioning

**L:PV Members: Yemi Fagun, Deborah Frimpong and David Winskill**

## Introduction to Specialised Commissioning

L:PV met with NHS England (London)'s NHSE(L) Director of Nursing and Quality (Specialised Commissioning (London Region), along with three colleagues covering the roles of Transformation and Children and Adolescent Mental Health (CAMHS).

Specialised Services are those that are provided for rare and complex conditions for which patient numbers are extremely small or where the cost of such services will significantly impact on local Clinical Commissioning Groups (CCGs).

Unlike other services, Specialised Services are usually commissioned at a national level and, in many cases services are provided at a limited number of centres. This offers much better care for patients but also presents issues in ensuring that regional (London) patient voices are heard when commissioning national services.

Specialised Commissioning covers six broad areas, called National Programmes of Care (NPoC). They are:

- Internal medicine - digestion, renal, hepatobiliary and circulatory system
- Cancer
- Mental health
- Trauma - traumatic injury, orthopaedics, head and neck and rehabilitation
- Women and children - women and children, congenital and inherited diseases
- Blood and infection - infection, immunity and haematology

L:PV focused on Child and Adolescent Mental Health (CAMHS), Neonatal services and the South London Transformation Plan; leaving the remaining strands for its 17/18 review.

## Organisation

Each NPoC is overseen by a Board. Clinical advice is provided by several Clinical Reference Groups (CRGs). In 2016 NHS England undertook a review of CRGs, reducing their numbers from over a hundred to less than fifty. L:PV understands that this reorganisation is now complete.

The terms of reference, structure and membership of NPoCs and CRGs is overseen at national level with the responsibility lying with the NHSE national team.

NHSE(L) is responsible for commissioning some of the services and for monitoring the Providers of those services.

## Patient Voice in Specialised Commissioning

Specialised Commissioning Advisory Groups include lay representation.

- CRGs have three lay members; one from a related charity and two carers/service users. When NPoC Boards consider recommendations from CRGs, the level of consultation with wider service users is of great interest to them. Anyone can get involved with the work of a CRG by registering as an interested stakeholder. This is an invaluable way in which a wide range of patient views can be heard. However, it is not clear to what extent patients/the public have engaged with the offer to register as stakeholders and going forward, L:PV will be interested in finding out more about this.
- Clinical Quality Review Groups (CQRGs) – are meetings where the quality of clinical services are monitored and assurance is sought. In London the Specialised Commissioning Team lead the CQRGs for its 5 Directly Commissioned Services - Royal National Orthopaedics, Royal Marsden , Royal Brompton, Great Ormand Street and Barts Healthcare (Barts site). There is good lay representation at the Barts CQRG and NHSEL are looking at how this can be replicated across the other CQRGs.
- Individual Funding Requests<sup>1</sup> (IFR) – there was strong lay membership of Individual IFR panels (two independent Chairs and three PPV members). L:PV heard that these lay members were valued and sometimes directly influenced the decisions that were made.
- Clinical Priorities Advisory Group (Independent Chair and four Patient and public voice members).
- Patient and Public Voice Assurance Group which was set up to make sure that the patient voice is incorporated into all aspects of Specialised Commissioning. This Group was discussed in more detail in L:PV's 2015 report.

L:PV learned that all policy development working groups had patient representation.

NHSE(L) confirmed that they recruit a lot “expert patient representatives with extensive experience of the NHS ...”. The amount and range of experience brought to the table by these representatives may have influenced the depth and type of training offered.

When asked about equality monitoring in order to ensure appropriate representation of seldom heard groups, we learned that a common practice is for PPV representatives to be

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<sup>1</sup> An individual funding request can be made for a treatment that is not routinely offered by the NHS when clinicians are of the view that a patient's clinical circumstances are clearly different to other patients with the same condition, and when there is a reason the patient would respond differently to other patients - and therefore gain more clinical benefit from the treatment (<https://www.england.nhs.uk/wp-content/uploads/2017/11/ifr-patient-guide.pdf>).

recruited informally via the recommendations of existing PPV groups. For this reason, no equality monitoring had been undertaken. However, wherever formal recruitment is undertaken (e.g. recruitment is ongoing for PV reps for the South West London transformation area) NHSE(L) intend to build equality monitoring into the recruitment process.

There is clearly a balancing act. Recruiting from existing groups has advantages: candidates can be quickly identified and recruited, bring with them knowledge and experience and have a proven track record. The downside is that how these groups (taken as a whole) tend to be unrepresentative of London and its diversity.

## Child and Adolescent Mental Health Services

CAMHS services are one of the services commissioned by NHSE(L). Below are two examples of how NHSE(L) are obtaining and using service users input to improve services.

### Examples of good practice

Tier 4 Services - NHSE(L) identified that the number and locations of beds in London was inadequate. L:PV was informed that the situation was such that there were no Learning Disability CAMHS beds and hardly any Adolescent beds in London.

To get input into new service design from service users, NHSE(L) commissioned Young Minds to carry out a consultation with young people and their parents/carers. When L:PV asked how the respondents were chosen, we were reassured that Young Minds had an established network of young people and carers and were able to tap into Youth Parliaments. Furthermore, they had a strong reputation based on their work with this population group.

The recommendations from the consultation report are already being used to inform staff training for new service providers. For example, all CAMHS units will now have a Service Users Forum. And how well the feedback and suggestions from these groups are taken on board will be assessed by NHSE Case Managers when conducting Case Review of Services.

### Examples of good practice

**Case and Treatment Reviews (CTRs)** are conducted before or within 10 days of a patient's admission to hospital, and are repeated every three months during the period of admission. The panel is made up an NHSE representative, a clinical expert/provider (independent of NHSE) and an "expert by experience" - a lay person. The reviews lasts a whole day and the panel must meet and talk to the young person involved.

L:PV was told of a young person who had complained that the choice of vegetarian meals was limited. This view was listened to and the Provider was asked to expand the choice.

## South London Transformation Plan

Over the last two years, local NHS organisations and councils have been drawing up plans to improve the health and social care of their populations and ensure the long-term sustainability of the health economy) The South London Transformation Plan (STP) is one of 44 STPs across England.

L:PV understands that this programme of work has strong Patient and Public representation and participation, especially in South East London. We were told that South West London is currently refreshing their lay representation and NHSE London is supporting them to do so. Vacancies are advertised through local HealthWatches as well as using STP Engagement leads' networks to publicise them.

There is evidence that this works well but it lacks a systematic approach. L:PV would like to see South London Transformation Partnership explore other ways of advertising PPV positions, we feel this could make PPV more representative of the general population.

L:PV spoke to two Patient and Public Voice (PPV) representatives and found much communality of experience:

- They were recruited by invitation and one mentioned the scarcity of people to sit on work streams;
- Both very aware and realistic about the constraints under which the NHS is operating;
- They both gave up a great deal of time to the panels they work on.
- They had not been offered training (but one had identified a need and was working on organising a training event);
- Neither had seen the NHS England Learning and Development brochure nor visited [www.england.nhs.uk/participation](http://www.england.nhs.uk/participation);
- They rarely had the opportunity to talk to other PPV representatives about their work, sharing best practice or common challenges;
- Their relationship (despite late papers for meetings) with their respective project managers was excellent;
- Although treated well and listened to, they felt parity of esteem with commissioners/clinicians was less than whole hearted;
- Both felt that many decisions are taken “up stream” of the meetings they attend and one spoke of being “... rubber stamp – we’ve been engaged with”;
- Both felt that their work was worthwhile and one spoke of being a critical friend and that “.. influence can be wielded”.



## **Neo-natal Services**

This service was included within NHSE(L)'s report and highlighted as good practice. However, despite several attempts, L:PV was unable to make contact with lead officers to research further. *This will be followed up in L:PV's 17/18 review.*

## **Specialised Commissioning Recommendations**

Our specific recommendations for Specialised Commissioning are:

- 1. When using national organisations such as Young Minds to obtain service user views, e.g in consultations, NHSE(L) should take extra care to ensure that the organisations understand the regional/local issues and the work is adequately targeted at London.*

### *Additional recommendations*

- 2. Consider introducing a regular means of reporting the feedback received by all Child and Adolescent Mental Health Services (CAMHS) via their secure Service Users Forum, e.g. quarterly reports. This information should be used proactively address on-going concerns and improve existing services and also to inform future commissioning decisions*
- 3. Explore the inconsistency of patient and public involvement in Clinical Quality Reference Groups by learning from the experiences of Barts Health NHS Trust and how they benefit from their involvement.*
- 4. For the South London Transformation Partnership explore other ways of advertising Patient and Public Voice positions, and open up recruitment to seldom heard groups.*

# Public Health, Armed Forces Health, and Health in the Justice System

**L:PV Members: Dawn Anderson, Nkechi Nwazota and David Winskill**

L:PV met with the former Head of Commissioning and the Director of Public Health to explore patient and public voice involvement within this wide-ranging subject.

## **Public Health - Immunisation & screening:**

L:PV were told by the former Head of Commissioning, that the focus for 2016/17 was on the MMR/BCG vaccines as well as prenatal Hepatitis B vaccine and screening. We heard that there was very poor uptake of vaccinations, especially amongst some groups such as the Jewish community.

However, uptake was increasing and we heard that the reason for this increase was due to the implementation of suggestions made by Patient Representative Groups. For instance, with the BCG and MMR vaccinations, pregnant women and new mothers had raised concerns that having to book separate appointments to have their babies immunised was a hindrance. Therefore, these immunisations are now offered by midwives in the community or the appointments were booked at the same time as other routine appointments. This has led to an increase in the number of children immunised.

Another success in the immunisation strand is the offer of flu vaccine jabs to all health care workers in the social care sector. All carers working in nursing homes and care homes etc. will receive free flu vaccines as long as they can provide evidence that they work with vulnerable people. L:PV heard that this initiative came about as a response to a social media campaign by social care workers who were required to pay so much for their vaccinations. Important wider outcomes of the initiative include; less worker sick leave and a lower likelihood of transmission to residents.

## **Recruitment**

L:PV asked how Patient Representatives were recruited onto the immunisation strand. We were told that most of the recruitment was done via social media, such as Twitter. The NHSE(L) Officer interviewed was an avid proponent of using social media to gather patient feedback and getting other messages across. He said that due to the transient and temporary nature of the patient group targeted for immunisation services, especially the neonatal and early years, social media was a more up to date and effective platform for recruiting patient and public representatives. This group changes postal addresses and phone numbers frequently but most times their social media identities are maintained.

## Public Health - Screening:

L:PV heard that there has been a decline in the number of women coming for cervical screening, and attributed this to the 'Jade Goody' effect wearing off.

In response, NHSE(L) teamed up with a charity to seek out new ways of encouraging women to attend for a cervical smear test. One of the ways introduced was to write personalised letters to eligible women inviting them to attend their cervical screening. This method is still being trialled to find out how effective it will be in increasing the uptake of cervical screening - but early signs are encouraging.

## Public Health Recommendations

- 1. Consider the establishment of an Advisory Board for immunisation and screening, to complement the social media and electronic communication.*
- 2. Consider using a metric for understanding and measuring the impact and use of different means of communications e.g. what has been the outcome of writing personalised reminders to women about screening - did it lead to an increase in uptake?*

*For our 2017/18 report, we intend to research*

- London Abdominal Aortic Aneurysm Screening and in particular feedback on the outcome of the survey carried out in 16/17, and whether it has led to changes in the procurement process.*
- An update on Social Media participation and how effective it is.*
- Other screening areas, such as adult immunisations and tuberculosis.*
- Patient recruitment and participation in diabetic eye screening.*

## Armed Forces Healthcare

L:PV learned that other than screening for older men's bowel cancer and cervical cytology, there is no direct commissioning of services for serving members of the armed forces. The centre piece of NHS England London's commissioning is the four-times-a-year meeting that brings together ex-service personnel together with forty or so support groups and charities.

The events attract good numbers of people and give an opportunity for

- Ex-service personnel in need of help or support to find it from the organisations that attend
- Organisations to explain what they offer and how to engage
- Feedback from service users on the quality of what is and what should be available

L:PV felt that this is a very particular case and that it has the potential to offer live feedback and commissioning engagement from the user groups supported by these charities.

*Whilst there are no specific recommendations from our work this year, L:PV has asked to be invited to the next event, in order to comment more fully.*

## **Health in the Justice System**

NHS England London work closely with both the Home Office and the Police and recognises that Health in Justice is essential to prevention and protection and has a direct impact on re-offending rates.

### **Overall Strategy for Health in the Justice System**

The Director of Public Health gave an update on his background and remit: Central London Clinical Commissioning Group, Sub group, Sexual Assault Referrals, Prison/Asylum Centres, Mental Health Support Network, Clinical Reform Group, procurement and bidding Processes.

L:PV were told that currently there is no overall strategy, pulling together the totality of the work in the Health the Justice System, however we were assured that this work is underway. Also that a Public /Assault and Sexual Assault Strategy is also in development and L:PV were informed that that the Patient's voice will be included in this.

L:PV understood that capturing the lived experience of those in the justice system was complex; not only due to the difficulties of access for those in custody, but also that the range of experience is diverse, with the need for both perpetrators and victims to have equal voice. For this reason there is no 'standing' patient voice committee of participants and involvement is always tailored to individuals. To overcome these challenges, NHSE(L) work in different ways to seek to embed the voice of PPV, including:

- Using **Inspirit** a participation and training organisation to undertake patient involvement across healthcare in the Justice System by providing service user engagement and feedback. There are some good examples of what engagement structures are in place, such as service user participation, accredited training and co-production of services. NHSE(L) often use Inspirit as a way to gain feedback when it is difficult to approach groups directly, such as those in custody. However some engagement projects have been postponed, such as the expansion of the Commissioning Technicians and the Plans for Service Procurement at Her Majesty's Young Offenders Institutions.
- **The Patient Participation Project** was formed to assess how activities of patient participation were being managed across the secure estate in London. They forged a set of standards to assist healthcare providers to improve. The remit of the project has been extended in 2018 to include setting up a steering group of patients, healthcare providers and Her Majesty's Prison and Probation Service governors and leads to support the Smoke Free initiative that is being rolled out across the prisons.

- **Child House Development** the Safeguarding team from the Nursing Directorate worked with Criminal Justice Colleagues and the Mayor's Office for Policing and Crime on further developing the Child House model during 2016/17. The Child House safeguards and supports young survivors of sexual violence and their non-offending family members across North Central and South West London Sustainable Transformation Partnership footprints. However, L:PV found that there had been little involvement of children and young people, and this we were told will be looked at in the following year.
- **Diversity:** L:PV were informed during interviews with NHS England London that BME groups are over-represented within the prison population and it was confirmed that these services are commissioned to the same standards as any other with regard to equality and diversity and access to translation services etc.

*L:PV recognises that the justice system is currently under intense scrutiny. Within the limited time allowed for this year's L:PV review, it is suggested that this will form a major part of our review in 2018/19. We would like to investigate how NHSE(L) is working to facilitate a safe environment for patient and public voice feedback.*

## Summary and next steps

This is the third review by London: Patient Voice, and we are pleased that we have been able to speak to more Patient and Public Voice (PPV) Partners during this short, intense review.

However we feel that there is a gap in our awareness of PPV partners' experiences and work on committees to see first hand their interactions and involvement.

We have made many recommendations, which whilst all are important and will assist NHSE(L) in improving the way they involve PPV in commissioning decisions, they will of course need to prioritise them. Therefore we have set out below our top five recommendations.

- **Developing whole boards and teams:** considering arranging development opportunities to involve commissioners, clinicians and patient and public voice partners. This could include whole board team development and joint training sessions on understanding the impact and opportunities offered by patient and public voice involvement.
- **Moving up the participation ladder by working towards co-design:** the Patient and Public Accountability Group is asked to do a piece of work to look at the feasibility and appropriateness of moving towards co-design, and / or engagement at an earlier stage of the commissioning cycle (all commissioning strands).
- **Auditing PPV involvement and Establishing a People Bank:** containing details of all PPV Partners and the details of the panels, boards and projects they are engaged with. This could also pick up some of the other recommendations around feedback.
- **Being fully aware of how NHSE(L) are meeting their duties in a delegated environment for GP commissioning:** NHSE(L) should, in future report on how they have fulfilled their statutory duties for engaging with patients and the public in commissioning services, set out clearly how they have done this for all GP services (not just re-procurement of services under the APMS contract), what evidence they have that patients and the public have been engaged effectively, and some examples of what difference the engagement has made.
- **PPV good practice and impact:** consider opportunities to bring together PPV Partners either virtually or face to face, to share their experiences and good practice examples and impact across all commissioning strands.

### Our next review

In our next review we hope to focus more on PPV Partners themselves, exploring the reality on the ground, how parity of esteem is mediated and how effectively they influence change.

We would like to visit boards in action as well as meeting / speaking with more PPV reps, have a presence at events, such as an Armed Forces quarterly meeting and London wide/ local training opportunities. We will be working with to NHSE(L) colleagues to facilitate this.

We also wish to focus on:

- **GP commissioning:** How far NHSE(L) is meeting its PPV responsibilities for GP commissioning; and how this might be improved.
- **Health in the Justice system**
- **Public health:**
  - London Abdominal Aortic Aneurysm Screening and in particular feedback on the outcome of the survey carried out in 16/17, and whether it has led to changes in the procurement process.
  - An update on Social Media participation and how effective it is.
  - Other screening areas, such as Adult immunisations and Tuberculosis.
  - Patient recruitment and participation in Diabetic eye screening.
- **Specialised commissioning:** Neo-natal Services and others not reviewed this time

## Interviews and evidence list

Below is a list of people interviewed by members of London Patient Voice during its investigations, and referenced notes of meetings that were used to aid the development of this report.

L:PV File ref	People interviewed	L:PV members involved
L:PV 2018 / 1	Penny Boxall NHS E (London) commissioning team, 4 PPV reps - Lucia, Lloyd, Gerald, Dinah	David Winskill Jane Allberry Brigitte Shallow
L:PV 2018 / 2	Ben Farrelly (BF) - Head of Procurement for NHS London	David Winskill Jane Allberry Brigitte Shallow
L:PV 2018 / 3	Vinice Thomas, Silvia Novo, Vimbai Egaru, Reshad Nunhuck - NHS E (London) Specialised Commissioning team	David Winskill, Deborah Frimpong, Yemi Fagun
L:PV 2018 / 4	Kenny Gibson, Head of Public Health Commissioning, NHS England (London Region) Matthew Bazeley, Director of Public Health, NHS England (London Region)	David Winskill Dawn Anderson Nkechi Nwazota, Deborah Nicolson - support
L:PV 2018 / 5	Martin Machray - Director of Nursing, NHSE(L) Helen Keynes - NWL Head of Quality/Regional Lead for Patient Experience and Patient Public Voice, NHSE(L)	David Winskill Su Turner - support
L:PV 2018 / 6	Ian Fair PPV partner	David Winskill
L:PV 2018 / 7	Lynn Wheeler PPV partner	David Winskill