Document number	Name of document
20	CCG case studies

NB. This is a CCG document. The PCT logo has been used as an interim measure whilst the CCG's logo is finalised

Summary of Document

Contents

Core Evidence Shown

Domain	*Description*	*Location*
1.1.C	Examples of CCG delivering measurable improvements in quality and productivity under delegated arrangements.	See Case Study 1, section 3 to show the impact of clinical involvement under delegated arrangements See Case Study 2 points 3.1, 3.2 and 3.4 to demonstrate measurable improvements under delegated arrangements See Case Study 3 point 2.3 to show innovation and improvements under delegated arrangements.
1.2.D	Examples of member practice involvement in decision-making.	Please see case study 3 - Peer Groups - point 2.2 - to demonstrate member practice involvement Please see case study 3 - Peer Groups - point 3.1 - bullet point 2 to show practice involvement in decision making Please see case study 3 - Peer Groups - point 3.1 - bullet point 7 to show the CCG drawing upon local practice information. See 360 stakeholder survey slide 24 & 42 and 360 summary stakeholder slide 11. This shows that stakeholders generally believe that the arrangements in place for involving stakeholders are effective.
2.2.B	Systems and processes for monitoring and acting on patient feedback, and particularly in identifying quality including safety issues.	Case study 1 - MRI Analysis - point 2.2 describes how various techniques were employed to engage a range of stakeholders Case study 2 - Contracting - point 2.3 describes how feedback from different groups was captured to inform decision-making Case study 4 - Engagement - sections 1, 2 and 3 describe a wide range of methods and channels employed by the CCG to engage its stakeholders
2.3.B	Examples of CCG engaging different groups and communities through a range of communications channels in the development of its vision, plan, or in broader CCG decision-making processes.	Case study 1 - MRI Analysis - point 2.2 describes how various techniques were employed to engage a range of stakeholders Case study 2 - Contracting - point 2.3 describes how feedback from different groups was captured to inform decision-making Case study 4 - Engagement - sections 1, 2 and 3 describe a wide range of methods and channels employed by the CCG to engage its stakeholders

3.2.A	Examples of CCG successfully taking devolved responsibility for commissioning budgets and delivering improvements.	Case study 1 - MRI Analysis - point 2.1 to show successful, devolved responsibility Case study 2 - Contracting - section 3 describes the impact of clinical leaders taking responsibility and delivering improvements Case study 3 - Peer Groups - point 2.3 describes how the CCG as well as member practices have taken responsibility for budgets and QIPP
3.3.C	Examples of CCG involvement, under delegated arrangements, in 2012-13 contracting round.	Case study 2 - Contracting - points 1.2, 2.3 and 3.5 specifically show clinicians meeting with providers Case study 3 - Peer Groups - points 2.3 and 2.4 to show CCG and member practice involvement in contracting round
4.2.1.K	Examples of CCG innovation.	Case study 1 - MRI Analysis - section 2 describes the innovative approach employed by the CCG to this task Please see case study 3 - Peer Groups - point 2.3 to show innovation and improvements under delegated arrangements Case study 4 - section 2 describes some of the innovative approaches taken by the CCG to engaging its stakeholders
4.3.1.B	CCG choice of case studies illustrates their approach and the impact they have had to date in at least one of the patient groups described.	Case study 1 - MRI Analysis - section 3 demonstrates the benefits for a number of patient groups listed of the improvements made to MRI scanning Case study 2 - Contracting - points 1.2, 2.3 and 3.1 to show which patient groups have been impacted by clinically led contracting. Case study 3 - Peer Groups - section 2.4 describes some of the groups impacted by Peer Group work, such as those with long term conditions and continuing healthcare needs. Section 3.1 - peer groups which allow for individual patient stories to be heard Case study 4 - Engagement - sections 2.3 and 3.1 describe how patient groups have been engaged to date by the CCG and section 3.3 lays out plans for future engagement
5.1.C	Examples of CCG collaboration with other CCGs and a multi-disciplinary range of clinicians.	Case study 2 - Contracting - point 1.1 shows collaboration with other CCGs Case study 1 - MRI Analysis - points 2.1 and 2.2 demonstrate the CCG working with multi-disciplinary clinicians See Document 7. List of Collaborative Arrangements - (a) Draft BEHH Collaborative Agreement: Please see section Titled 'Accountabilities and shared posts' which describes the accountabilities, and see figure 1 on page 5 for the collaborative operating model. Page 3 also describes how this collaboration would "enable the CCGs to achieve economies of scale".
6.1.D	Examples of CCG leadership development.	Case study 1 - MRI Analysis - point 2.1 shows CCG leadership development in action Case study 3 - Peer Groups - section 2.2 describes clinicians stretching themselves in leadership roles and seeking external support to aid development. Section 2.3 increased awareness amongst GP leaders of QIPP LINES. Section 3.1 - practice engagement at peer group level to promote development within practices
6.2.B	Examples where the CCG has enhanced clinical involvement in service redesign and improvement.	Case study 1 - MRI Analysis - points 1.1, 1.2, 1.3 and 3.3 to show clinical perspective and involvement in service improvement Case study 2 - Contracting - section 1, point 2.2, point 3.4 and point 3.5 to demonstrate clinical input in service redesign and improvement Case study 3 - Peer Groups - section 3 describes the impact of clinical involvement through the Peer Group structure

		Case study 4 - Engagement - point 3.2 describes patient recognition that clinical involvement is making a difference See Case study 4 - Engagement - point 3.2 describes patient recognition that clinical involvement is making a difference.
Additional Evidence Shown (if any)		
Domain	***Description***	***Location***
3.3.B	CCG involved under delegated arrangements in 2012-13 contracting round, including in monitoring delivery of 2012-13 contract through regular liaison with main providers, and benchmarking providers.	See Case study 2 - Contracting - points 1.2, 2.3 and 3.5 specifically show clinicians meeting with providers.
6.2.C	Lead clinicians selected from member practices for CCG commissioning priority areas.	See Case study 1 - MRI Analysis - section 2.1 demonstrates involvement of Tier 2 GPs.
3.1.2.B	Plans clearly demonstrate where and how the CCG is working with other CCGs to meet QIPP, and can demonstrate that stakeholders are aware of and understand CCG priorities.	See Case study 2 - Contracting - point 1.1 shows collaboration with other CCGs, which inevitably works toward the QIPP targets.
4.2.1.E	CCG has arrangements in place to proactively identify early warnings of a failing service.	See Case study 2 - Contracting - points 1.2, 2.3 and 3.5 specifically show clinicians meeting with providers. These show a means of identifying early warnings of a failing service.
1.1.B	Governance, decision-making and planning arrangements where quality is a priority and clinical views are foremost.	See Case study 1 - MRI Analysis - section 3 to show the impact of clinical involvement under delegated arrangements Please see case study 3 - Peer Groups - point 2.2 shows how a clinical focus encourages participation.
1.1.A	CCG has clearly articulated its shared mission, values and aims for improving quality	See Case study 4 - Engagement – section 2.5 articulates how the CCGs vision was communicated.
3.1.2	Plans clearly demonstrate where and how the CCG is working with other CCGs to meet QIPP, and can demonstrate that stakeholders are aware of and understand CCG priorities.	See document 20 - Case studies - (b) Acute contracting case study: This demonstrates collaboration with other CCGs to meet QIPP. Section 1.1. describes Harrow and Brent working together.

Case Study 1: MRI Analysis – Increasing patient safety and clinical outcomes project

CCG name: NHS Harrow CCG		
Case study title: MRI Analysis – Increasing patient safety and clinical outcomes project		
CCG case study number:	*1* of 4	**Word length for this case study** 585 of 2947
Does the case study provide core evidence?	Yes	**If yes, state domain criteria by deleting as appropriate:** 1.1, 1.2, 2.2, 2.3, 3.2, 4.2.1, 4.3.1, 6.1, 6.2
Does the case study provide supplementary evidence?	Y	**If yes, state for which domain criteria:** 1.1.B, 6.2.C

Patient groups	**Please tick all relevant:**
• Mothers and newborns	
• People with need for support with mental health	
• People with learning disabilities	
• People who need emergency and urgent care	✓
• People who need routine operations	✓
• People with long-term conditions	✓
• People at the end of life	
• People with continuing healthcare needs	

Description:	*This is the section for which the word limit applies*
1) Context: • **Why did you do it?** • **Who was involved?** • **When?** **2) Action** • **What did you do?** • **How did you do it?** 3) **Impact**	

1. Context

1.1. NHS Harrow has an obligation to provide quality healthcare to the patients who reside within Harrow. This care has to be delivered with a degree of financial responsibility.

1.2. We carried out an analysis on MRI usage which revealed that in some scenarios indications for MRI requests needed to be clarified – to this end we created forms.

1.3. MRIs are used by GPs to investigate a number of conditions – from chronic headaches to acute joint injuries. On many occasions comments have been passed by hospital and primary care clinicians regarding unnecessary/poor quality MRI imaging. This has led to repetition of scans resulting in - increased costs and unnecessary scans. To address these issues and improve quality for patients an analysis was requested by the NHS Harrow CCG Governing Board, culminating in recommendations

2. Action

2.1. The project was delegated to a pair of newly qualified GPs who had been appointed Tier 2 Commissioners. (This is a leadership development programme designed to develop the leadership capability of aspiring clinical leaders) They were requested to carry out an assessment of MRI usage and to present their findings and advice. Both of the GPs were provided with administrative support and CCG board mentorship, throughout the process.

2.2. A variety of methods was used to seek the views of key stakeholders. As well as collecting quantitative information regarding the numbers of MRIs requested and costs from the two main providers, a survey of all requesting GP's/ and CCG member practices was carried out. In addition, the opinion of secondary care clinicians was sought regarding the quality of imaging.

2.3. Verbal and electronic methods of communication were used including an online survey monkey. The findings of the stakeholder engagement were used to contribute to a solution that would improve quality and productivity.

2.4. Meetings with the local stakeholders led to the initiation of the idea of a generic tick box form. Ideas were finalised bearing in mind evidence based review of guidelines (Royal Colleges of GPs/Radiologists and NICE), recommendations in the form of request forms was formulated.

2.5. The forms were designed to make it simple for colleagues to make a decision on the basis of presenting signs and symptoms.

2.6. Following the above, a forum was convened in which practices were given a further opportunity to respond to a presentation regarding the proposed changes. Practices were introduced to the new request forms.

3. Impact

3.1. At the forum the results of the survey and presentation of clinical evidence as well as

opinions of various parties, were appreciated by the GPs. There was a discussion about the review and the forms that had been put forward as the new guidelines for initiating MRI requests. The financial benefit of the recommendations was also made apparent and used to further drive the proposal for change. We are currently assessing the benefit of the forms as it has only been 3 months since they were introduced.

3.2. A future audit of the impact of the changes in practice as well as the cost-benefit outcome is in the pipeline with the aim of carrying it out a year after implementation.

3.3. The success of this project has been attributed to clinicians driving the innovation initiated in response to poor quality patient provision. It has improved patient safety by reducing unnecessary MRI scanning and shown that clinicians working together can make a difference.

3.4. We would envisage that 25% of imaging requests would either be appropriately referred to orthopaedics or for physiotherapy.

Case Study 2: Strong clinical engagement that brings real added value to the contract development and management with NWLHT Hospitals

CCG name: NHS Harrow CCG		
Case study title: Strong clinical engagement that brings real added value to the contract development & management with NWLHT Hospitals		
CCG case study number:	2 of 4	**Word length for this case study** 790 of 2947
Does the case study provide core evidence?	Yes	**If yes, state domain criteria by deleting as appropriate:** 1.1, 2.2, 3.2, 3.3, 4.3.1, 5.1, 6.1, 6.2
Does the case study provide supplementary evidence?	Yes	**If yes, state for which domain criteria:** 3.1.2.B, 3.3.B, 4.2.1.E

Patient groups	**Please tick all relevant:**
• Mothers and newborns	✓
• People with need for support with mental health	
• People with learning disabilities	
• People who need emergency and urgent care	✓
• People who need routine operations	✓
• People with long-term conditions	✓
• People at the end of life	
• People with continuing healthcare needs	

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1. Context

1.1. Until 2011 provider contract negotiations and monitoring took place without clinical input. To address the gap, CCG clinicians from Harrow and Brent partnered with the Acute Contracting Vehicle (ACV) to provide clinical leadership and input into contract negotiations with the ACV and Clinical leadership in monitoring of the NWLH contract through the Clinical Quality Group (CQG) This involved twice weekly contract meetings from October 2011 to April 2012, resulting in an agreed contract with North West London Hospitals Trust (NWLHT) for 2012-13, including clinical quality performance indicators (KPIs) and CQUINs.

1.2. CQG meets monthly and is led by two CCG clinicians and attended by NWLHT representatives and the ACV to monitor, review and challenge the provider's clinical performance against all national standards, national, regional and local CQUIN's. For example areas of focus that have resulted in significant quality and patient experience improvements are:

- Maternity indicators
- HCAI rates
- The A&E patient pathway
- A&E discharge letters – to achieve acceptable quality standards the clinicians advised issuing of a performance notice due to unacceptable performance and recommendations to improve the pathway leading to an improvement in the quality of these summaries.

1.3. Member practices are aware of the meetings and feed into these meetings via the CCG clinical leads or an alert system set up in Harrow CCG for member practice GPs to raise concerns they are made aware of by patients and others. This has been invaluable in identifying trends across the health economy that may previously have gone unnoticed.

2. Action

2.1 The clinical input provided by Harrow CCG was pivotal in developing the agreed CQUINs based on clinical effectiveness and focused on measuring clinical outcomes.

2.2 The ACV was successful in negotiating a block contract with the acute provider for 2012/13 to ensure financial stability in the system. When discussions commenced there was an affordability gap in excess of £70 million. Clinical discussions focussed on Harrow's Out of Hospital strategy and plans to deliver services in the community using alternative clinical pathways. These clinical discussions were a significant lever in agreeing a block contract at 8.1% lower than the 2011/12 outturn. The full effects of Harrow's QIPP schemes were accounted for in this position.

2.3 Clinical feedback from practices, peer groups, CCG leads and the CQG identified there were issues impacting on the quality and safety of services. The involvement of clinicians resulted in improved discussions on quality because of their knowledge informed by feedback they receive on a day to day basis from patients. Via CQG, the specific qualities issued addressed were:

- Access to maternity services: - NWLHT provided a plan to meet targets relating to consultant cover and access to midwives.
- A&E targets not being met: - NWLHT report on their A&E targets monthly, clinical discussions focus on improving these targets.
- GPs not receiving A&E discharge letters: - NWLHT implemented plans to address this issue. GPs now receive timely discharge letters.
- Hospital infections: - NWLHT have reduced their rates of C difficile infection.
- Service alert forms from GPs to feedback issues of quality to the CCG, who subsequently raise these with the CQG after careful scrutiny.

3. Impact

3.1 Maternity services - Clinical and managerial commissioners are working together to hold NWLHT to account for the delivery of safe maternity services and have requested assurance plans to ensure that appropriate staffing levels are implemented and sustained, including 1:1 care in labour and consultant hours on the labour ward.

3.2 The block contract with the provider- The affordability gap was reduced, all parties agreed a contract value of £233 million. A further £10 million was agreed to be included into the block contract to support a number of business cases for the Trust to achieve improvements in the emergency pathway. The block contract was agreed by clinicians and managers as a workable solution to mitigate risks and augment joint working on the out of hospital strategy and the NWL service reconfiguration aimed at redesigning and improving care pathways.

3.3 Clinical involvement and taking on key leadership roles in contracting is supporting Harrow's clinical leadership strategy.

3.4 The CCG has been instrumental in challenging the provider on areas such as inappropriate coding. The successful challenges are expected to yield £2.675m in 2011/12.

3.5 Over 150 GP clinical hours have gone into extensive contract negotiations and monthly CQG meetings. The commitment level of the CCG lead clinicians has been unprecedented in Harrow.

4. Summary

4.1 The vital involvement of clinical commissioners working with providers in the ACV and CQG has been invaluable in ensuring an equal focus on patient quality, safety and finance. It has resulted in issues being addressed that in the past were not successfully brought to a conclusion.

Case Study 3: Setting up the development of Harrow Peer Groups

CCG name: NHS Harrow CCG		
Case study title: Setting up the development of Harrow Peer Groups		
CCG case study number:	*3* of 4	**Word length for this case study** 743 of 2947
Does the case study provide core evidence?	Y	**If yes, state domain criteria by deleting as appropriate:** 1.1, 1.2, 2.2, 3.2, 3.3, 4.2.1, 4.3.1, 6.1, 6.2
Does the case study provide supplementary evidence?	Y	**If yes, state for which domain criteria:** 1.1.B

Patient groups	**Please tick all relevant:**
• Mothers and newborns	✓
• People with need for support with mental health	✓
• People with learning disabilities	
• People who need emergency and urgent care	✓
• People who need routine operations	
• People with long-term conditions	✓
• People at the end of life	✓
• People with continuing healthcare needs	✓

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1) Context: • **Why did you do it?** • **Who was involved?** • **When?** **2) Action** • **What did you do?** • **How did you do it?** **3) Impact**	

1. Context

1.1. At the centre of the development of Clinical Commissioning, is the need for GP CCG Board members to be able to have an on-going dialogue with its member practices. As a result in August 2011, six Peer groups were developed across Harrow involving all practices and embedding clear two-way accountability for the elected leads and GPs across the area.

Since their inception, these Peer Groups continue to enable various items to be communicated and developed, of which 3 are described below.

2. Actions

2.1 Development of effective working within Peer Groups - There was recognition that communication between GPs in their role as members of a commissioning organisation were felt to be key. A current Pathfinder LES utilises £1 per head to fund monthly attendance to these geographically aligned groups.

Meaningful participation is encouraged through:

- The use of nominated GP practice leads who consistently attended.
- Clinical leaders from the CCG governing body, chair their own peer groups, enabling direct access and regular dialogue between every practice in the CCG membership with the governing body.
- Minutes and actions are closely monitored within each Peer Group and centrally.
- Agenda items are centrally agreed by the CCG Board
- utilisation of external facilitators to ensure Peer Groups are aware and see in action their role as part of the Governing Body.
- Sense checking developments such as new LES schemes and the Integrated care pilots prior to Governing Body sign off.
- Active participation of practice managers and practice staff, strengthening the base of commissioning to the entire practice.
- Putting the clinical focus into developing quality services.
- Involvement of aligned Prescribing Advisors (PA) into each Peer Group

2.2 Ownership of Delegated Budgets and QIPP

- Delegated Budget lines of activity are monitored monthly, resulting in changes in behaviour of physiotherapy referrals and encouraging the use of home exercise programmes.
- Harrow GPs are developing an increased awareness of QIPP lines.
- Monthly review of budgets broken down by peer group and practice are shared across the group in a way that is safe and challenging.
- The development of service alert forms are providing documentation and the ability to highlight safety and commissioning issues with Providers.
- Introduction of ScriptSwitch

2.3 Challenge and change of referral practices

- Peer group Involvement in District Nurse service redesign and holding the Provider to account for the service.

- Promotion of new services such as admission avoidance schemes with on-going feedback of development (STARRS) to drive quality care
- On-going audits of referrals with sharing and analysis of pathways to shape higher quality and more appropriate referral s.
- Development of practice such as utilising planned review for frequent attenders, improved care planning for carers where complex patients frequently attend A&E and utilisation of early review for COPD patients.

3. Impact

3.1 Peer groups contribute to a high level of practice engagement in the emerging CCG agenda. This includes:

- shared understanding of the financial challenge for Harrow through delegated budgets and to the whole CCG budget.
- member practices are involved in decision making e.g. ownership of the prescribing agenda and development of ScriptSwitch. Through a dedicated prescribing LES and strong involvement at peer group level, practices collectively delivered an underspend of £356,000 in the prescribing budget by March 2012.
- Excellent engagement in transformational projects such as ICP, providing 100% sign up to projects and attendance at role out events e.g. DMARDs training sessions.
- Widespread support for the CCG leadership as a result of effective two way communication.
- A shared vision on the care for the people of Harrow – the right services, delivered at the right time by the right people.
- An ability for the CCG to harness day to day clinical encounters to shape the commissioning of services e.g. district nurse redesign and on-going holding of the service to account.
- Awareness at Governing Body level of the variation of communities within each peer group e.g. variation in antenatal booking dates and a mechanism for adapting practice behaviour by promoting use of CAB for antenatal bookings.
- Ability to hear individual patient stories to inform and affect decision making e.g. review of Community services impacting of service design in Audiology.
- Service alert forms act as evidence for ACV challenges and to inform CQUINs in contracting rounds.
- Ability to deliver significant, in budget delegated budgets prescribing savings in an area which was previously felt to be exhausted by other means

3.2 A regular review of Peer Groups at the Governing Body ensures appropriate learning and organisational development to take place.

Case Study 4: Introducing our patients, communities and stakeholders to the vision of the CCG

CCG name: NHS Harrow CCG		
Case study title: Introducing our patients, communities and stakeholders to the vision of the CCG.		
CCG case study number:	4 of 4	**Word length for this case study** 829 of 2947
Does the case study provide core evidence?	Y	**If yes, state domain criteria by deleting as appropriate:** 2.2, 2.3, 4.2.1, 4.3.1, 6.1, 6.2
Does the case study provide supplementary evidence?	Y	**If yes, state for which domain criteria:** 1.1.A

Patient groups	**Please tick all relevant:**
• Mothers and newborns	✓
• People with need for support with mental health	✓
• People with learning disabilities	✓
• People who need emergency and urgent care	✓
• People who need routine operations	✓
• People with long-term conditions	✓
• People at the end of life	✓
• People with continuing healthcare needs	✓

Description:	*This is the section for which the word limit applies*
1) Context: • **Why did you do it?** • **Who was involved?** • **When?** **2) Action** • **What did you do?** • **How did you do it?** 3) **Impact**	

1. Context

1.1. *Why?* - The CCG is passionate about making a real positive difference to the way it commissions health services to the local population. Communication and engagement

with all its respective stakeholders is key to the success of the CCG.

1.2. *Who?* – More than 20 individual GPs, 5 practice managers, staff from the CCG team, other clinicians and representatives from patient, professional, voluntary, community and third sector groups.

1.3. *When?* – Since establishment in shadow form in March 2011, the CCG has overseen and executed a number of activities to develop robust stakeholder engagement, two of which are described below.

2. Actions

2.1. *What?* - **Establishment of CCG Communications Working Group**

2.2. *How?* - Harrow CCG has mobilised a group to plan, monitor and develop stakeholder engagement, aligned to the vision of effective partnership working across the borough. The group meets weekly for an hour and is led by the Vice Chair of the CCG and the lay member, who covers PPI. Membership includes the GP Stakeholder Engagement Officers, Head of Communication and Chair of Harrow LINk.

2.3. This group has the overarching responsibility for developing and maintaining an effective and committed approach to engage all necessary parties who are linked to the work of the CCG, including patients, practices, voluntary organisations and other associated groups amongst Harrow's diverse and ethnically vibrant population. The group produce the CCG's communication and engagement strategy, which was well received by Harrow LINKs and the Local Authority.

2.4. *What?* - **Stakeholder Engagement Event: NHS reforms; what do they mean for Harrow.**

2.5. *How?* - Under the direction of the communications working group, the CCG arranged and delivered a unique stakeholder engagement event on 19th June, 2012 to introduce the CCG to the local community and explain what clinical commissioning means for the borough. An extensive marketing campaign was launched, including using various patient groups and the LINk network. The invitation and an informative flyer on the CCG (who they are, what they do, and their vision) was sent out to numerous stakeholders in Harrow. The event was attended by over 100 people representing the community. The event commenced with an address from the CCG Chair on the CCG's vision, strategy and clinical priorities.

2.6. The keynote address was followed by smaller roundtable discussions each led by a CCG member. The topics covered included Harrow's out of hospital strategy, the Health and Wellbeing strategy and various commissioning areas (ranging from 111 services to Mental Health), which the CCG will be responsible for from April 2013. Every attendee was given an opportunity to engage with the CCG on areas which mattered to them, give feedback on the CCG's vision/strategy and also network with fellow participants.

3. Impact

3.1. *Impact of establishing the CCG Communications Working Group* - The group manage/co-ordinate all stakeholder engagement activity. As a result, CCG leads engage well with stakeholders including visits to the Harrow 'Rethink Support Group', a presentation at National Carers Week in June and a well-received Q&A session with over 120 patients in Pinner in July to discuss the future of the NHS. The communications and engagement strategy provides the pathway for successful engagement and has mapped a clear and defined route into the heart of Harrow.

3.2. *Impact of the Stakeholder Engagement Event* - The stakeholder event reflected an optimistic outlook for clinical commissioning and a willingness to engage with a broad spectrum of stakeholders across the borough. Feedback collated shows unanimous positivity, that stakeholders feel the CCG is willing to engage. Some of the views which resonated from attendees:

"I will take away the fact that people in charge of patient health are genuinely looking for ways to interact with the general public."

"Harrow CCG are ready to listen to what the people of Harrow need."

Feedback collated has been unanimously positive. From a total of 53 feedback forms received, attendees have scored the CCG highly on a scale of 1-6, in areas of usefulness, opportunity to feedback and interaction. The average score has been a positive rating of 4.6

3.3. A post event report was circulated to all attendees and those who are on the CCG's stakeholder register. The report, along with a list of actions arising from the discussions was presented at the first CCG Board meeting held in public. Along with this report, the Out of hospital strategy has been circulated for feedback and comments. Stakeholders have also been asked to add their names to a CCG newsletter circulation list which will be used to keep them abreast of future developments. The CCG has learnt Harrow's stakeholders want to be heard –there is overwhelming feedback that stakeholders appreciate the opportunity to contribute and would like to see similar events in the future. Hence another event has been planned for spring 2013 to allow further engagement and opportunity for the CCG to reach out to the wider community. In conclusion, the CCG's engagement strategy lays out the platform for future progression and effective communication.